STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: _____ B. WING _____	R-C 11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation from 11/06/19 to 11/08/19 and 11/12/19 to 11/14/19 with an exit via telephone on 11/15/19. The complaint investigations were initiated by the Forsyth County Department of Social Services on 10/01/19 and 10/04/19.	D 000		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule	D 188		

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D 188	Continued From page 1 .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Assisted Living (AL) unit for 27 of 90 shifts sampled for 30 days in May 2019, August 2019, and September 2019. The findings are: Review of the facility's 2019 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living with a capacity of 52 beds and a Special Care Unit (SCU) with a capacity of 48 beds. Review of the Resident Bed List Report dated 05/03/19 revealed: -There was a census of 47 residents in the AL unit, which required 28 staff hours on second shift.	D 188		

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-There was a SCU census of 43 residents, which required 43 staff hours on second shift.
-There should have been a total of 71 hours between the AL unit and SCU on second shift.

Review of the Employee Time Detail dated 05/03/19 revealed:
-There were 52.0 total staff hours provided on second shift between the AL unit and SCU.
-There was a shortage of 19 hours.
-It could not be determined how many of the 52.0 total staff hours were worked in the AL unit on second shift.

Review of the Resident Bed List Report dated 05/04/19 revealed:
-There was a census of 48 residents in the AL unit, which required 28 staff hours on first shift.
-There was a SCU census of 43 residents, which required 43 staff hours on first shift.
-There should have been a total of 71 aide hours between the AL unit and SCU on first shift and second shifts

Review of the Employee Time Detail dated 05/04/19 revealed:
-There were 59 total staff hours provided on first shift between the AL unit and SCU.
-There was a shortage of 12 staff hours.
-It could not be determined how many of the 59 total staff hours were worked in the AL unit on first shift.

Review of the Employee Time Detail dated 05/04/19 revealed:
-There were 49.75 total staff hours provided on second shift between the AL unit and SCU.
-There was a shortage of 21.75 staff hours.
-It could not be determined how many of the 49.75 total staff hours were worked in the AL unit

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D 188	Continued From page 3 on second shift. Review of the Resident Bed List Report dated 05/05/19 revealed: -There was a census of 47 residents in the AL unit, which required 28 staff hours on first shift. -There was a SCU census of 43 residents, which required 43 staff hours on first shift. -There should have been a total of 71 staff hours between the AL unit and SCU on first shift and second shift. Review of the Employee Time Detail dated 05/05/19 revealed: -There were 51 total staff hours provided on first shift between the AL unit and SCU. -There was a shortage of 20 staff hours. -It could not be determined how many of the 51 total staff hours were worked in the AL unit on first shift. Review of the Employee Time Detail dated 05/05/19 revealed: -There were 42.25 total staff hours provided on second shift between the AL unit and SCU. -There was a shortage of 28.75 staff hours. -It could not be determined how many of the 42.25 total staff hours were worked in the AL unit on second shift. Review of the Resident Bed List Report dated 08/18/19 revealed: -There was a census of 48 residents in the AL unit, which required 28 staff hours on second shift. -There was a SCU census of 39 residents, which required 39 staff hours on second shift. -There should have been a total of 67 staff hours between the AL unit and SCU on second shift.	D 188		

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Review of the Employee Time Detail dated 08/18/19 revealed:
-There were 55 total staff hours provided on second shift between the AL unit and SCU.
-There was a shortage of 12 staff hours.
-It could not be determined how many of the 55 total staff hours were worked in the AL unit on second shift.

Review of the Resident Bed List Report dated 08/19/19 revealed:
-There was a census of 48 residents in the AL unit, which required 28 staff hours on second shift.
-There was a SCU census of 39 residents, which required 39 staff hours on second shift.
-There should have been a total of 67 staff hours between the AL unit and SCU on second shift.

Review of the Employee Time Detail dated 08/19/19 revealed:
-There were 48.25 total staff hours provided on second shift between the AL unit and SCU.
-There was a shortage of 18.75 staff hours.
-It could not be determined how many of the 48.25 total staff hours were worked in the AL unit on second shift.

Review of the Resident Bed List Report dated 08/20/19 revealed:
-There was a census of 48 in the AL unit, which required 28 staff hours on second shift.
-There was a SCU census of 39 residents, which required 39 staff hours on second shift.
-There should have been a total of 67 staff hours between the AL unit and SCU on second shift.

Review of the Employee Time Detail dated 08/20/19 revealed:
-There were 49.5 total staff hours provided on

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second shift between the AL unit and SCU.
-There was a shortage of 17.5 staff hours.
-It could not be determined how many of the 49.5 total staff hours were worked in the AL unit on second shift.

Review of the Resident Bed List Report dated 08/20/19 revealed:
-There was a census of 48 residents in the AL unit, which required 16 staff hours on third shift.
-There was a SCU census of 39 residents, which required 31.2 staff hours on third shift.
-There should have been a total of 47.2 staff hours between the AL unit and SCU on third shift.

Review of the Employee Time Detail dated 08/20/19 revealed:
-There were 45.5 total staff hours provided on third shift between the AL unit and SCU.
-There was a shortage of 1.7 staff hours.
-It could not be determined how many of the 45.5 total staff hours were worked in the AL unit on third shift.

Review of the Resident Bed List Report dated 08/21/19 revealed:
-There was a census of 48 residents in the AL unit, which required 28 staff hours on second shift.
-There was a SCU census of 39 residents, which required 39 staff hours on second shift.
-There should have been a total of 67 staff hours between the AL unit and SCU unit on second shift.

Review of the Employee Time Detail dated 08/21/19 revealed:
-There were 57.5 total staff hours provided on second shift between the AL unit and SCU.
-There was a shortage of 9.5 staff hours.

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-It could not be determined how many of the 57.5 total staff hours were worked in the AL unit on second shift.

Review of the Resident Bed List Report dated 08/22/19 revealed:
-There was a census of 48 residents in the AL unit, which required 16 staff hours on third shift.
-There was a SCU census of 39 residents, which required 31.2 staff hours on third shift.
-There should have been a total of 47.2 staff hours between the AL unit and SCU on third shift.

Review of the Employee Time Detail dated 08/22/19 revealed:
-There were 38.5 total staff hours provided on third shift between the AL unit and SCU.
-There was a shortage of 8.7 staff hours.
-It could not be determined how many of the 38.5 total staff hours were worked in the AL unit on third shift.

Review of the Resident Bed List Report dated 08/23/19 revealed:
-There was a census of 48 residents in the AL unit, which required 28 staff hours on second shift and 16 staff hours on third shift.
-There was a SCU census of 40 residents, which required 40 staff hours on second shift and 32 staff hours on third shift.
-There should have been a total of 68 staff hours between the AL unit and SCU on second shift.
-There should have been a total of 48 staff hours between the AL unit and SCU on third shift.

Review of the Employee Time Detail dated 08/23/19 revealed:
-There were 57.75 total staff hours provided on second shift between the AL unit and SCU.
-There was a shortage of 9.25 staff hours.

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-It could not be determined how many of the 57.75 total staff hours were worked in the AL unit on second shift.

Review of the Employee Time Detail dated 08/23/19 revealed:
-There were 46.5 total staff hours provided on third shift between the AL unit and SCU.
-There was a shortage of 1.5 staff hours.
-It could not be determined how many of the 46.5 total staff hours were worked in the AL unit on third shift.

Review of the Resident Bed List Report dated 08/24/19 revealed:
-There was a census of 48 residents in the AL unit, which required 28 staff hours on second shift and 16 staff hours on third shift.
-There was a SCU census of 39 residents, which required 39 staff hours on second shift and 31.2 staff hours on third shift..
-There should have been a total of 67 staff hours between the AL unit and SCU on second shift.
-There should have been a total of 47.2 hours between the AL unit and SCU on third shift.

Review of the Employee Time Detail dated 08/24/19 revealed:
-There were 60 total staff hours provided on second shift between the AL unit and SCU.
-There was a shortage of 7 staff hours.
-It could not be determined how many of the 60 total staff hours were worked in the AL unit on second shift.

Review of the Employee Time Detail dated 08/24/19 revealed:
-There were 39.5 total staff hours provided on third shift between the AL unit and SCU.
-There was a shortage of 7.7 staff hours.

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D 188	Continued From page 8 -It could not be determined how many of the 39.5 total staff hours were worked in the AL unit on third shift. Review of the Resident Bed List Report dated 08/25/19 revealed: -There was a census of 48 residents in the AL unit, which required 28 staff hours on first shift and second shift and 16 staff hours on third shift. -There was a SCU census of 39 residents, which required 39 staff hours on first shift, 39 staff hours on second shift and 31.2 staff hours on third shift.. -There should have been a total of 67 staff hours between the AL unit and SCU on first shift, a total of 67 hours between the AL unit and SCU on second shift and a total of 47.2 hours between the AL unit and SCU on third shift.. Review of the Employee Time Detail dated 08/25/19 revealed: -There were 60.75 total staff hours provided on first shift between the AL unit and SCU. -There was a shortage of 6.25 staff hours. -It could not be determined how many of the 60.75 total staff hours were worked in the AL unit on first shift. Review of the Employee Time Detail dated 08/25/19 revealed: -There were 64.25 total staff hours provided on second shift between the AL unit and SCU. -There was a shortage of 2.75 staff hours. -It could not be determined how many of the 64.25 total staff hours were worked in the AL unit on second shift. Review of the Employee Time Detail dated 08/25/19 revealed: -There were 44 total staff hours provided on third	D 188		

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shift between the AL unit and SCU.
-There was a shortage of 3.2 staff hours.
-It could not be determined how many of the 44 total staff hours were worked in the AL unit on third shift.

Review of the Resident Bed List Report dated 08/30/19 revealed:
-There was a census of 49 residents in the AL unit, which required 16 staff hours on third shift.
-There was a SCU census of 39 residents, which required 31.2 staff hours on third shift.
-There should have been a total of 47.2 hours between the AL unit and SCU on third shift.

Review of the Employee Time Detail dated 08/30/19 revealed:
-There were 49.5 total staff hours provided on third shift between the AL unit and SCU.
-There was a shortage of 5.7 staff hours.
-It could not be determined how many of the 49.5 total staff hours were worked in the AL unit on third shift.

Review of the Resident Bed List Report dated 09/02/19 revealed:
-There was a census of 47 residents in the AL unit, which required 24 staff hours on third shift.
-There was a SCU census of 40 residents, which required 32 staff hours on third shift.
-There should have been a total of 56 staff hours between the AL unit and the SCU on third shift.

Review of the Employee Time Detail dated 09/02/19 revealed:
-There were 47.50 total staff hours provided on third shift between the AL unit and the SCU.
-There was a shortage of 8.50 aide hours.
-It could not be determined how many of the 47.50 total staff hours worked were worked in the

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D 188	Continued From page 10 AL unit on third shift. Review of the Resident Bed List Reports revealed: -On 09/03/19, there was a census of 47 residents in the AL unit, which required 24 hours on third shift. -There was a SCU census of 39 residents, which required 31.2 hours on third shift. -There should have been a total of 55.2 hours between the AL unit and the SCU on third shift. Review of the Employee Time Detail reports revealed: -On 09/03/19, there were 45.25 total staff hours provided on third shift between the AL unit and the SCU. -There was a shortage of 9.95 aide hours. -It could not be determined how many of the 45.25 total staff hours worked were worked in the AL unit on third shift. Review of the Resident Bed List Reports revealed: -On 09/06/19, there was a census of 47 residents in the AL unit, which required 28 hours on second shift. -There was a SCU census of 38 residents, which required 38 hours on second shift. -There should have been a total of 66 hours between the AL unit and the SCU on second shift. Review of the Employee Time Detail reports revealed: -On 09/06/19, there were 58.25 total staff hours provided on second shift between the AL unit and the SCU. -There was a shortage of 8.75 aide hours. -It could not be determined how many of the 57.25 total staff hours worked were worked in the	D 188		

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D 188	Continued From page 11 AL unit on second shift. Review of the Resident Bed List Report dated 09/07/19 revealed: -There was a census of 48 residents in the AL unit which required 28 hours on first shift. -There was a SCU census of 38 residents, which required 38 hours on first shift. -There should have been a total of 66 hours between the AL unit and the SCU on first shift. -There was a census of 48 residents in the AL unit which required 28 hours on second shift. -There was a SCU census of 38 residents, which required 38 hours on second shift. -There should have been a total of 66 hours between the AL unit and the SCU on second shift. -There was a census of 48 residents in the AL unit which required 24 hours on third shift. -There was a SCU census of 38 residents, which required 30.4 hours on third shift. -There should have been a total of 54.4 hours between the AL unit and the SCU on third shift. Review of the Employee Time Detail dated 09/07/19 revealed: -There were 63.25 total staff hours provided on first shift between the AL unit and the SCU. -There was a shortage of 2.75 aide hours. -It could not be determined how many of the 63.25 total staff hours worked were worked in the AL unit on first shift. -There were 49.25 total staff hours provided on second shift between the AL unit and the SCU. -There was a shortage of 16.75 aide hours. -It could not be determined how many of the 49.25 total staff hours worked were worked in the AL unit on second shift. -There were 41 total staff hours provided on third shift between the AL unit and the SCU. -There was a shortage of 13.4 aide hours.	D 188		

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-It could not be determined how many of the 41 total staff hours worked were worked in the AL unit on third shift.

Review of the Resident Bed List Report dated 09/19/19 revealed:
-There was a census of 48 residents in the AL unit which required 24 hours on third shift.
-There was a SCU census of 38 residents, which required 30.4 hours on third shift.
-There should have been a total of 54.4 hours between the AL unit and the SCU on third shift.
-There was a census of 48 residents in the AL unit which required 28 hours on second shift.
-There was a SCU census of 38 residents, which required 38 hours on second shift.
-There should have been a total of 66 hours between the AL unit and the SCU on second shift.

Review of the Employee Time Detail dated 09/19/19 revealed:
-There were 44.75 total staff hours provided on third shift between the AL unit and the SCU.
-There was a shortage of 9.65 aide hours.
-It could not be determined how many of the 44.75 total staff hours worked were worked in the AL unit on third shift.

Review of the Resident Bed List Report dated 09/20/19 revealed:
-There was a SCU census of 38 residents, which required 38 hours on second shift.
-There was a census of 48 residents in the AL unit which required 28 hours on second shift.
-There should have been a total of 66 hours between the SCU and the AL unit on second shift.

Review of the Employee Time Detail dated 09/20/19 revealed:
-There were 63.25 total staff hours provided on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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second shift between the AL unit and the SCU.
-There was a shortage of 20.75 aide hours.
-It could not be determined how many of the 63.25 total staff hours worked were worked in the AL unit on second shift.

Review of the Resident Bed List Report dated 09/21/19 revealed:
-There was a census of 48 residents in the AL unit which required 28 hours on first shift.
-There was a SCU census of 38 residents, which required 38 hours on first shift.
-There should have been a total of 66 hours between the AL unit and the SCU on first shift.
-There was a census of 48 residents in the AL unit which required 28 hours on second shift.
-There was a SCU census of 38 residents, which required 38 hours on second shift.
-There should have been a total of 66 hours between the AL unit and the SCU on second shift.

Review of the Employee Time Detail dated 09/21/19 revealed:
-There were 56 total staff hours provided on first shift between the AL unit and the SCU.
-There was a shortage of 10 aide hours.
-It could not be determined how many of the 56 total staff hours worked were worked in the AL unit on first shift.
-There were 51.5 total staff hours provided on second shift between the AL unit and the SCU.
-There was a shortage of 14.5 aide hours.
-It could not be determined how many of the 51.5 total staff hours worked were worked in the AL unit on second shift.

Interview with a Personal Care Aide (PCA) on 11/06/19 at 4:30am revealed:
-There were routinely 2 PCAs working on the AL unit during the third shift.

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-There was a medication aide (MA) in the SCU and in the AL unit some nights.
-If there were not 2 MAs working, the MA went back and forth between the SCU and the AL unit.
-The PCAs in the AL unit did not routinely assist in the SCU during the third shift.

Interview with a MA on 11/06/19 at 4:40am revealed:
-She was the only MA working on the third shift on 11/06/19.
-A second MA was scheduled but called out.
-She spent time in the SCU and in the AL and was responsible to administer medications to residents in both units during third shift.

Interview with another PCA on 11/14/19 at 1:33pm revealed:
-She worked first shift in the SCU and the AL unit.
-There were usually 2 MAs and 3 to 4 PCAs on 1st shift.
-On the AL unit, there were 2 MAs and 2 PCAs or 1 MA and 3 PCAs.
-If staff called out of work, most of the time that staff was not replaced during the shift.
-It was sometimes difficult to provide care for residents and complete all assigned tasks which included 15-minute and 30-minute checks on some residents, passing 2 snacks during her shift, taking residents out for 3 smoke breaks, setting up for lunch, in addition to bathing, dressing, toileting, and 2-hour resident checks.

Interview with the Resident Care Coordinator (RCC) on 11/14/19 at 4:25pm revealed:
-There were 1 MA and 3 PCAs scheduled to work in the AL unit on first, second, and third shifts.
-There were 1 MA and 5 PCAs scheduled to work in the SCU on 1st and second shifts and 1 MA (for both sides) and 4 PCAs in the SCU on third

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shift.
-The Administrator was responsible for creating a monthly schedule and she filled in staff names on the schedule if it was given to her incomplete.
-The facility policy was for staff who were calling out to call at least 4 hours prior to the start of their shift.
-The RCC and the SCU Coordinator were responsible for finding staff to fill in for shifts when there was a call out.
-The RCC and the SCU Coordinator were responsible for filling in on a shift until staff arrived when there was a call out.
-If the RCC or the SCU Coordinator was unable to find staff to fill in on a shift, they were responsible for working that shift.
-She did not know of any shifts that were short staffed.

Interview with the Administrator on 11/14/19 at 5:31pm revealed:
-She determined the rotations and created the monthly schedule for staff.
-She scheduled staff at the minimum to meet the number of residents.
-She staffed over the minimum when she was able to do so.
-She did not know of any days the facility was understaffed since she had been the Administrator.
-She did not know if the facility was understaffed in May 2019 as she was not the Administrator at that time.
-She usually staffed the AL unit with at least 1 Medication Aide (MA) and 3 PCAs on 1st and 2nd shifts, but she preferred to staff the AL side with 2 MAs and 2 PCAs.
-She usually staffed the AL side with 2 PCAs and shared the MA with the SCU on 3rd shift.
-She usually staffed the SCU with 1 MA and 5

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D 188	Continued From page 16 PCAs on 1st and 2nd shift, but she preferred 2 MAs and 4 PCAs on 1st and 2nd shifts in the SCU. -She usually staffed the SCU with 1 MA and 4 PCAs on 3rd shift, but she preferred 1 MA on each side. -She expected staff to inform management if someone called out or did not show up for their shift. -Sometimes staff did not contact management if staff did not show up for their shift. -The RCC or herself would try to call in another staff if there was a known callout. -She knew there were staff who clocked into work late and took an hour break which caused that staff's scheduled shift to be less than 8 hours. [Refer to Tag 0338 10A NCAC 13F .0909 Residents Rights]. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision]. The facility failed to assure aide hours met the minimum requirements for a special care unit (SCU) and Assisted Living (AL) and staff on duty were present at all times for 27 of 90 sampled shifts for 30 days in May 2019, August 2019, and September 2019, resulting in a resident elopement without staff's knowledge and sustaining a fractured hip; a confused resident who consumed an unknown substance; two residents who displayed agitation and aggressive behaviors and physically abused other residents, and a resident with altercations and falls; a staff yelling at a resident, another staff hitting another resident; a resident was forced to sit in the hallway all day to maintain continuous oxygen and 7 residents receiving injuries and bruises after being hit by other residents. This failure was	D 188		

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D 188	Continued From page 17 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 11/08/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 30, 2019.	D 188		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 8 sampled resident (#19) received assistance with bathing according to the resident's care plan. The findings are: Review of Resident #19's current FL-2 dated 06/24/19 revealed:	D 269		

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D 269	Continued From page 18 -Diagnoses included hypertension, cerebrovascular accident (CVA) with aphasia, arthritis of knees, and osteopenia. -Resident #19 was constantly disoriented and was ambulatory with wheelchair. -Resident #19 was incontinent of bladder and bowel at times and needed assistance with bathing and dressing. Review of Resident #19's previous FL-2 dated 02/23/18 revealed: -Resident #19 was constantly disoriented and was ambulatory with wheelchair. -Resident #19 was incontinent of bladder and bowel at times and needed assistance with bathing and dressing. Review of Resident #19's current care plan dated 07/16/19 (assessed by the facility Administrator but not signed by the physician) revealed: -Resident #19 was ambulatory with a wheelchair, had occasional bowel incontinence and daily bladder incontinence and was always disoriented with significant memory loss. -Resident #19 needed extensive assistance with bathing and transfers. Observation of Resident #19 on 11/14/19 at 8:50 am revealed: -Resident #19 was sitting in her wheelchair in her room. -Resident #19 had difficulty communicating due to speech problems. -Resident #19 was dressed and was groomed. -There were no odors detected in the room or immediate area surrounding the resident. Telephone interview with Resident #19's family member (Power of Attorney) on 11/14/19 at 9:20am revealed:	D 269		

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D 269	Continued From page 19 -Staff did not give the resident a shower because the resident was dirty and stinky when the family member came to the facility.. -Staff told her Resident #19 refused to allow the staff to help her take a shower. -Resident #19 rolled her wheel chair to the bathroom, in her room, and sponge bathed herself. -It was "unacceptable" to not shower the resident. -The facility did not call the family member when the resident was refusing to take a shower, she would find out when she came to the facility. -The resident occasionally had body odor when the family member came to the facility. -The family member came to the facility every week and sometimes helped the resident sponge bathe. -The family member had assisted Resident #19 with a shower on a few occasions. -The family member felt the staff should find a way to assure the resident was bathed regularly. Review of the facility's personal care aide (PCA) assignment sheets revealed: -Resident #19 was listed for showers on Monday, Wednesday, and Friday. -Examples of documentation Resident #19 refused a shower were as follows: On 11/13/19, Wednesday was circled and "decline" was documented; on 11/11/19, Monday was circled and "decline" was documented; on 11/06/19, Wednesday was circled and "decline" was documented; on 11/04/19, Monday was circled and "decline" was documented; on 11/01/19, Friday was circled "decline" was documented; on 10/23/19, Wednesday was circled and "decline" was documented. Interview with a medication aide/Supervisor (MA/S) on 11/14/19 at 5:00pm revealed:	D 269		

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D 269	Continued From page 20 -Resident #19's speech was very hard to understand. -Staff reported to the MA/S when Resident #19 refused her shower. -Resident #19 cleaned herself by sponge bathing using the sink in her toilet room. She did not allow staff to assist. -The MA/S had told the resident's family member about Resident #19 refusing to allow staff to give her a shower. -The MA/S had not notified Resident #19's physician for the resident refusing baths. -PCAs documented refused showers and the MA/S was responsible to review and sign off on the PCA assignment sheets for completion of resident's care to assigned residents. Interview with the Resident Care Coordinator (RCC) on 11/14/19 at 5:20pm revealed: -She knew Resident #19 refused showers frequently. -The RCC had worked as a MA/S at the facility prior to recently becoming the RCC and Resident #19 had refused showers since she came to the facility. -Resident #19's family member was aware Resident #19 routinely refused to allow staff to assist with showing her. -Resident #19 routinely rolled herself into the bathroom in her room and gave herself a sponge bath. -Resident #19 did not want staff to assist her with the sponge bath. Interview with the Administrator on 11/14/19 at 5:30pm revealed: -She was aware Resident #19 refused showers. -The RCC was responsible to notifying the resident's family regarding the resident not receiving routine baths for assistance.	D 269		

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D 269	Continued From page 21 Telephone interview with a representative at Resident #19's primary care physician's office (PCP) on 11/15/19 at 4:45pm revealed: -Resident #19's family member had mentioned to the PCP that Resident #19 refused to take showers for the staff at the facility. -Resident #19 was last seen in the PCP's office in September 2019.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision according to residents' assessed needs and current symptoms for 5 of 9 sampled residents (#1, #4, #10, #11 and #13) including a resident who eloped from the Special Care Unit (SCU) without staff's knowledge, resulting in a fractured hip (#13), a confused resident who consumed an unknown substance (#11), two residents who displayed agitation and aggressive behaviors and	D 270		

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physically abused other residents (#4 and #10), and a resident with altercations and falls (#1).

The findings are:

1. Review of Resident #13's current FL2 dated 09/25/18 revealed:
-Diagnoses included dementia, chronic obstructive pulmonary disease, and hypertension.
-The resident was documented as disoriented intermittently.
-The recommended level of care was the Special Care Unit (SCU).

Review of Resident #13's care plan dated 10/02/18 revealed:
-Resident #13 resided in the SCU.
-The resident was documented as forgetful and needed reminders.

Review of Resident #13's previous hospital discharge summary report dated 09/18/18 revealed:
-Resident #13 was being discharged to an assisted living facility.
-The discharge recommendations included "24/7 supervision and full-time direct care" for cognitive deficits, mobility, safety, and activities of daily living.

Review of Resident #13's progress notes revealed:
-On 09/25/18 at 10:06pm Resident #13 was outside and did not want to come back inside. The resident was fighting staff to stay outside.
-On 10/11/18 at 10:21am Resident #13 constantly tried to leave the facility. The resident threatened to bust a window out to leave the facility.
-On 05/04/19 at 10:02pm during safety rounds in SCU, it discovered that Resident #13 was not in

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D 270	Continued From page 23 the SCU. Review of Resident #13's Accident/Incident report dated 05/04/19 revealed at 9:40pm SCU staff observed Resident #13 was not in his room. Review of the Emergency Medical Services (911) communication event report dated 05/04/19 at 11:07pm revealed: -The facility staff called and reported Resident #13 eloped. -Facility staff told the officer Resident #13 may fight them because he did not want to come back to the facility. -Facility staff told the officer Resident #13 had refused his 8:00pm "dementia medication." Review of hospital report dated 05/05/19 revealed: -Resident #13 was present at the hospital complaining of pain in his left leg. -The resident told the medical staff that using his walker, going over bricks and he lost his balance and fell. -Resident #13 was hospitalized for surgery related to the hip fracture. Observation of the SCU on 11/06/19 at 8:00am revealed: -The nurses' station was in the center of the main hallway. -The nurses' station and the residents' common sitting area were adjoined by a wall. -There was a window in the center of the wall with a view of the common sitting area. -There were patio doors in the common sitting area. -On the wall by the patio doors was a keypad to put in a code to exit the SCU through the patio. -There was a brick wall that was five feet or greater in height surrounding the patio.	D 270		

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D 270	Continued From page 24 -There was a black cast iron gate to enter and exit the enclosed patio area. -There was an alarm that sounded when the gate was opened. Interview with Resident #13's family member on 11/15/19 at 12:12pm revealed: -She was Resident #13's contact person. -She did not know Resident #13 had eloped from the facility. -A friend had seen the silver alert and called her. -Resident #13 had memory cognitive deficit and should not be allowed on the street without being supervised. -Resident #13 needed the supervision of a locked unit because he did not remember the current history. -Resident #13 used to live with his family member, the family member died six years ago, but Resident #13 thought the family member was still alive. Interview with the SCU medication aide-supervisor on 11/14/19 at 8:50am revealed: -Resident #13 previously resided in the SCU. -The SCU should always be locked. -Residents residing in the SCU should not be able to elope or get out without being accompanied by an appointed responsible person. -Resident #13 had always talked about going back to another state, where he used to live. -Resident #13 always threatened one day he was going to leave the facility by breaking out a window and exiting through the window. -A couple of times she observed Resident #13 banging on the windows attempting to break them out. -She was not on duty when Resident #13 eloped from the facility..	D 270		

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D 270	Continued From page 25 -The medication aide that was on duty told her that Resident #13 got out through the patio doors in the common sitting area. -The medication aide and two of the other staff that were on duty when Resident #13 eloped no longer worked at the facility. -The patio doors should always be locked. -Any staff exiting through the patio doors had to use a code to get in and out of the patio doors. -Only facility staff had the code to get in and out of the patio doors. -It was believed that Resident #13 eloped through the patio doors that were not locked. -The resident must have climbed the brick wall surrounding the patio to get out of the facility. -Resident #13's room was directly across from the sitting area with the patio doors. -Staff going in and out of the doors could have left the door open and allowed Resident #13 to get out of the unit. -The only way Resident #13 could have eloped without staff knowledge was that a staff left the door open. Resident #13 would have had to climb the brick wall to get out of the enclosed patio due to the alarm on the gate. Interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 3:23pm revealed: -She did not work at the facility when Resident #13 eloped. -The SCU was a locked unit. -A resident that resided in the SCU should not be able to leave the unit unless they were accompanied by a responsible person or a staff. Interview with the Administrator on 11/14/19 at 3:40pm revealed: -She was not the Administrator when Resident #13 eloped from the facility.	D 270		

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D 270	Continued From page 26 -The SCU was always supposed to be locked and residents that resided in the SCU unit should not be able to elope. Attempted interviews on 11/08/19, 11/12/19 and 11/15/19 with the personal care aide/medication aide that was working 05/04/19 when Resident #13 eloped were unsuccessful. 2. Review of Resident #10's current FL2 dated 05/08/19 revealed: -Diagnoses included dementia, anxiety, depression, and gastroesophageal reflux disease. -The resident was documented as intermittently disoriented. -The recommended level of care was Special Care Unit (SCU). Review of Resident #10's care plan dated 05/20/19 revealed: -Resident #10 resided in the SCU. -The resident had unspecified dementia without behavioral disturbance. -The resident had anxiety disorder due to known physiological condition. -The resident had significant memory loss and must be directed. -There was documentation in the social/mental history that Resident #10 had depression/anxiety/dementia. -There was documentation the resident wandered. -There was documentation the resident had a history of mental illness. -There was no documentation in the section titled "injurious to self, others, and property." Review of Resident #10's quarterly profiles revealed: -On 06/26/19, the profile was completed by the	D 270		

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Administrator.
-The Administrator documented cognitive impairment assessed change was "dementia." The intervention documented was staff assistance.
-The Administrator documented behavior pattern assessed change was "combative." The intervention used was staff monitoring.
-On 10/01/19, the profile was completed by the Administrator.
-The Administrator documented cognitive impairment assessed change was "dementia." The intervention documented was staff assistance.
-The Administrator documented the behavior pattern assessed change was combative. The intervention documented was staff monitoring.

Review of Resident #10's record revealed there was no documentation of staff monitoring Resident #10's behavior pattern.

a. Review of Resident #10's progress notes dated 07/28/19 revealed at 4:21pm, Resident #10 was agitated and combative.

Review of Resident #10's Accident/Incident report dated 07/28/19 revealed:
-At 4:07 pm, Resident #10 was observed going in and out of other residents' rooms and appeared to be agitated. Staff was going to monitor the resident for 72 hours and document in the progress notes daily from 07/30/19 to 08/02/19.

Review of 911 communication log reports for Resident #10 dated 07/28/19 revealed at 3:03 pm, Resident #10 was being aggressive yelling at other residents. The resident was transported to the hospital.

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D 270	Continued From page 28 Interviews with a personal care aide 11/14/19 at 5:21pm revealed: -Resident #10 would go in and out of other residents' rooms and tell the residents to get out of his house. -Resident #10 yelled at residents' all the time. -She tried to watch Resident #10 more frequently. -If she did not see Resident #10 every thirty minutes she had to go see where he was at. -There was no documentation showing how often they monitored Resident #10. -Resident #10 frequently tried to put residents out of their rooms. -The PCAs stated they frequently checked on residents with aggressive behaviors, falls or residents that were exit-seeking. Review of Resident #10's progress notes revealed: -On 07/31/19 at 2:00pm, Resident #10 attempted to climb the wall in the outdoor sitting area. -On 08/04/19 at 1:24pm Resident #10 was very aggressive and physical with residents. -On 08/06/19 at 2:31pm, Resident #10 became aggressive towards other residents. Staff unable to redirect the resident. -On 08/06/19 at 2:44pm Resident #10 was in another resident's room and refused to get out of bed. b. Review of Resident #10's progress notes dated 08/11/19 revealed at 11:23pm, Resident #10 pushed another resident causing him to fall. Review of Resident #10's Accident/Incident report dated 08/11/19 revealed at 8:20 pm, Resident #10 was upset with another resident. Resident #10 would be monitored for 72 hours and document in the progress notes daily from 08/11/19 to 08/14/19.	D 270		

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D 270	Continued From page 29 Review of Resident #10's record revealed no documentation Resident #10 was monitored from 08/11/19 to 08/14/19. Interviews with a personal care aide on 11/13/19 at 4:38pm revealed: -When Resident #10 had aggressive behaviors he needed more attention that required one-on-one supervision and some days that was not possible due to the attention needed by the other residents. -Three PCAs stated previously the facility had sheets where staff documented monitoring residents that were checked on frequently. c. Review of Resident #10's progress notes dated 09/02/19 revealed at 11:21 pm, Resident #10 was combative and trying to remove residents from their bed. Review of Resident#10's Accident/Incident report dated 09/02/19 revealed at 10:49pm, Resident #10 was observed going in and out of rooms, trying to hit other residents. Resident #10 would be monitored for 72 hours from 09/03/19 to 09/06/19. Review of Resident #10's record revealed no documentation Resident #10 was monitored from 09/03/19 to 09/06/19. Interviews with a personal care aide on 11/13/19 at 4:38 pm revealed: -All PCAs stated Resident #10 was often in altercations with other residents because he thought he owned the facility and would go into other residents rooms and yell at the residents to get out of his house. -The facility did not have a specific monitoring	D 270		

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plan but tried to keep an eye on Resident #10 every 10 to 30 minutes.

d. Review of Resident #10's progress notes dated 09/05/19 revealed at 2:10pm Resident #10 was combative towards another resident.

Review of Resident#10's Accident/Incident report dated 09/05/19 revealed at 9:15am, Resident #10 was being combative towards another resident. There was documentation the resident should be monitored for 72 hours.

Review of Resident #10's record revealed no documentation Resident #10 was monitored.

Interviews with a personal care aide on 11/14/19 at 2:15pm revealed:
-Resident #10 yelled at residents' all the time.
-Sometimes if she did not see Resident #10 for ten minutes she tried to find out where the resident was at.
-When Resident #10 had aggressive behaviors he needed more attention that required one-on-one supervision and some days that was not possible due to the attention needed by the other residents.

Interview with a medication aide supervisor in the SCU on 11/13/19 at 3:19pm revealed:
-Resident #10 went up and down the hallway and forced residents out of their room.
-This would cause the residents to fight back to try and keep their room.
-She tried to give Resident #10 an as-needed medication if "he was not too far gone".
-Some days she was able to talk Resident #10 out of the agitation.
-On the days she could not talk Resident #10 out of the agitation he was sent out to the hospital.

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-No training had been provided on how to handle residents with aggressive behaviors.
-On 09/05/19 Resident #10 was combative, and he went into residents' rooms and was hitting the residents. When staff tried to take him out of the room but he started swinging trying to hit staff.
-The facility's monitoring policy was after an incident, such as a fall or aggressive behavior the resident was monitored for 72 hours.
-The monitoring consisted of checking the resident's vital signs and documenting the vital signs.
-The vital signs was the 72 hour monitoring system that staff documented.
-If there was documentation for behaviors that were done on the computer matrix system.
-It was the facility's policy that staff had to visually see residents' at least every two hours.
-If the resident was exit seeking then staff checks were completed every thirty minutes.
-Staff had not been told to increase supervision on Resident #10.
-Staff "laid eyes" on Resident #10 at least every two hours.

e. Review of Resident #10's progress notes dated 09/13/19 revealed at 1:25pm, Resident #10 was in the dining room and pushed another resident, grabbed other residents' walkers and verbalized "everyone can get out." Resident #10 attempted to strike a resident that was sitting in a wheelchair.

Review of Resident #10's Accident/Incident report dated 09/13/19 revealed at 1:13 pm, Resident #10 was in the dining room and pushed another resident, grabbed other residents' walkers and verbalized "everyone can get out." Resident #10 attempted to strike a resident that was sitting in a wheelchair.

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D 270	Continued From page 32 Review of Resident #10's record revealed there was no documentation of Resident #10 was monitored. Interviews with a personal care aides on 11/14/19 at 2:15pm revealed: -Resident #10 yelled at residents' all the time. -She tried to watch Resident #10 more frequently. -If she did not see Resident #10 every thirty minutes she had to go see where he was at. -There was no documentation showing how often they monitored Resident #10. -When Resident #10 was aggressive he needed his medications. -Sometimes if she did not see Resident #10 for ten minutes she tried to find out where the resident was at. -She was not able to do this each time she worked. -When a resident exhibited aggressive behaviors and was harming another resident staff had to intervene. f. Review of Resident #10's Accident/Incident reports dated 10/20/19 revealed at 5:52pm, Resident #10 was observed combative and throwing items. Review of 911 communication log reports for Resident #10 dated 10/201/9 revealed at 5:21pm, "A male resident [Resident #10] was pouring hot liquid on people." Review of Emergency Medical Services (EMS) reports for Resident #10 revealed: -On 10/20/19 Resident #10 was violent and aggressive. Staff told EMS the resident "acts like that all time." Staff told EMS the resident wandered the halls and tried to take another	D 270		

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resident's oxygen from them. The supervisor told the staff to ensure the resident went to the hospital because "he has been worse than normal for a while now. "Having behavioral/psychiatric episodes with behavioral disturbance".

g. Review of the Resident #10's Accident/Incident reports dated 11/01/19 revealed at 1:20pm Resident #10 was observed in an altercation with another resident. The staff was to monitor the resident for 72 hours.

Review of Resident #10's record revealed no documentation of monitoring for 72 hours after the 11/01/19 incident.

Review of 911 communication log reports for Resident #10 dated 11/01/19 revealed at 1:40 pm, Resident #10 was in the day room being aggressive.

Interviews with a personal care aide on 11/15/19 at 11:15am revealed:
-She tried to watch Resident #10 more frequently.
-If she did not see Resident #10 every thirty minutes she had to go see where he was at.
-There was no documentation showing how often they monitored Resident #10.
-All PCAs stated Resident #10 was often in altercations with other residents because he thought he owned the facility and would go into other residents rooms and yell at the residents to get out of his house.
-Often times Resident #10 did strike other residents.
-When staff heard yelling they tried to intervene as soon as possible.
-Resident #10 was fast because he would hit another resident before staff got to him to stop

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him.
-The facility did not have a specific monitoring plan but tried to keep an eye on Resident #10 every 10 to 30 minutes.

h. Review of Resident #10's progress notes revealed:
-On 11/05/19 at 8:30am, Resident #10 was trying to force another resident out of her room. He pulled the resident out of the room and was trying to get into the room and lock the door.
-On 11/05/19 at 10:50am Resident #10 was in the dayroom and became agitated and punched another resident in the mouth. The resident that was punched in the mouth fell to the floor.

Review of Resident #10's Accident/Incident report dated 11/05/19 revealed at 10:50 am, Resident #10 was observed striking another resident in the mouth. The resident that was punched fell to the floor.

Review of Emergency Medical Services (911) communication log report for Resident #10 revealed on 11/05/15 at 10:53am, Resident #10 had violent and aggressive behaviors and refused medications. Resident #10 was transported to the hospital.

Review of Emergency Medical Services (EMS) reports for Resident #10 revealed on 11/05/19 at 11:10 am, Resident #10 was experiencing behavioral/psychiatric episodes.

Interviews with a personal care aide on 11/13/19 at 4:38pm, 5:15pm revealed:
-On 11/05/19 Resident #10 had altercations with three residents.
-One male resident was kicked very hard in the leg; a female resident was repeatedly hit hard in

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the back the sound echoed; and a third female resident was hit in the mouth and fell to the floor.

Interview with a personal care aide on 11/14/19 at 2:00pm revealed:
-On 11/05/19 a resident was sleeping and Resident #10 hit the resident three times very hard in the back.
-Then Resident #10 pushed another resident to the floor.
-Resident #10 had previously hit her so hard it knocked the wind out of her and she lost her balance and fell to the floor.
-The personal care aide stated that she was now afraid of Resident #10.
-Resident #10 has hit other residents multiple times.
-When Resident #10 was having a bad day he was in altercations with other residents.
-Resident #10 had hit, pushed, or been in altercations with more than half the residents in the SCU.
-The facility did not have a specific system for monitoring Resident #10, she tried to "keep an eye on him".
-If Resident #10 was in an altercation with another resident she called the medication aide (MA) to intervene.

Interview with a medication aide (MA) on 11/14/19 at 8:30am revealed:
-Resident #10 was often aggressive.
-The resident often refused to allow staff to shave, shower, or give him as needed medications.
-It was the facility's policy to supervise residents every two hours.
-When she worked, she tried to "lay eyes" on the resident at least every hour.
-No instructions had been given regarding the

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frequent supervision of Resident #10.
-When she worked, she tried to keep residents with aggressive behaviors busy.
-This could not be easily accomplished because the staff was all over the unit helping other residents.
-She recalled an incident when Resident #10 had cornered another resident in her room.
-Resident #10 would not let the resident leave the room and he kept hitting the resident.
-Resident #10 hit another resident because he thought her room was his house.
-On 11/05/19 Resident #10, aggression started early that morning, around 8:30 am.
-Resident #10 entered another resident's room and they started yelling at each other.
-Later the same day a PCA yelled for her because Resident #10 was getting upset and hit another resident and the resident that was hit fell to the floor.
-There were no meetings with oncoming shifts to discuss Residents' behaviors or increased supervision.
-Four to five days per week Resident #10 had agitation behaviors.
-Resident #10 did a lot of yelling at other residents, but she was only aware of one incident when Resident #10 hit another resident.
-Resident #10's aggression was hard to gauge what ignited the resident's aggressive behaviors.
-Since she started in April 2019, no training had been provided to staff on how to handle residents with aggressive behaviors.
-She had observed that all staff in the SCU needed training on how to handle the residents with aggressive behaviors.

Interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm revealed:
-Resident #10 had good days and bad days.

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-Resident #10's baseline would be talking about his past, which sometimes "set him off."
-For his baseline the resident would go from a good day to a bad day in a matter of a moment based on what someone said to him.
-When the resident was having a bad day he was in every room.
-Some days there were no coping mechanisms to redirect Resident #10.
-Sometimes the resident would calm and be good for a couple of hours, then he would start all over again.
-Even when the resident had his as needed medications, 60% of the time it did not help him at all.
-She always tried to move the resident from the situation by suggesting going outside, but sometimes that did not work.
-She had only discussed psychiatric evaluation one time with the primary care provider (PCP) that was in October 2019.
-The resident was only seen once by psychiatric care, shortly after he was involuntarily committed to a psychiatric hospital.
-If she heard the resident's voice being escalated, she immediately responded.
-As far as supervising Resident #10 generally, it depended if the resident was in a situation where he was approaching other residents, then she stepped in just because she found the resident was more responsive to her.
-She told staff sometimes just let the resident have his space but keep their eyes on him.
-When Resident #10 was really agitated they had not discussed staff staying with the resident continually, because one-on-care was not provided at the facility.
-She had never asked if one-on-one care could be provided for Resident #10; she assumed if that was an option the Administrator would have

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informed her to implement process.
-She could not recall if Resident #10 was put on frequent safety checks and there was no documentation to show the safety checks were done for Resident #10.

Interview with the Administrator on 11/14/19 at 6:53pm revealed:
-If a resident had aggressive behaviors staff took time to figure out what was causing the aggressive behavior.
-She tried to teach staff about different behaviors it did not always work.
-Resident #10 thought every room in the facility was his house.
-She tried to increase supervision by getting staff to re-directed Resident #10.
-The facility did not provide one-on-one supervision.
-The 72-hour monitoring should have been documented.
-She did not check to ensure the monitoring had been documented.
-She was aware Resident #10 had altercations with other residents in which he hit, pushed to the floor, caused lips to bleed and some residents had knots on her heads.
-She thought Resident #10 would be a good fit for the facility once he got his medications straightened out.
-She had the PCP working with Resident #10 to help with his medications.

Review of the facility's guidelines for supervision of resident who exhibit difficult behaviors revealed:
-Upon observation of at-risk behavior, staff shall notify the supervisor. The supervisor shall assure the care manager is notified who is responsible for also notifying the Executive Director.

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-Any resident at-risk shall be placed on increased supervision and the guardian or responsible party is to be notified. A mental health referral shall be considered and discussed with the resident's physician.
-Any behavior which escalates to a threat to the resident or others shall require immediate intervention to assure safety as to move residents out of harm's way and call 911 (EMS).

Interview with Resident #10's family member on 11/12/19 at 5:04pm revealed:
-The facility staff informed her when Resident #10 had aggressive behavior issues that caused him to go to the hospital.
-Resident #10 had a history of aggressive behaviors.
-The resident was verbally abusive, then became physical.
-When Resident #10 became agitated "you didn't want to touch him because he would swing on you".

Interview with the Primary Care Provider (PCP) on 11/15/19 at 11:15am revealed:
-Resident #10 had unpredictable outburst.
-He was in a locked unit because he needed monitoring.
-She was often notified regarding the resident's behaviors.
-She was aware Resident #10 had physically assaulted other residents in the SCU.
-She had not discussed with facility staff a system how to supervise Resident #10 as a means of keeping other residents' safe from physical assault.
-Resident #10 had been referred to mental health and had an appointment in December 2019.

3. Review of Resident #1's current FL2 dated

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04/08/19 revealed:
-Diagnoses included dementia unspecified, diverticulitis, synovitis, and history of falls.
-The resident was documented as intermittently disoriented.
-The recommended level of care is SCU.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 03/06/19.

Review of Resident #1's care plan dated 04/08/19 revealed:
-Resident #1 resided in the Special Care Unit (SCU).
-The resident's memory was forgetful, and he needed reminders.

a. Review of Resident #1's hospital discharge report dated 04/10/19 revealed Resident #1 was diagnosed with a closed head injury.

Review of Resident #1's Accident/Incident report dated 04/10/19 revealed at 10:40 am Resident #1 was punched in the face by another resident. Staff would monitor for 72-hours.

