STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	R-C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 and the Wilson County Department of Social Services conducted a follow-up survey and complaint investigation on February 19 through February 22, 2019 and February 25 through February 28, 2019. The complaint investigations were initiated by the Wilson County Department of Social Services on January 29, 2019.	{D 000}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free from hazards as evidenced by bedbugs found in residents' rooms throughout the facility and resulted in one resident (#3) in the Special Care Unit suffering multiple bedbug bites to her cheek and jaw. The findings are: Observation of resident room #102 on 02/25/19 at 10:00am revealed: -All resident belongings had been removed from the room. -The mattress had been removed from the bed. -A technician from a local pest control provider	{D 079}		

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{D 079}	Continued From page 1 was spraying the room. Interview with a technician from a local pest control provider on 02/25/19 at 10:05am revealed: -He was spraying resident room #102 for bed bugs. -He had not seen live bed activity but he had just starting the process for treating the resident room. -He was not the usual technician for the facility but he had been there before about 5 or 6 months ago to treat another room for bed bugs. -The treatment process took approximately 2 hours to treat a room. -Bed bugs could be transferred from place to place either on a resident or in their belongings. -His company's office manager had sent instructions to the facility's Administrator on how to clean the residents' rooms and their belongings to prevent re-infestation of bed bugs. Observation of resident room #306 on 02/25/19 at 3:20pm revealed: -Staff were placing resident's belonings in trashbags and placing them in a room across the hall. -Two technicians from a local pest control provider were spraying the resident's room for bed bugs. Interview with a resident who lived in room #306 on 02/25/19 at 3:30pm revealed: -He had not been bitten by the bed bugs. -The staff had seen the bed bugs and reported them to the Administrator. Confidential interview with a staff member revealed: -A resident was returned to the facility from the	{D 079}		

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{D 079}	Continued From page 2	{D 079}		

hospital by Emergency Medical Services (EMS).
-The EMS staff told the staff member to keep the blankets because the resident had bed bugs.
-The staff member reported this to the Administrator but the room was not treated.
-The resident and his belongings were moved to another room a few days later.

Telephone interview with the office manager of a local pest control provider on 02/27/19 at 3:15pm revealed:
-She scheduled the technician's visits to the facility.
-Visits had been made to treat rooms with bed bugs since June 2018.
-Visits were made on 10/24/18 to treat room #201; on 12/04/18 to treat room #102; on 12/13/18 to treat an undocumented room; on 01/24/19 to treat room #309; on 02/05/19 to treat room #209.
-If all of the resident's belongings were either washed and dried or otherwise cleaned immediately after the room was sprayed, one treatment was all that was needed.
-She had sent an instruction sheet to the facility on how to prevent re-infestation.

Review of Resident #3's progress note dated 09/01/18 revealed:
-There was no documentation of the time this entry was made.
-Staff documented Resident #3 was lying in bed and had 3 fresh, reddened, raised bed bug bite marks along her left jawline and 1 bite mark on her left cheek.
-Staff took a flashlight and tape and pulled back a corner of Resident #3's fitted sheet.
-She found a bedbug in the seam of Resident #3's mattress, removed it with the tape, and killed the bedbug.

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{D 079}	Continued From page 3 -Staff documented this was the third time Resident #3 had been bitten by bed bugs or had to move out of her room because of bed bugs found in her room (there was no specification of how this time span took place). Review of Resident #3's progress note dated 09/03/18 during the 3:00pm - 11:00pm shift revealed: -