Review of Resident #1's record revealed no documentation of 72 hours of monitoring after the 04/10/19 incident.

Interview with Resident #1 family member on 11/05/19 at 2:50pm revealed:
-Resident #1 was admitted to the SCU on 03/06/19.
-On 04/10/19 Resident #1 fell to the floor out of a chair and received stitches.

b. Review of Resident #1's hospital discharge report dated 04/27/19 revealed Resident #1 was

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D 270	Continued From page 41 assaulted by another resident and received an injury to head, abrasion to face and right upper extremity. Review of Resident #1's Accident/Incident report dated 04/27/19 revealed Resident #1 got into an altercation with another resident. Interview with Resident #1 family member on 11/05/19 at 2:50 pm revealed on 04/27/19 Resident #1 was assaulted by another resident. -She visited Resident #1 at least once weekly. -Since Resident #1 moved into the facility he was assaulted by other residents twice and by a staff. c. Review of Resident #1's hospital discharge report dated 05/11/19 revealed Resident #1 had a fall and received closed head injury with laceration of scalp. Review of Resident #1's Accident/Incident report dated 05/11/19 revealed: -Resident #1 was found lying on the floor with a gash on his head and was bleeding. -The staff was to initiate the fall prevention program. Staff was to monitor for 72 hours for bruising, change in mental status, pain or other injuries related to falling and vital signs from 05/13/19 to 07/29/19. Review of Resident #1's record revealed no documentation of 72 hours of monitoring from 05/13/19 to 07/29/19. Interview with Resident #1 family member on 11/05/19 at 2:50pm revealed: -On 05/11/19, Resident #1 fell to the floor. -Resident #1 had fallen several times. -The facility staff did not call to inform her of the incidents.	D 270		

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-Resident #1 told her about all the incidents.
-If Resident #1 had behavior problems no one at the facility informed her about the behaviors.

d. Review of Resident #1's progress notes dated 05/13/19 revealed at 11:34am Resident #1 found lying on the floor on his left side.

Review of Resident #1's Accident/Incident reports revealed there was no accident/Incident report for the 05/13/19 incident.

e. Review of Resident #1's hospital discharge report dated 06/13/19 revealed Resident #1 had a fall and received laceration repair with stitches.

Review of Resident #1's Accident/Incident report dated 06/13/19 revealed at 2:15 pm Resident #1 was found lying on the floor on his left side. The staff was to initiate the fall prevention program. Staff was to monitor for 72 hours for bruising, change in mental status, pain or other injuries related to falling and vital signs from 06/14/19 through 07/29/19.

Review of an Emergency Medical Services (EMS) report dated 06/13/19 revealed:
-Resident #1 fell.
-The resident was bleeding from his scalp on the left side of his head above his eye.
-The facility staff reported the resident was standing, lost his balance and fell.

Interview with Resident #1 family member on 11/05/19 at 2:50pm revealed:
-On 06/13/19, Resident #1 was assaulted by another resident and fell to the floor and Resident #1 received stitches.
-Resident #1 had fallen several times.
-The facility staff did not call to inform her of the

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incidents.

f. Review of Resident #1's hospital discharge report dated 07/21/19 revealed Resident #1 was seen for dizziness, closed head injury, dementia with behavioral disturbance, unspecified dementia type, and acute urinary tract infection. The resident complained that the staff hit him with a cup.

Review of Resident #1's progress notes dated 07/21/19 revealed Resident #1 got into an altercation with a staff. The staff appeared to hit the resident.

Review of Resident #1's Accident/Incident report dated 07/21/19 revealed at 11:30am staff observed the resident appearing to be hit by a staff. Staff was to monitor status for 72 hours and charge progress notes daily.

Interview with Resident #1 family member on 11/05/19 at 2:50pm revealed:
-Resident #1 was admitted to the SCU on 03/06/19.
-On 07/21/19 Resident #1 told her that a staff member hit him in the head with a cup, he complained of dizziness and was sent to the hospital.
-She visited Resident #1 at least once weekly.
-Since Resident #1 moved into the facility he was assaulted by other residents twice and by a staff.
-The facility staff did not call to inform her of the incidents.

Review of Resident #1's electronic Medication Administration Record (eMARs) revealed:
-The resident's vital signs were checked on three dates (05/14/19, 05/15/19 and 05/16/19).
-The resident's vital signs were checked on three

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dates (06/14/19, 06/15/19, 06/16/19 and 06/17/19).
-The resident's vital signs were checked on three dates (07/21/19, 07/22/19, 07/23/19 and 07/24/19).

Review of Resident #1's record revealed there was no documentation the resident was monitored.

Interview with a personal care aide (PCA) on 11/13/19 at 5:26pm revealed:
-The facility previously had a sheet where staff documented residents that were checked on frequently.
-She had not documented on residents that were checked on frequently in several months.
-Residents that were checked frequently had aggressive behaviors, falls or residents that exhibited exit-seeking behaviors.
-She was unable to recall if Resident #1 was previously put on frequent checks.

Interview with a second PCA on 11/14/19 at 2:25pm revealed:
-Resident #1 used to keep knives in his room.
-She did not know if the resident pulled the knife on residents.

Interview with Resident #1's Primary Care Provider (PCP) on 11/15/19 at 12:12pm revealed:
-There was no documentation in their records regarding Resident #1's falls on 05/11/19 and on 06/13/19.
-There was no documentation regarding Resident #1 having an altercation with another resident on 04/10/19 and on 04/27/19.
-The PCP should have been notified of all incidents involving the resident, especially visits to the hospital.

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D 270	Continued From page 45 Interview with a MA on 11/14/19 at 10:21pm revealed: -Resident #1 had slight forgetfulness and sometimes he was "out of sorts." -Sometimes Resident #1 was moody and fussy, but that was not often. -When Resident #1 was moody he had to be watched because he would roll over other residents' feet if they were in his way in the hall. -Resident #1 would try to hit other residents with his wheelchair. -She recalled an incident when Resident #1 was hit by another resident and Resident #1's glasses were broken. -On an average Resident #1 got into altercations with other residents 2-3 times per week. -Resident #1 would take knives from the dining room and hide them in his room. -The staff did not know the resident had knives until he pulled them on someone. -She recalled incidents when Resident #1 pulled a knife on a visiting family member, PCA, and other residents. -Resident #1 never actually touched anyone with the knives, but he pulled the knives out and threatened others waving the knife at them. -In each incident when Resident #1 pulled the knife on residents' facility staff were not present, but heard loud voices and when staff went to see what was happened Resident #1 was observed with a knife pulled out and pointing it at the resident. -The incident when Resident #1 pulled the knife on the family member, it was the family member that informed facility staff the resident had a knife. -Resident #1 and his spouse shared a room and they did not allow staff in the room. -She recalled once when Resident #1 and his spouse were out of the room and staff tried to	D 270		

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quickly search the room for the knives, no knives were found.
-After Resident #1 moved out a lot of knives were found in the room.
-Resident #1 was not supervised more than the facility requirements every two hours, however, she sometimes provided supervision every hour when she had time.

Attempted telephone interview on 11/14/19 with staff involved in this incident was unsuccessful.

4. Review of Resident #4's current FL-2 dated 05/27/19 revealed:
-Diagnoses included dementia with behavioral disturbance, traumatic brain injury, major neurocognitive disorder with behaviors, anxiety, cognitive communication deficit, and history of alcohol abuse.
-Resident #4 was documented as constantly disoriented.
-The resident was documented as ambulatory.
-The recommended level of care was documented as Special Care Unit (SCU).
-The resident resided on the SCU.

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 03/07/19.
-His family member was listed as his power of attorney.

Review of Resident #4's Care Plan dated 08/14/19 revealed:
-The resident had wandering behaviors.
-The resident was injurious to others.
-The resident was always disoriented.
-The resident had significant memory loss and must be directed.

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D 270	Continued From page 47 Review of Resident #4's progress notes dated 06/11/19 revealed Resident #4 was combative with other residents and was transported to the emergency room for evaluation. Review of Resident #4's Accident/Incident report dated 06/11/19 revealed at 10:00 am, Resident #4 was combative with other residents while in the hallway and had to be transported to the emergency room. Review of an Emergency Medical Services (EMS) report for Resident #4 dated 06/11/19 revealed Resident #4 was transported to emergency room for evaluation of aggression and violence toward others. Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions. Interview with a personal care assistant (PCA) on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit staff and other residents. Interview with a second PCA on 11/13/19 at 5:26pm revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents. Interview with a medication aide (MA) on 1/13/19 at 12:20pm revealed: -He was a "bit much at times" due to his behaviors. -He would get very agitated quickly and sometimes just go "off".	D 270		

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D 270	Continued From page 48 Interview with a second MA on 11/14/19 at 9:47am revealed when Resident #4 started having behaviors or getting aggressive staff would try to figure out why. Review of Resident #4's progress notes dated 06/13/19 revealed Resident #4 was screaming and tried to fight other residents. Review of Resident #4's Accident/Incident report dated 06/13/19 revealed at 12:43am Resident #4 was screaming and tried to fight other residents. Review of an Emergency Medical Services (EMS) report for Resident #4 dated 06/13/19 revealed Resident #4 was transported to the emergency room for psychiatric evaluation due to verbal aggression and could not be reasoned with or calmed. He had also been non-compliant with medications for several days. Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions. Interview with a PCA on 11/13/19 at 4:38pm revealed if staff were unable to calm Resident #4 down, staff would get the MA or the nurse to assist. Interview with a second PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents. Interview with a third PCA on 11/13/19 at 4:38pm revealed Resident #4 was fine some days and others he would yell out in pain because his feet hurt him.	D 270		

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D 270	Continued From page 49 Interview with a MA on 1/13/19 at 12:20pm revealed: -He would get very agitated quickly and sometimes just go "off". -He was a "bit much at times" due to his behaviors. -Resident #4 did not like abrupt noises or to be yelled at; if so he got agitated very fast and sometimes "went off". Review of Resident #4's progress notes dated 07/15/19 revealed Resident #4 was fighting with another resident in the hallway and staff had to intervene. Review of Resident #4's Accident/Incident reports revealed there was no Accident/Incident report available for the 07/15/19 incident. Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions. Interview with a personal care assistant (PCA) on 11/13/19 at 4:38pm revealed: -Resident #4 had behaviors sometimes when his feet hurt; he would run or yell. -Staff made rounds on residents who wandered every 15-30 minutes and everyone else every 30 minutes to every 2 hours but usually rounded on Resident #4 every 15-30 minutes. Interview with a second PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents. Interview with a third PCA on 11/13/19 at 5:26pm	D 270		

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revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents.

Interview with a MA on 11/14/19 at 9:47am revealed:
-Sometimes he would walk all day and just need a nap, so staff would assist him to lay down and rub his head until he fell asleep.
-Only a few staff were able to get Resident #4 to calm down when he started escalating.

Review of Resident #4's progress notes dated 08/26/19 revealed:
-Resident #4 was found in another resident's room pushing a walker down on his chest.
-When staff tried to redirect him, he became combative with staff and chased them down the hallway and hit them several times. Resident #4 then picked up a walker and banged it into the wall before throwing it. He was transported to the emergency room.

Review of Resident #4's Accident/Incident report dated 08/26/19 revealed at 4:10pm, Resident #4 was found in another resident's room pushing a walker down on his chest. When staff tried to redirect him, he became combative with staff and chased them down the hallway and hit them several times. Resident #4 then picked up a walker and banged it into the wall before throwing it. He was transported to the emergency room.

Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions.

Interview with a PCA on 11/13/19 at 4:38pm revealed if they were unable to calm Resident #4

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down, they would get the medication aide (MA) or the nurse to assist.

Interview with a second PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents.

Interview with a third PCA on 11/13/19 at 5:26pm revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents.

Interview with a fifth PCA on 11/14/19 at 2:05pm revealed Resident #4 coped by eating food so sometime when he became aggressive staff would give him a snack to calm him down.

Interview with a MA on 1/13/19 at 12:20pm revealed "He could be a bit much at times due to his behaviors."

Interview with a second MA on 11/14/19 at 9:47am revealed:
-She worked first shift most of the time.
-Resident #4 liked to eat and liked positive reinforcement.
-Most of Resident #4's behaviors occurred on second and third shifts as the staff were not as attentive as first shift.

Review of Resident #4's progress notes dated 08/29/19 revealed Resident #4 was observed hitting another resident while in the day room.

Review of Resident #4's Accident/Incident report dated 08/29/19 revealed at 2:30pm Resident #4 was observed hitting another resident while in the day room. Special instructions on the incident report were to monitor status for 72 hours and

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document in the progress notes daily 08/29/19-09/01/19.

Review of Resident #4's record revealed no documentation of monitoring for 72 hours from 08/29/19-09/01/19.

Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions.

Interview with a PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents.

Interview with a second PCA on 11/13/19 at 4:38pm revealed:
-Staff made rounds on residents who wandered every 15-30 minutes and everyone else every 30 minutes to every 2 hours but usually rounded on Resident #4 every 15-30 minutes.

Interview with a third PCA on 11/13/19 at 5:26pm revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents.

Interview with a MA on 1/13/19 at 12:20pm revealed:
-He would get very agitated quickly and sometimes just go "off".
-He was a "bit much at times" due to his behaviors.

Interview with a second MA on 11/14/19 at 9:47am revealed:
-When Resident #4 started having behaviors or getting aggressive they would try to figure out why.

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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 270	Continued From page 53 -She had observed that all staff in the SCU needed training on how to handle the residents with aggressive behaviors as some had more training than others. Review of Resident #4's progress notes dated 10/03/19 revealed Resident #4 was pacing the unit and became agitated. He then picked up a chair and was swinging it at the wall as well as other residents. After a minute staff were able to get the chair from him. Review of Resident #4's Accident/Incident reports revealed there was no Accident/Incident report available for the 10/03/19 incident. Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions. Interview with a PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents. Interview with a second PCA on 11/13/19 at 5:26pm revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents. Interview with a medication aide (MA) on 1/13/19 at 12:20pm revealed: -He would get very agitated quickly and sometimes just go "off". -"He could be a bit much at times." Interview with a MA on 11/14/19 at 9:47am revealed: -Resident #4 usually walked non-stop and got tired so they laid him down for a nap and rubbed	D 270		

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his head until he fell asleep.
-Resident #4 did not like abrupt noises or to be yelled at; if so he got agitated very fast and sometimes "went off".
-When Resident #4 started having behaviors or getting aggressive staff would try to figure out why.
-Only a few staff were able to get Resident #4 to calm down when he started escalating.

Review of Resident #4's progress notes dated 10/16/19 revealed Resident #4 began yelling and then pinned another resident up against a wall and punched the resident in the back.

Review of Resident #4's Accident/Incident report dated 10/16/19 revealed at 10:45am Resident #4 began yelling and then pinned another resident up against a wall and punched her in the back.

Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions.

Interview with a third PCA on 11/13/19 at 4:38pm revealed:
-Resident #4 was fine some days and others he would yell out in pain because his feet hurt him.
-Resident #4 had behaviors sometimes when his feet hurt; he would run or yell.

Interview with a PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents.

Interview with a 3rd PCA on 11/13/19 at 5:26pm revealed:
-Resident #4 would be normal one minute and the next he was aggressive and hitting other

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residents.

Interview with a 5th PCA on 11/14/19 at 2:05pm revealed:
-Resident #4 coped by eating food so sometime when he became aggressive staff would give him a snack to calm him down.

Interview with a medication aide (MA) on 1/13/19 at 12:20pm revealed:
-He would get very agitated quickly and sometimes just go "off".
-He was a "bit much at times" due to his behaviors.

Interview with a MA on 11/14/19 at 9:47am revealed:
-Resident #4 did not like abrupt noises or to be yelled at; if so he got agitated very fast and sometimes "went off".
-Staff would also encourage Resident #4 as he liked positive reinforcement.

Review of Resident #4's progress notes revealed there was no progress note available for 10/03/19.

Review of Resident #4's Accident/Incident report dated 10/19/19 revealed at 10:48pm Resident #4 was observed pushing a second resident to the floor causing her to be sent to the emergency room for treatment. He was also combative and spit his medication on the medication aide (MA) then went to his room and turned over his television and its stand. Resident #4 was sent to the emergency room for evaluation.

Review of an Emergency Medical Services (EMS) report for Resident #4 dated 10/19/19 revealed Resident #4 was transported to the emergency

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room for evaluation of aggressive behavior due to shoving another resident. A second unit had to be dispatched for the resident that was assaulted.

Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions.

Interview with a PCA on 11/13/19 at 4:38pm revealed staff made rounds on residents who wandered every 15-30 minutes and everyone else every 30 minutes to every 2 hours but usually rounded on Resident #4 every 15-30 minutes.

Interview with a second PCA on 11/13/19 at 5:15pm revealed:
-Resident #4 got aggressive about every other day and he liked to hit other residents.
-Resident #4 had hit another resident 2 days ago and knocked him into a door causing him to hit his head; that resident had to be taken to the emergency room.
-Resident #4 was sent back to the emergency room.

Interview with a third PCA on 11/13/19 at 5:26pm revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents.

Interview with a fourth PCA on 11/14/19 at 2:05pm revealed Resident #4 would push and hit other residents (example: 3 weeks ago, or so he shoved a female resident).

Interview with a MA on 1/13/19 at 12:20pm revealed:
-She worked first shift most of the time.

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-He would get very agitated quickly and sometimes just go "off".
-He was a "bit much at times" due to his behaviors.
-Most of Resident #4's behaviors occurred on second and third shifts as the staff were not as attentive.

Interview with a second MA on 11/14/19 at 9:47am revealed:
-Sometimes he would walk all day and just need a nap, so staff would assist him to lay down and rub his head until he fell asleep.
-Only a few staff were able to get Resident #4 to calm down when he started escalating.

Review of Resident #4's progress notes dated 10/30/19 revealed Resident #4 became combative and began throwing chairs. Staff was unable to calm him down. He was sent to the emergency room for evaluation.

Review of Resident #4's Accident/Incident report dated 10/30/19 revealed Resident #4 became combative and began throwing chairs. He was sent to the emergency room for evaluation.

Review of an Emergency Medical Services (EMS) report for Resident #4 dated 10/30/19 revealed Resident #4 was transported to the emergency room for evaluation of agitation and throwing his clothes around in his room.

Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions.

Interview with a personal care assistant (PCA) on 11/13/19 at 4:38pm revealed if they were unable

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to calm Resident #4 down, they would get the medication aide (MA) or the nurse to assist.

Interview with a PCA on 11/13/19 at 5:15 pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents.

Interview with a 3rd PCA on 11/13/19 at 5:26pm revealed:
-Resident #4 would be normal one minute and the next he was aggressive and hitting other residents.

Interview with a MA on 1/13/19 at 12:20pm revealed:
-She worked first shift most of the time.
-He would get very agitated quickly and sometimes just go "off".
-He was a "bit much at times" due to his behaviors.
-Most of Resident #4's behaviors occurred on second and third shifts as the staff were not as attentive.

Interview with a second MA on 11/14/19 at 9:47am revealed:
-When Resident #4 started having behaviors or getting aggressive staff would try to figure out why.
-Staff would also encourage Resident #4 as he liked positive reinforcement.
-Sometimes he would walk all day and just need a nap, so staff would assist him to lay down and rub his head until he fell asleep.
-Only a few staff were able to get Resident #4 to calm down when he started escalating.

Review of Resident #4's progress notes revealed there was no progress note available for 11/06/19.

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D 270	Continued From page 59 Review of Resident #4's Accident/Incident report dated 11/06/19 revealed at 8:40pm Resident #4 was observed being aggressive and striking other residents while in the hallway. Resident #4 was taken to the emergency room. Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions. Interview with a PCA on 11/13/19 at 4:38pm revealed if they were unable to calm Resident #4 down, they would get the MA or the nurse to assist. Interview with a second PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents. Interview with a third PCA on 11/13/19 at 5:26pm revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents. Interview with a MA on 1/13/19 at 12:20pm revealed: -She worked first shift most of the time. -Resident #4 had behaviors sometimes when his feet hurt; he would run or yell. -He would get very agitated quickly and sometimes just go "off". -He was a "bit much at times" due to his behaviors. -Most of Resident #4's behaviors occurred on second and third shifts as the staff were not as attentive.	D 270		

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Interview with a second MA on 11/14/19 at 9:47am revealed:
-Only a few staff were able to get Resident #4 to calm down when he started escalating.
-Resident #4 usually walked non-stop and got tired so they laid him down for a nap and rubbed his head until he fell asleep.

Review of Resident #4's progress notes revealed there was no progress note available for 11/09/19.

Review of Resident #4's Accident/Incident report dated 11/09/19 revealed Resident #4 was observed grabbing another resident by the arm and scratching them. Resident #4 was taken to the emergency room.

Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions.

Interview with a PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents.

Interview with a second PCA on 11/13/19 at 5:26pm revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents.

Interview with a third PCA on 11/14/19 at 2:05pm revealed:
-Resident #4 would push and hit other residents (example: 3 weeks ago, or so he shoved a female resident).
-Resident #4 had hit another resident 2 days ago and knocked him into a door causing him to hit his head; that resident had to be taken to the

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emergency room.
-Resident #4 was sent back to the emergency room.

Interview with a MA on 1/13/19 at 12:20pm revealed:
-She worked first shift most of the time.
-He would get very agitated quickly and sometimes just go "off".
-He was a "bit much at times" due to his behaviors.
-Most of Resident #4's behaviors occurred on second and third shifts as the staff were not as attentive.

Interview with a second MA on 11/14/19 at 9:47am revealed when Resident #4 started having behaviors or getting aggressive they would try to figure out why.

Review of Resident #4's progress notes dated 11/11/19 revealed Resident #4 punched another resident in the face making him fall against a wall hitting his head causing him to have a laceration.

Review of Resident #4's Accident/Incident report dated 11/11/19 revealed Resident #4 was observed hitting a third resident causing him to fall. Resident #4 was transported to the emergency room for evaluation.

Interview with a PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents.

Review of Resident #4's record revealed there was no documentation of staff monitoring Resident #4's behavior or implementation of interventions.

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D 270	Continued From page 62 Interview with a PCA on 11/13/19 at 4:38pm revealed Resident #4 was fine some days and others he would yell out in pain because his feet hurt him. Interview with a PCA on 11/13/19 at 5:15pm revealed Resident #4 got aggressive about every other day and he liked to hit other residents. Interview with a second PCA on 11/13/19 at 5:26pm revealed Resident #4 would be normal one minute and the next he was aggressive and hitting other residents. Interview with a third PCA on 11/14/19 at 2:05pm revealed: -Resident #4 had hit another resident 2 days ago and knocked him into a door causing him to hit his head; that resident had to be taken to the emergency room. -Resident #4 was sent back to the emergency room. -Staff made rounds on residents who wandered every 15-30 minutes and everyone else every 30 minutes to every 2 hours but usually rounded on Resident #4 every 15-30 minutes. Interview with a MA on 1/13/19 at 12:20pm revealed: -She worked first shift most of the time. -He would get very agitated quickly and sometimes just go "off". -He was a "bit much at times" due to his behaviors. -Most of Resident #4's behaviors occurred on second and third shifts as the staff were not as attentive. -Resident #4 did not have any behaviors during 1st shift on 11/11/19.	D 270		

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Review of the facility's guidelines for supervision of resident who exhibit difficult behaviors revealed:
-Upon observation of at-risk behavior, staff shall notify the supervisor. The supervisor shall assure the care manager is notified who is responsible for also notifying the Executive Director.
-Any resident at-risk shall be placed on increased supervision and the guardian or responsible party is to be notified. A mental health referral shall be considered and discussed with the resident's physician.
-Any behavior which escalates to a threat to the resident or others shall require immediate intervention to assure safety as to move residents out of harm's way and call 911 (EMS).

Attempted interview with Resident #4's family member on 11/13/19 at 11:37 am unsuccessful.

Interview with the Activity Director on 11/14/19 at 2:25pm revealed:
-Resident #4 got "out of hand" easily.
-If Resident #4 bumped his toe he would punch someone.
-She has had to stop in the middle of activities to try to redirect residents including Resident #4, who were yelling and arguing because staff were too busy.

Interview with the Special Care Unit Coordinator (SCUC) on 11/14/19 at 2:46pm revealed:
-She tried to have in-services on how to approach Resident #4.
-She tried to get Resident #4 involved in activities.
-Resident #4 liked to walk the hall and wander back and forth but he always looked down.
-They tried to get Resident #4 to keep shoes on, so he did not hit his toe.
-Resident #4 got angry when he hit his toe or

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walked into a door frame.
-When Resident #4 had an episode, staff could feed him to defuse the situation.
-She tried to get Resident #4 into a dementia program, but the family declined.
-Resident #4 could get very combative.
-She recalled an incident in which Resident #4 attempted to get out; he just started swinging and then started toward staff, but she intervened, he grabbed her arms and just held them, so she held to his arms until he calmed down.
-She would not document any behaviors unless she saw them.
-Resident #4 did not have any behaviors at home.
-Resident #4 was on increased supervision due to his behaviors; he should have been checked on every 15 minutes.
-Other than keeping a closer eye on Resident #4, they have only tried increasing his sleep but that just made him angrier.
-The facility did not provide one on one supervision when a resident acted out.

Interview with the Administrator on 11/14/19 at 5:31pm revealed:
-If a resident had aggressive behaviors staff should take time to redirect and figure out what was causing the aggressive behavior.
-She tried to teach staff about different behaviors it did not always work.
-Staff should utilize as needed medications when a resident had severe or heightened behaviors.
-She was aware Resident #4 had altercations with other residents in which he hit, pushed to the floor, and caused some residents to have knots on her heads, bleeding from their heads and had to be sent to the emergency room.
-Resident #4 was sent to the emergency room to keep the other residents safe.
-Resident #4 always had behaviors but they

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recently had increased in frequency.
-Prior to October 2019 Resident #4 would pace and when he got that "look" you could scratch his back and have him to lay down to calm him but that stopped being effective.
-More recently, they used food as a motivator to calm Resident #4.
-Resident #4 recently had an increase in the frequency and severity of behaviors, especially on 2nd shift.
-She and the psychiatric provider both spoke with the hospital on 11/06/19 and 11/11/19 to have him placed in a geriatric psychiatric unit until he was stabilized.
-She was not allowed to refuse to accept Resident #4 back upon discharge from a hospital so to keep other resident's safe she placed him on 15-30 minute checks.
-The 15-30 minute checks had not been documented prior to 11/12/19 at which time she implemented
A "Increased Supervision & Accountability Checklist"and at the top of the form it documented how often a resident was to be checked on. The care managers or herself could determine the frequency of the supervisory checks.
-The staff documented the time, location, and their initials.
-She did not increase her staffing and the facility did not provide one on one staff even for a short period of time.
-The facility staff was evaluating if they could meet the needs of the aggressive residents.
-The facility staff did not do anything differently when Resident #4 returned to the facility over the weekend.
-When a resident had behaviors, she expected staff to come to the Resident Care Coordinator (RCC) or herself for guidance.

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-She expected staff to notify the physician when a resident had behaviors and she expected staff to call EMS especially if a resident could be endangering another resident.

Interview with Resident #4's Mental Health Provider on 11/14/19 at 1:30pm revealed:
-She started seeing Resident #4 in July.
-Resident #4 had been very combative and aggressive and had multiple hospitalizations.
-She had been seeing Resident #4 every 2 weeks.
-She had spoke to the emergency room doctor on 11/06/19 and 11/11/19 and tried to get him sent to a mental health inpatient facility until he was stable.
-The facility was not able to meet Resident #4's needs.

Interview with resident #4's Primary Care Physician (PCP) on 11/15/19 at 10:15am revealed:
-She knew Resident #4 had frequent behaviors.
-She had written an order for a psychiatric evaluation at the beginning of June but the facility was responsible for obtaining a consent from his Power of Attorney (POA).
-Resident #4's POA did not sign the consent right away.
-Resident #4's behaviors decreased for a short period then flared back up.
-Resident #4 needed to be admitted to a mental health dementia unit in which staff were aware of behaviors.
-Resident #4's medications had been adjusted several times but it did not help.

5. Review of Resident #11's current FL-2 dated 05/10/19 revealed:
-Diagnoses included vascular dementia with

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behaviors, anxiety, and hypertension.
-Resident #11 was documented as constantly disoriented.
-Resident #11 was documented as ambulatory and wandered.
-The recommended level of care was documented as Special Care Unit (SCU).
-The resident resided on the SCU.

Review of Resident #11's Care Plan dated 08/14/19 revealed:
-The resident had wandering behaviors.
-The resident was documented as always disoriented.
-The resident had significant memory loss and must be directed.

Review of Resident #11's Accident/Incident reports revealed:
-On 09/05/19 at 9:15am Resident #11 was observed in an altercation with another resident while in her room.
-On 09/05/19 at 5:38pm Resident #11 was observed eating tissue that had been dipped in a bucket with an unknown substance that had leaked from a heat/air conditioning unit. She was transported to the emergency room for treatment.

Review of an Emergency Medical Services (EMS) report for Resident #4 dated 09/05/19 revealed Resident #11 was transported to local emergency room for evaluation due to drinking an unknown amount of cleaning mixture.

Review of Resident #11's progress notes revealed:
- On 09/05/19 at 1:31pm Resident #11 was in an altercation with another resident. No injuries and resident representative notified.
-On 09/05/19 Resident #11 drank/ate water from

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a bucket, that housekeeping used to catch the water that leaked from the air conditioner located in the television room. Resident #11 was observed dipping tissue paper in the bucket then eating it.

Interview with Resident #11's family member on 11/13/19 at 10:23 am revealed the resident was sent to the emergency room for drinking an unknown liquid but it all turned out okay.

Interviews with four personal care aides (PCA) on 11/13/19 at 4:38pm, 5:15pm, 11/14/19 at 8:20am, and 2:05pm revealed:
-Resident #11 liked to wander around but she was not aggressive.
-Resident #11 had to be watched closely as she liked to put things in her mouth.
-Resident #11 liked to chew on tissue.
-Resident #11 was easily redirected with candy.

Interview with a medication aide (MA) on 11/14/19 at 9:47am revealed:
-Resident #11 was easily redirected.
-Resident #11 had to be watched closely as she liked to put stuff in her mouth.

Attempted interview on 11/13/19 and 11/14/19 at 3:30pm with a MA that was working on 09/05/19 when Resident #11 drank contaminated water from a bucket was unsuccessful.

Interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm revealed:
-Resident #11 liked to pick up everything and wandered around.
-She was informed by other staff members of the incident with Resident #11 drinking liquid and eating tissue from a bucket of contaminated water.

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D 270	Continued From page 69 -She had worked earlier that day but had left before the incident occurred. -She had not noticed a bucket earlier in the day by the heating/air conditioner unit. -There were no bleach or soap in the bucket because staff did not have access to those. Interview with the Administrator on 11/14/19 at 5:31pm revealed: -The heating/air conditioner unit in the SCU day room was dripping something so a bucket was placed under it. -Resident #11 was observed with the bucket. She placed something in the bucket and then removed it and placed it in her mouth. -Staff was not close enough to stop Resident #11. -When a resident had behaviors, she expected staff to come to the Resident Care Coordinator (RCC) or herself for guidance. -She expected staff to notify the physician when a resident had behaviors and she expected staff to call EMS especially if a resident could be endangering another person. Interview with resident #44's PCP on 11/15/19 at 10:05am revealed she did not recall if she had been made aware of the incident when Resident #11 might have drank/ate something from a bucket. _____ The facility failed to provide supervision to 5 of 9 sampled residents in the SCU resulted in one resident eloped without staff's knowledge resulting in a fractured hip (#13), a confused resident consuming an unknown substance that dripped from the heating/air conditioner unit (#11), two residents identified with physical and aggressive behaviors (#4 and #10), and a resident with altercations and falls resulting in injuries and sutures (#1). The facility's failure to	D 270		

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D 270	Continued From page 70 supervise residents in the SCU resulted in a serious injuries and serious neglect to residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/08/19 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 15, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 5 of 7 sampled residents (#2, #3, #4, #6, and #7) including follow-up with a medical equipment provider for portable oxygen equipment (#2) and nebulizer equipment (#7); notifying the primary care provider (PCP) regarding medical equipment not being available for residents with history of respiratory failure and	D 273		

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chronic obstructive pulmonary disease (#2 and #7); medications not being available (#2 and #3); refusal of medications, blood pressures and pulse (#4); and refusal of weights and a medication (#6).

The findings are:

1. Review of Resident #2's current FL2 dated 05/09/19 revealed:
-Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease with hypoxia, coronary disease, and depression.
-The recommended level of care for Resident #2 was the Special Care Unit (SCU).
-There was no order for oxygen on the FL2.

a. Review of Resident #2's hospital discharge summary report dated 04/26/19 revealed:
-Resident #2 was admitted for respiratory failure.
-The discharge orders and instructions were "wear 02 (oxygen) 3 liters via NC (nasal cannula) at all times."

Review of Resident #2's physician's orders dated 05/03/19 and 05/07/19 revealed an order for oxygen equipment.

Review of Resident #2's record revealed a 02 testing was done by the Primary Care Provider (PCP) nurse on 05/09/19. The resident's oxygen saturation level on room air was 84% (the normal range for oxygen saturation is 94 to 98 percent saturation).

Review of Resident #2's progress notes revealed:
-On 08/09/19 at 2:16 pm, Resident #2 tried to get up and walk around a lot today and did not want to stay on her oxygen.
-Staff redirected the resident and got her to sit

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down.
-On 09/03/19 at 2:15 pm, Resident #2 occasionally getting agitated, mostly because she wants to walk around, and the staff keeps redirecting her to sit down and wear the oxygen.

Review of Resident #2's electronic Medication Administration Records (eMARs) for August, September, October and November 2019 revealed:
-There was an entry for oxygen 3 liters continuously as follows:
-7:00 am to 3:00 pm, 3:00 pm to 11:00 pm and 11:00 pm to 7:00 am.
-Staff documented oxygen 3 liters were administered continuously.

Observation of Resident #2's room on 11/06/19 at 4:40 am revealed:
-The door to Resident #2's room was open.
-Resident #2 was sitting on the side of the bed.
-Resident #2's oxygen concentrator was in front of the resident.
-The resident did not have the nasal cannula on, it was laying on the floor in front of the machine.
-The personal care aide (PCA) did not attempt to put the oxygen on the resident.

Observation of Resident #2 on 11/06/19 at 8:00 am revealed:
-Resident #2 was sitting in the dining room consuming the breakfast meal.
-Resident #2 did not have oxygen on.
-There was no oxygen concentrator or portable oxygen tanks in the dining room with Resident #2.
-After the meal, the medication aide (MA) called Resident #2 and told the resident to sit in the chair that was placed by the medication cart.
-Between the medication cart and the chair was an oxygen concentrator.

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D 273	Continued From page 73 -There was a nasal cannula that was laying on top of the concentrator. -Resident #2 sat down in the chair and after her nebulizer treatment, the MA put the oxygen on Resident #2. Observation of the oxygen equipment in Resident #2's room on 11/06/19 at 8:40 am revealed: -There were four portable tanks in the room. -There was one small, two medium, and one large-sized portable oxygen cylinders. -The tanks were empty and two were non-operable. -There was a desk top home-fill oxygen concentrator sitting on the chest in the room. -The home-fill oxygen refillable concentrator did not work when turned to the on position. Observation of Resident #2's oxygen concentrator on 11/06/19 at 12:10pm revealed: -The concentrator was positioned in the main hallway between the medication cart and a straight back chair. -The equipment was on with sounds coming from the equipment. -There was a nasal cannula attached to the equipment. -The nasal cannula was laid across the top of the equipment. -There was a label on the equipment that showed the company that dispensed the equipment. Observation on 11/06/19 at 12:00 pm to 12:50 pm of the lunch meal revealed: -Resident #2 was sitting in the dining room consuming her meal. -Resident #2 did not have oxygen on. -There was no oxygen concentrator or portable oxygen tanks in the dining room with Resident #2. -The resident did not appear to be struggling to	D 273		

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breathe but every three to five minutes took deep long breaths.

Observation of Resident #2 without oxygen on 11/07/19 at various times throughout the day revealed:
-At 8:00 am Resident #2 was in the dining room eating breakfast with no oxygen on.
-At 9:11 am Resident #2 was in the common activity room with no oxygen on.
-The resident's concentrator was in the hallway by the medication cart, which was more than 10 feet from the resident.
-There were sounds coming from the concentrator indicating it was on.
-There was a nasal cannula attached to the machine.
-The surveyor observed Resident #2's respiration as 38.
-At 9:20 am the Special Care Unit (SCU) Coordinator took the concentrator into the activity room where Resident #2 was sitting.
-At 11:04 am Resident #2 was sitting on the sofa in the common area without her oxygen on. Staff put the resident's oxygen on at 11:07 am.
-At 12:00 pm Resident #2 was in the dining room for the lunch meal, there was no oxygen in the dining room with the resident.

Observation of Resident #2 on 11/08/19 from 12:00pm to 12:28pm revealed:
-Resident #2 was in the dining room sitting for the meal without her oxygen on.
-The oxygen concentrator was in the dining room.
-The nasal cannula was on the floor.
-There were three personal care aides (PCAs) and one MA in the dining room.
-No staff in the dining put Resident #2's oxygen on.
-During the meal, the resident took several long

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deep breaths.

Observation of Resident #2 on 11/13/19 at 1:08 pm revealed:
-Resident had been ambulating up and down the hallway without her oxygen on.
-A family member for another resident brought in a case of nutritional supplement and sat it on the counter at the nurses' station.
-Resident #2 got very agitated and stated, "you can't have beer in here."
-The resident started yelling at the staff standing by the nurse's station telling them beer was not allowed.
-The MA checked Resident #2's oxygen saturation level.
-The resident's oxygen saturation level was 51% when checked by the MA.
-The MA reapplied the resident's oxygen and after a minute her oxygen level came up to 96%.

Based on record review, observations, interviews on 11/06/19 it, was determined that Resident #2 was not interviewable.

Interview with a representative from the local Veteran's Administration on 11/06/19 at 9:34am revealed:
-The refillable concentrator and stand alone concentrator identified as being used by Resident #2 were not dispensed to Resident #2.
-The Veteran's Administration had not dispensed any oxygen equipment to Resident #2.
-No one at the facility had called to inform the equipment needed repair.
-If the facility had called regarding repairing the equipment for Resident #2, they would have been told the equipment could only be repaired for the individual it was dispensed for.
-They would have picked the equipment up

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D 273	Continued From page 76 because it could only be used for the individual it was dispensed for. Interview with the SCU Coordinator on 11/06/19 at 12:53pm revealed: -She was aware Resident #2's oxygen was 3 LPM continuous. -She was aware the resident went to meals without her oxygen. -Resident #2 was non-compliant with oxygen. -She had not questioned staff why the resident was not using her portable oxygen. -She did not know the refillable oxygen machine in Resident #2's room was broken. -Staff should have made her aware the machine did not work. -She did not know the oxygen concentrator used by Resident #2 was not the resident's concentrator. -She did not know if Resident #2 was using oxygen equipment that was not her own equipment. Interview with the medication aide supervisor (MA) on 11/06/19 at 12:45pm revealed: -Resident #2 did not have portable oxygen tanks. -She was aware Resident #2's oxygen was continuous at 3 liters per minute (LPM). -She was under the impression "it was okay" for the resident to go to meals without oxygen on. -She set Resident #2's oxygen level and she thought it was on 3 LPM. -Resident #2 sometimes changed the dial on the oxygen machine and unplugged the machine. -The portable refillable machine in Resident #2's room did not work. -The machine had not worked for four months. -She was not sure if anyone had checked with the oxygen equipment company to get the machine replaced.	D 273		

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D 273	Continued From page 77 -She thought the SCU Coordinator knew about the machine not working. -When a machine like that did not work or needed repair, it was the SCU Coordinator's responsibility to call about getting equipment repaired or replaced. -She was not aware the oxygen equipment used by Resident #2 did not belong to the resident. Interview with a MA on 11/07/19 at 3:23pm revealed: -Resident #2's home-fill oxygen concentrator was broken. -The refillable concentrator had been broken for at least four months. -When she took Resident #2 to meals, she did not wear oxygen because the resident did not have portable oxygen tanks. -She was not sure it was reported to anyone that the home-fill refill oxygen concentrator was broken. -She thought maybe the MA supervisor told the SCU Coordinator. -Usually, Resident #2 acted like she was short of breath in the morning when the resident first got up. -She was able to tell the resident was short of breath because the resident was panting with her breathing. -When Resident #2 was panting the resident took really deep breaths. -After the resident was on oxygen for a few minutes the resident's breathing was better. Interview with the Administrator on 11/08/19 at 11:10am revealed: -When staff (medication aide and personal care aides) were aware Resident #2's home-fill refill concentrator was broken they should have notified the proper people to reach the correct	D 273		

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people to have the concentrator repaired.
-She was not aware Resident #2's home-fill refill concentrator was broken or else she would have made sure it was repaired.
-She did not know the oxygen equipment used by Resident #2 did not belong to the resident.

Interview with a representative from the oxygen home care company on 11/08/19 at 1:00 pm revealed:
-The company received orders dated 05/09/19 for oxygen equipment for Resident #2.
-On 05/10/19, the company delivered brand-new oxygen equipment, concentrator with an attached home-fill refillable concentrator and two refillable portable tanks.
-No one at the facility had called to inform Resident #2's oxygen equipment was not working.
-If Resident #2 was not using the equipment dispensed on 05/09/19, then the facility should identify where the equipment was located.
-Resident #2 should be the only person using that equipment.

Interview with the MA/Supervisor on 11/13/19 at 4:07pm revealed:
-When Resident #2 first came to the facility she wore oxygen.
-Staff had a hard time keeping the oxygen on the resident, and it was soon discontinued.
-In April 2019, Resident #2 went to the hospital and returned with a discharge summary report.
-When Resident #2 returned from the hospital she was wearing oxygen again.
-The SCU Coordinator was responsible for reviewing the hospital report and identifying orders.
-Resident #2 was supposed to wear her oxygen at all day but the only way to keep it on her was to

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have her sit down beside the medication cart in the hallway.
-The home-fill refill concentrator in Resident #2's room has been broken for 3-4 months.
-The SCU Coordinator was aware of Resident #2's home-fill refillable concentrator not working.
-The SCU Coordiantor was responsible for calling to get the machine fixed.
-She was not sure why the SCU Coordinator did not call to have the machine fixed.
-The facility had a pulse oximeter, but she did not check Resident #2's oxygen saturation level.
-The only time Resident #2 wore oxygen was when the resident was sitting in a chair by the medication cart in the hallway.
-She had not noticed if Resident #2 was short of breath.
-Some days Resident #2 was severely agitated.
-When the PCP came to the facility, she verbally told the PCP that Resident #2 was not compliant with wearing her oxygen.
-When Resident #2 was agitated she never checked the resident oxygen saturation level.
-She had not considered Resident #2's agitation was related to being short of breath.

Interview with personal care aide (PCA) on 11/06/19 at 4:40pm revealed:
-Resident #2 never kept her oxygen on.
-Resident #2 liked to walk around, so the resident frequently took her oxygen off.
-If she put the oxygen on Resident #2 would take it off again.
-Resident #2 always went to the dining room without oxygen on.
-Resident #2's home-fill refillable concentrator had not worked for 3-4 months.

Interview with PCA on 11/07/19 at 5:54pm revealed:

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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-Resident #2 always went to the dining room without oxygen.
-She did not know who in management they were supposed to tell about the non-working refillable concentrator.
-She thought the MAs were to report the non-work machine to management.
-Resident #2 did not have portable oxygen tanks.
-She found out today (11/13/19) that Resident #2's oxygen was order continuous.
-She previously thought Resident #2's oxygen was ordered as needed.

Interview with PCA 11/13/19 at 4:47pm revealed:
-She had never seen Resident #2 with a portable oxygen tank.
-Resident #2 seemed agitated because she did not want to sit and put on the oxygen, the resident wanted to walk around.
-She was not aware Resident #2's oxygen was continuous.
-Resident #2 always went to the dining room without her oxygen on.
-She had never seen Resident #2 using portable oxygen tanks.

Interview with PCA on 11/14/19 at 2:25pm revealed:
-Resident #2 always went to the dining room without her oxygen on.
-Resident #2 had to sit in the hallway by the medication cart so staff could watch her to make sure she kept her oxygen on.
-If Resident #2 had portable oxygen tanks she would keep the oxygen on.
-Resident #2 sometimes appeared to have difficulty breathing and looked tired and worn out.
-She could also tell the resident was having difficulty breathing by the "compressions" of the resident's chest.

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-She then encouraged the resident to put the oxygen back on.
-On a good day Resident #2 kept her oxygen on two to three hours.

Interview with Resident #2's PCP on 11/07/19 at 4:38pm revealed:
-When she visited the facility staff verbally told her that Resident #2 was non-complaint with wearing her oxygen.
-She was not aware Resident #2 did not have portable oxygen tanks.
-When she visited the facility, she never went to the residents' rooms.
-She did not know if the resident had portable oxygen available.
-She had not considered Resident #2's non-compliance with oxygen could possibly be resolved if the resident had portable oxygen tanks.

b. Review of Resident #2's current FL2 dated 05/09/19 revealed:
-Diagnoses included Alzheimer's disease, gastroesophageal reflux disease, neuropathy, hyperlipidemia, anemia, hypothyroidism, coronary disease, vitamin D deficiency and depression.
-There was a physician's order for esomeprazole magnesium 40mg once daily (used to treat acid reflux).

Review of Resident #2's physician's orders dated 09/18/19 revealed esomeprazole magnesium 40mg once daily.

Review of Resident #2's October 2019 electronic Medication Administration Records (eMARs) Revealed:
-There was an entry for esomeprazole magnesium 40mg once daily at 6:00am.

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-There was documentation esomeprazole 40mg was unavailable on 10/10/19, 10/11/19, 10/12/19, 10/15/19, 10/16/19, 10/17/19, and 10/18/19.
-There was also documentation that staff administered esomeprazole 40mg on 10/13/19, 10/14/19, 10/19/19 and 10/20/19.

Interview with a pharmacist from the contracted pharmacy on 11/13/19 at 12:42pm revealed:
-On 08/21/19, the pharmacy dispensed 30 tablets of esomeprazole 40mg.
-In September 2019, no esomeprazole was dispensed.
-On 10/21/19, the pharmacy dispensed 30 tablets of esomeprazole 40mg.
-Protein Pump Inhibitor (PPI) medications for acid reflux medications were not automatically refilled.
-The facility staff had to call and request a refill of the medication.

Interview with the medication aide (MA) on 11/13/19 at 4:07pm revealed:
-Most medications were on a cycle fill system.
-Medication that were not cycle filled should be reordered when the medication was down to a three day supply.
-She did not know why Resident #2's esomeprazole was out of stock in October 2019.
-When she administered medications she was unable to see the documentation by other medication aides.
-The MA on the cart should let the Special Care Unit (SCU) Coordinator know the medication has not been delivered.
-The SCUC should call the pharmacy to inquire why the medication was not delivered.
-She did not know if Resident #2's PCP was notified when the medication was not available.

Interview with the Administrator on 11/14/19 at

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D 273	Continued From page 83 5:50pm revealed: -If a medication was not available staff should have ordered the medication from the pharmacy. -If staff were unable to re-order the medication the Resident Care Coordinator (RCC) and Primary Care Provider (PCP) both should be notified and the RCC should follow-up. -After the medication was ordered the medication should be in the facility that night if ordered before 5:00 pm. -The goal was not to run out of medications. -The medication aide should re-order medications when there was a three-day supply left. -To prevent residents' medications from running out, the medication aide was required to do weekly cart audits. -The RCC and SCU Coordinator were responsible to ensure cart audits were completed. Interview with Resident #2's Primary Care Provider (PCP) on 11/15/19 at 10:57am revealed: -If Resident #2 needed new order to refill esomeprazole the facility staff should have contacted her office. -She was not in her office and was unable to recall why esomeprazole was ordered for Resident #2. -She expected facility staff administer medications as ordered. 2. Review of Resident #4's current FL-2 dated 5/27/19 revealed: -Diagnoses included dementia with behavioral disturbance, traumatic brain injury, major neurocognitive disorder with behaviors, anxiety, cognitive communication deficit, and history of alcohol abuse. a. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for carbamazepine	D 273		

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D 273	Continued From page 84 (used to treat mood and agitation) 200 mg 3 times a day. Review of Resident #4's August 2019, September 2019, and October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for carbamazepine 200 mg 3 times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm daily. -Carbamazepine was documented as refused 20 of 93 opportunities from 08/01/19 to 08/31/19. -Carbamazepine was documented as refused 2 of 90 opportunities from 09/01/19 to 09/30/19. -Carbamazepine was documented as refused 1 of 93 opportunities from 10/01/19 to 10/31/19. Interview with a medication aide (MA) on 11/13/19 at 3:19pm revealed: -For refusal of medications the MA was supposed to contact the physician after the 2nd or 3rd refusal. However, they could only see the previous dose of medication in the computer. -After so many refusals, she would let the Special Care Unit (SCU) Coordinator and the primary care provider (PCP) know. -The SCU Coordinator printed the medication refusal list daily and reviewed it. Interview with the SCU Coordinator on 11/14/19 at 2:46 pm revealed: -She did not know if the facility had a policy regarding refusal of medications. -She would notify the physician after a resident had refused their medications 3 or 4 times. Interview with a first shift MA on 11/13/19 at 12:20pm revealed: -She had worked at the facility since April 2019. -After so many refusals, she would let the SCUC and the PCP know.	D 273		

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D 273	Continued From page 85 Interview with the Administrator on 11/14/19 at 5:30pm revealed: -The Resident Care Coordinator (RCC) was responsible to assure the physician was contacted for a resident refusing a treatment. -There should be documentation in the resident's progress notes regarding the physician notification. Review of Resident #4's record revealed there were no progress notes made for refusal of medication from 06/02/19 to 11/11/19. Telephone interview with Resident #4's PCP's Nurse Practitioner (NP) on 11/15/19 at 10:15pm revealed: -She had not been informed of the medication refusals. -Resident #4's mind was "not right" as he had a history of a traumatic brain injury. -She could not say whether or not Resident #4 refusing his medications had a good or bad effect on him. Based on observation, interview, and record review, it was determined Resident #4 was not interviewable. b. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for trazadone (used to treat sleep disorders) 200 mg daily at bedtime. Review of Resident #4's August 2019, September 2019 and October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for trazadone 200 mg daily at bedtime scheduled for administration at 8:00pm daily. -Trazadone was documented as refused 20 of 31	D 273		

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opportunities from 08/01/19 to 08/31/19.
-Trazadone was documented as refused 2 of 30 opportunities from 09/01/19 to 09/30/19.
-Trazadone was documented as not administered 4 of 30 opportunities 09/01/19 to 09/30/19 with a reason of medication not available.
-Trazadone was documented as refused 1 of 31 opportunities from 10/01/19 to 10/31/19.

Interview with a medication aide (MA) on 11/13/19 at 3:19pm revealed:
-For refusal of medications the MA was supposed to contact the physician after the 2nd or 3rd refusal. However, they could only see the previous dose of medication in the computer.
-After so many refusals, she would let the Special Care Unit (SCU) Coordinator and the primary care provider (PCP) know.
-The SCU Coordinator printed the medication refusal list daily and reviewed it.

Interview with the SCUC on 11/14/19 at 2:46pm revealed:
-When looking at the MAR, "drug/item unavailable" meant the medication was not on the cart.
-She did not know if the facility had a policy regarding refusal of medications.
-She would notify the physician after a resident had refused their medications 3 or 4 times.

-Interview with a first shift MA on 11/13/19 at 12:20pm revealed:
-She had worked at the facility since April 2019.
-After so many refusals, she would let the SCUC and the PCP know.

Interview with the Administrator on 11/14/19 at 5:30pm revealed:
-The Resident Care Coordinator (RCC) was

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responsible to assure the physician was contacted for a resident refusing a treatment.
-There should be documentation in the resident's progress notes regarding the physician notification.

Review of Resident #4's record revealed there were no progress notes made for refusal of medication from 06/02/19 to 11/11/19.

Telephone interview with Resident #4's PCP's Nurse Practitioner (NP) on 11/15/19 at 10:15pm revealed:
-She had not been informed of the medication refusals.
-Resident #4's mind was "not right" as he had a history of a traumatic brain injury.
-She could not say whether or not Resident #4 refusing his medications had a good or bad effect on him.

Based on observation, interview, and record review, it was determined Resident #4 was not interviewable.

c. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for benztropine (used to treat involuntary movements) 0.5 mg 2 times a day.

Review of Resident #4's August 2019, September 2019 and October 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for benztropine 0.5 mg twice daily scheduled for administration at 8:00am and 8:00pm daily.
-Benztropine was documented as refused 20 of 62 opportunities from 08/01/19 to 08/31/19.
-Benztropine was documented as refused 2 of 60 opportunities from 09/01/19 to 09/30/19.

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-Benztropine was documented as refused 1 of 62 opportunities from 10/01/19 to 10/31/19.

Interview with a medication aide (MA) on 11/13/19 at 3:19pm revealed:
-For refusal of medications the MA was supposed to contact the physician after the 2nd or 3rd refusal. However, they could only see the previous dose of medication in the computer.
-After so many refusals, she would let the Special Care Unit (SCU) Coordinator and the primary care provider (PCP) know.
-The SCU Coordinator printed the medication refusal list daily and reviewed it.

Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed:
-She did not know if the facility had a policy regarding refusal of medications.
-She would notify the physician after a resident had refused their medications 3 or 4 times.

Interview with a first shift MA on 11/13/19 at 12:20pm revealed:
-She had worked at the facility since April 2019.
-After so many refusals, she would let the SCUC and the PCP know.

Interview with the Administrator on 11/14/19 at 5:30pm revealed:
-The Resident Care Coordinator (RCC) was responsible to assure the physician was contacted for a resident refusing a treatment.
-There should be documentation in the resident's progress notes regarding the physician notification.

Review of Resident #4's record revealed there were no progress notes made for refusal of medication from 06/02/19 to 11/11/19.

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Telephone interview with Resident #4's PCP's Nurse Practitioner (NP) on 11/15/19 at 10:15pm revealed:
-She had not been informed of the medication refusals.
-Resident #4's mind was "not right" as he had a history of a traumatic brain injury.
-She could not say whether or not Resident #4 refusing his medications had a good or bad effect on him.

Based on observation, interview, and record review, it was determined Resident #4 was not interviewable.

d. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for famotidine (used to treat gastroesophageal reflux) 20 mg twice daily.

Review of Resident #4's August 2019, September 2019 and October 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for famotidine 20 mg twice daily scheduled for administration at 8:00am and 8:00pm daily.
-Famotidine was documented as refused 20 of 62 opportunities from 08/01/19 to 08/31/19.
-Famotidine was documented as refused 2 of 60 opportunities from 09/01/19 to 09/30/19.
-Famotidine was documented as refused 1 of 62 opportunities from 10/01/19 to 10/31/19.

Interview with a medication aide (MA) on 11/13/19 at 3:19pm revealed:
-For refusal of medications the MA was supposed to contact the physician after the 2nd or 3rd refusal. However, they could only see the previous dose of medication in the computer.

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-After so many refusals, she would let the Special Care Unit (SCU) Coordinator and the primary care provider (PCP) know.
-The SCU Coordinator printed the medication refusal list daily and reviewed it.

Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed:
-She did not know if the facility had a policy regarding refusal of medications.
-She would notify the physician after a resident had refused their medications 3 or 4 times.

Interview with a first shift MA on 11/13/19 at 12:20pm revealed:
-She had worked at the facility since April 2019.
-After so many refusals, she would let the SCU Coordinator and the PCP know.

Interview with the Administrator on 11/14/19 at 5:30pm revealed:
-The Resident Care Coordinator (RCC) was responsible to assure the physician was contacted for a resident refusing a treatment.
-There should be documentation in the resident's progress notes regarding the physician notification.

Review of Resident #4's record revealed there were no progress notes made for refusal of medication from 06/02/19 to 11/11/19.

Telephone interview with Resident #4's PCP's Nurse Practitioner (NP) on 11/15/19 at 10:15pm revealed:
-She had not been informed of the medication refusals.
-Resident #4's mind was "not right" as he had a history of a traumatic brain injury.
-She could not say whether or not Resident #4

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refusing his medications had a good or bad effect on him.

Based on observation, interview, and record review, it was determined Resident #4 was not interviewable.

e. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for atorvastatin (used to treat high cholesterol) 20 mg daily.
Review of Resident #4's August 2019, September 2019 and October 2019 electronic Medication Administration Record (eMAR) revealed Atorvastatin 20 mg daily scheduled for administration 8:00 pm daily.
-Atorvastatin was documented as refused 3 of 31 opportunities from 08/01/19 to 08/31/19.
-Atorvastatin was documented as refused 2 of 30 opportunities from 09/01/19 to 09/30/19.
-Atorvastatin was documented as refused 1 of 31 opportunities from 10/01/19 to 10/31/19.

Interview with a medication aide (MA) on 11/13/19 at 3:19pm revealed:
-For refusal of medications the MA was supposed to contact the physician after the 2nd or 3rd refusal. However, they could only see the previous dose of medication in the computer.
-After so many refusals, she would let the Special Care Unit (SCU) Coordinator and the primary care provider (PCP) know.
-The SCU Coordinator printed the medication refusal list daily and reviewed it.

Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed:
-She did not know if the facility had a policy regarding refusal of medications.
-She would notify the physician after a resident had refused their medications 3 or 4 times.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 92 Interview with a first shift MA on 11/13/19 at 12:20pm revealed: -She had worked at the facility since April 2019. -After so many refusals, she would let the SCU Coordinator and the PCP know. Interview with the Administrator on 11/14/19 at 5:30pm revealed: -The Resident Care Coordinator (RCC) was responsible to assure the physician was contacted for a resident refusing a treatment. -There should be documentation in the resident's progress notes regarding the physician notification. Review of Resident #4's record revealed there were no progress notes made for refusal of medication from 06/02/19 to 11/11/19. Telephone interview with Resident #4's PCP's Nurse Practitioner (NP) on 11/15/19 at 10:15pm revealed: -She had not been informed of the medication refusals. -Resident #4's mind was "not right" as he had a history of a traumatic brain injury. -She could not say whether or not Resident #4 refusing his medications had a good or bad effect on him. Based on observation, interview, and record review, it was determined Resident #4 was not interviewable. f. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for docusate sodium (used to treat constipation) 100 mg twice daily. Review of Resident #4's August 2019, September	D 273		

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D 273	Continued From page 93 2019 and October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for docusate sodium 100 mg twice daily scheduled for administration at 8:00am and 8:00pm daily. -Docusate Sodium was documented as refused 20 of 62 opportunities from 08/01/19 to 08/31/19. -Docusate sodium was documented as refused 2 of 60 opportunities from 09/01/19 to 09/30/19. -Docusate sodium was documented as not administered 21 of 60 opportunities 09/01/19 to 09/30/19 with a reason of medication not available. -Docusate sodium was documented as refused 1 of 62 opportunities from 10/01/19 to 10/31/19. Interview with a medication aide (MA) on 11/13/19 at 3:19pm revealed: -For refusal of medications the MA was supposed to contact the physician after the 2nd or 3rd refusal. However, they could only see the previous dose of medication in the computer. -After so many refusals, she would let the Special Care Unit (SCU) Coordinator and the primary care provider (PCP) know. -The SCU Coordinator printed the medication refusal list daily and reviewed it. Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed: -She did not know if the facility had a policy regarding refusal of medications. -She would notify the physician after a resident had refused their medications 3 or 4 times. Interview with a first shift MA on 11/13/19 at 12:20pm revealed: -She had worked at the facility since April 2019. -After so many refusals, she would let the SCUC and the PCP know.	D 273		

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D 273	Continued From page 94 Interview with the Administrator on 11/14/19 at 5:30pm revealed: -The Resident Care Coordinator (RCC) was responsible to assure the physician was contacted for a resident refusing a treatment. -There should be documentation in the resident's progress notes regarding the physician notification. Review of Resident #4's record revealed there were no progress notes made for refusal of medication from 06/02/19 to 11/11/19. Telephone interview with Resident #4's PCP's Nurse Practitioner (NP) on 11/15/19 at 10:15pm revealed: -She had not been informed of the medication refusals. -Resident #4's mind was "not right" as he had a history of a traumatic brain injury. -She could not say whether or not Resident #4 refusing his medications had a good or bad effect on him. Based on observation, interview, and record review, it was determined Resident #4 was not interviewable. g. Review of Resident #4's physician's order dated 7/25/19 revealed meloxicam (used to treat pain) 7.5 mg 2 times daily with food was ordered. Review of Resident #4's August 2019, September 2019 and October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for meloxicam 7.5 mg twice daily scheduled for administration at 8:00am and 8:00pm daily. -Meloxicam was documented as refused 20 of 62	D 273		

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opportunities from 08/01/19 to 08/31/19.
-Meloxicam was documented as refused 2 of 60 opportunities from 09/01/19 to 09/30/19.
-Meloxicam was documented as refused 1 of 62 opportunities from 10/01/19 to 10/31/19.

Interview with a medication aide (MA) on 11/13/19 at 3:19pm revealed:
-For refusal of medications the MA was supposed to contact the physician after the 2nd or 3rd refusal. However, they could only see the previous dose of medication in the computer.
-After so many refusals, she would let the Specail Care Unit (SCU) Coordinator and the primary care provider (PCP) know.
-The SCU Coordinator printed the medication refusal list daily and reviewed it.

Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed:
-She did not know if the facility had a policy regarding refusal of medications.
-She would notify the physician after a resident had refused their medications 3 or 4 times.

Interview with a first shift MA on 11/13/19 at 12:20pm revealed:
-She had worked at the facility since April 2019.
-After so many refusals, she would let the SCU Coordinator and the PCP know.

Interview with the Administrator on 11/14/19 at 5:30pm revealed:
-The Resident Care Coordinator (RCC) was responsible to assure the physician was contacted for a resident refusing a treatment.
-There should be documentation in the resident's progress notes regarding the physician notification.

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Review of Resident #4's record revealed there were no progress notes made for refusal of medication from 06/02/19 to 11/11/19.

Telephone interview with Resident #4's PCP's Nurse Practitioner (NP) on 11/15/19 at 10:15pm revealed:
-She had not been informed of the medication refusals.
-Resident #4's mind was "not right" as he had a history of a traumatic brain injury.
-She could not say whether or not Resident #4 refusing his medications had a good or bad effect on him.

Based on observation, interview, and record review, it was determined Resident #4 was not interviewable.

3. Review of Resident #7's current FL2 dated 05/14/19 revealed:
-Diagnoses included dementia, breast cancer, hypertension, and a history of rib fracture.
-In the medications section, there was a note which documented to see physician's orders.
-There were physician's orders attached to the FL2 and dated 05/14/19 which included orders for ipratropium-albuterol (duoneb) (a medication used to treat symptoms of chronic obstructive pulmonary disease (COPD) 0.5 mg-3 mg/ 3 mL inhale 1 vial via nebulizer 4 times daily at 9:00am, 1:00pm, 4:30pm, and 8:00pm.

Review of Resident #7's physician's order dated 05/21/19 revealed:
-There was an order for a nebulizer machine and all components.
-There was an order for duonebs 4 times daily.

Review of Resident #7's patient encounter

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summary dated 06/28/19 revealed:
-Resident #7 was seen by the Primary Care Provider (PCP) on 05/21/19 due to need for a nebulizer machine.
-A new order was written for the nebulizer machine and all components.
-There was an order for duonebs 4 times daily.

Review of Resident #7's physician's order dated 08/07/19 revealed:
-There was a note to the physician Resident #7 needed a nebulizer machine or order to discontinue duonebs.
-The PCP wrote an order to change duonebs to 4 times daily as needed and "needs nebulizer machine."
-It was documented the order was received by the Special Care Unit (SCU) Coordinator.

Review of Resident #7's patient encounter summary dated 08/20/19 revealed:
-Resident #7 was seen by the PCP on 08/07/19.
-There was documentation Resident #7 needed a nebulizer machine for her as needed respiratory treatment to treat a chronic cough and congestion.
-There was an order to discontinue scheduled nebulizer treatments and change to as needed for wheezing or shortness of breath.
-There was an order to obtain a nebulizer machine with all equipment.
-There was an order for duonebs as needed inhale 1 vial via hand held nebulizer 4 times daily as needed for wheezing, shortness of breath, coughing, and respiratory distress.
-There was a note documenting that it was okay to hold duonebs until the nebulizer arrived.

Review of Resident #7's patient encounter summary dated 10/09/19 revealed:

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-There was documentation Resident #7's family member reported to the PCP Resident #7 had a "terrible cough" that was productive.
-There was documentation staff reported to the PCP Resident #7 had a cough that was "chronic and possibly increased."
-The PCP's impression of Resident #7 included bilateral lower lobe chest congestion with cough and chronic bronchitis.

Review of Resident #7's physician's order dated 11/08/19 revealed obtain a nebulizer, "standard nebulizer with face mask" due to diagnosis of chronic obstructive pulmonary disease.

Review of Resident #7's electronic Medication Administration Record (eMAR) for May 2019 revealed:
-There was an entry for duonebs for nebulization o.5mg-3mg (2.5mg base)/3 mL inhale 1 vial via nebulizer four times daily to be administered at 9:00am, 1:00pm, 4:30pm, and 8:00pm.
-There was no documentation duonebs were administered for 110 of 124 opportunities from 05/01/19 through 05/31/19.
-The documented reasons why duonebs were not administered included: drug/item unavailable, other, refused, on hold, machine broken.

Review of Resident #7's eMAR for June 2019 revealed:
-There was an entry for duonebs for nebulization o.5mg-3mg (2.5mg base)/3 mL inhale 1 vial via nebulizer four times daily to be administered at 9:00am, 1:00pm, 4:30pm, and 8:00pm.
-There was no documentation duonebs were administered for 105 of 120 opportunities from 06/01/19 through 06/30/19.
-The documented reasons why duonebs were not administered included: drug/item unavailable and

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D 273	Continued From page 99 machine broken. Review of Resident #7's eMAR for July 2019 revealed: -There was an entry for duonebs for nebulization o.5mg-3mg (2.5mg base)/3 mL inhale 1 vial via nebulizer four times daily to be administered at 9:00am, 1:00pm, 4:30pm, and 8:00pm. -There was no documentation duonebs were administered for 124 of 124 opportunities from 07/01/19 through 07/31/19. -The documented reasons why duonebs were not administered included: drug/item unavailable and machine broken. Review of Resident #7's eMAR for August 2019 revealed: -There was an entry for duonebs for nebulization o.5mg-3mg (2.5mg base)/3 mL inhale 1 vial via nebulizer four times daily to be administered at 9:00am, 1:00pm, 4:30pm, and 8:00pm. -There was no documentation duonebs were administered for 89 of 92 opportunities from 08/01/19 through 08/23/19. -The documented reasons why duonebs were not administered included: drug/item unavailable and machine broken. -There was a discontinue date of 08/24/19 on the entry for duonebs. Review of Resident #7's eMAR for September, October, and November 2019 revealed there was no entry for duonebs inhale 1 vial via nebulizer four times times as needed. Review of Resident #7's progress notes for May through November 2019 revealed no documentation regarding duonebs or a nebulizer machine with components.	D 273		

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Observation of Resident #7's room on 11/07/19 at 3:39pm revealed there was no nebulizer machine in Resident #7's room.

Based on observation, interview, and record review, it was determined Resident #7 was not interviewable.

Interview with a representative from the contracted pharmacy on 10/07/19 at 3:11pm revealed:
-There was a current order dated 05/15/19 for duonebs 360 ml inhale 1 vial 4 times daily.
-There was a 30 day supply of 120 vials delivered to the facility on 05/16/19 at 7:02am.
-There had been no requests by the facility staff to refill duonebs.
-The pharmacy had not received an order for duonebs as 4 times daily as needed.
-The pharmacy had not received an order to discontinue duonebs.

Interview with a second shift Medication Aide on 11/07/19 at 3:48pm revealed:
-She did not know there was a physician's order for a nebulizer and treatments.
-Resident #7 was not administered nebulizer treatments.
-Resident #7 has never had a nebulizer in her room that she knew of.

Interview with the SCU Coordinator on 11/07/19 at 3:52pm revealed:
-She knew Resident #7 had physician's orders for a nebulizer machine and duonebs.
-Resident #7 did not currently have a nebulizer machine because there was an issue with Resident #7's insurance not covering the machine.
-Duonebs had been discontinued from the eMAR

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D 273	Continued From page 101 in August 2019 due to the note on Resident #7's patient encounter summary dated 08/20/19 documenting "okay to hold duonebs until the nebulizer arrived." -She had not followed up with Resident #7's PCP to let her know Resident #7 still did not have a nebulizer machine and did not administer duonebs as ordered. Interview with a representative at the medical equipment provider on 11/07/19 at 4:16pm revealed: -The medical equipment provider received a face sheet and verified insurance information for Resident #7 on 05/17/19. -Resident #7's insurance covered a regular nebulizer machine with a face mask. -The medical equipment provider received the patient encounter summary on 08/28/19 signed by the physician on 08/20/19 with orders for a nebulizer with all components and duonebs as needed inhale 1 vial via hand held nebulizer 4 times daily as needed. -She informed the medical equipment provider sales representative on 08/29/19 the medical equipment provider did not carry any hand held nebulizer machines. -She was not sure which type of machine the PCP wanted Resident #7 to have so she needed clarification of the order. -There was documentation the SCU Coordinator was notified in September 2019 that the medical equipment provider needed clarification of the physician's order. -The medical equipment provider needed the physician's order to say "nebulizer with a face mask." -The medical equipment provider had not received an order for a nebulizer for Resident #7 other than the one received on 08/28/19.	D 273		

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D 273	Continued From page 102 Interview with the medical equipment provider sales representative on 11/07/19 at 4:24pm revealed: -He last spoke with the SCU Coordinator in September 2019 regarding the medical equipment provider not being able to offer a hand held nebulizer. -He informed the SCU Coordinator the medical equipment provider was able to provide a standard nebulizer and that a new physician's order was needed. -The SCU Coordinator informed him she would work on getting a new order in September 2019. -He had not been contacted by the facility since September 2019 for follow up regarding Resident #7's nebulizer. -There were no issues with Resident #7's insurance covering a standard nebulizer. -He was contacted by the SCU Coordinator today on 11/07/19 regarding the order for a nebulizer for Resident #7. Interview with a first shift MA on 11/08/19 at 11:47am revealed: -She had never administered duonebs via a nebulizer to Resident #7. -Resident #7 did not currently have a nebulizer, but she did have one about 8 months ago. -The old nebulizer was broken as steam was no longer coming out through the mask. -She had documented on Resident #7's eMARs "drug/item not available and machine broken." -She had not talked to anyone regarding Resident #7 not having a nebulizer so that her duonebs could be administered. -The SCU Coordinator and the MAs were responsible for contacting the medical equipment provider for equipment repair and to order new equipment.	D 273		

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D 273	Continued From page 103 Interview with the Administrator on 11/08/19 at 4:25pm revealed: -She did not know Resident #7 did not have a nebulizer in the building for administration of duonebs. -The SCU Coordinator was responsible for ordering medical equipment in the SCU and the Resident Care Coordinator (RCC) was responsible for ordering medical equipment in the assisted living unit. -Staff was working on getting a nebulizer in the facility for Resident #7. Observation of Resident #7 on 11/12/19 at 9:49am revealed Resident #7 was seated in the nurse's station and was being administered duoneb through a nebulizer machine with a face mask. Interview with a MA Supervisor on 11/12/19 at 10:08am revealed: -She knew Resident #7 had physician's orders for duonebs via a nebulizer. -Resident #7 had been without her nebulizer for several months to due her nebulizer being broken. -The SCU Coordinator was responsible for contacting the medical equipment provider for repairs or to obtain a new nebulizer. -She had talked to the SCU Coordinator, but did not remember when, about Resident #7 not having a nebulizer and the SCU Coordinator told her she was trying to obtain orders for a new nebulizer. -Resident #7 did not have any difficulty breathing, but she had chest congestion. Interview with the PCP on 11/07/19 at 4:43pm revealed:	D 273		

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-She had written orders two times for a nebulizer machine for Resident #7.
-She did not know Resident #7 still did not have a nebulizer.
-Resident #7 needed duoneb via a nebulizer machine for diagnoses of chronic obstructive pulmonary disease (COPD) and chronic cough.
-Resident #7 had not had any hospitalizations due to symptoms of COPD.
-There were no negative outcomes of Resident #7 not having duonebs via the nebulizer.
-She expected the facility to obtain the nebulizer machine and all components after the first time it was ordered and she expected to be notified the nebulizer was still not in the facility.

Attempted interview with Resident #7's family member on 11/12/19 at 10:19 was unsuccessful.

4. Review of Resident #6's current FL2 dated 05/21/19 revealed diagnoses included acute gouty arthropathy, acute kidney failure diabetes mellitus, abnormal glucose, chronic kidney disease, hypertension, and acute and chronic deep vein thrombosis/embolism.

a. Review of Resident #6's physician's orders revealed:
-There was a physician's orders dated 06/29/19 for weekly weights to be obtained.
-There was a subsequent physician's order dated 09/16/19 to check weights daily.
-There was a hospital discharge summary dated 10/20/19 with no instructions regarding Resident #6's weights.

Review of Resident #6's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for check weight once

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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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weekly scheduled to be obtained on Mondays at 9:00am.
-"Not Administered: Refused" was documented on 08/05/19, 08/12/19, 08/19/19 and 08/26/19.

Review of Resident #6's September 2019 eMAR revealed:
-There was an entry for check weight once weekly scheduled to be obtained on Mondays at 9:00am.
-"Not Administered: Refused" was documented on 09/02/19, 09/09/19, and 09/16/19.
-On 09/20/19, there was an entry on the September eMAR for daily weights.
-Daily weights were documented as refused on 09/20/19, 09/21/19, 09/22/19, 09/23/19, 09/24/19, and on 09/25/19.
-There were documented daily weights from 09/2519 to 09/30/19.

Review of Resident #6's October 2019 eMAR revealed:
-There was an entry for daily weights.
-Daily weights were documented as refused from 10/03/19 through 10/06/19, from 10/12/19 through 10/15/19.
-Resident #6 was documented as in the hospital from 10/18/19 to 10/20/19.
-There were documented weights on 10/21/19 and 10/24/19.
-Resident #6 had documented refusals for weights on 10/22/19 and 10/23/19.
-Daily weights were discontinued by the pharmacy on 10/24/19 due to not being ordered on the hospital discharge summary dated 10/20/19.

Review of Resident #6's record revealed no documentation for notifying the resident's primary care provider (PCP) regarding refusing weekly

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weights or daily weights in August 2019, September 2019, or October 2019.

Interview with a dayshift medication aide (MA) on 11/13/19 at 1:45pm revealed:
-Resident #6 refused weekly weights routinely.
-Resident #6 allowed staff to obtain daily weights on a few occasions as were documented on the eMAR.
-She had not notified Resident #6's PCP regarding the resident refusing weights.

Interview with a second shift MA on 11/13/19 at 3:10pm revealed:
-She knew Resident #6 refused weights when ordered weekly and daily.
-Resident #6 allowed staff to weight her when she was in a good mood.
-She had not notified Resident #6's PCP regarding the resident refusing weights.

Telephone interview with Resident #6's primary care provider's Nurse Practitioner (NP) revealed:
-There was no documentation the facility had notified her for Resident #6's refusal of weights.
-She would expect the facility to notify her if a resident was not receiving a treatment or medication as ordered or refused treatments or medications.
-She visited the facility weekly and observed Resident #6 at least every other week when she visited the facility.
-Weights were ordered when Resident #6 had experienced an increase in lower leg edema.
-Resident #6's leg had not shown an increase in swelling nor had she observed any obvious change in the way her clothes fit (she watched residents' appearance for indications of weight gain or loss).
-She did not think Resident #6 had negative

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outcome from refusing weights and not being weighed.

Interview with the Administrator on 11/14/19 at 5:30pm revealed:
-The Resident Care Coordinator (RCC) was responsible to assure the physician was contacted for a resident refusing a treatment.
-There should be documentation in the resident's progress notes regarding the physician notification.

b. Review of Resident #6's physician's orders dated 05/04/19 and hospital discharge summary (for a fall) dated 10/20/19 revealed an order for nystatin powder (used to treat yeast infection) 100,000 units/gram apply powder twice daily to folds of stomach.

Review of Resident #6's August 2019, September 2019, and October 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for nystatin powder 2 times a day to fold of stomach and scheduled for administration 7:00am to 3:00pm and 3:00pm to 11:00pm daily.
-Nystatin powder was documented as refused 12 of 62 opportunities from 08/01/19 to 08/31/19.
-Nystatin powder was documented as refused 33 of 60 opportunities from 09/01/19 to 09/30/19.
-Nystatin powder was documented as refused 36 of 62 opportunities from 10/01/19 to 10/31/19 (Resident #6 was in the hospital from 10/18/19 to 10/20/19).

Review of Resident #6's record revealed no documentation for notifying the resident's primary care provider (PCP) regarding refusing nystatin powder in August 2019, September 2019, or October 2019.

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D 273	Continued From page 108 Interview with a first shift medication aide (MA) on 11/13/19 at 1:08 pm revealed for refusal of medications the MA was supposed to contact the physician after the 2nd or 3rd refusal. However, they can only see the previous dose of medication. Interview with a second first shift medication aide (MA) on 11/13/19 at 1:45pm revealed: -Resident #6 refused nystatin powder routinely. -Resident #6 allowed staff to apply nystatin powder to her stomach on a few occasions as were documented on the eMAR. -She had not notified Resident #6's PCP regarding the resident refusing nystatin powder. -The Resident Care Coordinator (RCC) reviewed the eMARs and would be responsible for notifying the PCP of refused medications. Interview with a second shift MA on 11/13/19 at 3:10pm revealed: -She knew Resident #6 refused nystatin powder routinely. -Resident #6 allowed staff to apply nystatin powder once in a while. -She had not notified Resident #6's PCP regarding the resident refusing nystatin powder. Interview with the Administrator on 11/14/19 at 5:30pm revealed: -The RCC was responsible to assure the physician was contacted for a resident refusing a medication. -There should be documentation in the resident's progress notes regarding the physician notification. Telephone interview with Resident #6's PCP's Nurse Practitioner on 11/15/19 at 8:28am	D 273		

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D 273	Continued From page 109 revealed: -There was no documentation the facility had notified her for Resident #6's refusal of nystatin powder. -She would expect the facility to notify her if a resident was not receiving a treatment or medication as ordered or refused treatments or medications. -She visited the facility weekly and observed Resident #6 at least every other week when she visited the facility. -Nystatin powder should probably be ordered as needed for Resident #6 but staff had not contacted her to request the order change. -She occasionally reviewed residents' eMARS when she had resident appointments but had not noticed the nystatin refusals. The facility failed to follow-up with the medical equipment provider to obtain portable oxygen equipment for a resident with a history of respiratory failure, and chronic obstructive pulmonary disease who had orders for continuous oxygen (#2) and for nebulizer equipment for a resident with a history of pneumonia and chronic obstructive pulmonary disease (#7); and did not notify the PCP when a resident with Alzheimer's disease refused multiple medications, and blood pressures and pulse checks (#4). 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 11/08/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	D 273		

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D 273	Continued From page 110 30, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure implementation of physician's orders for 1 of 7 sampled residents (Resident #2) with orders for continuous positive airway pressure (CPAP) and oxygen concentrator set at 3 liters per minute (LPM). The findings are: Review of Resident #2's current FL2 dated 05/09/19 revealed: -Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease with hypoxia, coronary disease, and depression. -The recommended level of care for Resident #2 was Special Care Unit (SCU).	D 276		

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D 276	Continued From page 111 -There was no order for CPAP on the FL2. Review of a hospital discharge summary report dated 04/26/19 revealed: -Resident #2 was admitted for respiratory failure. a. Review of a discharge orders dated 04/26/19 with instructions to "use CPAP every night." Observation of Resident #2's room and living space on 11/06/19 at 8:40 am revealed there was no CPAP machine available for the resident to use. Interview with a medication aide (MA) on 11/07/19 at 3:12 pm revealed she had worked at the facility since April 2019 and never saw Resident #2 using a CPAP. Interview with a representative from the home therapy equipment company on 11/08/19 at 1:00 pm revealed they had never received orders for at CPAP machine for Resident #2. Interview with the MA supervisor on 11/13/19 at 4:07pm revealed she never saw the resident use a CPAP. Interview with a personal care aide (PCA) on 11/13/19 at 4:47pm revealed she never saw Resident #2 with a CPAP machine. Interview with a second PCA on 11/14/19 at 2:25pm revealed she never saw Resident #2 with a CPAP machine. Interview with the primary care provider (PCP) on 11/07/19 at 4:38pm revealed: -She was aware that Resident #2 was hospitalized in April 2019 for respiratory failure.	D 276		

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D 276	Continued From page 112 -Resident #2 had a diagnoses of chronic obstructive pulmonary disease (COPD), which possibly why the CPAP was ordered. -When Resident #2 returned from the hospital she did not view the hospital discharge report. -She did not know Resident #2 was ordered a CPAP. -When she visited the facility, she did not see the residents in their room. -She went by what facility staff told her, and if they did not tell her about the CPAP or they did not clarify the order for the CPAP she did not know about the CPAP. -She expected facility staff to contact her to obtain an order for the CPAP or to at least clarify if she wanted the resident to wear a CPAP. Interview with the Administrator on 11/08/19 at 11:10am revealed: -She was not aware Resident #2 had an order for a CPAP. -When a resident returned from the hospital, the SCU Coordinator should have reviewed the hospital report and obtained a separate order for the CPAP. -After receiving the order, the SCU Coordinator should have sent the order to the pharmacy. -She did not start working at the facility until July 2019, so she could not say specifically what happened and why Resident #2 was not currently using a CPAP. -The staff that were at the facility in May 2019 were no longer at the facility. Based on record review, observations, interviews with staff it was determined that Resident #2 was not interviewable. b. Review of Resident #2's current FL2 dated 05/09/19 revealed:	D 276		

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-Diagnoses included Alzheimer disease, chronic obstructive pulmonary disease with hypoxia, coronary disease, and depression.
-The recommended level of care for Resident #2 was Special Care Unit (SCU).
-There was no order for oxygen on the FL2.

Review of a hospital discharge summary report dated 04/26/19 revealed:
-Resident #2 was admitted for respiratory failure.
-The discharge orders and instructions were "wear 02 (oxygen) 3 liters via NC (nasal cannula) at all times."

Review of Resident #2's record revealed a 02 test done by primary care practitioner's (PCP) nurse on 05/09/19. The resident's oxygen saturation level on room air was 84%.

Observation of Resident #2 on 11/06/19 at 4:40 am revealed:
--Resident #2 was sitting on the side of the bed.
-Resident #2's oxygen concentrator was in front of the resident.
-The resident did not have the nasal cannula on, it was laying on the floor in front of the machine.
-The personal care aide (PCA) did not attempt to put the oxygen on the resident.

Observation of Resident #2 on 11/06/19 at 8:00 am revealed:
-Resident #2 was sitting in the dining room consuming the breakfast meal.
-Resident #2 did not have oxygen on.
-There was no oxygen concentrator or portable oxygen tanks in the dining room with Resident #2.
-After the meal, the medication aide (MA) called Resident #2 and told the resident to sit in the chair that was placed by the medication cart.
-Between the medication cart and the chair was

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an oxygen concentrator.
-There was a nasal cannula that was laying on top of the concentrator.
-Resident #2 sat down in the chair and after her nebulizer treatment, the MA put the oxygen on Resident #2.
-The concentrator dial was on 2.5 liters per minute.

Observation of Resident #2 on 11/06/19 at 12:10pm revealed:
-The resident was sitting in a chair near the medication cart in the hallway.
-The concentrator was positioned in the main hallway between the medication cart and a straight back chair where Resident #2 was sitting.
-The equipment was on with sounds coming from the equipment.
-There was a nasal cannula attached to the equipment.
-The dial on the concentrator was set at 2.5 liters per minute.

Observation on 11/06/19 at 12:00 pm to 12:50 pm of the lunch meal revealed:
-Resident #2 was sitting in the dining room consuming her meal.
-Resident #2 did not have oxygen on.
-There was no oxygen concentrator or portable oxygen tanks in the dining room with Resident #2.
-The resident did not appear to be struggling to breathe but every three to five minutes took deep long breaths.
-The resident consumed the whole meal, which took fifty minutes without having her oxygen on.

Observation of Resident #2 without oxygen on 11/07/19 at various times throughout the day revealed:
-At 8:00 am Resident #2 was in the dining room

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eating breakfast with no oxygen on.
-At 9:11 am Resident #2 was in the common activity room with no oxygen on.
-The resident's concentrator was in the hallway by the medication cart, which was more than 10 feet from the resident.
-There were sounds coming from the concentrator indicating it was on.
-There was a nasal cannula attached to the machine.
-The surveyor observed Resident #2's respiration as 38.
-At 9:20 am the SCU Coordinator took the concentrator into the activity room where Resident #2 was sitting.
-At 11:04 am Resident #2 was sitting on the sofa in the common area without her oxygen on. Staff put the resident's oxygen on at 11:07 am.
-At 12:00 pm Resident #2 was in the dining room for the lunch meal, there was no oxygen in the dining room with the resident.

Observation of Resident #2 on 11/08/19 from 12:00pm to 12:28pm revealed:
-Resident #2 was in the dining room sitting for the meal without her oxygen on.
-The oxygen concentrator was in the dining room.
-The nasal cannula was on the floor.
-There were three personal care aides (PCAs) and one MA in the dining room.
-No staff in the dining put Resident #2's oxygen on.
-During the meal, the resident took several long deep breaths.

Observation of Resident #2 on 11/13/19 at 1:08 pm revealed:
-Resident had been ambulating up and down the hallway without her oxygen on.
-Resident #2 got very agitated and started yelling

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at the staff.
-The MA checked Resident #2's oxygen saturation level.
-The resident's oxygen saturation level was 51% when checked by the MA.
-The MA reapplied the resident's oxygen and after a minute her oxygen level came up to 96%.

Based on record review, observations, interviews on 11/06/19 it, was determined that Resident #2 was not interviewable.

Interview with the MA on 11/06/19 at 11:05 am revealed:
-She was aware that Resident #2's oxygen should be set at 3 LPM.
-She did not check the oxygen dial each time Resident #2 put the oxygen on.
-Each morning Resident #2's oxygen concentrator was put by the medication cart and she checked the dial to ensure it was on 3 LPM.
-Sometimes Resident #2 changed the dial on the oxygen machine.

Interview with the SCU Coordinator on 11/07/19 at 9:21 am revealed:
-The MAs were responsible to ensure the dial on Resident #2's oxygen concentrator was set on 3 LPM.
-She did not check the oxygen concentrator dial to ensure it was set at 3 LPM.

Interview with the Administrator on 11/08/19 at 11:10am revealed:
-She expected the MAs to ensure Resident #2's oxygen was set at the correct LPM as ordered.
-If Resident #2 had changed the dial the oxygen concentrator, then she expected MA to frequently check the dial to ensure the concentrator was set at the correct LPM.

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D 276	Continued From page 117 Based on record review, observations, interviews with staff and attempted interview with Resident #2 on 11/06/19 revealed it was determined Resident #2 was not interviewable.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 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: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to assure residents' rights were maintained for 10 of 15 residents (Residents #1, #2 #11, #12, #14, #15, #16, #17, #18, and #20) regarding staff yelling at a resident (#12), a staff [Staff G, personal care aide (PCA)] hitting a resident (#1), a resident being forced to sit in the hallway all day due to not having portable oxygen (#2) and residents receiving injuries and bruises after being hit by other residents (#11, #14, #15, #16, #17, #18, and #20). The findings are: 1. Review of Resident #12's current FL dated 05/09/19 revealed:	D 338		

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-Diagnoses included dementia with behaviors.
-Resident #12 was was documented as intermittently disoriented.
-The recommended level of care for the resident was Special Care Unit (SCU).

Review of Resident #12's care plan and profile dated 10/31/19 revealed Resident #12's cognitive impairments were high functioning, running on routine, some word problems, some loss of reasoning and frustrated by change.

Observation of Resident #12 on 11/06/19 at 8:38am revealed:
-Resident #12 resided in the SCU.
-Resident #12 was in her room in the bed.
-At 8:40am, a medication aide (MA) was heard talking to Resident #12 with a loud toned voice.
-The MA's voice was so loud her words could clearly be heard in a resident's room across the hall.
-The staff yelled to Resident #12 stating "#12, where is your walker?"
-"I told you to keep the walker with you."
-"This is the last time, I done told you about that walker."
-The MA went to get the walker and placed it by Resident #12's bed.
-The MA stated to Resident #12 "This conversation ain't goin to be had again!"
-The staff walked away and Resident #12 laid back down in the bed.

Interview with the MA on 11/07/19 at 3:01pm revealed:
-Resident #12 did not want to use her walker.
-The resident liked to smoke and would get light headed.
-Resident #12 would leave her walker and then yell down the hallway for staff to bring her a

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wheelchair.
-The resident thought the facility had an over flow of wheelchairs and one was always available for her.
-She verbally reminded Resident #12 to use her walker constantly.
-The resident would leave her walker in the dining room door and walk away to go and smoke.
-She had to remind Resident #12 at least two times every hour to get her walker.
-Yesterday on 11/06/19 when she asked Resident #12 about her walker, she did not realize that she was yelling, but she had to repeatedly tell the resident to get her walker.

Interview with the Administrator on 11/08/19 at 11:59am revealed:
-Resident #12 sometimes left her walker and wanted staff to bring her a wheelchair.
-She wanted the resident to use her activities of daily living as long as she possibly could.
-It appeared Resident #12 sometimes was aware when she was leaving the walker.
-However, regardless of the resident's behavior she still expected staff to be courteous and respectful regardless of the residents' disposition.
-Staff had been trained on caring for residents with Alzheimer's disease.
-Staff had residents' rights training and had on going training regarding sensitivity role playing to help them understand every resident's possible illness.
-She had not observed the MA yelling at residents.
-She had not had any complaints regarding the MA yelling at residents.

Interview with a therapist from the contract physical therapy company on 11/08/19 at 4:13pm revealed:

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-Resident #12 was currently receiving physical therapy to assist with using her walker and improving her gait.
-Resident #12 had dementia and there may be some forgetfulness due to the dementia.

Interview with Resident #12's primary care practitioner (PCP) on 11/15/19 at 11:37am revealed:
-Resident #12 was usually cooperative, but she could be stubborn.
-Resident #12 was normally easy to re-direct.
-The resident had dementia and was in a locked unit with the anticipation there would be some forgetfulness.
-To her knowledge Resident #12 did not have hearing loss or a difficult time understanding directions.

Based on record reviews, observations and interviews, it was determined Resident #12 was not interviewable.

2. Review of Resident #1's current FL2 dated 04/08/19 revealed:
-Diagnoses included dementia unspecified, diverticulitis, synovitis, and history of falls.
-The resident was documented as intermittently disoriented.
-The recommended level of care is Special Care Unit (SCU).

Review of Resident #1's care plan dated 04/08/19 revealed:
-Resident #1 resided in the SCU.
-The resident's memory was forgetful, and he needed reminders.

Review of Resident #1's hospital discharge report dated 07/21/19 revealed Resident #1 was seen

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for dizziness, closed head injury, dementia with behavioral disturbance, unspecified dementia type, and acute urinary tract infection. The resident complained that the staff hit him with a cup.

Review of Resident #1's progress note dated 07/21/19 revealed Resident #1 got into an altercation with a staff (Staff G/personal care aide). The staff appeared to hit the resident.

Review of Resident #1's Accident/Incident report dated 07/21/19 revealed at 11:30am staff observed the resident appearing to be hit by another staff. Staff was to monitor status for 72 hours and charge progress notes daily.

Interview with a medication aide (MA) on 11/06/19 at 12:39pm revealed:
-On 07/21/19 Resident #1 told her that Staff G, PCA hit him.
-The resident said Staff G hit him so hard that he became dizzy.
-She was seated in the nurses' station and did not see the full incident.
-She did not see Staff G's hands physically touch the resident, but she did see Staff G's arms and hands go up and back, and then come forward in motion as if she was going to hit the resident.
-She did not hear the sound of someone being hit.
-The resident immediately complained the staff hit him so hard that it made him dizzy.
-The facility did its own investigation and Staff G was off work until the investigation was completed.
-Resident #1 was sent to the Emergency Department (ED) for evaluation.

Interview with a second MA on 11/14/19 at

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D 338	Continued From page 122 10:21pm revealed: -She recalled the incident on 07/21/19 when Resident #1 accused Staff G of hitting him with a cup. -The resident was already moody and upset with everyone. -Resident #1 stated Staff G hit him in the face. -She did not observe the incident. -She did not see any redness on the resident's face. Interview with the Administrator on 11/07/19 at 8:49am revealed: -She was informed by the MA supervisor of the incident with Resident #1 accusing Staff G of hitting him. -She did her investigation and found out Resident #1 was agitated that day, which he sometimes did. -Staff G said Resident #1 hit her with his wheelchair and she lost her "footing," and her balance and the cup went flying out of her hand and hit Resident #1. -Staff G denied intentionally hitting Resident #1. -Resident #1 yelled out Staff G hit him with the cup. -Other staff had seen Staff G's hands go up in the air, but did not see Staff G physically hit Resident #1. -She had staff call the police to make a report. -Resident #1 was sent to the ED and it was found out that he had a urinary tract infection. -She also notified the Health Care Personnel Registry of the incident. Interview with Resident #1's family member on 11/05/19 at 2:50pm revealed: -Resident #1 was admitted to the SCU on 03/06/19. -She visited Resident #1 at least once weekly.	D 338		

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D 338	Continued From page 123 -On 07/21/19 Resident #1 told her that Staff G hit him in the head with a cup, he complained of dizziness and was sent to the hospital. -Since Resident #1 moved into the facility he had been assaulted twice by other residents and by staff. -After the incident on 07/21/19, and Resident #1 saying staff hit him she was "fed up" and moved Resident #1 out of the facility. -It did not matter if the cup was disposable Resident #1 was still hit with the cup. -Staff did not tell her about the incident and Resident #1 being hit with a cup. -She found out about the incident from Resident #1. Resident #1 was not available for interview on 11/05/19. Attempted telephone interview with Staff G on 11/08/19 at 4:53pm involved in this incident was not unsuccessful. 3. Review of Resident #2's current FL2 dated 05/09/19 revealed: -Diagnoses included Alzheimer disease, chronic obstructive pulmonary disease with hypoxia, coronary disease, and depression. -The recommended level of care for Resident #2 was Special Care Unit (SCU). -There was no order for oxygen on the FL2. Review of Resident #2's hospital discharge summary report dated 04/26/19 revealed: -Resident #2 was admitted for respiratory failure. -There was an order for oxygen 3 liters per minute (LPM) at all times. Observation of Resident #2 on 11/07/19 at 3:30pm revealed:	D 338		

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D 338	Continued From page 124 -Resident #2 was wearing oxygen via nasal cannula attached to an oxygen concentrator and sitting in a chair by the medication cart. -The resident attempted to get up several times and staff made her sit back down. Observation of Resident #2 on 11/08/19 at 1:40pm and 4:10pm revealed: -At 1:40pm Resident #2 was sitting in the chair by the medication cart in the main hallway. -The resident was wearing oxygen via nasal cannula attached to an oxygen concentrator and sleeping in the chair. -At 4:10pm Resident #2 was sitting in the chair near the medication cart in the main hallway. -The resident was wearing oxygen via canal cannula attached to an oxygen concentrator and stared at floor, then looked at everyone was they walked by her. -The resident attempted several times to reposition herself. Based on observations, records reviews and interviews on 11/06/19, it was determined that Resident #2 was not interviewable. Interview with the Special Care Unit (SCU) Coordinator on 11/06/19 at 12:53pm revealed: -She was aware Resident #2's oxygen was for 3 LPM continuous. -She was aware staff made Resident #2 sit in the hallway by the medication cart most of the day to keep her oxygen on. -Staff made the resident sit in the hallway because she was non-compliant with her oxygen. Interview with a personal care aide (PCA) on 11/06/19 at 4:40am revealed: -Resident #2 never kept her oxygen on. -If she put the oxygen on Resident #2 would take	D 338		

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it off because she liked getting up and walking around.

Interview with a second PCA on 11/13/19 at 4:47pm revealed:
-Resident #2 had to sit by the medication cart in the hallway because that was where the resident's oxygen concentrator was located.
-Staff kept the oxygen concentrator in the hallway to make sure Resident #2 did not get up and take her oxygen off.
-Resident #2 liked to walk around and she took her oxygen off so she could walk around.
-She had never seen Resident #2 with a portable oxygen tank.
-Resident #2 seemed agitated because she did not want to sit and put on the oxygen, the resident wanted to walk around.

Interview with a third PCA on 11/14/19 at 2:25pm revealed:
-She did not know Resident #2's oxygen was continuous.
-Resident #2 did not have portable oxygen tanks.
-She had never seen Resident #2 using portable oxygen tanks.
-Resident #2 had to sit in the hallway by the medication cart so staff could watch the resident to make sure she kept the oxygen on.
-She believed if Resident #2 had portable oxygen tanks she would keep the oxygen on.

Interview with the SCU Coordinator on 11/07/19 at 9:21am revealed:
-Sometimes the resident refused to put her oxygen on.
-Resident #2 was sitting in the hallway so staff could keep an eye on the resident when she took her oxygen off.
-She considered Resident #2 non-compliant with

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her oxygen because she always took her oxygen off.
-Resident #2 was made to sit in the hallway so the medication aide could ensure the resident did not get up and take her oxygen off.
-She did not know Resident #2's oxygen was ordered continuously at 3 LPM.
-She had not checked the resident's record.

Interview with a medication aide (MA) on 11/07/19 at 3:23pm revealed:
-Resident #2 did not have portable oxygen tanks therefore she had to sit in the hallway so the MA could view when she took her oxygen off.
-She realized that Resident #2 was bored sitting the hallway with nothing to do.
-Resident #2 liked to get up and walk.

Interview with the Administrator on 11/08/19 at 11:10am revealed:
-Residents should be treated with respect and dignity.
-She did not realize keeping Resident #2 sitting and not allowing the resident to move around was a residents' rights issue.

Interview with the MA supervisor on 11/13/19 at 4:07pm revealed:
-The only time Resident #2 wore oxygen was when the resident was sitting in a chair by the medication cart in the hallway.
-The only way to keep the oxygen on Resident #2 was to have the resident sit by the medication cart.
-There was nothing to do, so she tried to continually talk to Resident #2.

Interview with a personal care aide (PCA) on 11/07/19 at 5:54pm revealed:
-She had never seen Resident #2 using portable

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oxygen tanks.
-Resident #2 had to sit in the hallway by the medication cart so staff could watch her to make sure she kept her oxygen on.
-If Resident #2 had portable oxygen tanks she would keep the oxygen on.

4. Review of Resident #11's current FL2 dated 05/10/19 revealed:
-Diagnoses included vascular dementia with behaviors, anxiety, and hypertension.
-Resident #11 was documented as constantly disoriented and wandered.
-The recommended level of care was documented as Special Care Unit (SCU).
-The resident resided on the SCU.

Review of Resident #11's Care Plan dated 08/14/19 revealed:
-The resident had wandering behaviors.
-The resident was documented as always disoriented.
-The resident had significant memory loss and must be directed.

Review of Resident #11's progress notes dated 09/05/19 revealed at 1:31pm Resident #11 was in an altercation with another resident. No injuries and resident representative notified.

Review of Resident #11's Accident/Incident report dated 09/05/19 revealed:
-At 9:15am, Resident #11 was observed in an altercation with a resident while in her room.
-At 9:37am, Resident #11 was struck by another resident.
-Staff attempted to intervene but the other resident continued to strike Resident #11.

Based on record reviews, observations and

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interviews, it was determined Resident #11 was not interviewable.

Interview with Resident #11's family member on 11/13/19 at 10:26am revealed:
-On 09/05/19 facility staff told her they heard Resident #11 yelling and they were able to remove the other resident and get Resident #11 from behind the door.
-The facility staff informed the family member that Resident #11 was stuck behind the door because another resident was holding the door.
-The facility staff did not tell her Resident #11 was hit by another resident.

Interview with the SCU Coordinator on 11/14/19 at 3:31pm revealed:
-As far as she knew Resident #11 had no incidents of being hit or any occurrences.
-She was unable to recall Resident #11 being hit by another resident.

Interview with a medication aide (MA) on 11/13/19 at 3:54pm revealed:
-Resident #11 was involved in an altercation with another resident.
-The other resident had Resident #11 in the room behind the door and was hitting her.
-Staff pulled the other resident away and the other resident started fighting staff.

Interview with the Primary Care Provider (PCP) on 11/15/19 at 12:10pm revealed:
-She was not notified of an altercation on 09/05/19 involving Resident #11.
-She expected to be notified if the resident was hit by another resident even if there were no injuries.

5. Review of Resident #14's current FL2 dated

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05/04/19 revealed:
-Diagnoses included lewy body dementia.
-Resident #14 was documented as intermittently disoriented.
-The recommended level of care for Resident #14 was Special Care Unit (SCU).

Review of Resident #14's care plan dated 09/24/19 revealed:
-The resident was sometimes disoriented.
-The resident memory was forgetful and needed reminders.

Review of Resident #14's progress notes dated 11/05/19 revealed at 2:12pm Resident #14 was punched in the mouth and chest and knocked to the floor by another resident. Resident #14 was bleeding from the lip.

Review of Resident #14's Accident/Incident report dated 11/05/19 revealed at 10:50am Resident #14 was punched in the face and chest by another resident.

Interview with Resident #14's family member on 11/14/19 at 1:20pm revealed:
-He was trying to find another place for Resident #14 to live.
-The staff at the facility did not watch the residents'; something was always happening.
-A few weeks ago a male resident went into Resident #14's room and hit her and she received a knot.
-The facility staff would not tell him the resident that hit Resident #14.
-He had talked with the Administrator regarding Resident #14 being hit.

Interview with the SCU Coordinator on 11/14/19 at 3:31pm revealed:

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-She was aware that Resident #14 was hit by a resident that was frequently agitated.
-Resident #14 was not sent out to the hospital.
-The facility's plan to keep residents' safe from aggressive residents was for staff to respond as soon as they hear residents voices become escalated.

Interview with a MA on 11/13/19 at 3:54pm revealed:
-Resident #14 was hit by a male resident that was frequently agitated.
-Resident #14 was not taken to the hospital.
-She recalled Resident #14's lip was bleeding.

6. Review of Resident #15's current FL2 dated 05/29/19 revealed diagnoses of Alzheimer's disease without behavioral disturbance.
-Resident #15 was documented as intermittently disoriented.
-The recommended level of for Resident #15 was Special Care Unit (SCU).

Review of Resident #15's care plan dated 07/19/19 revealed:
-The resident wandered.
-The resident had significant memory loss and must be directed.

Review of Resident #15's Accident/Incident report dated 08/11/19 revealed at 8:20pm Resident #15 was observed being pushed by another resident and landing on floor on her bottom.

Review of Resident #15's progress notes dated 08/11/19 revealed at 10:47pm Resident #15 was pushed by another resident causing her to fall on her bottom to the floor.

Interview with Resident #15's family member on

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11/14/19 at 1:48pm revealed:
-She was informed of the incident in August 2019 when Resident #15 was pushed to the floor.
-The facility staff told her the resident had no injuries or bruises.
-To her knowledge there had been no more incidents involving Resident #15.

Interview with Resident #15's Primary Care Provider (PCP) on 11/15/19 at 12:06pm revealed:
-She checked her records and did not see any documentation in August or any other month notifying her that Resident #15 had been pushed to the floor by another resident.
-She would want to be notified to ensure the health and safety of the resident was being met at the facility.

Interview with a personal care aide (PCA) on 11/14/19 at 2:12pm revealed she was unable to recall the incident when Resident #15 was pushed to the floor by another resident.

Interview with the Administrator on 11/14/19 at 6:53pm revealed:
-If a resident was combative towards another resident, staff were to intervene immediately to protect the resident.
-Staff were to assess the resident and complete an incident report.
-She was aware some residents were involved in altercations with other residents in which they were hit, pushed to the floor, caused lips to bleed and some residents had knots on their heads.
-She told staff to monitor the aggressive residents more frequently.
-There was no specific time frames as to how often staff were to monitor residents.

7. Review of Resident #20's current FL-2 dated

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 132 11/11/19 revealed: -Diagnoses included Alzheimer's dementia, atrial fibrillation, chronic kidney disease stage 3, hypertension, gastroesophageal reflux disorder, iron deficiency, and vitamin D deficiency. -There was documentation the resident was constantly disoriented and wandered. -The recommended level of care was documented as Special Care Unit (SCU). Review of Resident #20's Resident Profile/Care Plan dated 01/28/19 revealed the resident was documented as always disoriented and had significant memory loss. Review of the progress notes for a named male resident dated 11/11/19 revealed: -The male resident was observed punching Resident #20 in the face making Resident #20 fall against a wall and hit his head. -Resident #20 was taken to the emergency department as a result of the incident. Review of Resident #20's progress notes dated 11/11/19 revealed: -Resident #20 was in the hallway eating a snack and another resident punched him in the face causing him to fall into the wall. -Resident #20 received a laceration to the back of his head. -Resident #20 was transported to the emergency department at the local hospital. Review of the Accident/Incident report for the named male resident dated 11/11/19 revealed: -The incident occurred in the hallway. -The named male resident was observed hitting Resident #20 causing Resident #20 to fall. Review of Resident #20's Accident/Incident report	D 338		

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dated 11/11/19 revealed:
-The incident occurred in the hallway.
-Resident #20 was observed being hit by the named male resident.
-The named male resident caused Resident #20 to fall and hit his head.
-Resident #20 exhibited signs of pain.
-Resident #20 had a laceration and abrasion to the back of his head.
-First aid was administered to Resident #20 and his head was wrapped with a gauze.
-Resident #20 was transported via ambulance to the local emergency department.

Based on observations, interviews, and record reviews, it was determined Resident #20 was not interviewable.

Interview with Resident #20's family member on 11/15/19 at 1:15pm revealed the facility had informed her of the incident and had transported Resident #20 to the emergency department.

Interview with a personal care aide (PCA) on 11/13/19 at 5:15pm revealed:
-She observed another resident punch Resident #20 in the face so hard he was knocked into a door on 11/11/19.
-Resident #20 had a lump on his head and had to be sent to the emergency department.
-To protect the residents, any resident that had exhibited aggressive behaviors was sent to the emergency department to be evaluated.

Interview with a second PCA on 11/14/19 at 4:51pm revealed:
-On 11/11/19, a resident was walking down the hallway and staff heard a loud thump.
-All the staff ran down to assist. Some staff held the other resident and the PCA sat Resident #20

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up and held pressure to his head.
-Resident #20 was taken to the emergency department.

8. Review of Resident #17's FL-2 dated 06/18/19 revealed:
-Diagnosis included dementia.
-The resident was documented as intermittently disoriented.
-The recommended level of care was documented as Special Care Unit (SCU).

Review of Resident #17's Resident Profile/Care Plan dated 06/26/19 revealed Resident #17 was always disoriented and had significant memory loss.

Review of Resident #17's progress notes dated 10/19/19 revealed:
-Resident #17 was pushed by a named male resident.
-Resident #17 hit her head as a result of being pushed.
-Resident #17 had a knot on the back-right side of her head.

Review of the an Accident/Incident report for the named male resident dated 10/19/19 revealed:
-The incident occurred in the hallway.
-He was observed pushing another resident to the floor.

Review of Resident #17's Accident/Incident report dated 10/19/19 revealed:
-The incident occurred in the hallway.
-Resident #17 was observed sitting on the floor with her head against the wall.
-Resident #17 exhibited pain.
-Resident #17 had a bump on the back of her head.

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-Resident #17 was transported to the local emergency department.

Review of an Emergency Department Discharge Instruction form for Resident #17 dated 10/19/19 revealed:
-The reason for the visit was a fall.
-Diagnosis was closed head injury.

Based on observations, interviews, and record reviews, it was determined Resident #17 was not interviewable.

Interview with Resident #17's family member on 11/13/19 at 10:01am revealed:
-Resident #17 was moved out of the facility due to neglect.
-Two weeks ago, another resident shoved Resident #17 causing the to hit her head on the wall.
-Resident #17 had to be taken to the emergency room.
-Last week they observed a resident punch her in the ribs, but there were no staff on the hall.

Interview with the Administrator on 11/14/19 at 5:31pm revealed:
-She knew about the incident with Resident #17 that occurred on 08/26/19.
-Resident #17 was taken to the emergency department.
-To protect the residents, any resident that had exhibited aggressive behaviors was sent to the emergency department to be evaluated.

Interview with Resident #17's primary care provider (PCP) on 11/15/19 at 10:35am revealed:
-She knew about the incident on 10/19/19.
-Resident #17 had to go to the emergency department and was diagnosed with a closed

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head injury.
-Resident #17 did not have any behavior issues.

9. Review of Resident #16's current FL-2 dated 05/29/19 revealed:
-Diagnoses included dementia with behavioral disturbance, diabetes type 2, hypertension, and history of a stroke.
-There was documentation the resident was intermittently disoriented.
-The recommended level of care was documented as Special Care Unit (SCU).

Review of Resident #16's Resident Profile/Care Plan dated 06/26/19 revealed:
-There was documentation the resident was sometimes disoriented; his memory was forgetful and needed reminders.
-There was documentation the resident was verbally abusive.

Review of the progress notes for the named male resident dated 08/26/19 revealed:
-The named male resident was noted to be in Resident #16's room.
-Staff heard yelling.
-The named male resident was in the Resident #16's bathroom doorway pushing a walker down on top of Resident #16.
-Staff asked the named male resident to stop, but he refused.
-Staff attempted to redirect the named male resident, but he became combative.

Review of Resident #16's progress notes dated 08/26/19 revealed:
-Resident #16 was lying on his back in the bathroom floor yelling for help.
-The named male resident was in Resident #16's bathroom holding Resident #16's walker and

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pushing down on Resident #16's chest.
-Staff approached to assist Resident #16, but the named male resident pushed harder.
-When staff was able to redirect the named male resident, Resident #16 was lying on his back with his head near the wall and his feet were under his walker.
-Staff was able to assist Resident #16 to a sitting position and assessed him.
-Resident #16 did not have any injuries.
-Resident #16 refused to go to the hospital for evaluation.
-Resident #16 was able to ambulate without staff assistance.

Review of the Accident/Incident report for the named male resident dated 08/26/19 revealed:
-The named male resident was noted to be in Resident #16's room.
-Staff heard calls for help.
-Upon arrival, the named male resident was in Resident #16's bathroom doorway pushing a walker down on top of Resident #16.
-Staff asked the named male resident to stop but he refused.
-Staff attempted to redirect the named male resident but he became combative and hit staff several times.

Review of the Accident/Incident report for Resident #16 dated 08/26/19 revealed:
-Resident #16 was in his room.
-Resident #16 was lying on his back in the bathroom with the named male resident holding his walker.
-No injury was noted.
-Resident #16 was not taken to the emergency room.

Based on observations, interviews, and record

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reviews, it was determined Resident #16 was not interviewable.

Interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm revealed:
-Another resident was in Resident #16's room. Resident #16 was found lying on the floor and another resident was in front of Resident #16 with a walker.
-Resident #16 declined to go to the emergency room.

Interview with the Administrator on 11/14/19 at 5:31pm revealed:
-She knew about the incident with Resident #16 that occurred on 08/26/19.
-Resident #16 was not taken to the emergency room.
-To protect the residents, any resident that had exhibited aggressive behaviors was sent to the emergency department to be evaluated.

Attempted telephone interview with Resident #16's primary care provider (PCP) on 11/15/19 at 1:30pm was unsuccessful.

10. Review of Resident #18's current FL-2 dated 05/09/19 revealed:
-Diagnoses included Alzheimer's dementia, schizophrenia, Diabetes Mellitus type II, chronic obstructive pulmonary disease, Hepatitis C, and Osteoarthritis.
-There was documentation the resident was constantly disoriented.
-The resident was injurious to property.
-The recommended level of care was documented as Special Care Unit (SCU).

Review of Resident #18's Resident Profile/Care Plan dated 01/28/19 revealed the resident was

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documented as sometimes disoriented; her memory was forgetful, and she needed reminders.

Review of the progress notes for the named male resident dated 10/16/19 revealed:
-The male resident was heard yelling at Resident #18 as he had her pinned against the wall.
-The male resident punched Resident #18 in the back.
-Staff took the male resident to his room.

Review of Resident #18's progress notes dated 10/16/19 revealed:
-Resident #18 was pinned up on the wall by another resident.
-Resident #18 was punched in the back.
-Resident #18 was not injured.

Review of the Accident/Incident report for the named male resident dated 10/16/19 revealed:
-The incident occurred in the hallway.
-The named resident was observed hitting Resident #18 in the back.
-Resident #18 did not have any injuries.

Review of the Accident/Incident report for Resident #18 dated 10/16/19 revealed:
-Resident #18 was observed pinned against the wall by the named male resident .
-Resident #18 was punched in the back.
-No injury was noted.
-Resident #18 was not taken to the emergency department.

Based on observations, interviews, and record reviews, it was determined Resident #18 was not interviewable.

Interview with Resident #18's family member on

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D 338	Continued From page 140 11/13/19 at 12:53am revealed: -Resident #18 may not get the attention she needed due to the many behaviors on the unit. -A male resident had assaulted her twice, the last time being on 11/16/19. Interview with the Administrator on 11/14/19 at 5:31pm revealed: She knew about the incident with Resident #18 on 10/16/19. -Resident #18 was not transported to the emergency department as she did not incur any injuries. -To protect the residents, any resident that had exhibited aggressive behaviors was sent to the emergency department to be evaluated. Interview with Resident #18's primary care provider (PCP) on 11/15/19 at 10:25am revealed: -Resident #18 had one episode of being aggressive. -She knew about the incident on 10/16/19. -Resident #18 was a good fit for the special care unit. _____ The facility failed to protect residents from abuse and neglect resulting in a SCU resident being yelled at by staff (#12), a resident being made to sit all day in hallway to maintain continuous oxygen therapy (#2), a resident being hit by a staff with a cup (#1), and residents (#11, #14, #15, #16, #17, #18, and #20) being hit, and pushed to the floor resulting in multiple injuries from physically aggressive residents. The facility's failure resulted in physical harm and serious neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/08/19 for	D 338		

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D 338	Continued From page 141 this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 15, 2019.	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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 8 (#3, #4, and #7) sampled residents regarding medications for a mood disorder, an amino acid supplement (#3), a laxative (#4), an antibiotic, a bronchodialator (#7). The findings are: 1. Review of Resident #3's FL-2 dated 05/29/19 revealed diagnoses included dementia, a. Review of Resident #3's FL-2 dated 05/29/19	D 358		

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revealed there was an order for divalproex (used to treat mood disorders) 125 mg 2 capsules 3 times daily.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry for divalproex 125 mg 2 capsules 3 times daily scheduled for administration at 7:00 am, 1:00 pm, and 8:00 pm daily.
-Divalproex 125 mg mg was not documented as administered on 10/17/19, 10/18/19, 10/20/19, and 10/21/19 with a documented reason of medication not available/on order; and on 10/23/19 at 2:00 pm with a documented reason of "last shift pass".

Observation of Resident #3's medications on hand on 11/07/19 at 11:47 am revealed:
-There were 2 partially filled blister packs of Divalproex 125 mg caps with instructions to take 2 capsules (25mg) three times a day.
-Both cards were dispensed on 08/02/19.
-Card #1 had 14 of 30 capsules remaining and card #2 had 14 of 30 capsules remaining.

Interview with a medication aide (MA) on 11/13/19 at 3:19pm revealed:
-When new orders were received, the Special Care Unit (SCU) Coordinator and the Resident Care Coordinator (RCC) were responsible for sending the orders to the pharmacy.
-The SCU Coordinator and the RCC were responsible for approving the new medication orders entered on the eMAR.
-When medications were not in the building, the MAs were instructed to inform the SCU Coordinator or the RCC.
-The MAs checked for medications available on the night shift.

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D 358	Continued From page 143 -When a new medication came in, it had a requisition form attached that staff removed and placed in the resident's record. -The MAs did not have access to new orders until the medications showed up on the eMAR. -Each MA was assigned a group of residents for eMAR audits to ensure medications were on hand. -The audits were completed weekly and given to the SCU Coordinator or the RCC. -She did not recall when the last eMAR audit was completed. Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed: -The Administrator generally ran a daily report; sometimes she would run the report every other day for missed medications. -She had not looked at the report for missed medications. -She had not instructed the staff to let her know if they were looking for medications or if medications needed to be reordered. -Medications were reordered weekly when on cycle fill but if blister packs were being used, they had to be reordered when the there was 3 doses of medication remaining. -Medications should only be documented as administered if the medication was given to the resident. She expected the MAs to contact the pharmacy when a medication was not available. -Medications should only be documented as administered if the medication was given to the resident. Interview with the Administrator on 11/14/19 at 5:31pm revealed: -MAs were responsible for administering medications.	D 358		

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D 358	Continued From page 144 -She expected the MAs to document accurately. -MAs were responsible for auditing the medication carts weekly. -We changed over to a multidose pack at the beginning of October. -The RCC and SCU Coordinator were responsible for ensuring all medications were in the building, ensuring medications were administered as ordered, and that the resident had an adequate supply. -The Administrator randomly ran an audit report to see if medications were administered, but she did not run the report routinely. -There was not a routine audit by the corporate Nurse for monitoring medication administration. Interview with the Resident #3's primary care provider on 11/15/19 at 10:05am revealed she was not aware of medications were not being administered to Resident #3. Based on observation, interview, and record review, it was determined Resident #3 was not interviewable. b. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for L-Carnitine (an amino acid supplement) 250 mg 4 tablets (1,000 mg) 2 times daily. Review of Resident #3's October 2019 eMAR revealed: -There was an entry for L-Carnitine 250 mg 4 tablets (1,000 mg) 2 times daily scheduled for administration at 9:00am and 9:00pm daily. -L-Carnitine was not documented as administered 21 of 62 opportunities with a documented reason of "drug/item unavailable" and 5 of 62 opportunities stating the medication had been discontinued.	D 358		

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 145 Review of Resident #3's November 2019 eMAR revealed: -There was an entry for L-Carnitine 250 mg 4 tablets (1,000 mg) 2 times daily scheduled for administration 9:00am and 9:00pm daily. -L-Carnitine was not documented as administered 7 of 10 opportunities with a documented reason of "drug/item unavailable" and 2 of 7 with a documented reason of on order at pharmacy. Observation of Resident #3's medications on hand on 11/07/19 at 11:47 am revealed there was no L-Carnitine available on the medication cart, or in over-stock. Interview with a medication aide (MA) on 11/13/19 at 3:19 pm revealed: -When new orders were received, the Special Care Unit (SCU) Coordinator and the Resident Care Coordinator (RCC) were responsible for sending the orders to the pharmacy. -The SCU Coordinator and the RCC were responsible for approving the new medication orders entered on the eMAR). -When medications were not in the building, he MAs were instructed to inform the SCU Coordinator or the RCC. -The MAs checked for medications available on night shift. -When a new medication came in, it had a requisition form attached that staff removed and placed in the resident's record. -The MAs did not have access to new orders until the medication showed up on the eMAR. -Each MA was assigned a group of residents for eMAR audits to ensure medications were on hand. -The audits were completed weekly and given to	D 358		

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the SCU Coordinator or the RCC.
-She did not recall when the last eMAR audit was completed.

Interview with a second MA on 11/14/19 at 9:47am revealed:
-She had never administered L-Carnitine to Resident #3.
-She did not realize she had marked L-Carnitine as given and stated it must have been a mistake.
-She noticed last night that there was no L-Carnitine available for Resident #3.
-She had not called the pharmacy regarding L-Carnitine not being available.
-When she did not have a medication on the cart, she would tell the SCU Coordinator or a more experienced MA.

Interview with a representative from the contracted pharmacy on 11/13/19 at 10:30am revealed:
-They had tried to fill the prescription for L-Carnitine for Resident #3 several times but each time it got canceled either by insurance or by the facility.
-L-Carnitine was on back order with the manufacturer.
-The facility and the physician was made aware on 05/08/19, 07/10/19, 09/06/19, 09/19/19, 10/13/19, and 10/19/19.
-The pharmacy had not received a response from either the facility or the physician.
-The pharmacy had not received an order to discontinue L-Carnitine.

Interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm revealed:
-She knew that Resident #3 did not have any L-carnitine available.
-The Administrator generally ran a daily report;

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sometimes she would run the report every other day for missed medications.
-She had not looked at the report for missed medications.
-She had not instructed the staff to let her know if they were looking for medications or if medications needed to be reordered.
-Medications were reordered weekly when on cycle fill but if blister packs were being used, they had to be reordered when the there was 3 doses of medication remaining.
-Medications should only be documented as administered if the medication was given to the resident.
She expected the MA's to contact the pharmacy when a medication was not available.
-Medications should only be documented as administered if the medication was given to the resident.

Interview with the Administrator on 11/14/19 at 5:31pm revealed:
-MAs were responsible for administering medications.
-She expected the MAs to document accurately.
-MAs were responsible for auditing the medication carts weekly.
-We changed over to a multidose pack at the beginning of October.
-The RCC and SCU Coordinator were responsible for ensuring all medications were in the building, ensuring medications were administered as ordered, and that the resident had an adequate supply.
-The Administrator randomly ran an audit report to see if medications were administered but she did not run the report routinely.
-There was not a routine audit by the corporate Nurse for monitoring medication administration.

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D 358	Continued From page 148 Interview with the Resident #3's primary care provider on 11/15/19 at 10:05am revealed she was not aware of medications not being administered to Resident #3. Based on observation, interview, and record review, it was determined Resident #3 was not interviewable. 2. Review of Resident #4's FL-2 dated 5/27/19 revealed: -Diagnoses included dementia with behavioral disturbance, traumatic brain injury, major neurocognitive disorder with behaviors, anxiety, cognitive communication deficit, and history of alcohol abuse. -There was an order for docusate sodium 100 mg twice daily (used to treat constipation). Review of Resident #4's September 2019 eMAR revealed: -There was an entry for docusate sodium 100 mg 2 times daily scheduled for administration at 8:00am and 8:00pm daily. -Docusate sodium was not documented as administered 21 of 60 opportunities from 09/01/19 to 09/30/19, with a reason of "drug/item unavailable" documented 21 times. Observation of Resident #4's medication on hand on 11/08/19 at 12:24pm revealed: -There were 2 bottles of Docu 50 mg/5ml (give 10 mls (100mg) twice daily. -They bottles were dispensed on 09/18/19 and had 946 ml. -Bottle 1 of 2 had been opened and had a small amount remaining. -Bottle 2 of 2 was full and had not been opened. Interview with a medication aide (MA) on 11/13/19	D 358		

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D 358	Continued From page 149 at 3:19pm revealed: -When new orders were received, the Special Care Unit (SCU) Coordinator and the Resident Care Coordinator (RCC) were responsible for sending the orders to the pharmacy. -The SCU Coordinator and the RCC were responsible for approving the new medication orders entered on the eMAR. -When medications were not in the building, the MAs were instructed to inform the SCU Coordinator or the RCC. -The MAs checked for medications available on the night shift. -When a new medication came in, it had a requisition form attached that staff removed and placed in the resident's record. -The MAs did not have access to new orders until the medications showed up on the eMAR. -Each MA was assigned a group of residents for eMAR audits to ensure medications were on hand. -The audits were completed weekly and given to the SCUC or the RCC. -She did not recall when the last eMAR audit was completed. Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed: -The Administrator generally ran a daily report; sometimes she would run the report every other day for missed medications. -She had not looked at the report for missed medications. -She had not instructed the staff to let her know if they were looking for medications or if medications needed to be reordered. -Medications were reordered weekly when on cycle fill but if blister packs were being used, they had to be reordered when the there was 3 doses of medication remaining.	D 358		

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D 358	Continued From page 150 -Medications should only be documented as administered if the medication was given to the resident. She expected the MAs to contact the pharmacy when a medication was not available. -Medications should only be documented as administered if the medication was given to the resident. Interview with the Administrator on 11/14/19 at 5:31pm revealed: -MAs were responsible for administering medications. -She expected the MAs to document accurately. -MAs were responsible for auditing the medication carts weekly. -We changed over to a multidose pack at the beginning of October. -The RCC and SCU Coordinator were responsible for ensuring all medications were in the building, ensuring medications were administered as ordered, and that the resident had an adequate supply. -The Administrator randomly ran an audit report to see if medications were administered but she did not run the report routinely. -There was not a routine audit by the corporate Nurse for monitoring medication administration. Interview with the Resident 4's primary care provider (PCP) on 11/15/19 at 10:15am revealed: -She was not aware of medications not being administered to Resident #4. -She could not say that Resident #4 not receiving medications had a good or bad effect on the resident. Based on observation, interview, and record review, it was determined Resident #4 was not interviewable.	D 358		

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3. Review of Resident #7's FL2 dated 05/14/19 revealed diagnoses included dementia, breast cancer, hypertension, and history of rib fracture.

a. Review of Resident #7's hospital After Visit Summary dated 10/30/19 revealed:
-Resident #7 was seen in the local hospital emergency department due to a fall.
-Resident #7 had a laceration of the forehead as a result of the fall.
-There were instructions to start taking doxycycline hyclate 100 mg capsule 1 capsule twice daily for 10 days (an antibiotic used to treat bacterial infections).

Review of Resident #7's electronic Medication Administration Record for October 2019 revealed there was no entry for doxycycline hyclate 100mg 1 capsule twice daily for 10 days.

Review of Resident #7's electronic Medication Administration Record for November 2019 revealed there was no entry for doxycycline hyclate 100mg 1 capsule twice daily for 10 days.

Observation of Resident #7 on 11/07/19 at 5:32pm revealed Resident #7 had a bruise on her right eye and a knot on her right forehead with stitches.

Observation of Resident #7's medication available for administration on 11/08/19 at 11:37am revealed there was no doxycycline hyclate on the medication cart.

Interview with the Special Care Unit (SCU) Coordinator on 11/08/19 at 12:19pm and revealed:

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-Resident #7 was sent out to the emergency department on 10/30/19 because she fell out of her wheelchair and hit her head.
-She was responsible for reviewing hospital discharge summaries for changes in medication and new medication orders.
-She had not looked at Resident #7's hospital after visit summary until today, 11/08/19.
-She saw the order for doxycycline hyclate 100 mg when she "found" Resident #7's hospital after visit summary.

Interview with a representative from the contracted pharmacy on 11/08/19 at 12:38pm revealed the pharmacy did not have a current order for doxycycline hyclate 100 mg capsule 1 capsule twice daily for 10 days.

Interview with a Medication Aide (MA) on 11/08/19 at 5:34pm revealed:
-Resident #7 had a fall on 10/30/19.
-She received Resident #7 back into the facility on 10/30/19 and completed a progress note on 10/30/19 documenting Resident #7 was back at the facility with a laceration.
-She reviewed the hospital After Visit Summary and saw the order for doxycycline hyclate.
-She faxed the order for doxycycline hyclate to the pharmacy on the night of 10/30/19.
-She had not seen doxycycline hyclate on the eMAR for Resident #7.
-She had not contacted the pharmacy to see why the doxycycline hyclate was not delivered because she had been off from work and just came back to work on yesterday.
-She did not know if anyone else had contacted the pharmacy regarding doxycycline hyclate for Resident #7.

A second interview with the SCU Coordinator on

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11/08/19 at 5:52pm revealed:
-New orders were placed in the "bucket folder system."
-The "bucket folder system" included a yellow folder labeled "Bucket #1, NEW PHYSICIAN ORDERS: Task- Faxed new order to the pharmacy and waiting for order(s) to show up in the eMAR system."
-Resident #7's hospital after visit summary was in Bucket #1, but she had not checked Bucket #1 until today.
-The bucket folders should be checked daily, but she did not always checks, but she did not always check the folders daily because she looked for orders on the MA work station and MAs also placed orders under her door.
-She "found" a fax receipt where the order for doxycycline hyclate was faxed to the pharmacy on 10/30/19, but she did not think anyone followed up with the pharmacy to see why the medication was not delivered.
-She refaxed the order for doxycycline hyclate to the pharmacy on today.

Interview with a MA/Supervisor on 11/13/19 at 3:54pm revealed:
-She did not know there was an order for doxycline hyclate dated 10/30/19.
-Doxycycline hyclate was not on Resident #7's eMAR and she had not administered doxycycline hyclate.
-The SCU Coordinator was responsible for making sure new orders were sent to the pharmacy and were and were on the eMAR.

Interview with the Administrator on 11/08/19 at 4:25pm revealed:
-She did not know there was an order for an antibiotic dated 10/30/19.
-The SCU Coordinator was responsible for

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reviewing new orders in the SCU.
-She expected medication to be administered as ordered.

Interview with the Primary Care Provider (PCP) on 11/07/19 at 4:43pm revealed:
-She did not know there was a physician's order for doxycycline hyclate dated 10/30/19 for Resident #7 resulting from a hospital visit and did not know the doxycycline had not been started or administered.
-She expected medication to be administered as ordered.

b. Review of Resident #7's FL2 dated 05/14/19 revealed there were physician's orders attached to the FL2 and dated 05/14/19 which included orders for ipratropium-albuterol (duoneb) (a medication used to treat symptoms of chronic obstructive pulmonary disease (COPD) 0.5 mg-3 mg/ 3 mL inhale 1 vial via nebulizer 4 times daily at 9:00am, 1:00pm, 4:30pm, and 8:00pm.

Review of Resident #7's physician's order dated 05/21/19 revealed:
-There was an order for a nebulizer machine and all components.
-There was an order for duonebs 4 times daily.

Review of Resident #7's patient encounter summary dated 06/28/19 revealed:
-Resident #7 was seen by the Primary Care Provider (PCP) on 05/21/19 due to need for a nebulizer machine.
-A new order was written for the nebulizer machine and all components.
-There was an order for duonebs 4 times daily.

Review of resident #7's physician's order dated 08/07/19 revealed:

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D 358	Continued From page 155 -There was a note to the physician Resident #7 needed a nebulizer machine or order to discontinue duonebs. -The PCP wrote an order to change duonebs to 4 times daily as needed. Review of Resident #7's patient encounter summary dated 08/20/19 revealed: -There was documentation Resident #7 needed a nebulizer machine for her as needed respiratory treatment to treat her chronic cough and congestion as needed. -There was an order to discontinue scheduled nebulizer treatments and change to as needed for wheezing or shortness of breath. -There was an order to obtain a nebulizer machine with all equipment. -There was an order for duonebs as needed inhale 1 vial via hand held nebulizer 4 times daily as needed for wheezing, shortness of breath, coughing, and respiratory distress. -There was a note documenting that it was okay to hold duonebs until the nebulizer machine arrived. Review of Resident #7's patient encounter summary dated 10/09/19 revealed: -There was documentation Resident #7's family member reported to the PCP Resident #7 had a "terrible cough" that was productive. -There was documentation staff reported to the PCP Resident #7 had a cough that was "chronic and possibly increased." -The PCP's impression of Resident #7 included bilateral lower lobe chest congestion with cough and chronic bronchitis. Review of Resident #7's eMAR for August 2019 revealed: -There was an entry for duonebs for nebulization	D 358		

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D 358	Continued From page 156 0.5mg-3mg (2.5mg base)/3 mL inhale 1 vial via nebulizer four times daily to be administered at 9:00am, 1:00pm, 4:30pm, and 8:00pm. -There was no documentation duonebs were administered for 89 of 92 opportunities from 08/01/19 through 08/23/19. -The documented reasons why duonebs were not administered included: drug/item unavailable and machine broken. -There was a discontinue date of 08/24/19 on the entry for duonebs. Review of Resident #7's eMAR for September, October, and November 2019 revealed there was no entry for duonebs inhale 1 vial via nebulizer four times times as needed as ordered on 08/07/19. Observation of Resident #7's room on 11/07/19 at 3:39pm revealed there was no nebulizer machine in Resident #7's room. Observation of Resident #7's medication available for administration on 11/08/19 at 11:37am revealed there were no duonebs on the medication cart. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. Interview with a representative from the contracted pharmacy on 10/07/19 at 3:11pm revealed: -There was a current order dated 05/15/19 for duonebs 360 ml inhale 1 vial 4 times daily. -There was a 30 day supply of 120 vials delivered to the facility on 05/16/19 at 7:02am. -There had been no requests by the facility to refill duonebs.	D 358		

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D 358	Continued From page 157 -The pharmacy had not received an order for duonebs as 4 times daily as needed. -The pharmacy had not received an order to discontinue duonebs. Interview with a second shift medication aide (MA) on 11/07/19 at 3:48pm revealed: -Resident #7 was not administered nebulizer treatments. -Resident #7 has never had a nebulizer in her room that she knew of. Interview with the Special Care Unit (SCU) Coordinator on 11/07/19 at 3:52pm revealed: -She knew Resident #7 had physician's orders for duonebs. -Resident #7 did not currently have a nebulizer machine because there was an issue with Resident #7's insurance not covering the machine. -Duonebs had been discontinued from the eMAR in August 2019 due to the note on Resident #7's patient encounter summary dated 08/20/19 documenting "okay to hold duonebs until the nebulizer arrived." -She had not followed up with Resident #7's PCP to let her know Resident #7's duonebs and nebulizer were not in the facility to be administered as ordered. Interview with a first shift MA on 11/08/19 at 11:47am revealed: -She had never administered duonebs to Resident #7. -Resident #7 did not currently have a nebulizer machine. -She had documented on Resident #7's eMARs "drug/item not available and machine broken." -She had not talked to anyone regarding Resident #7 not having a nebulizer so that her duonebs	D 358		

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D 358	Continued From page 158 could be administered. Interview with the Administrator on 11/08/19 at 4:25pm revealed: -She did not know Resident #7 was not being administered duonebs as ordered by the physician. -She expected medication to be administered as ordered by the physician. Interview with a MA/Supervisor on 11/12/19 at 10:08am revealed: -She knew Resident #7 had physician's orders for duonebs. -Resident #7 had been without her nebulizer machine for several months due to her nebulizer machine being broken. -She had talked to the SCU Coordinator, but did not remember when, about Resident #7 not having a nebulizer machine for administration of duonebs and the SCU Coordinator told her she was trying to get orders to get a new one. -Resident #7 did not have any difficulty breathing, but she had chest congestion. Interview with Resident #7's PCP on 11/07/19 at 4:43pm revealed: -Resident #7 needed duoneb via a nebulizer machine for diagnoses of chronic obstructive pulmonary disease (COPD) and chronic cough. -Resident #7 had not had any hospitalizations due to symptoms of COPD. -There were no negative outcomes of Resident #7 not having duonebs via the nebulizer machine. -Duonebs should not have been discontinued, but changed from scheduled to as needed. -She expected duonebs to be administered as ordered.	D 358		

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D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for 7 of 7 residents sampled (#2, #3, #4, #5, #6, #7, and #10) resulting in medications with multiple administration times being administered too close to the next scheduled administration times and medications such as insulin being administered too early or too late. The findings are: 1. Review of Resident #6's current FL2 dated 05/21/19 revealed diagnoses included acute gouty arthropathy, acute kidney failure diabetes mellitus, abnormal glucose, chronic kidney disease, hypertension, and acute and chronic deep vein thrombosis/embolism. a. Review of Resident #6's physician's orders dated 05/21/19 and current physicians orders dated 10/20/19 revealed a physician's order for gabapentin (used to treat nerve pain) 300 mg three times a day. Medications recommended for dosing more than one time a day should be administered according	D 364		

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to assigned time intervals to assure blood concentration levels remain consistent and side effects from altered therapeutic ranges are minimized.

Review of Resident #6's August 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for gabapentin 300 mg three times a day scheduled for 10:00am, 1:00pm, and 9:00pm.
-Gabapentin 300 mg was documented for administered late 6 of 93 opportunities in August 2019 with examples as follows:
-On 08/03/19, scheduled for 10:00am and documented as late administration at 11:41am; the next dose was administered at 1:00pm.
-On 08/16/19, scheduled for 1:00pm and documented as late administration at 2:44pm; the next dose was administered at 8:00pm.
-On 08/31/19, scheduled for 8:00am and documented as late administration at 10:49am; the next dose was administered at 2:00pm.

Review of Resident #6's September 2019 eMAR revealed:
-There was an entry for gabapentin 300 mg three times a day scheduled for 8:00am, 2:00pm, and 8:00pm.
-Gabapentin was documented as late administration 7 out of 90 opportunities with examples as follows:
-On 09/05/19, scheduled for 8:00am and documented as late administration at 10:11am; the next dose was administered at 2:00pm.
-On 09/06/19, scheduled for 8:00am and documented as late administration at 10:20am; the next dose was administered at 2:00pm.
-On 09/07/19, scheduled for 8:00am and documented as late administration at 9:42am; the

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next dose was administered at 2:00pm.
-On 09/19/19, scheduled for 8:00am and documented as late administration at 9:45am and given; the next dose was administered at 2:00pm.

Review of Resident #6's October 2019 eMAR revealed:
-There was an entry for gabapentin 300 mg three times a day scheduled for 8:00am, 2:00pm, and 8:00pm.
-Gabapentin was documented as late administration as follows:
-On 10/24/19, scheduled for 1:00pm and documented as late administration at 2:23pm and given; next dose was administered at 2:00pm.

Review of Resident #6's November 2019 eMAR revealed there was an entry for gabapentin 300 mg three times a day scheduled for 9:00am, 1:00pm, and 9:00pm. Gabapentin was not documented for late administration from 11/01/19 to 11/06/19.

Interview with Resident #6 on 11/13/19 at 1:50pm revealed:
-She did not pay much attention to the time she received her medications.
-Resident #6 may have received medications later the scheduled time but she did not recall a particular instance.
-Resident #6 had not experienced any increased pain and suffering due to medications being missed or late.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

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D 364	Continued From page 162 Refer to the interview with a first shift MA on 11/13/19 at 1:08pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. b. Review of Resident #6's physician's orders dated 05/21/19 and current physician's orders dated 10/20/19 revealed a physician's order for tramadol (used to treat moderate pain) 50 mg tablets 2 tablets three times a day. Medications recommended for dosing more than one time a day should be administered according to assigned time intervals to assure blood concentration levels remain consistent and side effects from altered therapeutic ranges are minimized. Review of Resident #6's August 2019 electronic medication administration record (eMAR) revealed: -There was an entry for tramadol 50mg take 2 tablets three times a day scheduled for 9:00am, 1:00pm, and 9:00pm. -Tramadol 50mg was documented for administered late 10 of 93 opportunities in August 2019 with examples as follows: -On 08/03/19, scheduled for 9:00am and documented as late administration at 11:43am; the next dose was administered at 2:13pm. -On 08/07/19, scheduled for 1:00pm and documented as late administration at 2:44pm; the next dose was administered at 9:00pm. -On 08/25/19, scheduled for 9:00am and documented as late administration at 10:41am; the next dose was administered at 1:00pm.	D 364		

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D 364	Continued From page 163 -On 08/31/19, scheduled for 9:00am and documented as late administration at 10:49am; the next dose was administered at 1:00pm. Review of Resident #6's September and October 2019 eMARs revealed: -There was an entry for tramadol 50mg take 2 tablets three times a day scheduled for 9:00am, 1:00pm, and 9:00pm. -Tramadol 50mg was documented for administered late 6 of 90 opportunities in September 2019 and 4 of 93 opportunities in October 2019 with examples as follows: -On 09/06/19, scheduled for 9:00am and documented as late administration at 10:20am; the next dose was administered at 2:28pm. -On 09/07/19, scheduled for 1:00pm and documented as late administration at 2:37pm; the next dose was administered at 9:00pm. -On 10/01/19, scheduled for 9:00am and documented as late administration at 10:26am; the next dose was administered at 2:13pm. Review of Resident #6's November 2019 eMAR revealed there was an entry for tramadol 50mg take 2 tablets three times a day scheduled for 9:00am, 1:00pm, and 9:00pm. Tramadol was not documented as late administration from 11/01/19 to 11/06/19. Interview with Resident #6 on 11/13/19 at 1:50pm revealed: -She did not pay much attention to the time she received her medications. -Resident #6 may have received medications later the scheduled time, but she did not recall a particular instance. -Resident #6 had not experienced any increased pain and suffering due to medications being missed or late.	D 364		

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D 364	Continued From page 164 Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to the interview with a first shift MA on 11/13/19 at 1:08pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. 2. Review of Resident #3's FL-2 dated 05/29/19 revealed diagnoses included dementia. a. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for diltiazem (used to treat hypertension) 90 mg 3 times daily. Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for diltiazem 90 mg 3 times daily scheduled for administration at 9:00am, 1:00pm, and 9:00pm daily. -Diltiazem was documented as administered late 17 of 93 opportunities from 08/01/19 to 08/31/19 with a reason of "resident care" documented. -Examples included: on 08/11/19 diltiazem 90 mg was administered at 11:09am instead of 9:00am with the next dose administered at 2:02pm and on 08/25/19 diltiazem 90 mg was administered at 10:26pm instead of 9:00pm with the next dose administered on 08/26/19 at 9:00am. Review of Resident #3's September 2019 eMAR	D 364		

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revealed:
-There was an entry for diltiazem 90 mg 3 times daily scheduled for administration at 9:00am, 2:00pm, and 9:00pm daily.
-Diltiazem was documented as administered late 10 of 90 opportunities from 09/01/19 to 09/30/19, with a reason of "computer issues" documented once, no reason not documented once, and 8 times a reason of "resident care" was documented.
-Examples included: on 09/13/19 diltiazem 90 mg was administered at 10:33am instead of 9:00am with the next dose administered at 2:00pm and on 09/18/19 diltiazem 90 mg was administered at 10:26am instead of 9:00am with the next dose administered at 2:00pm.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry for diltiazem 90 mg 3 times daily scheduled for administration at 9:00am, 2:00pm, and 9:00pm daily.
-Diltiazem was documented as administered late 6 of 93 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 2 times and no reason was documented 4 times.
-Examples included: on 10/02/19 diltiazem 90 mg was administered at 10:52 pm instead of 9:00pm with the next dose administered on 10/03/19 at 9:00am and on 09/20/19 diltiazem 90 mg was administered at 10:57pm instead of 9:00pm with the next dose administered on 10/21/19 at 9:00am.

Review of Resident #3's November 2019 eMAR revealed:
-There was an entry for diltiazem 90 mg 3 times daily scheduled for administration at 9:00am, 2:00pm, and 9:00pm daily.
-Diltiazem was documented as administered late

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D 364	Continued From page 166 2 of 15 opportunities from 11/01/19 to 11/05/19 with a reason of "resident care" documented 1 time and no reason documented 1 time. -For example, on 11/02/19, diltiazem 90 mg was administered at 10:25am instead of 9:00am with the next dose administered at 2:00pm. Interview with Resident #3's primary care provider (PCP) on 11/15/19 at 10:05am revealed: -She was not aware of medications being administered late to Resident #3. -Resident #3 was at risk of having uncontrolled hypertension when she did not receive her blood pressure medications as ordered. -Resident #3 needed to keep a consistent blood pressure and pulse so that she did not go into an arrhythmia. Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to the interview with a first shift MA on 11/13/19 at 1:08pm. Refer to interview with the Special Care Unit Coordinator (SCUC) on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. Based on observation, interview, and record review, it was determined Resident #3 was not interviewable. b. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for metoprolol (used to treat hypertension) 100 mg 2 times daily.	D 364		

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D 364	Continued From page 167 Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol 100 mg 2 times daily scheduled for administration at 8:00am and 8:00pm daily. -Metoprolol was documented as administered late 26 of 93 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 21 times and no reason documented 5 times. -Examples included: on 08/11/19, metoprolol 100 mg was administered at 11:09am instead of 8:00am with the next dose administered at 8:00pm and on 08/12/19 metoprolol 100 mg was administered at 11:06am instead of 8:00am with the next dose administered at 8:00pm. Review of Resident #3's September 2019 eMAR revealed: -There was an entry for metoprolol 100 mg 2 times daily scheduled for administration at 9:00am and 9:00pm daily. -Metoprolol was documented as administered late 12 of 90 opportunities from 09/01/19 to 09/30/19, with a reason of "computer issues" documented once, no reason documented once, and 10 times a reason of "resident care" was documented. -Examples included: on 09/13/19, metoprolol 100 mg was administered at 10:33am instead of 9:00am with the next dose administered at 9:00pm and on 09/18/19 metoprolol 100 mg was administered at 10:26am instead of 9:00am with the next dose administered on 09/19/19 at 9:00am. Review of Resident #3's October 2019 eMAR revealed: -There was an entry for metoprolol 100 mg 2 times daily scheduled for administration at	D 364		

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8:00am and 8:00pm daily.
-Metoprolol was documented as administered late 8 of 93 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 7 times and no reason was documented 1 time.
-Examples included: on 10/09/19, metoprolol 100 mg was administered at 10:17 am instead of 8:00am with the next dose administered at 8:00pm and on 10/22/19, metoprolol 100 mg was administered at 10:00am instead of 8:00am with the next dose administered at 8:00pm.

Review of Resident #3's November 2019 eMAR revealed:
-There was an entry for metoprolol 100 mg 2 times daily scheduled for administration at 8:00am and 8:00pm daily.
-Metoprolol was documented as administered late 2 of 15 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 2 times.
-For example, on 11/03/19, metoprolol 100 mg was administered at 9:06am instead of 8:00am with the next dose administered at 8:00pm.

Interview with Resident #3's primary care provider (PCP) on 11/15/19 at 10:05am revealed:
-She was not aware of medications being administered late to Resident #3.
-Resident #3 was at risk of having uncontrolled hypertension when she did not receive her blood pressure medications as ordered.
-Resident #3 needed to keep a consistent blood pressure and pulse so that she did not go into an arrhythmia.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift

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medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

Based on observation, interview, and record review, it was determined Resident #3 was not interviewable.

c. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for Eliquis (a blood thinner) 5 mg 2 times daily.

Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Eliquis 5 mg 2 times daily scheduled for administration at 8:00am and 8:00pm daily.
-Eliquis was documented as administered late 26 of 93 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 20 times and no reason documented 6 times.
-Examples included: on 08/11/19, Eliquis 5 mg was administered at 11:09am instead of 8:00am with the next dose administered at 8:00pm and on 08/12/19 metoprolol 100 mg was administered at 11:06am instead of 8:00am with the next dose administered at 9:28pm.

Review of Resident #3's September 2019 eMAR revealed:
-There was an entry for Eliquis 5 mg 2 times daily scheduled for administration at 9:00am and

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9:00pm daily.
-Eliquis was documented as administered late 10 of 90 opportunities from 09/01/19 to 09/30/19, with a reason of "computer issues" documented once, no reason documented once, and 8 times a reason of "resident care" was documented.
-Examples included: on 09/13/19, Eliquis 5 mg was administered at 10:33am instead of 9:00am with the next dose administered at 9:00 pm and on 09/18/19, Eliquis 5 mg was administered at 10:26am instead of 9:00am with the next dose documented as not available.
-Eliquis 5 mg was documented as not administered on 09/02/19 at 9:00pm and 09/18/19 at 9:00pm with a documented reason of "drug unavailable".

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry for Eliquis 5 mg 2 times daily scheduled for administration at 9:00am and 9:00pm daily.
-Eliquis was documented as administered late 6 of 93 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 2 times and no reason was documented 4 times.
-Examples included: on 10/02/19, Eliquis 5 mg was administered at 10:52pm instead of 9:00pm with the next dose administered on 10/03/19 at 9:00am and on 10/26/19, Eliquis 5 mg was administered at 10:51pm instead of 9:00pm with the next dose administered on 10/27/19 at 9:00am.

Review of Resident #3's November 2019 eMAR revealed:
-There was an entry for Eliquis 5 mg 2 times daily scheduled for administration at 8:00am and 8:00pm daily.
-Eliquis was documented as administered late 2

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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 364	Continued From page 171 of 15 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 1 time and no documented reason 1 time. -For example, on 11/02/19, Eliquis 5 mg was administered at 10:25am instead of 9:00am with the next dose administered at 9:00pm. Interview with Resident #3's primary care provider)PCP) on 11/15/19 at 10:05am revealed she was not aware of medications being administered late to Resident #3. Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to the interview with a first shift MA on 11/13/19 at 1:08pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. Based on observation, interview, and record review, it was determined Resident #3 was not interviewable. d. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for divalproex (used to treat mood disorders) 125 mg 2 capsules 3 times daily. Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for divalproex 125 mg 2	D 364		

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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capsules 3 times daily scheduled for administration at 7:00am, 1:00pm, and 6:00pm daily.
-Divalproex was documented as administered late 11 of 93 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 9 times and no reason documented 2 times.
-Examples included: on 08/05/19 divalproex 250 mg was administered at 10:27am instead of 7:00am with the next dose administered at 1:00pm and on 08/12/19, divalproex 250 mg was administered at 11:06am instead of 7:00am with the next dose administered at 1:00pm.

Review of Resident #3's September 2019 eMAR revealed:
-There was an entry for divalproex 125 mg 2 capsules 3 times daily scheduled for administration at 7:00am, 1:00pm, and 8:00pm daily.
-Divalproex was documented as administered late 10 of 90 opportunities from 09/01/19 to 09/30/19, with a reason of "computer issues" documented 1 time, no reason documented 2 times, and 7 times a reason of "resident care" was documented.
-Examples included: on 09/12/19, divalproex was administered at 9:26 am instead of 7:00 am with the next dose administered at 1:00 pm and on 09/22/19, divalproex was administered at 9:51am instead of 7:00 am with the next dose administered 1:00pm.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry for divalproex 125 mg 2 capsules 3 times daily scheduled for administration at 7:00am, 1:00pm, and 8:00pm daily.

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D 364	Continued From page 173 -Divalproex was documented as administered late 5 of 93 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 5 times. -Examples included: on 10/22/19, divalproex 250 mg was administered at 12:02 pm instead of 9:00 am with the next dose administered at 2:00 pm and on 10/26/19, divalproex 250 mg was administered at 10:51pm instead of 9:00pm with the next dose administered on 10/27/19 at 9:00 am. Review of Resident #3's November 2019 eMAR revealed: -There was an entry for divalproex 125 mg 2 capsules 3 times daily scheduled for administration 9:00 am, 2:00 pm, and 9:00 pm daily. -Divalproex was documented as administered late 2 of 15 opportunities from 11/01/19 to 11/05/19 with a reason of "resident care" documented 1 time and no reason documented 1 time. -For example, on 11/02/19, divalproex 250 mg was administered at 10:25 am instead of 9:00 am with the next dose administered at 9:00 am. Interview with Resident #3's primary care provider on 11/15/19 at 10:05am revealed she was not aware of medications being administered late to Resident #3. Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.	D 364		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 174 Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. Based on observation, interview, and record review, it was determined Resident #3 was not interviewable. e. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for Restasis (used to treat chronic dry eye) 0.05% 1 drop in both eyes 2 times daily. Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Restasis 0.05% 1 drop in both eyes 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -Restasis was documented as administered late 24 of 93 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 17 times and no reason documented 7 times. -Examples included: on 08/11/19, Restasis was administered at 11:09 am instead of 8:00 am with the next dose administered at 8:00 pm and on 08/12/19, Restasis was administered at 11:06 am instead of 8:00 am with the next dose administered at 9:28 pm. Review of Resident #3's September 2019 eMAR revealed: -There was an entry for Restasis 0.05% 1 drop in both eyes 2 times daily scheduled for administration at 9:00 am and 9:00 pm daily. -Restasis was documented as administered late 10 of 90 opportunities from 09/01/19 to 09/30/19,	D 364		

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with a reason of "computer issues" documented 1 time, no reason documented 3 times, and 7 times a reason of "resident care" was documented.
-Examples included: on 09/10/19, Restasis was administered at 10:31 am instead of 9:00 am with the next dose administered at 10:09 pm and on 09/13/19, Restasis was administered at 10:33 am instead of 9:00 am with the next dose administered at 9:00 pm.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry for Restasis 0.05% 1 drop in both eyes 2 times daily scheduled for administration at 9:00 am and 9:00 pm daily.
-Restasis was documented as administered late 6 of 93 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 3 times and no reason was documented 3 times.
-For example, on 10/09/19, Restasis was administered at 10:17 am instead of 9:00 am with the next dose administered at 9:00 pm.

Review of Resident #3's November 2019 eMAR revealed:
-There was an entry for Restasis 0.05% 1 drop in both eyes 2 times daily scheduled for administration at 9:00 am and 9:00 pm daily.
-Restasis was documented as administered late 2 of 15 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 1 time and no documented reason 1 time.
-For example, on 11/02/1,9 Restasis was administered at 10:25 am instead of 9:00 am with the next dose administered at 9:00 pm.

Interview with Resident 3's primary care provider on 11/15/19 at 10:05am revealed she had not been made aware of medications being administered late to Resident #3.

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D 364	Continued From page 176 Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to the interview with a first shift MA on 11/13/19 at 1:08pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. Based on observation, interview, and record review, it was determined Resident #3 was not interviewable. f. Review of Resident #3's physician's order dated 06/05/19 revealed an order for triamcinolone (used to treat skin rash) 0.1% apply to rash 4 times a daily. Review of Resident #3's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for triamcinolone 0.1% apply 4 times daily scheduled for application at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm daily. -Triamcinolone was documented as applied late 17 of 124 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 16 times and no reason documented 1 time. -Examples included: on 08/11/19, triamcinolone was applied at 11:09 am instead of 9:00 am with the next dose applied at 2:02 pm and on 08/12/19, triamcinolone was applied at 11:06 am	D 364		

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instead of 9:00 am with the next dose applied at 1:00 pm.

Review of Resident #3's September 2019 eMAR revealed:
-There was an entry for triamcinolone 0.1% 4 times daily scheduled for application at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm daily.
-Triamcinolone was documented as applied late 14 of 120 opportunities from 09/01/19 to 09/30/19, with a reason of "computer issues" documented 1 time, no reason documented 4 times, and 9 times a reason of "resident care" was documented.
-Examples included: on 09/09/19, triamcinolone was applied at 6:43 pm instead of 5:00 pm with the next dose applied at 9:00 pm and on 09/19/19, triamcinolone was applied at 6:29 pm instead of 5:00 pm with the next dose applied at 9:00 pm.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry for triamcinolone 0.1% 4 times daily scheduled for application at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm daily.
-Triamcinolone was documented as applied late 9 of 120 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 5 times and no reason was documented 4 times.
-Examples included: on 10/02/19, triamcinolone was applied at 10:52 pm instead of 9:00 pm with the next dose applied on 10/03/19 at 9:00 am and on 10/09/19, triamcinolone was applied at 7:54 pm instead of 5:00 pm with the next dose applied at 9:00 pm.

Review of Resident #3's November 2019 eMAR revealed:
-There was an entry for triamcinolone 0.1% 4

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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times daily scheduled for application at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm daily.
-Triamcinolone was documented as applied late 3 of 15 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 2 times and no reason documented 1 time.
-For example, on 11/02/19, triamcinolone was applied at 2:30 pm instead of 1:00 pm with the next dose applied at 5:00 pm.

Interview with Resident #3's primary care provider on 11/15/19 at 10:05am revealed she was not aware of medications being administered late to Resident #3.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

Based on observation, interview, and record review, it was determined Resident #3 was not interviewable.

g. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for L-Carnitine (an amino acid supplement) 250 mg 4 tablets (1,000 mg) 2 times daily.

Review of Resident #3's August 2019 electronic

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D 364	Continued From page 179 Medication Administration Record (eMAR) revealed: -There was an entry for L-Carnitine 250 mg 4 tablets (1,000 mg) 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -L-Carnitine was documented as administered late 26 of 62 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 19 times and no reason documented 7 times. -Examples included: on 08/11/19, L-Carnitine was administered at 11:09 am instead of 8:00 am with the next dose administered at 8:00 pm and on 08/12/19, L-Carnitine was administered at 11:06 am instead of 8:00 am with the next dose administered at 9:28 pm . Review of Resident #3's September 2019 eMAR revealed: -There was an entry for L-Carnitine 250 mg 4 tablets (1,000 mg) 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -L-Carnitine was documented as administered late 10 of 90 opportunities from 09/01/19 to 09/30/19, with a reason of "computer issues" documented 1 time, no reason documented 2 times, and 7 times a reason of "resident care" was documented. -Examples included: on 09/10/19, L-Carnitine was administered at 10:31 am instead of 9:00 am with the next dose administered on 09/11/19 at 9:00 am and on 09/13/19, L-Carnitine was administered at 10:33 am instead of 9:00 am with the next dose administered at 9:00 pm. Review of Resident #3's October 2019 eMAR revealed: -There was an entry for L-Carnitine 250 mg 4 tablets (1,000 mg) 2 times daily scheduled for administration 9:00 am and 9:00 pm daily.	D 364		

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D 364	Continued From page 180 -L-Carnitine was documented as administered late 4 of 62 opportunities from 10/01/19 to 10/31/19. With a reason of "resident care" documented 1 time and no reason was documented 3 times. -For example: on 10/09/19, L-Carnitine was administered at 10:17 am instead of 9:00 am with the next dose administered at 9:00 pm. Observation of medications on hand on 11/07/19 at 11:47 am revealed there was no L-Carnitine available on the medication cart, or in over-stock. Interview with a medication aide (MA) on 11/14/19 at 9:47 am revealed: -She had never administered L-Carnitine to Resident #3. -She did not realize she had marked L-Carnitine as given and stated it must have been a mistake. -She noticed last night that there was no L-Carnitine available for Resident #3. -She had not called the pharmacy regarding L-Carnitine not being available. -When she did not have a medication on the cart, she would tell the Special Care Unit (SCU) or a more experienced MA. Interview with a representative from the contracted pharmacy on 11/13/19 at 10:30 am revealed: -They had tried to fill the prescription for L-Carnitine for Resident #3 several times but each time it got canceled either by insurance or by the facility. -L-Carnitine was on back order with the manufacturer. -The facility and the physician was made aware on 05/08/19, 07/10/19, 09/06/19, 09/19/19, 10/13/19, and 10/19/19. -The pharmacy had not received a response from	D 364		

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either the facility or the physician.
-The pharmacy had not received an order to discontinue L-Carnitine.

Interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46 pm revealed She knew that Resident #3 did not have any L-carnitine available.

Interview with the Resident #3's primary care provider on 11/15/19 at 10:05am revealed she was not aware of medications being administered late to Resident #3.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

Based on observation, interview, and record review, it was determined Resident #3 was not interviewable.

2. Review of Resident #4's FL-2 dated 5/27/19 revealed diagnoses included dementia with behavioral disturbance, traumatic brain injury, major neurocognitive disorder with behaviors, anxiety, cognitive communication deficit, and history of alcohol abuse.

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a. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for carbamazepine (used to treat mood and agitation) 200 mg 3 times a day.

Review of Resident #4's physician's order dated 11/01/19 revealed an order to change carbamazepine to 200 mg 2 tablets 3 times daily.

Review of Resident #4's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for carbamazepine 200 mg 3 times daily scheduled for administration at 9:00 am, 1:00 pm, and 9:00 pm daily.
-Carbamazepine was documented as administered late 8 of 93 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 8 times.
-Examples included: on 08/11/19, carbamazepine was administered at 11:19 am instead of 9:00 am with the next dose administered at 1:00 pm and on 08/25/19, carbamazepine was administered at 10:42 am instead of 9:00 am with the next dose administered at 1:00 pm.

Review of Resident #4's September 2019 eMAR revealed:
-There was an entry for carbamazepine 200 mg 3 times daily scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily.
-Carbamazepine was documented as administered late 6 of 90 opportunities from 09/01/19 to 09/30/19, with a reason of "resident care" was documented 6 times.
-Examples included: on 09/24/19, carbamazepine was administered at 10:12 am instead of 8:00 am with the next dose administered at 1:00 pm and on 09/30/19, carbamazepine was administered at 10:11 am instead of 8:00 am with the next dose

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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 364	Continued From page 183 administered at 1:00 pm. Review of Resident #4's October 2019 eMAR revealed: -There was an entry for carbamazepine 200 mg 3 times daily scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily. -Carbamazepine was documented as administered late 17 of 93 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 15 times and no reason documented 2 times. -Examples included: on 10/21/19, carbamazepine was administered at 10:35 am instead of 8:00 am with the next dose administered at 2:00 pm and on 10/22/19, carbamazepine was administered at 10:42 am instead of 8:00 am with the next dose administered 2:00 pm. Review of Resident #4's November 2019 eMAR revealed: -There was an entry for carbamazepine 200 mg 2 tablets 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -Carbamazepine was documented as administered late 2 of 15 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 2 times. -For example, on 11/04/19, carbamazepine was administered at 9:57 am instead of 8:00 am with the next dose administered at 8:00 pm. Interview with Resident 4's primary care provider (PCP) on 11/15/19 at 10:15am revealed: -She had not been made aware of medications being administered late to Resident #4. -She could not say that Resident #4 receiving late medications had a good or bad effect on the resident.	D 364		

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D 364	Continued From page 184 Refer to interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to Interview with a first shift MA on 11/13/19 at 1:08 pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46 pm. Refer to the interview with the Administrator on 11/14/19 at 5:31 pm. Based on observation, interview, and record review, it was determined Resident #4 was not interviewable. b. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for benztropine (used to treat involuntary movements) 0.5 mg 2 times a day. Review of Resident #4's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for benztropine 0.5 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -Benztropine was documented as administered late 17 of 62 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 16 times and no reason documented 1 time. -Examples included: on 08/10/19, benztropine was administered at 10:46 am instead of 8:00 am with the next dose administered at 8:00 pm and on 08/11/19, benztropine was administered at 11:04 am instead of 8:00 am with the next dose	D 364		

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administered at 8:00 pm.

Review of Resident #4's September 2019 eMAR revealed:
-There was an entry for benztropine 0.5 mg 2 times daily scheduled for administration at 9:00 am and 9:00 pm daily.
-Benztropine was documented as administered late 8 of 60 opportunities from 09/01/19 to 09/30/19, with no reason documented 1 time and a reason of "resident care" was documented 7 times.
-Examples included: on 09/24/19, benztropine was administered at 10:12 am instead of 8:00 am with the next dose administered at 8:00 pm and on 09/30/19, benztropine was administered at 10:11 am instead of 8:00 am with the next dose administered 8:00 pm.

Review of Resident #4's October 2019 eMAR revealed:
-There was an entry for benztropine 0.5 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily.
-Benztropine was documented as administered late 17 of 62 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 15 times and no reason was documented 2 times.
-For example: on 10/09/19, benztropine was administered at 11:50 pm instead of 8:00 pm with the next dose administered on 10/10/19 at 9:00 am.

Review of Resident #4's November 2019 eMAR revealed:
-There was an entry for benztropine 0.5 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily.
-Benztropine was documented as administered

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late 2 of 15 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 1 time and no documented reason 1 time.
-For example, on 11/04/19, benztropine was administered at 9:57 am instead of 8:00 am with the next dose administered at 8:00 pm.

Interview with Resident 4's primary care provider on 11/15/19 at 10:15am revealed:
-She had not been made aware of medications being administered late to Resident #4.
-She could not say that Resident #4 receiving late medications had a good or bad effect on the resident.

Refer to interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to Interview with a first shift MA on 11/13/19 at 1:08 pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46 pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31 pm.

Based on observation, interview, and record review, it was determined Resident #4 was not interviewable.

c. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for docusate sodium (used to treat constipation) 100 mg twice daily.

Review of Resident #4's August 2019 electronic

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Medication Administration Record (eMAR) revealed:
-There was an entry for docusate sodium 100 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily.
-Docusate sodium was documented as administered late 17 of 62 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 16 times and no reason documented 1 time.
-Examples included: on 08/10/19, docusate sodium was administered at 10:46 am instead of 8:00 am with the next dose administered at 8:00 pm and on 08/11/19, docusate sodium was administered at 11:04 am instead of 8:00 am with the next dose administered at 8:00 pm.

Review of Resident #4's September 2019 eMAR revealed:
-There was an entry for docusate sodium 100 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily.
-Docusate sodium was documented as administered late 5 of 60 opportunities from 09/01/19 to 09/30/19, with a reason of "resident care" documented 5 times.
-Examples included: on 09/24/19, docusate sodium was administered at 10:12 am instead of 8:00 am with the next dose administered at 8:00 pm and on 09/30/19, docusate sodium was administered at 10:11 am instead of 8:00 am with the next dose administered at 8:00 pm.

Review of Resident #4's October 2019 eMAR revealed:
-There was an entry for docusate sodium 100 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily.
-Docusate sodium was documented as administered late 17 of 62 opportunities from

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D 364	Continued From page 188 10/01/19 to 10/31/19, with a reason of "resident care" documented 16 times and no reason was documented 1 time. -For example: on 10/09/19, docusate sodium was administered at 11:50 pm instead of 8:00 pm with the next dose administered on 10/10/19 at 9:35 am and on 10/22/19, docusate sodium was administered at 10:42 am instead of 8:00 am with the next dose administered 8:00 pm. . Review of Resident #4's November 2019 eMAR revealed: -There was an entry for docusate sodium 100 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -Docusate sodium was documented as administered late 2 of 10 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 1 time and no documented reason 1 time. -For example, on 11/04/19, docusate sodium was administered at 9:57 am instead of 8:00 am with the next dose administered at 8:00 pm. Interview with Resident 4's primary care provider (PCP) on 11/15/19 at 10:15am revealed: -She had not been made aware of medications being administered late to Resident #4. -She could not say that Resident #4 receiving late medications had a good or bad effect on the resident. Refer to interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to Interview with a first shift MA on 11/13/19 at 1:08 pm.	D 364		

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D 364	Continued From page 189 Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46 pm. Refer to the interview with the Administrator on 11/14/19 at 5:31 pm. Based on observation, interview, and record review, it was determined Resident #4 was not interviewable. d. Review of Resident #4's physician's order dated 7/25/19 revealed there was an order for meloxicam 7.5 mg (used to treat pain) 2 times daily with food. Review of Resident #4's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for meloxicam 7.5 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -Meloxicam was documented as administered late 17 of 62 opportunities from 08/01/19 to 08/31/19, with a reason of "resident care" documented 16 times and no reason documented 1 time. -Examples included: on 08/10/19, meloxicam was administered at 10:46 am instead of 8:00 am with the next dose administered at 8:00 pm and on 08/11/19, meloxicam was administered at 11:04 am instead of 8:00 am with the next dose administered at 8:00 pm. Review of Resident #4's September 2019 eMAR revealed: -There was an entry for meloxicam 7.5 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -Meloxicam was documented as administered	D 364		

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D 364	Continued From page 190 late 5 of 60 opportunities from 09/01/19 to 09/30/19, with a reason of "resident care" documented 5 times. -Examples included: on 09/24/19, meloxicam was administered at 10:12 am instead of 8:00 am with the next dose administered at 8:00 pm and on 09/30/19, meloxicam was administered at 10:11 am instead of 8:00 am with the next dose administered at 8:00 pm. Review of Resident #4's October 2019 eMAR revealed: -There was an entry for meloxicam 7.5 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -Meloxicam was documented as administered late 17 of 62 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 16 times and no reason was documented 1 time. -For example: on 10/09/19, meloxicam was administered at 11:50 pm instead of 8:00 pm with the next dose administered on 10/10/19 at 9:35 am and on 10/22/19, meloxicam was administered at 10:42 am instead of 8:00 am with the next dose administered 8:00 pm. Review of Resident #4's November 2019 eMAR revealed: -There was an entry for meloxicam 7.5 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily. -Meloxicam was documented as administered late 2 of 10 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 1 time and no documented reason 1 time. -For example, on 11/04/19, meloxicam was administered at 9:57 am instead of 8:00 am with the next dose administered at 8:00 pm.	D 364		

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Interview with Resident 4's primary care provider (PCP) on 11/15/19 at 10:15am revealed:
-She had not been made aware of medications being administered late to Resident #4.
-She could not say that Resident #4 receiving late medications had a good or bad effect on the resident.

Refer to interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to Interview with a first shift MA on 11/13/19 at 1:08 pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46 pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31 pm.

Based on observation, interview, and record review, it was determined Resident #4 was not interviewable.

e. Review of Resident #4's physician's orders dated 09/16/19 revealed there was an order for haloperidol concentrate 2mg/ml give 2 ml (4mg) twice daily (used to treat mood disorders).

Review of Resident #4's September 2019 eMAR revealed:
-There was an entry for haloperidol 4 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily.
-Haloperidol was documented as administered late 5 of 28 opportunities from 09/17/19 to

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09/30/19, with a reason of "resident care" documented 7 times.
-Examples included: on 09/21/19, haloperidol was administered at 10:29 pm instead of 8:00 pm with the next dose administered on 09/22/19 at 9:55 am and on 09/24/19, haloperidol was administered at 10:12 am instead of 8:00 am with the next dose administered 8:00 pm.

Review of Resident #4's October 2019 eMAR revealed:
-There was an entry for haloperidol 4 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily.
-Haloperidol was documented as administered late 17 of 62 opportunities from 10/01/19 to 10/31/19, with a reason of "resident care" documented 15 times and no reason was documented 2 times.
-For example: on 10/09/19, haloperidol was administered at 11:53 pm instead of 8:00 pm with the next dose administered on 10/10/19 at 9:39 am and on 10/22/19, haloperidol was administered at 10:42 am instead of 8:00 am with the next dose administered at 8:00 pm.

Review of Resident #4's November 2019 eMAR revealed:
-There was an entry for haloperidol 4 mg 2 times daily scheduled for administration at 8:00 am and 8:00 pm daily.
-Haloperidol was documented as administered late 2 of 10 opportunities from 11/01/19 to 11/05/19, with a reason of "resident care" documented 1 time and no documented reason 1 time.
-For example, on 11/04/19, haloperidol was administered at 9:57 am instead of 8:00 am with the next dose administered at 8:00 pm.

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D 364	Continued From page 193 Observation of medications on hand on 11/08/19 at 12:24 pm revealed: -There was 1 opened bottle of haloperidol 2mg/ml approximately half full. -There were 5 new bottles of haloperidol 2mg/ml which contained 15 ml each with a dispense date of 10/16/19. Interview with Resident 4's primary care provider (PCP) on 11/15/19 at 10:15am revealed: -She had not been made aware of medications being administered late to Resident #4. -She did not believe Resident #4's behavior would had been any different if he had received haloperidol as ordered. -Resident #4's behaviors had calmed down but recently increased again. Refer to interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to Interview with a first shift MA on 11/13/19 at 1:08 pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46 pm. Refer to the interview with the Administrator on 11/14/19 at 5:31 pm. Based on observation, interview, and record review, it was determined Resident #4 was not interviewable. 3. Review of Resident #5's current FL2 dated 05/21/19 revealed diagnoses included diabetes	D 364		

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mellitus II, muscle weakness, and gastrostomy status.

a. Review of Resident #5's current FL2 dated 05/21/19 revealed:
-In the medications section, there was a note documenting to see physician's orders.
-There were physician's orders attached to the FL2 and dated 05/14/19 which included orders for amlodipine 2.5 mg 1 tablet twice daily (used to treat high blood pressure).

Review of Resident #5's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for amlodipine 2.5 mg and scheduled for administration at 8:00am and 7:00pm.
-There was a second entry for amlodipine 2.5 mg and scheduled for administration at 9:00am and 9:00pm.
-Amlodipine was documented as administered late for 4 of 62 opportunities and administered early for 2 of 62 opportunities from 08/01/19 through 08/31/19.
-Examples of amlodipine administered late were as follows:
-On 08/05/19, amlodipine was scheduled for administration at 8:00pm, but was documented as administered late at 9:48pm; the next dose was documented as administered at 9:21am on 08/06/19.
-On 08/30/19, amlodipine was scheduled for administration at 9:00pm but was documented as administered early at 5:33pm (3 hours and 27minutes prior to the scheduled adminstration time of 9:00pm); the next dose was documented as administered at 9:00am on 08/31/19.

Review of Resident #5's electronic eMAR for

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September 2019 revealed:
-There was an entry for amlodipine 2.5 mg and scheduled for administration at 9:00am and 9:00pm.
-Amlodipine was documented as administered early for 1 of 60 opportunities from 09/01/19 through 09/30/19.
-On 09/21/19, amlodipine was scheduled for administration at 9:00am but was documented as administered early at 7:19am (1 hour and 41 minutes prior to the scheduled administration time of 9:00pm); the next dose was documented as administered at 9:00am on 09/22/19.

Review of Resident #5's electronic eMAR for October 2019 revealed:
-There was an entry for amlodipine 2.5 mg and scheduled for administration at 9:00am and 9:00pm.
-Amlodipine was documented as administered late for 2 of 62 opportunities from 10/01/19 through 10/31/19.
-On 10/15/19, amlodipine was scheduled for administration at 9:00am, but was documented as administered late at 10:21am; the next dose was documented as administered at 9:00pm.
-On 10/24/19, amlodipine was scheduled for administration at 9:00pm, but was documented as administered late at 10:22pm; the next dose was documented as administered at 9:00am on 10/25/19.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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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medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

b. Review of Resident #5's current FL2 dated 05/21/19 revealed:
-In the medications section, there was a note documenting to see physician's orders.
-There were physician's orders attached to the FL2 and dated 05/14/19 which included orders for divalproex 125 mg 1 capsule three times daily (used to treat seizures).

Review of Resident #5's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for divalproex 125 mg 1 capsule three times daily and scheduled for administration at 8:00am, 1:00pm, and 7:00pm.
-Divalproex was documented as administered late for 6 of 93 opportunities and administered early for 2 of 93 opportunities from 08/01/19 through 08/31/19.
-Examples of divalproex 125 mg documented as administered late were as follows:
-On 08/05/19, divalproex was scheduled for administration at 8:00am, but was documented as administered late at 9:48am; the next dose was documented as administered at 1:00pm.
-On 08/30/19, divalproex was scheduled for administration at 9:00pm, but was documented as administered early at 5:33pm (3 hours and 27 minutes prior to the scheduled administration

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time of 9:00pm); the next dose was documented as administered at 9:00am on 08/31/19.

Review of Resident #5's electronic eMAR for September 2019 revealed:
-There was an entry for divalproex 125 mg 1 capsule three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Divalproex was documented as administered late for 6 of 90 opportunities and administered early for 1 of 90 opportunities from 09/01/19 through 09/30/19.
-Examples of divalproex 125 mg documented as administered late were as follows:
-On 09/17/19, divalproex 125 mg was scheduled for administration at 1:00pm, but was documented as administered late at 2:31pm; the next dose was documented as administered at 9:00pm.
-On 09/21/19, divalproex 125 mg was scheduled for administration at 9:00am, but was documented as administered early at 7:19am (1 hour and 41xminutes prior to the scheduled administration time of 9:00am; the next dose was documented as administered at 1:00pm.

Review of Resident #5's electronic eMAR for October 2019 revealed:
-There was an entry for divalproex 125 mg 1 capsule three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Divalproex 125 mg was documented as administered late for 4 of 93 opportunities from 10/01/19 through 10/31/19.
-Examples of divalproex 125 mg documented as administered late were as follows:
-On 10/24/19, divalproex 125mg was scheduled for administration at 1:00pm, but was documented as administered late at 2:37pm; the next dose was documented as administered at

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10:22pm.
-On 10/24/19, divalproex 125mg was scheduled for administration at 9:00pm, but was documented as administered late at 10:22pm; the next dose was documented as administered at 9:00am on 10/25/19.

Review of Resident #5's electronic eMAR for November 2019 revealed:
-There was an entry for divalproex 125 mg 1 capsule three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Divalproex was documented as administered late for 1 of 15 opportunities from 11/01/19 through 11/05/19.
-On 11/05/19, divalproex 125 mg was scheduled for administration at 1:00pm but was documented as administered late at 2:44pm; the next dose was documented as administered at 9:00pm.

Based on observation, interview, and record review, it was determined Resident #5 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide(MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

c. Review of Resident #5's current FL2 dated

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05/21/19 revealed:
-In the medications section, there was a note documenting to see physician's orders.
-There were physician's orders attached to the FL2 and dated 05/14/19 which included orders for humalog 100 unit/mL administer per sliding scale before meals (a rapid-acting insulin used to lower elevated blood sugar levels).

Review of Resident #5's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for Humalog 100 unit/mL administer per sliding scale before meals and scheduled for administration at 7:00am, 11:30am, and 4:30pm.
-Humalog was documented as administered late for 5 of 93 opportunities from 08/01/19 through 08/31/19.
-Examples of Humalog documented as administered lated were as follows:
-On 08/09/19, Humalog was scheduled for administration at 4:30pm, but was documented as administered late at 6:13pm; the next dose was documented as administered at 7:00am on 08/10/19.
-On 08/13/19, Humalog was scheduled for administration at 4:30pm but was documented as administered late at 7:08pm; the next dose was documented as administered at 7:36am on 08/14/19.

Review of Resident #5's electronic eMAR for September 2019 revealed:
-There was an entry for Humalog 100 unit/mL administer per sliding scale before meals and scheduled for administration at 7:00am, 11:30am, and 4:30pm.
-Humalog was documented as administered late for 4 of 90 opportunities from 09/01/19 through

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09/30/19.
-Examples of Humalog documented as administered late were as follows:
-On 09/04/19, Humalog was scheduled for administration at 7:30am, but was documented as administered late at 9:58am; the next dose was documented as administered at 11:30am.
-On 09/16/19, Humalog was scheduled for administration at 7:30pm, but was documented as administered late at 10:00pm; the next dose was documented as administered at 11:30am.

Based on observation, interview, and record review, it was determined Resident #5 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

d. Review of Resident #5's current FL2 dated 05/21/19 revealed:
-In the medications section, there was a note documenting to see physician's orders.
-There were physician's orders attached to the FL2 and dated 05/14/19 which included orders for Levemir 100unit/mL insulin inject 35 units every morning and 12 units at bedtime (a long-acting insulin used to control blood sugar levels).

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D 364	Continued From page 201 Review of a subsequent physician's order dated 10/01/19 revealed to increase Levemir from 35 units every morning to 40 units every morning. Review of Resident #5's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for Levemir 100 unit/mL inject 35 units every morning and scheduled for administration at 6:30am. -There was a second entry for Levemir 100 unit/mL inject 35 units every morning and scheduled for administration at 9:00am. -There was a third entry for Levemir 100 unit/mL inject 12 units at bedtime and scheduled for administration at 7:00pm. -There was a fourth entry for Levemir 100 unit/mL inject 12 units at bedtime and scheduled for administration at 9:00pm. -Levemir was documented as administered late for 5 of 62 opportunities and administered early 2 of 62 opportunities from 08/01/19 through 08/31/19. -Examples of Levemir documented as adminstered late were as follows: -On 08/03/19, Levemir was scheduled for administration at 6:30am, but was documented as administered late at 9:13am; the next dose was documented as administered at 7:00pm. -On 08/30/19, Levemir was scheduled for administration at 9:00pm, but was documented as administered early at 6:11pm (2 hours and 49 minutes prior to the scheduled administration time of 9:00pm, the next dose was documented as administered at 6:30am on 09/01/19. Review of Resident #5's electronic eMAR for September 2019 revealed: -There was an entry for Levemir 100 unit/mL	D 364		

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inject 35 units every morning and scheduled for administration at 6:30am.
-There was a second entry for Levemir 100 unit/mL inject 35 units every morning and scheduled for administration at 8:00am.
-There was a third entry for Levemir 100 unit/mL inject 12 units at bedtime and scheduled for administration at 9:00pm.
-Levemir was documented as administered late for 1 of 60 opportunities from 09/01/19 through 09/30/19.
-On 09/10/19, Levemir was scheduled for administration at 6:30am, but was documented as administered late at 7:40am; the next dose was documented as administered at 10:00pm.

Review of Resident #5's electronic eMAR for October 2019 revealed:
-There was an entry for Levemir 100 unit/mL inject 40 unit every morning and scheduled for administration at 6:30am.
-There was a second entry for Levemir 100 unit/mL inject 12 units at bedtime and scheduled for administration at 9:00pm.
-Levemir was documented as administered late for 1 of 62 opportunities from 10/01/19 through 10/31/19.
-On 10/24/19 Levemir was scheduled for administration at 9:00pm, but was documented as administered late at 10:22pm; the next dose was documented as administered at 6:30am on 10/25/19.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

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Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

4. Review of Resident #7's FL2 dated 05/14/19 revealed diagnoses included dementia, breast cancer, hypertension, and history of rib fracture.

a. Review of Resident #7's physician's orders dated 05/14/19 revealed acetaminophen 325mg 2 tablets four times a day (used to treat mild pain).

Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for acetaminophen 325 mg 2 tablets four times daily and scheduled for administration at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was asecond entry for acetaminophen 325 mg 2 tablets four times daily and scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Acetaminophen was documented as administered late for 35 of 124 opportunities from 08/01/19 through 08/31/19.
-Examples of acetaminophen 325 mg documented as administered late were as follows:
-On 08/12/19, acetaminophen 325 mg was scheduled for administration at 9:00pm, but was documented as administered late at 11:28pm; the

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next dose was documented as administered at 10:16am on 08/13/19.
-On 08/29/19, acetaminophen 325 mg was scheduled for administration at 8:00am, but was documented as administered late at 9:43am; the next dose was documented as administered at 12:00pm.

Review of Resident #7's electronic eMAR for September 2019 revealed:
-There was an entry for acetaminophen 325 mg 2 tablets four times daily and scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Acetaminophen 325 mg was documented as administered late for 26 of 120 opportunities from 09/01/19 through 09/30/19.
-Examples of acetaminophen 325 mg documented as administered late were as follows:
-On 09/09/19, acetaminophen 325 mg was scheduled for administration at 4:00pm, but was documented as administered late at 6:41pm; the next dose was documented as administered at 9:04pm.
-On 09/13/19, acetaminophen 325 mg was scheduled for administration at 8:00am, but was documented as administered late at 11:05am; the next dose was documented as administered at 12:00pm.

Review of Resident #7's electronic eMAR for October 2019 revealed:
-There was an entry for acetaminophen 325 mg 2 tablets four times daily and scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Acetaminophen 325 mg was documented as administered late for 32 of 124 opportunities from 10/01/19 through 10/31/19.

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D 364	Continued From page 205 -Examples of acetapminohen 325 mg documented as administered late were as follows: -On 10/02/19, acetaminophen 325 mgwas scheduled for administration at 8:00am, but was documented as administered late at 10:26am; the next dose was documented as administered at 12:00pm. -On 10/09/19, acetaminophen 325 mg was scheduled for administration at 4:00pm, but was documented as administered late at 8:32pm; there was documentation acetaminophen 325 mg was documented as administered at 8:00pm in addition to the late administration at 8:32pm; the next dose was documented as administered at 8:00am on 10/10/19. Review of Resident #7's electronic eMAR for November 2019 revealed: -There was an entry for acetaminophen 325 mg 2 tablets four times daily and scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Acetaminophen 325 mg was documented as administered late for 9 of 120 opportunities from 11/01/19 through 11/06/19. -Examples of acetaminophen 325 mg documented as administered late were as follows: -On 11/01/19, acetaminophen 325 mg was scheduled for administration at 4:00pm, but was documented as administered late at 5:43pm; the next dose was documented as administered at 8:00pm. -On 11/06/19, acetaminophen 325 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:01am; the next dose was documented as administered at 12:00pm.	D 364		

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D 364	Continued From page 206 Based on observation, interview, and record review, it was determined Resident #7 was not interviewable. Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to the interview with a first shift MA on 11/13/19 at 1:08pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. b. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for diclofenac sodium gel 1% apply 2 gm topically to affected area twice daily (used to treat pain). Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for diclofenac sodium gel 1% apply 2 gm topically to affected area twice daily and scheduled for applicaiton at 8:00am and 8:00pm. -Diclofenac sodium gel was documented as applied late for 29 of 62 opportunities from 08/01/19 through 08/31/19. -Examples of diclofenac sodium gel 1% documented as applied lated were as follows. -On 08/02/19, diclofenac sodium gel 1% was scheduled for application at 8:00am, but was documented as applied late at 10:22am; the next dose was documented as applied at 9:00pm.	D 364		

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D 364	Continued From page 207 -On 08/11/19, diclofenac sodium gel 1% was scheduled for applicaiton at 8:00am, but was documented as applied late at 10:56am; the next dose was documented as applied at 8:00am on 08/12/19. Review of Resident #7's electronic eMAR for September 2019 revealed: -There was an entry for diclofenac sodium gel 1% apply 2 gm topically to affected area twice daily and scheduled for application at 8:00am and 8:00pm. -Diclofenac sodium gel 1% was documented as applied late for 10 of 60 opportunities from 09/01/19 through 09/30/19. -Examples of diclofenac sodium gel 1% documented as applied late were as follows: -On 09/04/19, diclofenac sodium gel 1% was scheduled for application at 8:00pm, but was documented as applied late at 10:21am; the next dose documented as was applied at 8:00pm. -On 09/13/19, diclofenac sodium gel 1% was scheduled for application at 8:00am, but was documented as applied late at 11:17am; the next dose was documented as applied at 8:00pm. Review of Resident #7's electronic eMAR for October 2019 revealed: -There was an entry for diclofenac sodium gel 1% apply 2 gm topically to affected area twice daily and scheduled for application at 8:00am and 8:00pm. -Diclofenac sodium gel 1% was documented as applied late for 6 of 62 opportunities from 10/01/19 through 10/31/19. -Examples of diclofenac sodium gel 1% documented as applied late were as follows: -On 10/02/19, diclofenac sodium gel 1% was scheduled for application at 8:00am, but was documented as applied late at 10:26am; the next	D 364		

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dose was documented as applied at 8:00pm.
-On 10/22/19, diclofenac sodium gel 1% was scheduled for application at 8:00am, but was documented as applied late at 9:58am; the next dose was documented as applied at 8:00pm.

Review of Resident #7's electronic eMAR for November 2019 revealed:
-There was an entry for diclofenac sodium gel 1% apply 2 gm topically to affected area twice daily and scheduled for application at 8:00am and 8:00pm.
-Diclofenac sodium gel was documented as applied late for 4 of 11 opportunities from 11/01/19 through 11/06/19.
-Examples of diclofenac sodium gel 1% documented as applied late were as follows:
-On 11/03/19, diclofenac sodium gel 1% was scheduled for application at 8:00am, but was documented as applied late at 9:47am; the next dose was documented as applied at 8:00pm.
-On 11/06/19, diclofenac sodium gel 1% was scheduled for application at 8:00am, but was documented as applied late at 10:01am; it could not be determined when the next dose was documented as applied according to the eMAR.

Based on observation, interview, and record review, it was determined Resident #7 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

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Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

c. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for ferrous sulfate 325 mg 1 tablet twice daily with meals (used to treat low iron).

Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for ferrous sulfate 325 mg 1 tablet twice daily with meals and scheduled for administration at 8:00am and 8:00pm.
-Ferrous sulfate 325 mg was documented as administered late for 29 of 62 opportunities from 08/01/19 through 08/31/19.
-Examples of ferrous sulfate 325 mg documented as administered late were as follows:
-On 08/05/19, ferrous sulfate 325 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:20am; the next dose was documented as administered at 8:00pm.
-On 08/11/19, ferrous sulfate 325 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:56am; the next dose was documented as administered at 8:00am on 08/12/19.

Review of Resident #7's electronic eMAR for September 2019 revealed:
-There was an entry for ferrous sulfate 325 mg 1 tablet twice daily with meals and scheduled for administration at 8:00am and 8:00pm.
-Ferrous Sulfate 325 mg was documented as administered late for 10 of 60 opportunities from

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09/01/19 through 09/30/19.
-Examples of ferrous sulfate 325 mg documented as administered late were as follows:
-On 09/13/19, ferrous sulfate 325 mg was scheduled for administration at 8:00am, but was documented as administered late at 11:17am; the next dose was documented as administered at 8:00pm.
-On 09/27/19, ferrous sulfate 325 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:14am; the next dose was documented as administered at 8:00pm.

Review of Resident #7's electronic eMAR for October 2019 revealed:
-There was an entry for ferrous sulfate 325 mg 1 tablet twice daily with meals and scheduled for administration at 8:00am and 4:00pm.
-Ferrous sulfate 325 mg was documented as administered late for 9 of 62 opportunities from 10/01/19 through 10/31/19.
-Examples of ferrous sulfate 325 mg documented as administered late were as follows:
-On 10/02/19, ferrous sulfate 325 mgwas scheduled for administration at 8:00am, but was documented as administered late at 10:26am; the next dose was documented as administered at 4:00pm.
-On 10/22/1,9 ferrous sulfate 325 mgwas scheduled for administration at 8:00am, but was documented as administered late at 9:58am; the next dose was documented as administered at 4:00pm.

Review of Resident #7's electronic eMAR for November 2019 revealed:
-There was an entry for ferrous sulfate 325 mg 1 tablet twice daily with meals and scheduled for administration at 8:00am and 4:00pm.

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D 364	Continued From page 211 -Ferrous Sulfate 325 mg was documented as administered late for 5 of 11 opportunities from 11/01/19 through 11/06/19. -Examples of ferrous sulfate 325 mg documented as administered late were as follows: -On 11/01/19, ferrous sulfate 325 mg was scheduled for administration at 4:00pm, but was documented as administered late at 5:38pm; the next dose was documented as administered at 9:00am on 11/02/19. -On 11/06/19, ferrous sulfate 325 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:01am; it could not be determined when the next dose was documented as administered according to the eMAR. Based on observation, interview, and record review, it was determined Resident #7 was not interviewable. Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to the interview with a first shift MA on 11/13/19 at 1:08pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. d. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for hydroxyzine HCL 25 mg 1 tablet three times daily (used to treat allergy symptoms or anxiety).	D 364		

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D 364	Continued From page 212 Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for hydroxyzine HCL 25 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm. -Hydroxyzine was documented as administered late for 13 of 93 opportunities from 08/01/19 through 08/31/19. -Examples of hydroxyzine 25 mg documented as administered late were as follows: -On 08/11/19, hydroxyzine 25 mg was scheduled for administration at 9:00am, but was documented as administered late at 10:56am; the next dose was documented as administered at 1:00pm. -On 08/12/19, hydroxyzine 25 mg was scheduled for administration at 9:00pm, but was documented as administered late at 11:28pm; the next dose was documented as administered at 10:16am on 08/13/19. Review of Resident #7's electronic eMAR for September 2019 revealed: -There was an entry for hydroxyzine HCL 25 mg 1 tablet three times daily and scheduled for administration at 8:00am, 2:00, and 8:00pm. -Hydroxyzine 25 mg was documented as administered late for 10 of 90 opportunities from 09/01/19 through 09/30/19. -Examples of hydroxyzine 25 mg documented as administered late were as follows: -On 09/04/19, hydroxyzine 25 mgwas scheduled for administration at 8:00am, but was documented as administered late at 10:21am; the next dose was documented as administered at 2:00pm. -On 09/13/19, hydroxyzine 25 mgwas scheduled for administration at 8:00am, but was	D 364		

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documented as administered late at 11:17am; the next dose was documented as administered at 2:00pm.

Review of Resident #7's electronic eMAR for October 2019 revealed:
-There was an entry for hydroxyzine HCL 25 mg 1 tablet three times daily and scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Hydroxyzine 25 mg was documented as administered late for 6 of 93 opportunities from 10/01/19 through 10/31/19.
-Examples of hydroxyzine 25 mg documented as administered late were as follows:
-On 10/02/19, hydroxyzine 25 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:26am; the next dose was documented as administered at 2:00pm.
-On 10/22/19, hydroxyzine 25 mg was scheduled for administration at 8:00am, but was documented as administered late at 9:58am; the next dose was documented as administered at 2:00pm.

Review of Resident #7's electronic eMAR for November 2019 revealed:
-There was an entry for hydroxyzine HCL 25 mg 1 tablet three times daily and scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Hydroxyzine 25 mg was documented as administered late for 4 of 16 opportunities from 11/01/19 through 11/06/19.
-Examples of hydroxyzine 25 mg documented as administered late were as follows:
-On 11/03/19, hydroxyzine was scheduled for administration at 8:00am, but was documented as administered late at 9:47am; the next dose was documented as administered at 2:00pm.
-On 11/06/19, hydroxyzine 25 mg was scheduled

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for administration at 8:00am, but was documented as administered late at 10:01am; it could not be determined when the next dose was documented as administered according to the eMAR.

Based on observation, interview, and record review, it was determined Resident #7 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

e. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for memantine 5 mg 1 tablet twice daily (used to treat symptoms of Alzheimer's disease).

Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for memantine 5 mg 1 tablet twice daily and scheduled for administration at 8:00am and 8:00pm.
-Memantine was documented as administered late for 30 of 62 opportunities from 08/01/19 through 08/31/19.
-Examples of memantine 5 mg documented as

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administered late were as follows:
-On 08/11/19, memantine 5 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:56am; the next dose was documented as administered at 8:21pm.
-On 08/12/19, memantine 5 mg was scheduled for administration at 8:00pm, but was documented as administered late at 11:27pm; the next dose was documented as administered at 10:16am on 08/13/19.

Review of Resident #7's electronic eMAR for September 2019 revealed:
-There was an entry for memantine 5 mg 1 tablet twice daily and scheduled for administration at 8:00am and 8:00pm.
-Memantine 5 mg was documented as administered late for 10 of 60 opportunities from 09/01/19 through 09/30/19.
-Examples of memantine 5 mg documented as administered late were as follows:
-On 09/04/19, memantine 5 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:21am; the next dose was documented as administered at 8:00pm.
-On 09/13/19, memantine 5 mg was scheduled for administration at 8:00am, but was documented as administered late at 11:17am; the next dose was documented as administered at 8:00pm.

Review of Resident #7's electronic eMAR for October 2019 revealed:
-There was an entry for memantine 5 mg 1 tablet twice daily and scheduled for administration at 8:00am and 8:00pm.
-Memantine 5 mg was documented as administered late for 6 of 31 opportunities from

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D 364	Continued From page 216 10/01/19 through 10/31/19. -Examples of memantine 5 mg documented as administered late were as follows: -On 10/02/19, memantine 5 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:26am; the next dose was documented as administered at 8:00pm. -On 10/22/19, memantine 5 mg was scheduled for administration at 8:00am, but was documented as administered late at 9:58am; the next dose was documented as administered at 8:00pm. Review of Resident #7's electronic eMAR for November 2019 revealed: -There was an entry for memantine 5 mg 1 tablet twice daily and scheduled for administration at 8:00am and 8:00pm. -Memantine 5 mg was documented as administered late for 4 of 11 opportunities from 11/01/19 through 11/06/19. -Examples of memantine 5 mg documented as administered late were as follows: -Examples included: on 11/03/19, memantine 5 mg was scheduled for administration at 8:00am, but was documented as administered late at 9:47am; the next dose was documented as administered at 8:00pm. -On 11/06/19, memantine 5 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:01am; it could not be determined when the next dose was documented as administered according to the eMAR. Based on observation, interview, and record review, it was determined Resident #7 was not interviewable.	D 364		

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Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MAon 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

f. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for tramadol 50 mg 1 tablet three times daily (used to treat moderate pain).

Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 8:00pm.
-There was a second entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Tramadol 50 mg was documented as administered late for 14 of 93 opportunities from 08/01/19 through 08/31/19.
-Examples of tramadol 50 mg documented as administered late were as follows:
-On 08/11/19, tramadol 50 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:55am; the next dose was documented as administered at 1:00pm.
-On 08/12/19, tramadol 50 mg was scheduled for administration at 8:00pm, but was documented

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as administered late at 11:27pm; the next dose was documented as administered at 10:10am on 08/13/19.

Review of Resident #7's electronic eMAR for September 2019 revealed:
-There was an entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-There was a second entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Tramadol 50 mgwas documented as administered late for 5 of 90 opportunities from 09/01/19 through 09/30/19.
-Examples of tramadol 50 mg documented as administered late were as follows:
-On 09/04/19, tramadol 50 mg was scheduled for administration at 9:00am, but was documented as administered late at 11:31am; the next dose was documented as administered at 1:00pm.
-On 09/13/19, tramadol 50 mg was scheduled for administration at 8:00am, but was documented as administered late at 11:17am; the next dose was documented as administered at 2:27pm.

Review of Resident #7's electronic eMAR for October 2019 revealed:
-There was an entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Tramaol 50 mg was documented as administered late for 4 of 93 opportunities from 10/01/19 through 10/31/19.
-Examples of tramadol 50 mg documented as administered late were as follows:
-On 10/02/19, tramadol 50 mg was scheduled for administration at 9:00pm, but was documented as administered late at 10:52pm; the next dose was documented as administered at 9:00am on

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10/03/19.
-On 10/26/19, tramadol 50 mg was scheduled for administration at 9:00pm, but was documented as administered late at 10:46pm; the next dose was documented as administered at 9:00am on 10/27/19.

Review of Resident #7's electronic eMAR for November 2019 revealed:
-There was an entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Tramadol 50 mg was documented as administered late for 3 of 16 opportunities from 11/01/19 through 11/06/19.
-Examples of tramadol 50 mg documented as administered late were as follows:
-On 11/02/19, tramadol 50 mg was scheduled for administration at 9:00am, but was documented as administered late at 10:23am; the next dose was documented as administered at 2:28pm.
-On 11/02/19, tramadol 50 mg was scheduled for administration at 1:00pm, but was documented as administered late at 2:28pm; the next dose was documented as administered at 9:00pm.

Based on observation, interview, and record review, it was determined Resident #7 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit

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D 364	Continued From page 220 (SCU) Coordinator on 11/14/19 at 2:46pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. g. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for triamcinolone acetonide cream 0.7% apply to rash 4 times daily (used to treat skin conditions such as rash, allergies, and eczema). Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for triamcinolone acetonide cream apply to rash 4 times daily and scheduled for application at 9:00am, 1:00pm, 5:00pm and 9:00pm. -Triamcinolone acetonide cream was documented as applied late for 16 of 124 opportunities from 08/01/19 through 08/31/19. -Examples of triamcinolone acetonide cream documented as applied late were as follows: -On 08/12/19, triamcinolone acetonide cream was scheduled for application at 9:00pm, but was documented as applied late at 11:29pm; the next dose was documented as applied at 10:16am on 08/13/19. -On 08/25/19, triamcinolone acetonide cream was scheduled for application at 5:00pm, but was documented as applied late at 6:43pm; the next dose was documented as applied at 9:00pm. Review of Resident #7's electronic eMAR for September 2019 revealed: -There was an entry for triamcinolone acetonide cream apply to rash 4 times daily and scheduled for application at 8:00am, 12:00pm, 4:00pm and 8:00pm. - Triamcinolone acetonide cream was	D 364		

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documented as applied late for 27 of 120 opportunities from 09/01/19 through 09/30/19.
-Examples of triamcinolone acetonide cream documented as applied late were as follows:
-On 09/09/19, triamcinolone acetonide cream was scheduled for application at 4:00pm, but was documented as applied late at 6:42pm; the next dose was documented as administered at 9:05pm.
-On 09/13/19, triamcinolone acetonide cream was scheduled for application at 8:00am, but was documented as applied late at 11:17am; the next dose was documented as administered at 12:00pm.

Review of Resident #7's electronic eMAR for October 2019 revealed:
-There was an entry for triamcinolone acetonide cream apply to rash 4 times daily and scheduled for application at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-Triamcinolone acetonide cream was documented as applied late for 32 of 124 opportunities from 10/01/19 through 10/31/19.
-Examples of triamcinolone acetonide cream documented as applied late were as follows:
-On 10/02/19 triamcinolone acetonide cream was scheduled for application at 8:00am, but was documented as applied late at 10:25am; the next dose was documented as administered at 12:00pm.
-On 10/17/19 triamcinolone acetonide cream was scheduled for application at 12:00pm, but was documented as applied late at 1:57pm; the next dose was documented as administered at 5:42pm.

Review of Resident #7's electronic eMAR for November 2019 revealed:
-There was an entry for triamcinolone acetonide

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cream apply to rash 4 times daily and scheduled for application at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-Triamcinolone acetonide cream was documented as applied late for 10 of 21 opportunities from 11/01/19 through 11/06/19.
-Examples of triamcinolone acetonide cream documented as applied late were as follows:
-On 11/02/19, triamcinolone acetonide cream was scheduled for application at 12:00pm, but was documented as applied late at 2:30pm; the next dose was documented as administered at 5:38pm.
-On 11/06/19, triamcinolone acetonide cream was scheduled for application at 8:00am, but was documented as applied late at 10:02am; the next dose was documented as administered at 8:00pm; it could not be determined when the next dose was documented as administered according to the eMAR.

Based on observation, interview, and record review, it was determined Resident #7 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

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D 364	Continued From page 223 5. Review of Resident # 10's current FL2 dated 05/08/19 revealed diagnoses included dementia, gastroesophageal reflux disease, low back pain, depression, anxiety, and hyperlipidemia. Review of physician's orders dated 09/10/19 revealed an order for Depakote Sprinkles (divalproex) 125 mg (used to treat manic episodes) 1 capsule twice daily. Review of Resident #10's electronic Medication Administration Record (eMAR) for September 2019 revealed: -There was an entry for divalproex capsules delayed release sprinkle 125 mg 1 capsule twice daily for agitation and aggression with dementia scheduled for administration at 8:00am and 8:00pm. -Divalproex 125 mg was documented as administered late for 6 of 38 opportunities from 09/12/19 through 09/30/19. -Examples of divalproex 125 mg documented as administered late were as follows: -On 09/22/19, divalproex 125 mg was scheduled for administration at 8:00am, but was documented as administered late at 9:53am; the next dose was documented as administered at 8:00pm. -On 09/30/19, divalproex 125 mg was scheduled for administration at 8:00am, but was documented as administered late at 09:35am; the next dose was documented as administered at 8:00pm. Review of Resident #10's MAR for October 2019 revealed: -There was an entry for divalproex capsules delayed release sprinkle 125 mg 1 capsule twice daily for agitation and aggression with dementia scheduled for administration at 8:00am and	D 364		

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D 364	Continued From page 224 8:00pm. -Divalproex 125 mg was documented as administered late for 13 of 62 opportunities from 10/01/19 through 10/31/19. -Examples of divalproex 125 mg documented as administered late were as follows: -On 10/22/19, divalproex was scheduled for administration at 8:00am, but was documented as administered late at 10:03am; the next dose was documented as administered at 8:00pm. -On 10/30/19, divalproex 125 mg was scheduled for administration at 8:00am, but was documented as administered late at 10:06am; the next dose was documented as administered at 8:00pm. Based on interviews, observations, and record reviews, it was determined Resident #10 was not available in the facility to interview. Interview with Resident #10's Primary Care Provider (PCP) on 11/15/19 at 9:44am revealed: -Resident #10 had behavior issues, but she could not blame Resident #10's behaviors on late medications including divalproex or missing divalproex for one day as documented on the eMAR. -Resident #10 had a low valproic acid level of 27 on 09/24/19. -The normal valproic acid level ranged from 50 to 100. -Sometimes there were no behaviors when valproic acids levels were low and sometimes there were no behavior issues when valproic acid levels were within range. -Resident #10 had ongoing behavior issues. -She expected for medication to be administered as ordered. Based on observation, interview, and record	D 364		

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review, it was determined Resident #7 was not interviewable.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

6. Review of Resident #2's current FL2 dated 05/09/19 revealed diagnoses included Alzheimer's disease, gastroesophageal reflux disease, chronic obstructive pulmonary disease (COPD) neuropathy, hyperlipidemia, anemia, hypothyroidism, coronary disease, vitamin D deficiency and depression.

a. Review of Resident #2's current FL2 dated 05/09/19 revealed there was a physician's order for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily (a bronchodilator used to treat COPD).

Review of Resident #2's hospital discharge summary report dated 04/26/19 revealed:
-Resident #2 was admitted for respiratory failure.
-The discharge orders included albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.

Review of Resident #2's physician's orders dated

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09/18/19 revealed albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.

Review of Resident #2's August 2019 electronic Medication Administration Record (eMARs) revealed:
-There was an entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily and scheduled for administration at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was a second entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily and scheduled for administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation albuterol was administered late 14 times of 124 opportunities. Examples of late administration were as follows:
-On 08/09/19 scheduled for 9:00pm and documented as late administration at 10:43pm.
-On 08/11/19 scheduled for 9:00am and documented as late administration at 10:47am.
-On 08/12/19 scheduled for 9:00pm and documented as late administration at 11:00pm.
-On 08/14/19 scheduled for 9:00pm and documented as late administration at 10:37pm.
-On 08/22/19 scheduled for 5:00pm and documented as late administration at 6:21pm.
-On 08/30/19 scheduled for 8:00am and documented as late administration at 9:36am.
-On 08/30/19 scheduled for 4:00pm and documented as late administration at 5:37pm.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily and scheduled for administration at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was a second entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times

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daily and scheduled for administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation albuterol was administered late 19 times of 124 opportunities. Examples of late administration were as follows:
-On 09/04/19 scheduled for 12:00pm and documented as late administration at 1:40pm.
-On 09/07/19 scheduled for 4:00pm and documented as late administration at 6:27pm.
-On 09/08/19 scheduled for 4:00pm and documented as late administration at 6:07pm.
-On 09/09/19 scheduled for 4:00pm and documented as late administration at 6:05pm.
-On 09/10/19 scheduled for 4:00pm and documented as late administration at 5:34pm.
-On 09/13/19 scheduled for 8:00am and documented as late administration at 10:46am.
-On 09/24/19 scheduled for 4:00pm and documented as late administration at 6:19pm.
-On 09/25/19 scheduled for 4:00pm and documented as late administration at 5:52pm.
-On 09/30/19 scheduled for 4:00pm and documented as late administration at 5:48pm.

Review of Resident #2's October 2019 eMAR revealed:
-There was an entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.
-There was documentation albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial was scheduled for administration at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was a second entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily and scheduled for administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation albuterol was administered late 11 times of 124 opportunities. Examples of late administration were as follows:
-On 10/07/19 scheduled for 4:00pm and

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documented as late administration at 6:27pm.
-On 10/09/19 scheduled for 4:00pm and documented as late administration at 7:13pm.
-On 10/11/19 scheduled for 8:00am and documented as late administration at 10:37am.
-On 10/17/19 scheduled for 4:00pm and documented as late administration at 5:33pm.
-On 10/20/19 scheduled for 12:00pm and documented as late administration at 1:54pm.
-On 10/22/19 scheduled for 8:00am and documented as late administration at 9:50am.
-On 10/30/19 scheduled for 12:00pm and documented as late administration at 2:18pm.

Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am.

Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm.

Refer to the interview with a first shift MA on 11/13/19 at 1:08pm.

Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

b. Review of Resident #2's current FL2 dated 05/09/19 revealed a physician's order for triamcinolone acetonide cream 1% apply to skin four times daily (used to treat dermatitis, allergies and itching).

Review of Resident #2's physician's orders dated 09/18/19 revealed triamcinolone acetonide cream 1% apply to skin four times daily.

Review of Resident #2's August 2019 electronic

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Medication Administration Record (eMARs) revealed:
-There was an entry for triamcinolone acetonide cream 1% apply to skin four times daily and scheduled for application at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was documentation triamcinolone acetonide cream 1% apply to skin four times daily was applied late 12 times of 124 opportunities. Examples of late application were as follows:
-On 08/09/19 scheduled for 9:00pm and documented as late application at 10:43pm.
-On 08/11/19 scheduled for 9:00am and documented as late application at 10:47am.
-On 08/12/19 scheduled for 9:00pm and documented as late application at 11:00pm.
-On 08/14/19 scheduled for 9:00pm and documented as late application at 10:37pm.
-On 08/22/19 scheduled for 5:00pm and documented as late application at 6:21pm.
-On 08/25/19 scheduled for 9:00am and documented as late application at 10:20am.

Review of Resident #2's September 2019 electronic Medication Administration Record (eMARs) revealed:
-There was an entry for triamcinolone acetonide cream 1% apply to skin four times daily and scheduled for application at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was documentation triamcinolone acetonide cream 1% apply to skin four times daily was applied late 8 times of 124 opportunities. Examples of late application were as follows:
-On 09/07/19 scheduled for 5:00pm and documented as late application at 6:27pm.
-On 09/10/19 scheduled for 9:00pm and documented as late application at 10:28pm.
-On 09/13/19 scheduled for 9:00pm and documented as late application at 10:46pm.

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D 364	Continued From page 230 -On 09/13/19 scheduled for 1:00pm and documented as late application at 2:33pm. -On 09/15/19 scheduled for 5:00pm and documented as late application at 6:50pm. -On 09/20/19 scheduled for 9:00pm and documented as late application at 10:59pm. Review of Resident #2's October 2019 electronic Medication Administration Record (eMARs) revealed: -There was an entry for triamcinolone acetonide cream 1% apply to skin four times daily and scheduled for application at 9:00am, 1:00pm, 5:00pm, and 9:00pm. -There was documentation triamcinolone acetonide cream 1% apply to skin four times daily was applied late 8 times of 124 opportunities. Examples of late application were as follows: -On 10/07/19 scheduled for 5:00pm and documented as late application at 6:27pm. -On 10/13/19 scheduled for 9:00pm and documented as late application at 10:46pm. -On 10/13/19 scheduled for 1:00pm and documented as late application at 2:33pm. -On 10/15/19 scheduled for 5:00pm and documented as late application at 6:50pm. -On 10/20/19 scheduled for 9:00pm and documented as late application at 10:59pm. Refer to the interview with the facility's primary care provider (PCP) on 11/07/19 at 9:05am. Refer to the interview with a second shift medication aide (MA) on 11/07/19 at 3:00pm. Refer to the interview with a first shift MA on 11/13/19 at 1:08pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 2:46pm.	D 364		

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D 364	Continued From page 231 Refer to the interview with the Administrator on 11/14/19 at 5:31pm. Interview with the facility's PCP on 11/07/19 at 9:05am revealed: -She knew the facility had several medications administered late at one time a few months ago. -Medications scheduled for administration once daily did not concern her unless the medication was scheduled according to a certain length of time before a meal. -She expected the MAs to administer medications within the 1 hour before or after grace period. -The facility had notified her a few times for medications administered late but not a lot of times. -The facility needed to inform her of medications administered more than 1 hour late to be evaluated on an individual basis. -The eMAR should be accurate for medication administration time to reflect the effectiveness of medications. Interview with a second shift MA on 11/07/19 at 3:00pm revealed: -When the computer went past one hour from the scheduled time for administration, the medication was flagged as late. -Some staff were documenting "gvn" (given) which she understood was to be used if the medication was administered, but for some reason, was not documented on the eMAR at the time of administration and later showed up as a late medication. -She did not routinely administer medications and did not document on the eMAR (clicking off for administered) before going to the next resident. -There could be an occasional entry that had been entered because the computer may not	D 364		

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have interfaced with the WiFi in order to document at the time the medication was administered.
-She suspected most of the entries documented as late were not just documented late, but were administered late due to MA's work load and staff call outs or late shift arrivals.

Interview with a first shift MA on 11/13/19 at 1:08 pm revealed:
-When medications were administered late, there may have been only 1 MA on the medication cart.
-Medications that were documented late and administered late were the same thing and it meant the medications were administered outside of the 1 hour window after the scheduled time.
-Sometimes, the facility had 1 MA on night shift to cover both sides.
-Each MA was assigned a group of residents to complete weekly eMAR audits to ensure medications were on hand.
-Once the audits were completed, the audit forms were given to the SCU Coordinator or the RCC.
-For refusal of medications, the MA was supposed to contact the physician after the second or third refusal. However, MAs could only see the previous dose of medication.
-The SCU Coordinator printed the medication refusal list daily.

Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed:
-When looking at the MAR, "late administration"' meant the medications were given late and "drug/item unavailable" meant the medication was not on the cart.
-Some MAs helped more with personal care so their medications were passed late.
-The Administrator generally ran a daily report; sometimes she would run the report every other

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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 364	Continued From page 233 day for late administration of medications. -She had not looked at the report for late administration of medications. -She did not know some medications had been given 2 hours late. -She had not instructed the staff to let her know if they were looking for medications or if medications needed to be reordered. -Medications were reordered weekly. -Medications should only be documented as administered if the medication was given to the resident. -She thought if medications were administered on time, then behaviors would be decreased. Interview with the Administrator on 11/14/19 at 5:31pm revealed: -MAs were responsible for administering medications. -She expected the MAs to document accurately. -MAs were responsible for auditing the medication carts weekly. -We changed over to a multidose pack at the beginning of October. -The RCC and SCU Coordinator were responsible for ensuring all medications were in the building, ensuring medications were administered as ordered, and that the resident had an adequate supply. -The Administrator randomly ran an audit report to see if medications were administered on time or if medications were not administered but she did not run the report routinely. -There was not a routine audit by the corporate Nurse for monitoring medication administration.	D 364		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 234 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 interviews and record reviews, the facility failed to assure staff documented on the electronic Medication Administration Record (eMAR) the administration of medications immediately following the administration and prior to administering medications to the next resident for 6 of 7 sampled residents (Residents #2, #3, #4, #5, #6, and #7). The findings are: 1. Review of Resident #6's current FL2 dated 05/21/19 revealed diagnoses included acute gouty arthropathy, acute kidney failure, diabetes mellitus, abnormal glucose, chronic kidney disease, hypertension, and acute and chronic deep vein thrombosis/embolism. a. Review of Resident #6's physician's orders dated 05/21/19 and current physicians orders dated 10/20/19 revealed a physician's order for gabapentin (used to neuropathy) 300 mg three times a day.	D 366		

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D 366	Continued From page 235 Review of Resident #6's August 2019 electronic medication administration record (eMAR) revealed: -There was an entry for gabapentin 300 mg three times a day scheduled for 10:00am, 1:00pm, and 9:00pm from 08/01/19 to 08/28/19 and scheduled for 8:00am, 2:00pm, and 8:00pm from 08/28/19 to 08/31/19. -Gabapentin was documented as late administration for 5 of 93 opportunities for August 2019 with examples as follows: -On 08/21/19, scheduled for 1:00pm and documented as late administration at 2:22pm. -On 08/28/19, scheduled for 2:00pm and documented as late administration at 3:22pm. -On 08/29/19, scheduled for 8:00am and documented as late administration at 9:21am. Review of Resident #6's September 2019 and October 2019 eMARs revealed: -There was an entry for gabapentin 300 mg three times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -Gabapentin was as late administration for 12 of 90 opportunities in September 2019 and 2 of 93 opportunities in October 2019 with examples as follows: -On 09/02/19, scheduled for 8:00am and documented as late administration at 10:11am. -On 09/19/19, scheduled for 8:00am and documented as late administration at 9:45am. -On 10/01/19, scheduled for 8:00am and documented as late administration at 10:26am. -On 10/23/19, scheduled for 9:00am and documented as late administration at 10:15am. Review of Resident #6's November 2019 eMAR revealed there was an entry for gabapentin 300 mg three times a day scheduled for 9:00am, 1:00pm, and 9:00pm. Gabapentin was	D 366		

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documented as late as follows:
-On 11/02/19, scheduled for 9:00am and documented as late administration at 10:29am.
-On 11/04/19, scheduled for 1:00pm and documented as late administration at 2:33pm.

Interview with Resident #6 on 11/13/19 at 1:50pm revealed:
-She did not pay much attention to the time she received her medications.
-Resident #6 may have received medications later the scheduled time but she did not recall a particular instance.
-Resident #6 had not experienced any increased pain and suffering due to medications being missed or late.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

b. Review of Resident #6's physician's orders dated 05/21/19 and current physician's orders dated 10/20/19 revealed a physician's order for tramadol (used to treat pain) 50 mg tablets 2 tablets three times a day.

Review of Resident #6's August 2019, September 2019, and October 2019 electronic medication administration record (eMARs) revealed:
-There was an entry for tramadol 50mg take 2 tablets three times a day scheduled for 9:00am, 1:00pm, and 9:00pm.
-Tramadol had late documentation of administration for 4 of 93 opportunities in August 2019, 4 of 90 opportunities in September 2019, and 4 of 93 opportunities in October 2019 with examples as follows:

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D 366	Continued From page 237 -On 08/21/19, scheduled for 1:00pm and documented as late administration at 2:22pm. -On 08/24/19, scheduled for 1:00pm and documented as late administration at 2:49pm. -On 09/03/19, scheduled for 1:00pm and documented as late administration at 2:26pm. -On 09/09/19, scheduled for 1:00pm and documented as late administration at 2:04pm. -On 10/01/19, scheduled for 9:00am and documented as late administration at 10:26am. -On 10/01/19, scheduled for 1:00pm and documented as late administration at 2:13pm and given. Review of Resident #6's November 2019 eMAR revealed there was an entry for tramadol 50mg take 2 tablets three times a day scheduled for 9:00am, 1:00pm, and 9:00pm. Tramadol was documented as late, given (gvn) as follows: -On 11/01/19, scheduled for 9:00am and documented as late administration at 10:46am. -On 11/02/19, scheduled for 9:00pm and documented as late administration at 10:28pm. Interview with Resident #6 on 11/13/19 at 1:50pm revealed: -She did not pay much attention to the time she received her medications. -Resident #6 may have received medications later the scheduled time but she did not recall a particular instance. -Resident #6 had not experienced any increased pain and suffering due to medications being missed or late. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm.	D 366		

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D 366	Continued From page 238 c. Review of Resident #6's physician's orders dated 05/21/19 and hospital discharge summary dated 10/20/19 revealed an order for Novolog Flexpen U-100 Inject 10 units subcutaneously three times daily before meals. Hold for blood sugar less than 50. Interview with a kitchen staff on 11/08/19 at 4:13pm revealed the times for serving residents on the assisted living side were 7:30am for breakfast, 11:30am for lunch, and 4:30pm for dinner. Snacks were served at 10:00am, 2:00pm and 7:30pm. Review of Resident #6's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog Flexpen U-100 inject 10 units subcutaneously three times daily before meals. Hold for blood sugar less than 50 was listed and scheduled for administration at 6:30am, 11:30am, and 4:30pm. -Novolog Flexpen U-100 was documented as late administration, given (gvn) for 4 of 93 opportunities with examples as follows: -On 08/08/19, scheduled for 6:30am and documented as late administration at 7:33am. -On 08/11/19, scheduled for 11:30am and documented as late administration at 1:56pm. -On 08/26/19, scheduled for 4:30pm and documented as late administrationat 5:33pm. Review of Resident #6's September 2019 eMAR revealed: -There was an entry for Novolog Flexpen U-100 inject 10 units subcutaneously three times daily before meals. Hold for blood sugar less than 50 was listed and scheduled for administration at 7:30am, 11:30am, and 4:30pm.	D 366		

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D 366	Continued From page 239 -Novolog Flexpen U-100 was documented as late administration, given (gvn) on 09/03/19 scheduled for 4:30pm. Review of Resident #6's September 2019, and October 2019 and November 2019 eMAR revealed: -There was an entry for Novolog Flexpen U-100 inject 10 units subcutaneously three times daily before meals. Hold for blood sugar less than 50 was listed and scheduled for administration at 7:30am, 11:30am, and 4:30pm. -Novolog Flexpen U-100 was documented as late administration-charted late, given (gvn) as follows on 09/03/19, scheduled for 4:30pm and documented as late administration-charted late at 5:37pm and given. -Novolog Flexpen U-100 was documented aslate, given (gvn) for 3 of 90 opportunities for October 2019 and 2 of 30 opportunities in November 2019 with examples as follows: -On 10/05/19, scheduled for 7:30am and documented as late administration at 9:40am. -On 10/13/19, scheduled for 11:30am and documented as late administration at 1:06pm. -On 10/15/19, scheduled for 11:30am and documented as late administration at 1:27pm. -On 11/05/19, scheduled for 7:30am and documented as late administration at 8:35am. -On 11/05/19, scheduled for 4:30pm and documented as late administration at 5:58pm. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. 2. Review of Resident #4's current FL-2 dated 05/27/19 revealed:	D 366		

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D 366	Continued From page 240 -Diagnoses included dementia with behavioral disturbance, traumatic brain injury, major neurocognitive disorder with behaviors, anxiety, cognitive communication deficit, and history of alcohol abuse. a. Review of Resident #4's FL-2 dated 5/27/19 revealed there was an order for carbamazepine (used to treat mood and agitation) 200mg 3 times a day. Review of Resident #4's August 2019, September 2019, and October 2019 electronic Medication Administration Record (eMAR) revealed carbamazepine 200mg 3 times daily scheduled for administration 8:00am, 2:00pm, and 8:00pm daily. Examples of carbamazepine documented as late, given (gvn) were as follows: -On 08/10/19, scheduled for 9:00pm and documented as late administration at 10:19pm. -On 09/05/19, scheduled for 8:00pm and documented as late administration at 10:41pm. -On 10/01/19, scheduled for 8:00pm and documented as late administration late at 9:11pm. Based on record review, observation and interviews with staff it was determined that Resident #4 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. b. Review of Resident #4's FL-2 dated 05/27/19 revealed there was an order for trazadone (used to treat sleep disorders) 200mg daily at bedtime.	D 366		

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Review of Resident #4's August 2019, September 2019, and October 2019 electronic Medication Administration Record (eMAR) revealed trazadone 200mg daily at bedtime scheduled for administration 8:00 pm daily.
Examples of trazodone documented as late, given (gvn) were as follows:
-On 08/10/19, scheduled for 9:00pm and documented as late administration at 10:19pm.
-On 09/27/19, scheduled for 9:00pm and documented as late administration at 10:54pm.
-On 10/04/19, scheduled for 9:00pm and documented as late administration at 10:56pm.

Based on record review, observation and interviews with staff it was determined that Resident #4 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

c. Review of Resident #4's FL-2 dated 05/27/19 revealed there was an order for benztropine (used to treat involuntary movements) 0.5mg 2 times a day.

Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed benztropine 0.5mg twice daily scheduled for administration 8:00am and 8:00pm daily.
Examples of benztropine documented as late, given (gvn) were as follows:
-On 08/22/19, scheduled for 8:00pm and documented as late administration at 9:53pm.
-On 09/05/19, scheduled for 8:00pm and

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documented as late administration at 10:40pm.
-On 10/13/19, scheduled for 8:00am and documented as late administration at 9:23am.
-On 11/04/19, scheduled for 8:00am and documented as late administration at 9:57am.

Based on record review, observation and interviews with staff it was determined that Resident #4 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

d. Review of Resident #4's FL-2 dated 05/27/19 revealed there was an order for famotidine (used to treat gastroesophageal reflux) 20mg twice daily.

Review of a physician's order dated 10/05/19 revealed an order to decrease famotidine to 20mg daily at bedtime.

Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed famotidine 20mg twice daily scheduled for administration 8:00am and 8:00pm daily.
Examples of famotidine documented as late administration, given (gvn) as follows:
-On 09/05/19, scheduled for 8:00pm and documented as late administration at 10:42pm.
-On 10/01/19, scheduled for 8:00pm and documented as late administration at 9:11pm.
-On 11/01/19, scheduled for 8:00pm and documented as late administration at 9:22pm.

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D 366	Continued From page 243 Based on record review, observation and interviews with staff it was determined that Resident #4 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. e. Review of Resident #4's FL-2 dated 05/27/19 revealed there was an order for atorvastatin (used to treat high cholesterol) 20mg daily. Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed Atorvastatin 20mg daily scheduled for administration 8:00 pm daily. Examples of atorvastatin documented as late administration, given (gvn) as follows: -On 09/07/19, scheduled for 8:00pm and documented as late administration at 9:06 pm. -On 10/01/19, scheduled for 8:00pm and documented as late administration at 9:11pm. -On 11/01/19, scheduled for 8:00pm and documented as late administration at 9:13 pm. Based on record review, observation and interviews with staff it was determined that Resident #4 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. f. Review of Resident #4's FL-2 dated 05/27/19 revealed there was an order for docusate sodium	D 366		

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D 366	Continued From page 244 (used to treat constipation) 100mg twice daily. Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed docusate sodium 100mg twice daily scheduled for administration 8:00am and 8:00pm daily. Examples of docusate sodium documented as late administration, given (gvn) as follows: -On 09/05/19, scheduled for 8:00pm and documented as late administration at 10:42pm. -On 10/01/19, scheduled for 8:00pm and documented as late administration at 9:11pm. -On 11/01/19, scheduled for 8:00pm and documented as late administration at 9:22pm. Based on record review, observation and interviews with staff it was determined that Resident #4 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. g. Review of Resident #4's physician's order dated 07/25/19 revealed there was an order for meloxicam (used to treat pain) 7.5mg 2 times daily with food. Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed meloxicam 7.5mg twice daily scheduled for administration 8:00am and 8:00pm daily. Examples of meloxicam documented as late administration, given (gvn) as follows:	D 366		

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-On 09/05/19, scheduled for 8:00pm and documented as late administration at 10:42pm.
-On 10/01/19, scheduled for 8:00pm and documented as late administration at 9:11pm.
-On 11/01/19, scheduled for 8:00pm and documented as late administration at 9:14pm.

Based on record review, observation and interviews with staff it was determined that Resident #4 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

3. Review of Resident #3's FL-2 dated 05/29/19 revealed diagnoses included dementia.

a. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for diltiazem (used to treat hypertension) 90mg 3 times daily.

Review of Resident #4's August 2019, September 2019, and October 2019 electronic Medication Administration Record (eMAR) revealed an entry for diltiazem 90mg 3 times daily scheduled for administration 9:00am, 1:00pm, and 9:00pm daily.
Examples of diltiazem documented as late administration, given (gvn) as follows:
-On 08/09/19, scheduled for 9:00pm and documented as late administration at 10:48pm.
-On 09/23/19, scheduled for 9:00am and documented as late administration at 11:29am.
-On 10/02/19, scheduled for 9:00pm and documented as late administration at 10:52pm.

Based on record review, observation and

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interviews with staff it was determined that Resident #3 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

b. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for metoprolol (used to treat hypertension) 100mg 2 times daily.

Review of Resident #4's August 2019, September 2019, and October 2019 electronic Medication Administration Record (eMAR) revealed an entry metoprolol 100mg 2 times daily scheduled for administration 8:00am and 8:00pm daily. Examples of metoprolol documented as late administration, given (gvn) as follows:
-On 09/10/19, scheduled for 9:00pm and documented as late administration at 10:09pm.
-On 09/20/19, scheduled for 9:00pm and documented as late administration at 10:57pm.
-On 09/23/19, scheduled for 9:00am and documented as late administration at 11:29am.

Based on record review, observation and interviews with staff it was determined that Resident #3 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

c. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for Eliquis (a blood thinner) 5mg 2 times daily.

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D 366	Continued From page 247 Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed an entry for Eliquis 5mg 2 times daily scheduled for administration 8:00am and 8:00pm daily. Examples of Eliquis documented as late administration, given (gvn) as follows: -On 09/20/19, scheduled for 9:00pm and documented as late administration at 10:57pm. -On 09/23/19, scheduled for 9:00am and documented as late administration at 11:29am. -On 10/02/19, scheduled for 9:00pm and documented as late administration at 10:52pm. -On 10/26/19, scheduled for 9:00pm and documented as late administration at 10:51pm. Based on record review, observation and interviews with staff it was determined that Resident #3 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. d. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for divalproex (used to treat mood disorders) 125mg 2 capsules 3 times daily. Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed an entry for divalproex 125mg 2 capsules 3 times daily scheduled for administration 7:00am, 1:00pm, and 6:00pm daily. Examples of divalproex documented as late	D 366		

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administration, given (gvn) as follows:
-On 08/05/19, scheduled for 6:00pm and documented as late administration at 7:41pm.
-On 09/10/19, scheduled for 8:00pm and documented as late administration at 10:09pm.
-On 10/26/19, scheduled for 9:00pm and documented as late administration at 10:51pm.

Based on record review, observation and interviews with staff it was determined that Resident #3 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

e. Review of Resident #3's FL-2 dated 05/29/19 revealed there was an order for Restasis (used to treat chronic dry eye) 0.05% 1 drop in both eyes 2 times daily.

Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed an entry for Restasis 0.05% 1 drop in both eyes 2 times daily scheduled for administration 8:00am and 8:00pm daily. Examples of Restasis documented as late administration, given (gvn) as follows:
-On 09/20/19, scheduled for 9:00pm and documented as late administration at 10:57pm.
-On 09/23/19, scheduled for 9:00am and documented as late administration at 11:29am.
-On 10/02/19, scheduled for 9:00pm and documented as late administration at 10:52pm.

Based on record review, observation and interviews with staff it was determined that

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D 366	Continued From page 249 Resident #3 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. f. Review of Resident #3's physician's order dated 06/05/19 revealed an order for triamcinolone (used to treat rash) 0.1% apply to rash 4 times a daily. Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed an entry for triamcinolone 0.1% apply 4 times daily scheduled for administration 9:00am, 1:00pm, 5:00pm, and 9:00 pm daily. Examples of triamcinolone documented as late administration, given (gvn) as follows: -On 08/09/19, scheduled for 9:00pm and documented as late administration at 10:48pm. -On 09/23/19, scheduled for 9:00am and documented as late administration at 11:29am. -On 10/02/19, scheduled for 9:00pm and documented as late administration at 10:52pm. Based on record review, observation and interviews with staff it was determined that Resident #3 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. g. Review of Resident #3's physician's order dated 06/05/19 revealed an order for donepezil	D 366		

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(used to enhance memory) 10mg daily at bedtime.

Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed an entry for donepezil 10mg daily at bedtime.
Examples of donepezil documented as late administration, given (gvn) as follows:
-On 08/05/19, scheduled for 6:00pm and documented as late administration at 7:41pm.
-On 09/20/19, scheduled for 9:00pm and documented as late administration at 10:57pm.
-On 10/02/19, scheduled for 9:00pm and documented as late administration at 10:52pm.

Based on record review, observation and interviews with staff it was determined that Resident #3 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

h. Review of Resident #3's physician's order dated 06/05/19 revealed an order for melatonin 5mg daily at bedtime.

Review of Resident #4's August 2019, September 2019, October 2019 and November 2019 electronic Medication Administration Record (eMAR) revealed an entry for melatonin 15mg daily at bedtime.
Examples of melatonin 5mg documented as late administration, given (gvn) as follows:
-On 08/09/19, scheduled for 9:00pm and documented as late administration at 10:48pm.

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D 366	Continued From page 251 -On 09/20/19, scheduled for 9:00pm and documented as late administration at 10:57pm. -On 10/02/19, scheduled for 9:00pm and documented as late administration at 10:52pm. Based on record review, observation and interviews with staff it was determined that Resident #3 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. 4. Review of Resident #5's current FL2 dated 05/21/19 revealed diagnoses included diabetes mellitus II, muscle weakness, and gastrostomy status. a. Further review of Resident #5's current FL2 revealed: -In the medications section, there was a note which stated to see physician's orders. -There were physician's orders attached to the FL2 and dated 05/14/19 which included orders for amlodipine 2.5 mg 1 tablet twice daily. Review of Resident #5's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for amlodipine 2.5 mg and scheduled for administration at 8:00am and 7:00pm. -There was a second entry for amlodipine 2.5 mg and scheduled for administration at 9:00am and 9:00pm. -Amlodipine was documented as administered late, given (gvn) for 4 of 62 opportunities and administered early for 2 of 62 opportunities from	D 366		

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D 366	Continued From page 252 08/01/19 through 08/31/19. -Examples of amlodipine documented as administered late, given (gvn) were as follows: -On 08/10/19, amlodipine was scheduled for administration at 7:00pm but was documented as administered at 8:5pm -On 08/12/19, amlodipine was scheduled for administration at 8:00am but was documented as administered at 9:23am. Review of Resident #5's electronic eMAR for October 2019 revealed: -There was an entry for amlodipine 2.5 mg and scheduled for administration at 9:00am and 9:00pm. -Amlodipine was documented as administered late, given (gvn) for 1 of 62 opportunities from 10/01/19 through 10/31/19. -On 10/14/19, amlodipine was scheduled for administration at 9:00am but was documented as administered at 10:21am Review of Resident #5's electronic eMAR for November 2019 revealed: -There was an entry for amlodipine 2.5 mg and scheduled for administration at 9:00am and 9:00pm. -Amlodipine was documented as administered late, given (gvn) for 3 of 10 opportunities from 10/01/19 through 11/11/19. -On 11/01/19, amlodipine was scheduled for administration at 9:00pm but was documented as administered at 11:11pm. -On 11/02/19, amlodipine was scheduled for administration at 9:00pm but was documented as administered at 12:27am. -On 11/05/19, amlodipine was scheduled for administration at 9:00pm but was documented as administered at 10:41pm.	D 366		

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D 366	Continued From page 253 Based on observation, interview, and record review, it was determined Resident #5 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. b. Further review of Resident #5's current FL2 revealed: -In the medications section, there was a note which stated to see physician's orders. -There were physician's orders attached to the FL2 and dated 05/14/19 which included orders for divalproex 125 mg 1 capsule three times daily. Review of Resident #5's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for divalproex 125 mg 1 capsule three times daily and scheduled for administration at 8:00am, 1:00pm, and 7:00pm. -Divalproex was documented as administered late, given (gvn) for 6 of 93 from 08/01/19 through 08/31/19. -Examples of divalproex documented as late administration, given (gvn) were as follows: -On 08/10/19, divalproex was scheduled for administration at 7:00pm but was documented as administered at 8:50pm. -On 08/29/19, divalproex was scheduled for administration at 1:00pm but was documented as administered at 2:43pmm. Review of Resident #5's electronic eMAR for September 2019 revealed: -There was an entry for divalproex 125 mg 1 capsule three times daily and scheduled for	D 366		

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administration at 9:00am, 1:00pm, and 9:00pm.
-Divalproex was documented as administered late, given (gvn) for 1 of 90 opportunities from 09/01/19 through 09/30/19.
-On 09/03/19, divalproex was scheduled for administration at 1:00pm but was documented as administered at 2:35pm.

Review of Resident #5's electronic eMAR for October 2019 revealed:
-There was an entry for divalproex 125 mg 1 capsule three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Divalproex was documented as administered late, given (gvn) for 2 of 93 opportunities from 10/01/19 through 10/31/19.
-On 10/14/19, divalproex was scheduled for administration at 9:00pm but was documented as administered at 10:32pm.
-On 10/19/19, divalproex was scheduled for administration at 1:00pm but was documented as administered at 2:19pm.

Review of Resident #5's electronic eMAR for November 2019 revealed:
-There was an entry for divalproex 125 mg 1 capsule three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Divalproex was documented as administered late, given (gvn) for 4 of 15 opportunities from 11/01/19 through 11/05/19.
-Examples of divalproex documented as late administration, given (gvn) were as follows:
-On 11/01/19, divalproex was scheduled for administration at 9:00pm but was documented as administered at 11:11pm.
-On 11/02/19, divalproex was scheduled for administration at 9;00pm but was documented as administered at 12:27am.

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Based on observation, interview, and record review, it was determined Resident #5 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

c. Further review of Resident #5's current FL2 revealed:
-In the medications section, there was a note which stated to see physician's orders.
-There were physician's orders attached to the FL2 and dated 05/14/19 which included orders for humalog 100 unit/mL administer per sliding scale before meals.

Review of Resident #5's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for humalog 100 unit/mL administer per sliding scale before meals and scheduled for administration at 7:00am, 11:30am, and 4:30pm.
-Humalog was documented as administered late, given (gvn) for 2 of 93 opportunities from 08/01/19 through 08/31/19.
-On 08/07/19, humalog was scheduled for administration at 11:30am but was documented as administered at 2:43pm.
-On 08/12/19, humalog was scheduled for administration at 7:00am but was documented as administered at 8:07pm.

Review of Resident #5's electronic eMAR for September 2019 revealed:
-There was an entry for humalog 100 unit/mL administer per sliding scale before meals and

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scheduled for administration at 7:00am, 11:30am, and 4:30pm.
-Humalog was documented as administered late, given (gvn) for 3 of 90 opportunities from 09/01/19 through 09/30/19.
-On 09/06/19, humalog was scheduled for administration at 7:30am but was documented as administered at 9:12am.
-On 09/20/19, humalog was scheduled for administration at 7:30am but was documented as administered at 8:34am.
-On 09/24/19, humalog was scheduled for administration at 11:30am but was documented as administered at 12:36pm.

Review of Resident #5's electronic eMAR for October 2019 revealed:
-There was an entry for humalog 100 unit/mL administer per sliding scale before meals and scheduled for administration at 7:00am, 11:30am, and 4:30pm.
-Humalog was documented as administered late, given (gvn) for 3 of 93 opportunities from 10/01/19 through 10/31/19.
-On 10/01/19, humalog was scheduled for administration at 7:30am but was documented as administered at 9:01am.
-On 10/05/19, humalog was scheduled for administration at 7:30am but was documented as administered at 9:00am.
-On 10/23/19, humalog was scheduled for administration at 4:30am but was documented as administered at 6:11pm.

Based on observation, interview, and record review, it was determined Resident #5 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

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D 366	Continued From page 257 Refer to the interview with the Administrator on 11/14/19 at 5:31pm. 5. Review of Resident #7's FL2 dated 05/14/19 revealed diagnoses included dementia, breast cancer, hypertension, and history of rib fracture. a. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for acetaminophen (used for comfort) 325mg 2 tablets four times a day. Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for acetaminophen 325 mg 2 tablets four times daily and scheduled for administration at 9:00am, 1:00pm, 5:00pm, and 9:00pm. -There was a second entry for acetaminophen 325 mg 2 tablets four times daily and scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Acetaminophen was documented as administered late, given (gvn) for 10 of 124 opportunities from 08/01/19 through 08/31/19. -Examples of acetaminophen documented as late administration, given (gvn) were as follows: -On 08/13/19, acetaminophen was scheduled for administration at 5:00pm but was documented as administered at 8:25pm. -On 08/24/19, acetaminophen was scheduled for administration at 5:00pm but was documented as administered at 9:48pm. Review of Resident #7's electronic eMAR for September 2019 revealed: -There was an entry for acetaminophen 325 mg 2 tablets four times daily and scheduled for administration at 8:00am, 12:00pm, 4:00pm, and	D 366		

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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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8:00pm.
-Acetaminophen was documented as administered-charted late, given (gvn) for 13 of 120 opportunities from 09/01/19 through 09/30/19.
-Examples of acetaminophen documented as late administration, given (gvn) were as follows:
-On 09/10/19, acetaminophen was scheduled for administration at 8:00pm but was documented as administered at 10:03pm.
-On 09/24/19, acetaminophen was scheduled for administration at 4:00pm but was documented as administered at 6:11pm.

Based on interviews, observations, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

b. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for diclofenac sodium gel 1% (used to treat pain) apply 2 gm topically to affected area twice daily.

Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for diclofenac sodium gel 1% apply 2 gm topically to affected area twice daily and scheduled for administration at 8:00am and 8:00pm.
-Diclofenac sodium gel was documented as administered late, given (gvn) for 2 of 62 opportunities from 08/01/19 through 08/31/19.
-On 08/07/19, diclofenac sodium gel was

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scheduled for administration at 8:00pm but was documented as administered at 9:03pm.
-On 08/25/19, diclofenac sodium gel was scheduled for administration at 8:00pm but was documented as administered at 9:03pm.

Review of Resident #7's electronic eMAR for September 2019 revealed:
-There was an entry for diclofenac sodium gel 1% apply 2 gm topically to affected area twice daily and scheduled for administration at 8:00am and 8:00pm.
-Diclofenac sodium gel was documented as administered late, given (gvn) for 1 of 60 opportunities from 09/01/19 through 09/30/19.
-On 09/10/19, diclofenac sodium gel was scheduled for administration at 8:00pm but was documented as administered at 10:03pm.

Based on interviews, observations, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

c. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for ferrous sulfate 325 mg (used to treat low iron) 1 tablet twice daily with meals.

Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for ferrous sulfate 325 mg 1 tablet twice daily with meals and scheduled for administration at 8:00am and 8:00pm.

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-Ferrous sulfate was documented as administered late, given (gvn) for 3 of 62 opportunities from 08/01/19 through 08/31/19.
-On 08/07/19, ferrous sulfate was scheduled for administration at 8:00pm but was documented as administered at 9:03pm.
-On 08/24/19, ferrous sulfate was scheduled for administration at 8:00pm but was documented as administered at 9:50pm.
-On 08/25/19, ferrous sulfate was scheduled for administration at 8:00pm but was documented as sdministered at 9:03pm.

Review of Resident #7's electronic eMAR for September 2019 revealed:
-There was an entry for ferrous sulfate 325 mg 1 tablet twice daily with meals and scheduled for administration at 8:00am and 8:00pm.
-Ferrous Sulfate was documented as administered late, given (gvn) for 1 of 60 opportunities from 09/01/19 through 09/30/19.
-On 09/10/19, ferrous sulfate was scheduled for administration at 8:00pm but was documented as administered at 10:03pm.

Based on interviews, observations, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

d. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for hydroxyzine HCL 25 mg (used to treat allergy symptoms or anxiety) 1 tablet three times daily.

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D 366	Continued From page 261 Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for hydroxyzine HCL 25 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm. -Hydroxyzine was documented as administered late, given (gvn) for 1 of 93 opportunities from 08/01/19 through 08/31/19. -On 08/09/19, hydroxyzine, was scheduled for administration at 9:00pm but was documented as administered at 10:39pm. Review of Resident #7's electronic eMAR for September 2019 revealed: -There was an entry for hydroxyzine HCL 25 mg 1 tablet three times daily and scheduled for administration at 8:00am, 2:00, and 8:00pm. -Hydroxyzine was documented as administered late, given (gvn) for 1 of 90 opportunities from 09/01/19 through 09/30/19. -On 09/10/19, hydroxyzine was scheduled for administration at 8:00pm but was documented as administered at 10:03pm. Based on interviews, observations, and record reviews, it was determined Resident #7 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. e. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for memantine 5 mg (used to treat symptoms of Alzheimer's disease) 1 tablet twice daily.	D 366		

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D 366	Continued From page 262 Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for memantine 5 mg 1 tablet twice daily and scheduled for administration at 8:00am and 8:00pm. -Memantine was documented as administered late, given (gvn) for 3 of 62 opportunities from 08/01/19 through 08/31/19. -On 08/07/19, memantine was scheduled for administration at 8:00pm but was documented as administered at 9:03pm. -On 08/24/19, memantine was scheduled for administration at 8:00pm but was documented as administered at 9:50pm. -On 08/25/19, memantine was scheduled for administration at 8:00pm but was documented as administered at 9:03pm. Review of Resident #7's electronic eMAR for September 2019 revealed: -There was an entry for memantine 5 mg 1 tablet twice daily and scheduled for administration at 8:00am and 8:00pm. -Memantine was documented as administered-charted late, given (gvn) for 1 of 60 opportunities from 09/01/19 through 09/30/19. -On 09/10/19, memantine was scheduled for administration at 8:00pm but was documented as administered at 10:03pm. Based on interviews, observations, and record reviews, it was determined Resident #7 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm.	D 366		

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D 366	Continued From page 263 f. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for tramadol 50 mg (used to treat pain) 1 tablet three times daily. Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed: -There was an entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 8:00pm. -There was a second entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Tramadol was documented as administered late, given (gvn) for 2 of 93 opportunities from 08/01/19 through 08/31/19. -On 08/07/19, tramadol was scheduled for administration at 8:00pm but was documented as administered at 9:04pm. -On 08/25/19, tramadol was scheduled for administration at 8:00pm but was documented as administered at 9:02pm. Review of Resident #7's electronic eMAR for September 2019 revealed: -There was an entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was an entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm. -Tramadol was documented as administered late, given (gvn) for 2 of 90 opportunities from 09/01/19 through 09/30/19. -On 09/11/19, tramadol was scheduled for administration at 9:00pm but was documented as administered at 10:55am. -On 09/20/19, tramadol was scheduled for	D 366		

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administration at 9:00pm but was documented as administered at 10:58pm.

Review of Resident #7's electronic eMAR for October 2019 revealed:
-There was an entry for tramadol 50 mg 1 tablet three times daily and scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-Tramaol was documented as administered late, given (gvn) for 2 of 93 opportunities from 10/01/19 through 10/31/19.
-On 10/02/19, tramadol was scheduled for administration at 9:00pm but was documented as administered at 10:52pm.
-On 10/30/19, tramadol was scheduled for administration at 1:00pm but was documented as administered at 2:20pm.

Based on interviews, observations, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

g. Review of Resident #7's physician's orders dated 05/14/19 revealed a physician's order for triamcinolone acetonide cream 0.7% (used to treat skin conditions such as rash, allergies, and eczema) apply to rash 4 times daily.

Review of Resident #7's electronic Medication Administration Record (eMAR) for August 2019 revealed:
-There was an entry for triamcinolone acetonide cream apply to rash 4 times daily and scheduled for application at 9:00am, 1:00pm, 5:00pm and

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9:00pm.
-Triamcinolone acetonide cream was documented as applied late for 6 of 124 opportunities from 08/01/19 through 08/31/19.
-Examples of triamcinolone acetonide cream docmented as late application were as follows:
-On 08/24/19, triamcinolone acetonide cream was scheduled for application at 5:00pm but was documented as applied at 9:48pm.
-On 08/30/19, triamcinolone acetonide cream was scheduled for application at 4:00pm but was documented as applied at 5:55pm.

Review of Resident #7's electronic eMAR for September 2019 revealed:
-There was an entry for triamcinolone acetonide cream apply to rash 4 times daily and scheduled for application at 8:00am, 12:00pm, 4:00pm and 8:00pm.
- Triamcinolone acetonide cream was documented as applied late for 10 of 120 opportunities from 09/01/19 through 09/30/19.
-Examples of triamcinolone acetonide cream dcoumented as late application were as follows:
On 09/07/19, triamcinolone acetonide cream was scheduled for application at 4:00pm but was documented as applied at 7:20pm.
-On 09/10/19, triamcinolone acetonide cream was scheduled for application at 8:00pm but was documented as applied at 10:03am.

Based on interviews, observations, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

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6. Review of Resident #2's current FL2 dated 05/09/19 revealed:
-Diagnoses included Alzheimer's disease, gastroesophageal reflux disease, chronic obstructive pulmonary disease (COPD) neuropathy, hyperlipidemia, anemia, hypothyroidism, coronary disease, vitamin D deficiency and depression.
-There was a physician's order for albuterol sulfate solution 2.5mg (0.083%) (used to treatment COPD and shortness of breath) inhale 1 vial four times daily.

a. Review of a hospital discharge summary report dated 04/26/19 revealed:
-Resident #2 was admitted for respiratory failure.
-The discharge orders included albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.

Review of a physician's order sheet in Resident #2's record signed by the Primary Care Practitioner (PCP) dated 09/18/19 revealed medication orders for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.

Review of Resident #2's August 2019 electronic Medication Administration Record (eMARs) revealed:
-There was an entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.
-There was documentation albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial was scheduled for administration daily at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was a second entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.
-There was documentation albuterol sulfate

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solution 2.5mg (0.083%) inhale 1 vial was scheduled for administered daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation albuterol was documented as administered late 14 times of 124 opportunities. Examples of late administration as follows:
-On 08/09/19, scheduled for 9:00pm and documented as administered at 10:43pm.
-On 08/11/19, scheduled for 9:00am and documented as administered at 10:47am.
-On 08/12/19, scheduled for 9:00pm and documented as administered at 11:00pm.
-On 08/14/19, scheduled for 9:00pm and documented as administered at 10:37pm.
-On 08/22/19, scheduled for 5:00pm and documented as administered at 6:21pm.
-On 08/25/19, scheduled for 9:00am and documented as administration-charted late at 10:20am.
-On 08/30/19, scheduled for 8:00am and documented as administered at 9:36am.
-On 08/30/19, scheduled for 4:00pm and documented as administered at 5:37pm.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.
-There was documentation albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial was scheduled for administration daily at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-There was a second entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily.
-There was documentation albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial was scheduled for administered daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.

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D 366	Continued From page 268 -There was documentation albuterol was documented as administered late 19 times of 124 opportunities. Examples of late administration as follows: -On 09/04/19, scheduled for 12:00pm and documented as late administration-charted late at 1:40 pm. -On 09/07/19, scheduled for 4:00pm and documented as administered at 6:27pm. -On 09/08/19, scheduled for 4:00pm and documented as administered at 6:07pm. -On 09/09/19, scheduled for 4:00pm and documented as administered at 6:05pm. -On 09/10/19, scheduled for 4:00pm and documented as administered at 5:34pm. -On 09/13/19, scheduled for 8:00am and documented as administered at 10:46am. -On 09/18/19, scheduled for 8:00am and documented as administered at 9:32am. -On 09/19/19, scheduled for 4:00pm and documented as ladministered at 5:31pm. -On 09/24/19, scheduled for 12:00pm and documented as administered at 1:24pm. -On 09/24/19, scheduled for 4:00pm and documented as administered at 6:19pm. -On 09/25/19, scheduled for 4:00pm and documented as administered at 5:52pm. -On 09/30/19, scheduled for 4:00pm and documented as administered at 5:48pm. Review of Resident #2's October 2019 eMAR revealed: -There was an entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times daily. -There was documentation albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial was scheduled for administration daily at 9:00am, 1:00pm, 5:00pm, and 9:00pm. -There was a second entry for albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial four times	D 366		

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daily.
-There was documentation albuterol sulfate solution 2.5mg (0.083%) inhale 1 vial was scheduled for administered daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation albuterol was documented as administered late 11 times of 124 opportunities. Examples of late administration as follows:
-On 10/07/19, scheduled for 4:00pm and documented as administered at 6:27pm.
-On 10/09/19, scheduled for 4:00pm and documented as administered at 7:13pm.
-On 10/11/19, scheduled for 8:00am and documented as administered at 10:37am.
-On 10/17/19, scheduled for 4:00pm and documented as administered at 5:33pm.
-On 10/20/19, scheduled for 12:00pm and documented as administered at 1:54pm.
-On 10/22/19, scheduled for 8:00am and documented as administered at 9:50am.
-On 10/30/19, scheduled for 8:00pm and documented as administered at 9:33pm.
-On 10/30/19, scheduled for 12:00pm and documented as administered at 2:18pm.

Refer to interview with a second shift medication aide on 11/07/19 at 3:00pm.

Refer to the interview with the Administrator on 11/14/19 at 5:31pm.

b. Review of Resident #2's current FL2 dated 05/09/19 revealed a physician's order for triamcinolone acetonide cream (used to treat dermatitis, allergies and itching) 1% apply to skin four times daily.

Review of a physician's order sheet in Resident #2's record signed by the Primary Care

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D 366	Continued From page 270 Practitioner (PCP) dated 09/18/19 with orders for triamcinolone acetonide cream 1% apply to skin four times daily. Review of Resident #2's August 2019 electronic Medication Administration Record (eMARs) revealed: -There was an entry for triamcinolone acetonide cream 1% apply to skin four times daily. -There was documentation for triamcinolone acetonide cream 1% apply to skin four times daily was scheduled for application daily at 9:00am, 1:00pm, 5:00pm, and 9:00pm. -There was documentation triamcinolone acetonide cream 1% apply to skin four times daily was documented as applied late 12 times of 124 opportunities. Examples of late application as follows: -On 08/09/19, scheduled for 9:00pm and documented as applied at 10:43pm. -On 08/11/19, scheduled for 9:00am and documented as applied at 10:47am. -On 08/12/19, scheduled for 9:00pm and documented as applied at 11:00pm. -On 08/14/19, scheduled for 9:00pm and documented as applied at 10:37pm. -On 08/22/19, scheduled for 5:00pm and documented as applied at 6:21pm. -On 08/25/19, scheduled for 9:00am and documented as applied at 10:20am. Review of Resident #2's September 2019 electronic Medication Administration Record (eMARs) revealed: -There was an entry for triamcinolone acetonide cream 1% apply to skin four times daily. -There was documentation for triamcinolone acetonide cream 1% apply to skin four times daily was scheduled for application daily at 9:00am, 1:00pm, 5:00pm, and 9:00pm.	D 366		

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D 366	Continued From page 271 -There was documentation triamcinolone acetonide cream 1% apply to skin four times daily was applied late 8 times of 124 opportunities. Examples of late application as follows: -On 09/07/19, scheduled for 5:00pm and documented as applied at 6:27pm. -On 09/10/19, scheduled for 9:00pm and documented as applied at 10:28pm. -On 09/13/19, scheduled for 9:00pm and documented as applied at 10:46pm. -On 09/13/19, scheduled for 1:00pm and documented as applied at 2:33pm. -On 09/15/19, scheduled for 5:00pm and documented as applied at 6:50pm. -On 09/19/19, scheduled for 5:00pm and documented as applied at 6:22pm. -On 09/20/19, scheduled for 9:00pm and documented as applied at 10:59pm. Review of Resident #2's October 2019 electronic Medication Administration Record (eMARs) revealed: -There was an entry for triamcinolone acetonide cream 1% apply to skin four times daily. -There was documentation for triamcinolone acetonide cream 1% apply to skin four times daily was scheduled for application daily at 9:00am, 1:00pm, 5:00pm, and 9:00pm. -There was documentation triamcinolone acetonide cream 1% apply to skin four times daily was applied late 8 times of 124 opportunities. Examples of late application as follows: -On 09/20/19, scheduled for 9:00pm and documented as applied at 10:59pm. -On 10/07/19, scheduled for 5:00pm and documented as applied at 6:27pm,. -On 10/10/19, scheduled for 9:00pm and documented as applied at 10:28pm. -On 10/13/19, scheduled for 9:00pm and documented as applied at 10:46pm.	D 366		

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D 366	Continued From page 272 -On 10/13/19, scheduled for 1:00pm and documented as applied at 2:33pm. -On 10/15/19 scheduled for 5:00pm and documented as applied at 6:50pm. -On 10/17/19 scheduled for 5:00pm and documented as applied at 6:20pm. -On 10/19/19 scheduled for 5:00pm and documented as applied at 6:22pm. -On 10/20/19 scheduled for 9:00pm and documented as applied at 10:59pm. Based on record review, observation and interviews with staff it was determined that Resident #2 was not interviewable. Refer to the interview with a second shift medication aide on 11/07/19 at 3:00pm. Refer to the interview with the Administrator on 11/14/19 at 5:31pm. _____ Interview with a second shift medication aide on 11/07/19 at 3:00pm revealed: -When the the time was one hour past the scheduled time for administration, the medication flagged as late. -Some staff were documenting "gvn" (given) which she understood was to be used if the medication was administered but for some reason was not documented on the eMAR at the time of administration and later showed up as a late medication. -She did not routinely administer medications and not document on the eMAR (clicking off for administered) before going to the next resident. -There could be an occasional entry that had be entered because the computer may not have interfaced with the WiFi in order to document at the time the medication was documented. -She suspected most of the entries documented	D 366		

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D 366	Continued From page 273 as late were not just documented late (accuracy of the eMAR), but were administered late due to medication aide (MA) work load and staff call outs or late shift arrivals. Interview with the Administrator on 11/14/19 at 5:31 pm revealed: -She expected the MAs to document accurately, after they administered medications and before going to the next resident for medication administration. -The Administrator randomly ran an audit report to see if medications were administered on time or if medications were not administered but she did not run the report routinely. -There was not a routine audit by the corporate Nurse for monitoring medication administration.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering	D 367		

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D 367	Continued From page 274 the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMAR) for 2 of 7 sampled residents (Residents #2, and #3) related to the documentation of administration of an amino acid supplement (#3), and a reflux medication and vitamin supplement (#2). The findings are: 1. Review of Resident #3's FL-2 dated 05/29/19 revealed: -Diagnoses included dementia. -There was an order for L-Carnitine (an amino acid supplement) 250mg 4 tablets (1,000mg) 2 times daily. Review of Resident #3's October 2019 eMAR revealed: -There was an entry for L-Carnitine 250mg 4 tablets (1,000mg) 2 times daily scheduled for administration 9:00am and 9:00pm daily. -L-Carnitine was documented as administered 36 of 62 opportunities from 10/01/19 to 10/31/19. -L-Carnitine was documented as not	D 367		

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administered 22 of 62 opportunities with a documented reason of "drug/item unavailable" for 21 of 62 opportunities and with a documented reason of "Discontinued" for 5 of 62 opportunities.

Review of Resident #3's November 2019 eMAR revealed:
-There was an entry for L-Carnitine 250mg 4 tablets (1,000mg) 2 times daily scheduled for administration 9:00am and 9:00pm daily.
-L-Carnitine was documented as administered 3 of 10 opportunities from 11/01/19 to 11/05/19.
-L-Carnitine was documented as not administered 7 of 10 opportunities with a documented reason of "drug/item unavailable" 7 of 10 opportunities.

Observation of medications on hand on 11/07/19 at 11:47am revealed there was no L-Carnitine available on the medication cart, or in over-stock.

Review of Resident #3's progress notes revealed:
-On 10/23/19, the Administrator documented that the contracted pharmacy did not put the L-Carnitine in the multidose pack; the pack was processed incorrectly. She reordered on 10/23/19 and expected the medication by late the next day.
-On 10/31/19, the Special Care Unit (SCU) Coordinator documented that she spoke with a representative from Resident #3's physicians office regarding the L-Carnitine not being available due to being on back order and there was no known date for availability.

Interview with a medication aide (MA) on 11/14/19 at 9:47am revealed:
-She had never administered L-Carnitine to Resident #3, but she had administered her other medications.
-She did not realize she had marked L-Carnitine

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as given and stated it must have been a mistake.
-She noticed last night that there was no L-Carnitine available for Resident #3 and reported it to the SCUC.
-The contracted pharmacy provided medications for Resident #3.
-She had not called the pharmacy regarding L-Carnitine not being available.

Telephone interview with a representative from the contracted pharmacy on 11/13/19 at 10:30am revealed:
-They had tried to fill the prescription for L-Carnitine for Resident #3 several times but each time it got canceled either by insurance or by the facility.
-L-Carnitine was on back order with the manufacturer so they never dispensed any for Resident #3.
-The facility and the physician was made aware on 05/08/19, 07/10/19, 09/06/19, 09/19/19, 10/13/19, and 10/19/19.
-The pharmacy had not received a response from either the facility or the physician.
-The pharmacy had not received an order to discontinue L-Carnitine.

Interview with the SCU Coordinator on 11/14/19 at 2:46pm revealed:
-She expected MAs to contact the pharmacy if medications were not available.
-Medications should only be documented as administered if the medication was given to the resident.

Interview with the Administrator on 11/14/19 at 5:31pm revealed:
-MAs were responsible for administering medications.
-She expected the MAs to document accurately.

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D 367	Continued From page 277 -She expected the MAs to order medications from the pharmacy. -MAs were to notify the RCC or SCU Coordinator and let the physician know when a resident did not have medications available. -MAs were responsible for notifying the care managers and the RCC and SCU Coordinator should follow up after medications were ordered. -MAs audit the medication carts weekly. -The facility changed over to a multidose pack at the beginning of October 2019. -The RCCs were responsible for ensuring all medications were in the building and that the resident had an adequate supply. -She could run a report for drug/item unavailable to see what medications were documented as not in the building. -She tried to run the report daily, but had not ran it in a few days. -There were no corporate audits completed on medications. 2. Review of Resident #2's current FL2 dated 05/09/19 revealed: -Diagnoses included Alzheimer's disease, gastroesophageal reflux disease, neuropathy, hyperlipidemia, anemia, hypothyroidism, coronary disease, vitamin D deficiency and depression. -There was a physician's order for esomeprazole magnesium (used to treat acid reflux) 40mg once daily. a. Review of a physician's order sheet in Resident #2's record signed by the Primary Care Practitioner (PCP) dated 09/18/19 revealed an order for esomeprazole magnesium 40mg once daily. Review of Resident #2's October 2019 electronic Medication Administration Records (eMARs)	D 367		

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Revealed:
-There was an entry esomeprazole magnesium (used to treat acid reflux) 40mg was scheduled once daily at 6:00am.
-There was documentation esomeprazole 40mg was unavailable on 10/10/19, 10/11/19, 10/12/19, 10/15/19, 10/16/19, 10/17/19, and 10/18/19.
-There was also documentation that staff administered esomeprazole 40mg on 10/13/19, 10/14/19, 10/19/19 and 10/20/19.

Interview with a pharmacist from the contracted pharmacy on 11/13/19 at 12:42 pm revealed:
-On 08/21/19, the pharmacy dispensed 30 tablets of esomeprazole 40mg.
-In September 2019, no esomeprazole was dispensed.
-On 10/21/19, the pharmacy dispensed 30 tablets of Esomeprazole 40mg.
-Proton-pump inhibitors (PPI) medications used for long-lasting reduction of stomach acid production were not automatically refilled.
-The facility staff had to call and request a refill of the medication.

Interview with Resident #2's Primary Care Provider (PCP) on 11/15/19 at 10:57 am revealed:
-If Resident #2 needed a new order to refill esomeprazole the facility staff should have contacted her office.
-She expected facility staff administer medications as ordered.

Interview with a medication aide (MA) on 11/13/19 at 4:07pm revealed:
-If Resident #2's esomeprazole was not available the MA should not document the medications were administered.
-If a medication was not available the MA should

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try to find out why the medication was not available.
-They should document the medication was not available.

Interview with the Administrator on 11/14/19 at 5:50 pm revealed:
-She expected the MA to document accurately on the eMARs.
-If a medication was not available staff should initial and document the medication was administered.
-The eMARs were not reviewed for medication not administered.

b. Review of Resident #2's current FL2 dated 05/09/19 revealed:
-Diagnoses included Alzheimer's disease and vitamin D deficiency.
-There was a physician's order for vitamin D2 50,000 units weekly.

Review of a physician's order sheet in Resident #2's record signed by the Primary Care Practitioner (PCP) dated 09/18/19 revealed an order for vitamin D2 50,000 units weekly.

Review of Resident #2's September 2019 electronic Medications Administration Records (eMARs) revealed:
-There was an entry for vitamin D2 50,000 units scheduled weekly.
-There was documentation staff administered vitamin D2 50,000 every day on 09/10/19, 09/11/19, 09/13/19, 09/16/19, 09/22/19, 09/23/19, and 09/30/19.

Interview with the Administrator on 11/14/19 at 5:50 pm revealed:
-She expected staff to document accurately on

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D 367	Continued From page 280 the eMARs. -If a medication was not available staff should not initial and document the medication was administered. -The eMARs were not reviewed for medication not administered.	D 367		
D 427	10A NCAC 13F .1106 Settlement Of Cost Of Care 10A NCAC 13F .1106 Settlement Of Cost Of Care (a) If a resident of an adult care home, after being notified by the facility of its intent to discharge the resident in accordance with Rule .0702 of this Subchapter, moves out of the facility before the period of time specified in the notice has elapsed, the facility shall refund the resident an amount equal to the cost of care for the remainder of the month minus any nights spent in the facility during the notice period. The refund shall be made within 14 days after the resident leaves the facility. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the balance of 1 of 1 sampled resident's (#9) cost of care funds were refunded within 14 days of the resident's discharge date, resulting in a delay of 218 days. The findings are: Review of Resident #9's Resident Register revealed Resident #9 was admitted to the facility	D 427		

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D 427	Continued From page 281 on 01/07/16. Review of Resident #9's record revealed there was no documentation of the date of discharge/death. Review of the facility's Refund Policy dated 05/23/16 revealed: -Refunds shall occur when there is death of a resident. -Refunds will be processed and sent to the resident or responsible person within 14 days of move-out. Review of an email from the corporate treasury assistant dated 09/30/19 at 11:11am revealed: -The email was addressed to the assistant corporate cash manager and another corporate staff. -There was a Payable Invoice which documented there was a resident refund due in the amount of $443.99. -There was documentation Resident #9 had expired on 03/11/19 and a check was to be made payable to the estate of Resident #9. Review of an email from the assistant corporate cash manager dated 09/30/19 at 11:21am revealed: -The email was addressed to another corporate staff. -There were directions for the corporate staff to issue a check for Resident #9's refund and mail out as soon as possible. Review of an email from a corporate staff dated 09/30/19 at 11:50am revealed the staff had issued the check for Resident #9's refund and mailed it to the facility.	D 427		

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D 427	Continued From page 282 Review of an email from the facility Administrator dated 10/15/19 at 11:17am revealed Resident #9's refund check had been received at the facility and was ready to be mailed out or picked up. Review of an Account Detail for Resident #9 revealed: -Income of $1515 was received by the facility on 03/01/19. -There was a monthly room charge of $488.71 deducted for 03/01/19 through 03/10/19. -There was $582.30 applied to an outstanding balance for the monthly room charge for January 2017. -The balance for March 2019 totaled $0 but there was no documentation of the refund of $443.99. Telephone interview with Resident #9's family member on 11/06/19 at 9:01am revealed: -Resident #9 passed away on 03/11/19. -She was told by the Business Office Manager (BOM) that 11 days would be deducted from Resident #9's monthly income and she would receive the balance of around $1000. -She had contacted the facility on several different occasions between March 2019 and October 2019 regarding a refund of Resident #9's funds. -She received a settlement of Resident #9's funds in October 2019, but she could not remember the exact date. -The settlement of funds she received was for a little over $400, but she was satisfied with the amount received. -She was told Resident #9 had an outstanding balance which was deducted from her monthly income for March, but she never received an itemized statement.	D 427		

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Interview with the BOM on 11/07/19 at 4:50pm revealed:
-It was her responsibility to request resident refunds from the corporate office and the corporate office sent a check to the facility to distribute to the resident or responsible party.
-The check was usually distributed to the responsible party within 30 days if a resident passed away.
-She did not know what happened with Resident #9's refund as she was out on leave.
-When she returned to the facility, she was not involved with the process of obtaining a refund for Resident #9.
-She did not know how much Resident #9's refund check should have been, but she knew Resident #9 had an outstanding balance which had not been satisfied.

Interview with the Administrator on 11/08/19 at 8:05am revealed:
-She had been working at the facility since July 2019.
-Resident #9 passed away on 03/11/19.
-Resident #9's family member contacted her in July 2019 regarding the refund check.
-She communicated with the corporate office and requested a refund check for Resident #9 in July 2019, but it was not issued.
-She did not know why the refund check was not issued when she requested it.
-She was working with staff in the corporate accounting department who left the company and she had to start over with her request for a refund from a new staff person.
-She was unsure of the dates of her requests for a refund.
-The refund check was issued by the corporate office on 10/04/19 and mailed to the facility.
-The refund check was mailed from the facility to

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D 427	Continued From page 284 Resident #9's family member on 10/15/19. Interview with a representative from the corporate accounting department on 11/12/19 at 10:45am revealed: -The refund process was the facility sent a request for a refund to the corporate office, the check was forwarded to the facility and the facility forwarded the check to the family of the discharged resident. -The refund process took about 30 days and sometimes longer. -There was a request for Resident #9's refund generated in the computer system on 06/12/19. -There did not appear to be any requests for a refund prior to 06/12/19. -A check in the amount of $443.99 was sent to the facility on 09/30/19. -She did not know why the check was not issued and sent to the facility prior to 09/30/19 when Resident #9 passed away on 03/11/19.	D 427		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	D 451		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to immediately notify the local county Department of Social Services (DSS) for incidents involving 1 of 7 sampled residents (Resident #1), and 2 of 10 extended sampled residents (#10 and #11) regarding residents who were repeatedly sent to the hospital for mental health evaluations (#10) and who received medical care for injuries (#1 and #11).

The findings are:

1. Review of Resident #10's current FL2 dated 05/08/19 revealed:
-Diagnoses dementia, anxiety, depression, and gastroesophageal reflux disease.
-The resident was documented as intermittently disoriented.
-The recommended level of care was special care unit (SCU).

Review of Resident #10's care plan dated 05/20/19 revealed:
-Resident #10 resided in the SCU.
-The resident had unspecified dementia without behavioral disturbance.
-The resident had anxiety disorder due to known physiological condition.
-The resident significant memory loss and must be directed.
-There was documentation in the social/mental history that Resident #10 had depression/anxiety/dementia.
-There was documentation the resident wandered.
-There was documentation the resident had a history of mental illness.
-There was no documentation in the section titled

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D 451	Continued From page 286 "injurious to self, others, and property." Review of the quarterly profiles in Resident #10's record revealed: -On 06/26/19 the profile was completed by the Administrator. -The Administrator documented cognitive impairment assessed change was "dementia." The intervention documented was staff assistance. -The Administrator documented behavior pattern assessed change was "combative." The intervention used was staff monitoring. -On 10/01/19 the profile was completed by the Administrator. -The Administrator documented cognitive impairment assessed change was "dementia." The intervention documented was staff assistance. -The Administrator documented the behavior pattern assessed change was combative. The intervention documented was staff monitoring. 2. Review of Resident #10's current FL2 dated 05/08/19 revealed: -Diagnoses included dementia, anxiety, depression, and gastroesophageal reflux disease. -The resident was documented as intermittently disoriented. -The recommended level of care was Special Care Unit (SCU). Review of Resident #10's care plan dated 05/20/19 revealed: -Resident #10 resided in the SCU. -The resident had unspecified dementia without behavioral disturbance. -The resident had anxiety disorder due to known physiological condition. -The resident had significant memory loss and	D 451		

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must be directed.
-There was documentation in the social/mental history that Resident #10 had depression/anxiety/dementia.
-There was documentation the resident wandered.
-There was documentation the resident had a history of mental illness.
-There was no documentation in the section titled "injurious to self, others, and property."

a. Review of Resident #10's progress notes dated 07/28/19 revealed at 4:21pm, Resident #10 was agitated and combative.

Review of Resident #10's Accident/Incident report dated 07/28/19 revealed:
-At 4:07 pm, Resident #10 was observed going in and out of other residents' rooms and appeared to be agitated.

Review of Emergency Medical Service (911) communication log reports for Resident #10 dated 07/28/19 revealed at 3:03pm, Resident #10 was being aggressive yelling at other residents. The resident was transported to the hospital.

Interview with a medication aide supervisor in the SCU on 11/13/19 at 3:19pm revealed:
-When Resident #10 was agitated he went up and down the hallway and forced the other residents out of their rooms.
-This would cause the other residents to fight back to try and keep their room.
-She tried to give Resident #10 an as-needed medication if "he was not too far gone".
-Some days she was able to talk Resident #10 out of the agitation.
-On the days she could not talk Resident #10 out of the agitation he was sent out to the hospital.'

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-On 07/28/19, Resident #10 was combative and attempted to fight residents and staff.

Refer to interview with the Administrator on 11/14/19 at 4:15pm.

b. Review of Resident #10's progress notes dated 09/02/19 revealed at 11:21pm, Resident #10 was combative and trying to remove residents from their bed.

Review of Resident#10's Accident/Incident report dated 09/02/19 revealed at 10:49pm, Resident #10 was observed going in and out of rooms, trying to hit other residents. Resident #10 was sent to the hospital for psychiatric evaluation.

Interview with a medication aide supervisor in the SCU on 11/13/19 at 3:19pm revealed:
-On 09/02/19, Resident #10 was combative, and he tried to remove other residents from their room.
-It was difficult to get the resident to calm down, so the resident was sent to the hospital for an evaluation.
-An incident report was completed and given to the SCU Coordinator.

Refer to interview with the Administrator on 11/14/19 at 4:15pm.

c. Review of Resident #10's progress notes dated 09/05/19 revealed at 2:10pm Resident #10 was combative towards another resident.

Review of Resident#10's Accident/Incident report dated 09/05/19 revealed at 9:15am, Resident #10 was being combative towards another resident.

Interview with a medication aide supervisor in the

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SCU on 11/13/19 at 3:19pm revealed:
-This would cause the residents to fight back to try and keep their room.
-She tried to give Resident #10 an as-needed medication if "he was not too far gone".
-Some days she was able to talk Resident #10 out of the agitation.
-On the days she could not talk Resident #10 out of the agitation he was sent out to the hospital.
-On 09/05/19 Resident #10 was combative, and he went into residents' rooms and was hitting the residents. When staff tried to take him out of the room, but he started swinging trying to hit staff.

Refer to interview with the Administrator on 11/14/19 at 4:15pm.

d. Review of Resident #10's progress notes dated 09/13/19 revealed at 1:25pm, Resident #10 was in the dining room and pushed another resident, grabbed other residents' walkers and verbalized "everyone can get out." Resident #10 attempted to strike a resident that was sitting in a wheelchair.

Review of Resident #10's Accident/Incident report dated 09/13/19 revealed at 1:13pm, Resident #10 was in the dining room and pushed another resident, grabbed other residents' walkers and verbalized "everyone can get out." Resident #10 attempted to strike a resident that was sitting in a wheelchair.

Review of Resident #10's record revealed there was no documentation of Resident #10 was monitored.

Interview with a medication aide supervisor in the SCU on 11/13/19 at 3:19pm revealed:
-This would cause the residents to fight back to

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try and keep their room.
-She tried to give Resident #10 an as-needed medication if "he was not too far gone".
-Some days she was able to talk Resident #10 out of the agitation.
-On the days she could not talk Resident #10 out of the agitation he was sent out to the hospital.
-On 09/13/19 Resident #10 was combative and attempted to attack several residents.
-When staff attempted redirect the resident, he started hitting staff.
-The resident was sent to the hospital and an Accident/Incident report was prepared and given to the SCU Coordinator.

Refer to interview with the Administrator on 11/14/19 at 4:15pm.

e. Review of Resident #10's Accident/Incident reports dated 10/20/19 revealed at 5:52pm, Resident #10 was observed combative and throwing items.

Review of 911 communication log reports for Resident #10 dated 10/201/9 revealed at 5:21pm, "A male resident [Resident #10] was pouring hot liquid on people."

Review of Emergency Medical Services (EMS) reports for Resident #10 revealed:
-On 10/20/19 Resident #10 was violent and aggressive. Staff told EMS the resident "acts like that all time." Staff told EMS the resident wandered the halls and tried to take another resident's oxygen from them. The supervisor told the staff to ensure the resident went to the hospital because "he has been worse than normal for a while now. "Having behavioral/psychiatric episodes with behavioral disturbance".

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D 451	Continued From page 291 Interview with a medication aide supervisor in the SCU on 11/13/19 at 3:19pm revealed: -On 10/20/19, was very combative and throwing things. -He was in the dining room and throwing hot coffee. -Attempting to take harm other residents. -She called the Administrator and was told to send the resident to the hospital. -She prepared an Accident/Incident report and it was given to the SCU Coordinator. Refer to interview with the Administrator on 11/14/19 at 4:15pm. f. Review of the Resident #10's Accident/Incident reports dated 11/01/19 revealed at 1:20pm Resident #10 was observed in an altercation with another resident. Review of 911 communication log reports for Resident #10 dated 11/01/19 revealed at 1:40pm, Resident #10 was in the day room being aggressive. The resident was sent to the hospital for an evaluation. Interview with a medication aide supervisor in the SCU on 11/13/19 at 3:19pm revealed: -On 11/01/19, Resident #10 was in an altercation with another resident. -Attempts to redirect the resident failed, so he was sent out to the hospital. -She prepared an Accident/Incident report and it was given to the SCU Coordinator. Refer to interview with the Administrator on 11/14/19 at 4:15pm. g. Review of Resident #10's progress notes	D 451		

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revealed:
-On 11/05/19 at 8:30am, Resident #10 was trying to force another resident out of her room. He pulled the resident out of the room and was trying to get into the room and lock the door.
-On 11/05/19 at 10:50am Resident #10 was in the dayroom and became agitated and punched another resident in the mouth. The resident that was punched in the mouth fell to the floor.

Review of Resident #10's Accident/Incident report dated 11/05/19 revealed at 10:50 am, Resident #10 was observed striking another resident in the mouth. The resident that was punched fell to the floor.

Review of Emergency Medical Services (911) communication log report for Resident #10 revealed on 11/05/15 at 10:53am, Resident #10 had violent and aggressive behaviors and refused medications. Resident #10 was transported to the hospital.

Review of Emergency Medical Services (EMS) reports for Resident #10 revealed on 11/05/19 at 11:10am, Resident #10 was experiencing behavioral/psychiatric episodes.

Interview with a medication aide supervisor in the SCU on 11/13/19 at 3:19pm revealed:
-On 11/05/19, Resident #10 was aggressive all morning.
-The resident had an altercation with several residents.
-The resident had aggressive behaviors and was sent to the hospital.
-Accident/Incident reports were completed and given to the SCU Coordinator.
-The SCU Coordinator or the Administrator were responsible for sending the reports to the county

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D 451	Continued From page 293 Adult Home Specialist. Interview with the Adult Home Specialist on 11/12/19 at 11:41am revealed: -She did not have any incident reports for Resident #10. -She had informed the facility many times that they should send her Accident/Incident reports. Refer to interview with the Administrator on 11/14/19 at 4:15pm. 2. Review of Resident #1's current FL2 dated 04/08/19 revealed: -Diagnoses included dementia unspecified, diverticulitis, synovitis, and history of falls. -The resident was documented as intermittently disoriented. -The recommended level of care was SCU. a. Review of Resident #1's hospital discharge report dated 04/10/19 revealed Resident #1 was diagnosed with a closed head injury. Review of Resident #1's Accident/Incident report dated 04/10/19 revealed at 10:40 am Resident #1 was punched in the face by another resident. Interview with Resident #1 family member on 11/05/19 at 2:50 pm revealed: -Resident #1 was admitted to the SCU on 03/06/19. -On 04/10/19 Resident #1 fell to the floor out of a chair and received stitches. Refer to interview with the Administrator on 11/14/19 at 4:15pm. b. Review of Resident #1's hospital discharge report dated 04/27/19 revealed Resident #1 was	D 451		

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assaulted by another resident and received an injury to head, abrasion to face and right upper extremity.

Review of Resident #1's Accident/Incident report dated 04/27/19 revealed Resident #1 got into an altercation with another resident.

Interview with Resident #1 family member on 11/05/19 at 2:50 pm revealed on 04/27/19 Resident #1 was assaulted by another resident.
-She visited Resident #1 at least once weekly.
-Since Resident #1 moved into the facility he was assaulted by other residents twice and by a staff.

Refer to interview with the Administrator on 11/14/19 at 4:15pm.

c. Review of Resident #1's hospital discharge report dated 05/11/19 revealed Resident #1 had a fall and received closed head injury with laceration of scalp.

Review of Resident #1's Accident/Incident report dated 05/11/19 revealed:
-Resident #1 was found lying on the floor with a gash on his head and was bleeding.

Interview with Resident #1 family member on 11/05/19 at 2:50 pm revealed:
-On 05/11/19, Resident #1 fell to the floor.
-Resident #1 had fallen several times.
-The facility staff did not call to inform her of the incidents.
-Resident #1 told her about all the incidents.
-If Resident #1 had behavior problems no one at the facility informed her about the behaviors.

Refer to interview with the Administrator on 11/14/19 at 4:15pm.

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d. Review of Resident #1's progress notes dated 05/13/19 revealed at 11:34 am Resident #1 found lying on the floor on his left side.

Review of Resident #1's Accident/Incident reports revealed there was no accident/Incident report for the 05/13/19 incident.

Refer to interview with the Administrator on 11/14/19 at 4:15pm.

e. Review of Resident #1's hospital discharge report dated 06/13/19 revealed Resident #1 had a fall and received laceration repair with stitches.

Refer to interview with the Administrator on 11/14/19 at 4:15pm.

Review of Resident #1's Accident/Incident report dated 06/13/19 revealed at 2:15 pm Resident #1 was found lying on the floor on his left side. The staff was to initiate the fall prevention program.

Review of an Emergency Medical Services (EMS) report dated 06/13/19 revealed:
-Resident #1 fell.
-The resident was bleeding from his scalp on the left side of his head above his eye.
-The facility staff reported the resident was standing, lost his balance and fell.

Interview with Resident #1 family member on 11/05/19 at 2:50pm revealed:
-On 06/13/19, Resident #1 was assaulted by another resident and fell to the floor and Resident #1 received stitches.
-Resident #1 had fallen several times.
-The facility staff did not call to inform her of the incidents.

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D 451	Continued From page 296 Refer to interview with the Administrator on 11/14/19 at 4:15pm. Interview with a personal care aide (PCA) dated 11/13/19 at 5:26pm revealed: -If a resident had an accident/incident she immediately got the medication aide (MA) supervisor that was on duty. -The MA completed an incident report. Interview with a MA on 11/14/19 at 10:21pm revealed: -When a resident had an Accident/Incident resulting in injury she completed an accident/incident report. -The report was given to the SCU Coordinator for review. -The SCU Coordinator or the Administrator were responsible for faxing the reports to county Adult Home Specialist. Interview with the Adult Home Specialist on 11/12/19 at 11:41am revealed: -She had incident report for Resident #1 dated 04/10/19 and 05/11/19. -She did not have any other incident reports for Resident #1. -She had informed the facility many times that they needed to send her Accident/Incident reports especially when a resident was sent out to the hospital. Refer to interview with the Administrator on 11/14/19 at 4:15 pm. 4. Review of Resident #11's current FL-2 dated 05/10/19 revealed: -Diagnoses included vascular dementia with behaviors, anxiety, and hypertension.	D 451		

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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 451	Continued From page 297 -Resident #11 was constantly disoriented. -Resident #11 was ambulatory. -Resident #11 had wandering behaviors. -The recommended level of care was documented as special care unit (SCU). Review of the facility's progress notes revealed: -On 09/05/19 Resident #11 drank/ate water from a bucket, that housekeeping used to catch the water that leaked from the air conditioner located in the television room. Resident #11 was observed dipping tissue paper in the bucket then eating it. Review of the facility's Accident/Incident reports for Resident #11 revealed: -On 09/05/19 at 5:38pm Resident #11 was observed eating tissue that had been dipped in a bucket. She was transported to the emergency room for treatment. Review of Emergency Medical Services (EMS) reports for Resident #4 revealed on 09/05/19 Resident #11 was transported to local emergency room for evaluation due to drinking an unknown amount of cleaning mixture. Interview with Resident #11's family member on 11/13/19 at 10:23am revealed the resident was sent to the emergency room for drinking an unknown liquid but it all turned out okay. Interview with a MA on 11/14/19 at 9:47am revealed: -She was not on duty when Resident # drank or ate tissue dipped in a bucket. -Resident #11 was easily redirected. -Resident #11 had to be watched closely as she liked to put stuff in her mouth.	D 451		

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D 451	Continued From page 298 Interview with the Adult Home Specialist on 11/12/19 at 11:41am revealed: -She did not have any incident reports for Resident #11. -She had informed the facility many times that they should send her accident/incident reports. Refer to interview with the Administrator on 11/14/19 at 4:15pm. Interview with the Administrator on 11/14/19 at 4:15pm. -She did not send every report of a resident going out to the hospital to DSS. -She thought that she only had to send reports if the resident had a change in her health status after the hospital visit.	D 451		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to immediately notify the local county Department of Social Services (DSS) for incidents involving 1 of 7 sampled residents (Residents #1) who received medical care for injuries from staff.	D 453		

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D 453	Continued From page 299 The findings are: Review of Resident #1's hospital discharge report dated 07/21/19 revealed Resident #1 was seen for dizziness, closed head injury, dementia with behavioral disturbance, unspecified dementia type, and acute urinary tract infection. The resident complained that the staff hit him with a cup. Review of Resident #1's progress notes dated 07/21/19 revealed Resident #1 got into an altercation with a staff. The staff appeared to hit the resident. Review of Resident #1's Accident/Incident report dated 07/21/19 revealed at 11:30 am staff observed the resident appearing to be hit by a staff. Interview with Resident #1 family member on 11/05/19 at 2:50pm revealed: -Resident #1 was admitted to the SCU on 03/06/19. -On 07/21/19 Resident #1 told her that a staff member hit him in the head with a cup, he complained of dizziness and was sent to the hospital. -She visited Resident #1 at least once weekly. -Since Resident #1 moved into the facility he was assaulted by other residents twice and by a staff. -The facility staff did not call to inform her of the incidents. Interview with a personal care aide (PCA) dated 11/13/19 at 5:26pm revealed: -If a resident had an accident/incident she immediately got the medication aide (MA) supervisor that was on duty.	D 453		

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D 453	Continued From page 300 -The MA completed an incident report. Interview with a MA on 11/14/19 at 10:21pm revealed: -When a resident had an Accident/Incident resulting in injury she completed an accident/incident report. -The report was given to the SCU Coordinator for review. -The SCU Coordinator or the Administrator were responsible for faxing the reports to county Adult Home Specialist. Interview with the Adult Home Specialist on 11/12/19 at 11:41am revealed: -She had incident report for Resident #1 dated 04/10/19 and 05/11/19. -She did not have any other incident reports for Resident #1. The staff involved in the incident with Resident #1 was not available for interview.	D 453		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.	D 465		

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D 465	Continued From page 301 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 27 of 90 shifts sampled for 30 days in May 2019, August 2019, and September 2019. The findings are: Review of the facility's 2019 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living with a capacity of 52 beds and a Special Care Unit (SCU) with a capacity of 48 beds. Review of the Resident Bed List Report dated 05/03/19 revealed: -There was a SCU census of 43 residents, which required 43 staff hours on second shift. -There was a census of 47 residents in the AL unit, which required 28 staff hours on second shift. -There should have been a total of 71 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 05/03/19 revealed: -There were 52.0 total staff hours provided on second shift between the SCU and the AL unit. -There was a shortage of 19 staff hours. -It could not be determined how many of the 52.0 total staff hours worked were worked in the SCU on second shift. Review of the Resident Bed List Report dated 05/04/19 revealed: -There was a SCU census of 43 residents, which	D 465		

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required 43 staff hours on first shift.
-There was a census of 48 residents in the AL unit, which required 28 staff hours on first shift.
-There should have been a total of 71 hours between the SCU and AL unit on first shift.

Review of the Employee Time Detail dated 05/04/19 revealed:
-There were 59 total staff hours provided on first shift between the SCU and the AL unit.
-There was a shortage of 12 staff hours.
-It could not be determined how many of the 59 total staff hours worked were worked in the SCU on first shift.

Review of the Resident Bed List Report dated 05/04/19 revealed:
-There was a SCU census of 43 residents, which required 43 staff hours on second shift.
-There was a census of 48 in the AL unit, which required 28 staff hours on second shift.
-There should have been a total of 71 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 05/04/19 revealed:
-There were 49.75 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 21.75.
-It could not be determined how many of the 49.75 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 05/05/19 revealed:
-There was a SCU census of 43 residents, which required 43 staff hours on first shift.
-There was a census of 47 in the AL unit, which required 28 staff hours on first shift.
-There should have been a total of 71 hours

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between the SCU and AL unit on first shift.

Review of the Employee Time Detail dated 05/05/19 revealed:
-There were 51 total staff hours provided on first shift between the SCU and the AL unit.
-There was a shortage of 20 hours.
-It could not be determined how many of the 51 total staff hours worked were worked in the SCU on first shift.

Review of the Resident Bed List Report dated 05/05/19 revealed:
-There was a SCU census of 43 residents, which required 43 staff hours on second shift.
-There was a census of 47 in the AL unit, which required 28 staff hours on second shift.
-There should have been a total of 71 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 05/05/19 revealed:
-There were 42.25 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 28.75.
-It could not be determined how many of the 42.25 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 08/18/19 revealed:
-There was a SCU census of 39 residents, which required 39 staff hours on second shift.
-There was a census of 48 in the AL unit, which required 28 staff hours on second shift.
-There should have been a total of 67 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 08/18/19 revealed:

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-There were 55 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 12.
-It could not be determined how many of the 55 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 08/19/19 revealed:
-There was a SCU census of 39 residents, which required 39 staff hours on second shift.
-There was a census of 48 in the AL unit, which required 28 staff hours on second shift.
-There should have been a total of 67 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 08/19/19 revealed:
-There were 48.25 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 18.75.
-It could not be determined how many of the 48.25 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 08/20/19 revealed:
-There was a SCU census of 39 residents, which required 39 staff hours on second shift.
-There was a census of 48 in the AL unit, which required 28 staff hours on second shift.
-There should have been a total of 67 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 08/20/19 revealed:
-There were 49.5 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 17.5 hours.
-It could not be determined how many of the 49.5

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total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 08/20/19 revealed:
-There was a SCU census of 39 residents, which required 31.2 staff hours on third shift.
-There was a census of 48 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 47.2 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 08/20/19 revealed:
-There were 45.5 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 1.7 hours.
-It could not be determined how many of the 45.5 total staff hours worked were worked in the SCU on third shift.

Review of the Resident Bed List Report dated 08/21/19 revealed:
-There was a SCU census of 39 residents, which required 39 staff hours on second shift.
-There was a census of 48 in the AL unit, which required 28 staff hours on second shift.
-There should have been a total of 67 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 08/21/19 revealed:
-There were 57.5 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 9.5 hours.
-It could not be determined how many of the 57.5 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated

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08/22/19 revealed:
-There was a SCU census of 39 residents, which required 31.2 staff hours on third shift.
-There was a census of 48 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 47.2 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 08/22/19 revealed:
-There were 38.5 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 8.7 hours.
-It could not be determined how many of the 38.5 total staff hours worked were worked in the SCU on third shift.

Review of the Resident Bed List Report dated 08/23/19 revealed:
-There was a SCU census of 40 residents, which required 40 staff hours on second shift.
-There was a census of 48 in the AL unit, which required 28 staff hours on second shift.
-There should have been a total of 68 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 08/23/19 revealed:
-There were 57.75 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 9.25 hours.
-It could not be determined how many of the 57.75 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 08/23/19 revealed:
-There was a SCU census of 40 residents, which required 32 staff hours on third shift.
-There was a census of 48 in the AL unit, which

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required 16 staff hours on third shift.
-There should have been a total of 48 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 08/23/19 revealed:
-There were 46.5 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 1.5 hours.
-It could not be determined how many of the 46.5 total staff hours worked were worked in the SCU on third shift.

Review of the Resident Bed List Report dated 08/24/19 revealed:
-There was a SCU census of 39 residents, which required 39 staff hours on second shift.
-There was a census of 48 in the AL unit, which required 28 staff hours on second shift.
-There should have been a total of 67 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 08/24/19 revealed:
-There were 60 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 7 hours.
-It could not be determined how many of the 60 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 08/24/19 revealed:
-There was a SCU census of 39 residents, which required 31.2 staff hours on third shift.
-There was a census of 48 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 47.2 hours between the SCU and AL unit on third shift.

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D 465	Continued From page 308 Review of the Employee Time Detail dated 08/24/19 revealed: -There were 39.5 total staff hours provided on third shift between the SCU and the AL unit. -There was a shortage of 7.7 hours. -It could not be determined how many of the 39.5 total staff hours worked were worked in the SCU on third shift. Review of the Resident Bed List Report dated 08/25/19 revealed: -There was a SCU census of 39 residents, which required 39 staff hours on first shift. -There was a census of 48 in the AL unit, which required 28 staff hours on first shift. -There should have been a total of 67 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 08/25/19 revealed: -There were 60.75 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 6.25 hours. -It could not be determined how many of the 60.75 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 08/25/19 revealed: -There was a SCU census of 39 residents, which required 39 staff hours on second shift. -There was a census of 48 in the AL unit, which required 28 staff hours on second shift. -There should have been a total of 67 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 08/25/19 revealed: -There were 64.25 total staff hours provided on second shift between the SCU and the AL unit.	D 465		

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-There was a shortage of 2.75 hours.
-It could not be determined how many of the 64.25 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 08/25/19 revealed:
-There was a SCU census of 39 residents, which required 31.2 staff hours on third shift.
-There was a census of 48 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 47.2 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 08/25/19 revealed:
-There were 44 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 3.2 hours.
-It could not be determined how many of the 44 total staff hours worked were worked in the SCU on third shift.

Review of the Resident Bed List Report dated 08/30/19 revealed:
-There was a SCU census of 39 residents, which required 31.2 staff hours on third shift.
-There was a census of 49 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 47.2 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 08/30/19 revealed:
-There were 49.5 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 5.7 hours.
-It could not be determined how many of the 49.5 total staff hours worked were worked in the SCU on third shift.

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D 465	Continued From page 310 Review of the Resident Bed List Report dated 09/02/19 revealed: -There was a SCU census of 40 residents, which required 32 staff hours on third shift. -There was a census of 47 residents in the AL unit, which required 24 staff hours on third shift. -There should have been a total of 56 staff hours between the AL unit and the SCU on third shift. Review of the Employee Time Detail dated 09/02/19 revealed: -There were 47.50 total staff hours provided on third shift between the AL unit and the SCU. -There was a shortage of 8.50 aide hours. -It could not be determined how many of the 47.50 total staff hours worked were worked in the SCU unit on third shift. Review of the Resident Bed List Reports revealed: -On 09/03/19, there was a SCU census of 39 residents, which required 31.2 hours on third shift. -There was a census of 47 residents in the AL unit, which required 24 hours on third shift. -There should have been a total of 55.2 hours between the AL unit and the SCU on third shift. Review of the Employee Time Detail reports revealed: -On 09/03/19, there were 45.25 total staff hours provided on third shift between the AL unit and the SCU. -There was a shortage of 9.95 aide hours. -It could not be determined how many of the 45.25 total staff hours worked were worked in the SCU unit on third shift. Review of the Resident Bed List Reports	D 465		

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revealed:
-On 09/06/19, there was a SCU census of 38 residents, which required 38 hours on second shift.
-There was a census of 47 residents in the AL unit, which required 28 hours on second shift.
-There should have been a total of 66 hours between the AL unit and the SCU on second shift.

Review of the Employee Time Detail reports revealed:
-On 09/06/19, there were 58.25 total staff hours provided on second shift between the AL unit and the SCU
-There was a shortage of 8.75 aide hours.
-It could not be determined how many of the 57.25 total staff hours worked were worked in the SCU unit on second shift.

Review of the Resident Bed List Report dated 09/07/19 revealed:
-There was a SCU census of 38 residents, which required 38 hours on first shift.
-There was a census of 48 residents in the AL unit which required 28 hours on first shift.
-There should have been a total of 66 hours between the AL unit and the SCU on first shift.
-There was a SCU census of 38 residents, which required 38 hours on second shift.
-There was a census of 48 residents in the AL unit which required 28 hours on second shift.
-There should have been a total of 66 hours between the AL unit and the SCU on second shift.
-There was a SCU census of 38 residents, which required 30.4 hours on third shift.
-There was a census of 48 residents in the AL unit which required 24 hours on third shift.
-There should have been a total of 54.4 hours between the AL unit and the SCU on third shift.

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D 465	Continued From page 312 Review of the Employee Time Detail dated 09/07/19 revealed: -There were 63.25 total staff hours provided on first shift between the AL unit and the SCU. -There was a shortage of 2.75 aide hours. -It could not be determined how many of the 63.25 total staff hours worked were worked in the SCU unit on first shift. -There were 49.25 total staff hours provided on second shift between the AL unit and the SCU. -There was a shortage of 16.75 aide hours. -It could not be determined how many of the 49.25 total staff hours worked were worked in the SCU unit on second shift. -There were 41 total staff hours provided on third shift between the AL unit and the SCU. -There was a shortage of 13.4 aide hours. -It could not be determined how many of the 41 total staff hours worked were worked in the SCU unit on third shift. Review of the Resident Bed List Report dated 09/19/19 revealed: -There was a SCU census of 38 residents, which required 30.4 hours on third shift. -There was a census of 48 residents in the AL unit which required 24 hours on third shift. -There should have been a total of 54.4 hours between the AL unit and the SCU on third shift. -There was a SCU census of 38 residents, which required 38 hours on second shift. -There was a census of 48 residents in the AL unit which required 28 hours on second shift. -There should have been a total of 66 hours between the AL unit and the SCU on second shift. Review of the Employee Time Detail dated 09/19/19 revealed: -There were 44.75 total staff hours provided on third shift between the AL unit and the SCU.	D 465		

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D 465	Continued From page 313 -There was a shortage of 9.65 aide hours. -It could not be determined how many of the 44.75 total staff hours worked were worked in the SCU unit on third shift. Review of the Resident Bed List Report dated 09/20/19 revealed: -There was a SCU census of 38 residents, which required 38 hours on second shift. -There was a census of 48 residents in the AL unit which required 28 hours on second shift. -There should have been a total of 66 hours between the SCU and the AL unit on second shift. Review of the Employee Time Detail dated 09/20/19 revealed: -There were 63.25 total staff hours provided on second shift between the AL unit and the SCU. -There was a shortage of 20.75 aide hours. -It could not be determined how many of the 63.25 total staff hours worked were worked in the SCU unit on second shift. Review of the Resident Bed List Report dated 09/21/19 revealed: -There was a census of 48 residents in the AL unit which required 28 hours on first shift. -There was a SCU census of 38 residents, which required 38 hours on first shift. -There should have been a total of 66 hours between the AL unit and the SCU on first shift. -There was a census of 48 residents in the AL unit which required 28 hours on second shift. -There was a SCU census of 38 residents, which required 38 hours on second shift. -There should have been a total of 66 hours between the AL unit and the SCU on second shift. Review of the Employee Time Detail dated 09/21/19 revealed:	D 465		

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-There were 56 total staff hours provided on first shift between the AL unit and the SCU unit.
-There was a shortage of 10 aide hours.
-It could not be determined how many of the 56 total staff hours worked were worked in the AL unit on first shift.
-There were 51.5 total staff hours provided on second shift between the AL unit and the SCU.
-There was a shortage of 14.5 aide hours.
-It could not be determined how many of the 51.5 total staff hours worked were worked in the AL unit on second shift.

Interview with a Personal Care Aide (PCA) on 11/06/19 at 4:30am revealed:
-There were routinely 2 PCA working on the assisted living (AL) unit during the third shift.
-There was a medication aide (MA) in the Special Care Unit (SCU) and in the AL unit some nights.
-If there were not 2 MAs working, the MA went back and forth between the SCU and the AL unit.
-The PCAs in the AL unit did not routinely assist in the SCU during the third shift.

Interview with the MA on 11/06/19 at 4:40am revealed:
-She was the only MA working on the third shift on 11/06/19.
-A second MA was scheduled but called out.
-She spent time in the SCU in the AL and was responsible to administer medications to residents in both units during third shift.

Interview with a PCA on 11/13/19 at 5:26 pm revealed:
-The SCU was sometimes short staffed on 2nd shift.
-The MA or nurse would usually try to call staff members in to work when short staffed.
-They would at least ask another staff member

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work long enough to all the residents went to bed.

Interview with a Personal Care Aide (PCA) on 11/14/19 at 1:30pm revealed:
-She usually worked in the SCU on first shift.
-On first shift there were usually 2 Medication Aides (MAs) and 3 to 4 PCAs.
-Sometimes there were less than 3 PCAs if staff called out.
-Staff were usually not replaced if they called out of work.

Interview with another PCA on 11/14/19 at 1:33pm revealed:
-She worked first shift in the SCU and the AL unit.
-There were usually 2 MAs and 3 to 4 PCAs on 1st shift.
-On the AL unit, there were 2 MAs and 2 PCAs or 1 MA and 3 PCAs.
-If staff called out of work, most of the time that staff was not replaced during the shift.
-It was sometimes difficult to provide care for residents and complete all assigned tasks which included 15-minute and 30-minute checks on some residents, passing 2 snacks during her shift, taking residents out for 3 smoke breaks, setting up for lunch, in addition to bathing, dressing, toileting, and 2-hour resident checks.

Interview with a 5th PCA on 11/14/19 at 2:05 pm revealed:
-She usually worked 1st shift in the SCU.
-There were not enough staff to handle all the behaviors on the SCU. They needed 4-5 more PCA's.
-Staff stayed very busy on 1st shift as they got most of the residents up and bathed them, got them to breakfast and lunch, passed 2 snacks, had 3 cigarette breaks, and completed regular rounds every 2 hours with some residents being

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rounded on every 15-30 minutes.

Interview with a housekeeper on 11/14/19 at 2:18 pm revealed:
-She usually worked first shift in the SCU.
-She was not allowed to assist with personal care but could walk the residents down the hallway.
-She believed 2nd shift needed more staff due to the number of residents with behaviors.

Interview with a MA on 11/14/19 at 4:47pm revealed:
-She usually worked in the SCU on either second or third shifts.
-There were usually 1 MA and 4 PCAs, sometimes 3 PCAs, on second shift.
-There were usually 1 MA and 3 to 4 PCAs on third shift.
-She thought the facility was understaffed often between the hours of 2pm and 5pm due to staff coming to work late.

Interview with a PCA on 11/15/19 at 11:54am revealed:
-She usually worked in the SCU on 3rd shift.
-There was usually 1 MA and 2 PCA on third shift.
-If a PCA called out on third shift, that staff was usually not replaced.

Interview with the Special Care Unit (SCU) Coordinator on 10/14/19 at 3:28pm revealed:
-The Administrator was responsible for creating a monthly staffing schedule.
-If a MA or PCA called out of work, she and the AL Resident Care Coordinator (RCC) were responsible for calling staff to fill that shift.
-She provided direct care as needed about 3 to 6 times a day.
-She felt like there was enough staff on first, second, and third shifts to meet the residents'

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D 465	Continued From page 317 needs. Interview with the Administrator on 11/14/19 at 5:31 pm revealed: -She determined the rotations and created the monthly schedule for employees. -She scheduled staff at the minimum to meet the number of residents. -She staffed over the minimum when she was able to do so. -She did not know of any days the facility was understaffed since she had been the Administrator. -She did not know if the facility was understaffed in May 2019 as she was not the Administrator at that time. -She usually staffed the AL side with 2 PCAs and shared the MA with the SCU on 3rd shift. -She usually staffed the SCU with 1 MA and 5 PCA's on 1st and 2nd shift, but she preferred 2 MA's and 4 PCA's on 1st and 2nd shifts in the SCU. -She usually staffed the SCU with 1 MA and 4 PCAs on 3rd shift, but she preferred 1 MA on each side. -She expected staff to inform management if someone called out or did not show up for their shift. -Sometimes staff did not contact management if staff did not show up for their shift. -The RCC or herself would try to call in another employee if there was a known callout. -She knew there were staff who clocked into work late and took an hour break which caused that staff's scheduled shift to be less than 8 hours. [Refer to Tag 0338 10A NCAC 13F .0909 Residents Rights]. [Refer to Tag 270 10A NCAC 13F .0901(b)	D 465		

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D 465	Continued From page 318 Personal Care and Supervision]. The facility failed to assure aide hours met the minimum requirements for a special care unit (SCU) and Assisted Living (AL) and staff on duty were present at all times for 27 of 90 sampled shifts for 30 days in May 2019, August 2019, and September 2019, resulting in a resident elopement without staff's knowledge and sustaining a fractured hip; a confused resident who consumed an unknown substance; two residents who displayed agitation and aggressive behaviors and physically abused other residents, and a resident with altercations and falls; a staff yelling at a resident, another staff hitting another resident; a resident was forced to sit in the hallway all day to maintain continuous oxygen and 7 residents receiving injuries and bruises after being hit by other residents. This 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 11/08/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 30, 2019.	D 465		
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.	D914		

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D914	Continued From page 319 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all residents were free from neglect related to personal care and other staffing, Ach medication aide training and competency, health care, Special Care Unit staff, Personal Care and Supervision, Residents' Rights and implementation. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision according to residents' assessed needs and current symptoms for 5 of 9 sampled residents (#1, #4, #10, #11 and #13) including a resident who eloped from the Special Care Unit (SCU) without staff's knowledge, resulting in a fractured hip (#13), a confused resident who consumed an unknown substance (#11), two residents who displayed agitation and aggressive behaviors and physically abused other residents (#4 and #10), and a resident with altercations and falls (#1). [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 2. Based on interviews and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal and other staffing, Special Care Unit staff, personal care and supervision, health care, resident rights, medication administration, reporting of accidents and incidents, settlement of cost of care, Ach infection prevention requirements and Ach medication aides; training and competency. [Refer to Tag 980 G.S. 131D-25 Implementation (Type A1 Violation)].	D914		

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D914	Continued From page 320 3. Based on observations, interviews, and record reviews the facility failed to assure residents' rights for 10 of 15 residents (Residents #1, #2 #11, #12, #14, #15, #16, #17, #18, and #20) regarding staff yelling at a resident (#12), a staff (Staff G, personal care aide (PCA)) hitting a resident (#1), a resident being forced to sit in the hallway all day due to not having portable oxygen (#2) and residents receiving injuries and bruises after being hit by other residents (#11, #14, #15, #16, #17, #18, and #20). [Refer to Tag D0338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).] 4. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Assisted Living (AL) unit for 27 of 90 shifts sampled for 30 days in May 2019, August 2019, and September 2019. [Refer to Tag D 0188 10A NCAC 13F .0604(d) Personal Care and Other Staffing (Type B Violation).] 5. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 5 of 7 sampled residents (#2, #3, #4, #6, and #7) including follow-up with a medical equipment provider for portable oxygen equipment (#2) and nebulizer equipment (#7); notifying the primary care provider (PCP) regarding medical equipment not being available for residents with history of respiratory failure and chronic obstructive pulmonary disease (#2 and #7); medications not being available (#2 and #3); refusal of medications, blood pressures and pulse (#4); and refusal of weights and a medication (#6). [Refer to Tag D0273 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 6. Based on record reviews and interviews, the	D914		

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D914	Continued From page 321 facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 27 of 90 shifts sampled for 30 days in May 2019, August 2019, and September 2019. [Refer to Tag D 0465 10A NCAC 13F .1308 Special Care Unit Staff (Type B Violation).] 7. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 sampled staff (Staff A, Staff B, and Staff F) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff A, Staff B, and Staff F), and passed the state written medication aide exam (Staff B and Staff F) prior to administering medications. [Refer to Tag D 0935 G.S. 131D4.5(B)(b) Ach Medication Aides; Training and Competency (Type B Violation).]	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents.	D932		

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D932	Continued From page 322 b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure sanitation of oxygen equipment, including cleaning	D932		

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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
D932	Continued From page 323	D932		

procedures, agents, and schedules 1 of 1 sampled residents (Resident #2) with orders for continuous oxygen.

The findings are:

Based on observations, interviews, and record reviews, the facility failed to assure sanitation of oxygen equipment, including cleaning procedures, agents, and schedules 1 of 1 sampled resident (Resident #2) with orders for continuous oxygen.

The findings are:

Review of Resident #2's current FL2 dated 05/09/19 revealed:
-Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease with hypoxia, coronary disease, and depression.
-The recommended level of care for Resident #2 was Special Care Unit (SCU).
-There was no order for oxygen on the FL2.

Review of a hospital discharge summary report dated 04/26/19 revealed Resident #2 was admitted for respiratory failure.

Observation of Resident #2's oxygen concentrator on 11/06/19 at 8:00 am revealed:
-There was a green tag attached to the machine for "Preventive Maintenance check."
-The dates on the green tag revealed the equipment was last serviced on 12/27/16, the next date for the equipment to be serviced was 06/12/17.
-There was a sticky substance on the machine near the port where the nasal cannula connects to the machine.
-There was a brown substance splattered at

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D932	Continued From page 324 various spots on the machine. Based on record review, observations, interviews with staff it was determined that Resident #2 was not interviewable. Interview on with the MA supervisor on 11/13/19 at 4:07 pm revealed no staff at the facility had cleaned Resident #2's oxygen machine or called to have the machine serviced. Interview with the MA supervisor on 11/13/19 at 4:07 pm revealed: -She did not clean Resident #2's oxygen equipment. -She did not know the oxygen equipment needed to be serviced. -She had not contacted the oxygen equipment company to have Resident #2's oxygen equipment serviced Interview with the SCU Coordinator on 11/07/19 at 9:21 am revealed: -She had worked at the facility since July 2019. -She had not noticed Resident #2's oxygen equipment needed to be cleaned and serviced. -She did not know the oxygen concentrator did not belong to Resident #2. Interview with the Administrator on 11/08/19 at 11:10am revealed she was not aware Resident #2's oxygen concentrator needed to be cleaned and serviced. Interview with a representative from the local Veteran's Administration on 11/06/19 at 9:34am revealed: -The refillable concentrator and stand alone concentrator identified as being used by Resident #2 were not dispensed to Resident #2.	D932		

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D932	Continued From page 325 -The Veteran's Administration had not dispensed any oxygen equipment to Resident #2. -No one at the facility had called to inform the equipment needed repair. -If the facility had called regarding repairing the equipment for Resident #2, they would have been told the equipment could only be repaired for the individual it was dispensed for. -They would have picked the equipment up because it could only be used for the individual it was dispensed for. -It is recommended oxygen equipment be served and/or cleaned as needed or at least every 3 to 6 months. Interview with a representative from the oxygen home care company on 11/08/19 at 1:00 pm revealed: -The company received orders dated 05/09/19 for oxygen equipment for Resident #2. -On 05/10/19, the company delivered brand-new oxygen equipment, concentrator with an attached home-fill refillable concentrator and two refillable portable tanks. -No one at the facility had called to inform Resident #2's oxygen equipment was not working. -If Resident #2 was not using the equipment dispensed on 05/09/19, then the facility should identify where the equipment was located. -Resident #2 should be the only person using that equipment.	D932		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.	D935		

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D935	Continued From page 326 (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	D935		

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D935	Continued From page 327	D935		

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

Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 sampled staff (Staff A, Staff B, and Staff F) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff A, Staff B, and Staff F), and passed the state written medication aide exam (Staff B and Staff F) prior to administering medications.

The findings are:

1. Review of Staff A's, Medication Aide (MA), personnel record revealed:
-Staff A was hired on 03/27/18 as a Personal Care Aide (PCA).
-Staff A was transferred to the position of MA on 09/12/19.
-There was documentation of a 5-hour medication administration course dated 08/16/19.
-There was documentation of a 10-hour medication administration course dated 04/30/19.
-There was no documentation of employment verification showing Staff A worked as a medication aide within the last 24 months.
-There was documentation she completed her Medication Clinical Skills Checklist on 09/17/19.

Review of residents' electronic Medication Administration Records (eMARS) for September 2019 revealed Staff A documented administration

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D935	Continued From page 328 of medications on 09/21/19. Review of residents' electronic Medication Administration Records (eMARS) for October 2019 revealed Staff A documented administration of medications for 12 days in October 2019. Interview with Staff A on 11/12/19 at 9:55am revealed: -She had worked at the facility for about 8 months. -She was hired as a PCA and became a MA in September 2019. -She remembered completing her 5 and 10-hour medication training on the computer. -She started working on the 10-hour training first, but she did not remember when. -She was pulled from her computer training to work on the floor for a while and then went back and completed her 5-hour training in August 2019. -The facility's community nurse checked her off after she completed the 5-hour training on the computer. -She had not taken her medication administration exam yet, but she was scheduled to take the exam on 12/11/19. -She had been scheduled to take the medication administration exam previously, but she had to reschedule due to unforeseen circumstances. Refer to the interview with the facility's community nurse on 11/08/19 at 5:00pm. Refer to interview with the Business Office Manager (BOM) on 11/14/19 at 2:18pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/14/19 at 2:27pm.	D935		

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D935	Continued From page 329 Refer to interview with the Special Care Unit Coordinator (SCUC) on 11/14/19 at 3:29pm. Refer to interview with the Administrator on 10/14/19 at 5:31pm. 2. Review of Staff B's, Medication Aide (MA), personnel record revealed: -Staff B was hired on 12/04/18 as a Personal Care Aide (PCA). -Staff B was transferred to the position of MA on 08/22/19. -There was documentation of a 5-hour medication administration course dated 07/31/19. -There was documentation of a 10-hour medication administration course dated 04/02/19. -There was no documentation of employment verification showing Staff B worked as a medication aide within the last 24 months. -There was documentation she completed her Medication Clinical Skills Checklist on 08/22/19. -There was no documentation Staff B had passed the state written MA exam. Review of residents' electronic Medication Administration Records (eMARs) for August 2019 revealed Staff B documented administration of medications for 3 days on August 2019. Review of residents' eMARs for September 2019 revealed Staff B documented adminstration of medications for 18 days in September 2019. Review of residents' electronic Medication Administration Records (eMARS) for October 2019 revealed Staff B documented administration of medications for 15 days in October 2019. Interview with Staff B on 11/08/19 at 5:34 pm revealed:	D935		

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D935	Continued From page 330 -She started working at the facility as a MA at the end of August 2019. -She thought she took the 5 and 10-hour training in August 2019 on the computer. -After she completed the 5 and 10-hour training on the computer, the facility's community nurse watched her complete a medication pass, obtain fingerstick blood sugars, and give insulin. -The facility's community nurse did not conduct any of her training. -She had not taken the medication administration exam, but she planned to take it in December 2019. Refer to the interview with the facility's community nurse on 11/08/19 at 5:00pm. Refer to interview with the Business Office Manager (BOM) on 11/14/19 at 2:18pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/14/19 at 2:27pm. Refer to interview with the Special Care Unit(SCU) Coordinator on 11/14/19 at 3:29pm. Refer to interview with the Administrator on 10/14/19 at 5:31pm. 3. Review of Staff F's, Medication Aide (MA), personnel record revealed: -Staff F was hired on 03/27/19 as a Personal Care Aide (PCA). -Staff F was transferred to the position of MA on 06/05/19. -There was documentation of a 5-hour medication administration course dated 05/12/19. -There was documentation of a 10-hour medication administration course dated 05/31/19. -There was documentation she completed a	D935		

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Medication Clinical Skills Validation Checklist on 06/05/19.
-There was documentation she completed a second Medication Clinical Skills Validation Checklist on 10/22/19.
-There was no documentation Staff F had passed the state written MA exam.

Review of residents' eMARs for September 2019 revealed Staff F documented administration of medications for 6 days in September 2019.

Review of residents' eMARS for October 2019 revealed Staff F documented administration of medications for 6 days in October 2019.

Review of residents' eMARS for November 2019 revealed Staff F documented administration of medications on 11/06/19.

Interview with Staff F on 11/06/19 at 5:00am revealed:
-She started working at the facility as a MA a few months ago.
-She administered medications including insulin and oral medications, and obtained finger stick blood sugar values for residents on the Assisted Living unit and the Special Care Unit (SCU).
-She had not taken the written medication examination.

Interview with the Administrator on 11/08/19 at 4:50pm revealed:
-She and the Business Office Mananger (BOM) had audited staff records in October 2019 and discovered Staff F had not taken the state medication aide test.
-She thought Staff F could have a new Medication Clinical Skills Validation checklist completed in order to administer medications for 60 more days

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D935	Continued From page 332 while awaiting to schedule and take the medication aide test. -MAs were responsible to schedule and take the medication aide test themselves. Attempted telephone interview with Staff F on 11/13/19 and 11/14/19 was unsuccessful. Refer to the interview with the facility's community nurse on 11/08/19 at 5:00pm. Refer to interview with the Business Office Manager (BOM) on 11/14/19 at 2:18pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/14/19 at 2:27pm. Refer to interview with the Special Care Unit (SCU) Coordinator on 11/14/19 at 3:29pm. Refer to interview with the Administrator on 10/14/19 at 5:31pm. Interview with the facility's community nurse on 11/08/19 at 5:00pm revealed he reviewed medication aide staff training records and did medication aide's 5 hour, or 10 hour certificate sign-off as each medication aide completed required work Interview with the Business Office Manager (BOM) on 11/14/19 at 2:18pm revealed: -The BOM, RCC, and SCU Coordinator were responsible for ensuring the 5, 10, and 15-hour medication administration training. -The BOM let the RCC or the SCU Coordinator know if the 5, 10, or 15-hour medication administration training needed to be completed and they would schedule the training. -MA's completed the 5, 10, or 15-hour training on	D935		

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the computer and then the facility's community nurse came to the facility to complete checkoffs for the MAs.
-Letting the RCC and the SCU Coordinator know a staff needed to take the medication administration exam may have been something she was supposed to do, but she had never told either that a staff needed to take the medication administration test.

Interview with the Resident Care Coordinator (RCC) on 11/14/19 at 2:27pm revealed:
-The Administrator or the BOM were responsible for making sure the 5, 10, or 15-hour medication administration training was completed.
-She thought the Administrator was responsible for making sure MAs passed the medication administration test.
-She did not know the 5, 10, or 15-hour medication administration training was supposed to be taught by a qualified instructor.

Interview with the SCU Coordinator on 11/14/19 at 3:29pm revealed:
-She assumed the facility community nurse was responsible for making sure the 5, 10, or 15-hour medication administration training was completed.
-She did not know how the 5, 10, or 15-hour was completed (on the computer or with by an instructor).
-She did not know who was responsible for ensuring the MAs took and passed the medication administration test.

Interview with the Administrator on 10/14/19 at 5:31pm revealed:
-The BOM was responsible for ensuring the 5, 10, or 15-hour training and was completed.
-The BOM was responsible for ensuring MAs

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D935	Continued From page 334 were scheduled to take the medication administration test. -She completed a calendar of training dates for staff and gave a copy to the BOM, the RCC and the SCUC. -The BOM, RCC, and the SCU Coordinator were responsible for following up to ensure trainings and tests had been completed. -The 5, 10, or 15-hour medication administration trainings were completed on the computer by staff and staff followed up with the facility's community nurse after the computer training was completed. -There were two different dates on the MAs 5 and 10-hour certificates due to the MA completing the computer training on one date and being checked off by the facility community nurse on a later date. -It was her understanding the computerized 5, 10, or 15-hour training was a state approved training for MAs. -She did not know the 5, 10, or 15-hour training needed to be taught by a qualified instructor. The facility failed to ensure the 5, 10, or 15-hour medication aide training for 3 of 3 sampled medication aides (Staff A, Staff B, and Staff F) with no previous employment verification as a medication aide within the last 24 months, and the state approved Medication Aide test was passed within 60 days of validation for 2 of 3 sampled staff (Staff B and Staff F) prior to the staff administering medications to the residents. This failure increased the risk for medication errors and was detrimental to the health, safety and welfare of residents, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/08/19 for this violation.	D935		

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D935	Continued From page 335 CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 30, 2019.	D935		
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 interviews and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care and other staffing, Special Care Unit staff, personal care and supervision, health care, resident rights, medication administration, reporting of accidents and incidents, settlement of cost of care, Ach infection prevention requirements and Ach medication aides; training and competency. The findings are: Non-compliance was identified at violation level in the following rule areas: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision according to residents' assessed needs and	D980		

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D980	Continued From page 336 current symptoms for 5 of 9 sampled residents (#1, #4, #10, #11 and #13) including a resident who eloped from the Special Care Unit (SCU), without staff's knowledge, resulting in a fractured hip (#13), a confused resident who consumed an unknown substance (#11), two residents who displayed agitation and aggressive behaviors and physically abused other residents (#4 and #10), and a resident with altercations and falls (#1). [Refer to Tag D0270 10A NCAC 13F .0902(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews the facility failed to assure residents' rights for 10 of 15 residents (Residents #1, #2 #11, #12, #14, #15, #16, #17, #18, and #20) regarding staff yelling at a resident (#12), a staff (Staff G, personal care aide (PCA)) hitting a resident (#1), a resident being forced to sit in the hallway all day due to not having portable oxygen (#2) and residents receiving injuries and bruises after being hit by other residents (#11, #14, #15, #16, #17, #18, and #20). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 5 of 7 sampled residents (#2, #3, #4, #6, and #7) including follow-up with a medical equipment provider for portable oxygen equipment (#2) and nebulizer equipment (#7); notifying the primary care provider (PCP) regarding medical equipment not being available for residents with history of respiratory failure and chronic obstructive pulmonary disease (#2 and #7); medications not being available (#2 and #3); refusal of medications, blood pressures and pulse (#4); and refusal of weights and a medication	D980		

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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
D980	Continued From page 337 (#6). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Assisted Living (AL) unit for 27 of 90 shifts sampled for 30 days in May 2019, August 2019, and September 2019. [Refer to Tag D0188 10A NCAC 13F .0604(d) Personal Care and other Staffing (Type B Violation)]. 5. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 27 of 90 shifts sampled for 30 days in May 2019, August 2019, and September 2019. [Refer to Tag D465 10A NCAC 13F .1308 Special Care Unit Staffing (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 sampled staff (Staff A, Staff B, and Staff F) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff A, Staff B, and Staff F), and passed the state written medication aide exam (Staff B and Staff F) prior to administering medications. [Refer to Tag D 0935 G.S. 131D4.5(B)(b) Ach Medication Aides; Training and Competency (Type B Violation).] The Administrator neglected to assure responsibility for the overall operation, administration, management and supervision of the facility resulting in a resident eloping from the SCU without staff's knowledge and sustainted a fractured hip; a confused resident consumed an unknown substance; two residents who displayed	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: _____ B. WING _____	R-C 11/15/2019

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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D980	Continued From page 338 agitation and aggressive behaviors and physically abused other residents; staff yelling at a resident, a staff hitting another resident; a resident being forced to sit in the hallway all day due to not having portable oxygen, and residents receiving injuries and bruises after being hit by other residents; notifying the primary care provider (PCP) regarding medical equipment not being available for residents with history of respiratory failure and chronic obstructive pulmonary disease; medications not being available; refusal of medications, a minimum number of staff were present at all times to meet the needs of residents residing in the AL and SCU unit for 27 of 90 shifts sampled for 30 days; and 3 MAs who had not completed the MA requirements prior to administering medications. This neglect resulted in serious physical harm and injury to residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/06/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 1, 2019.	D980		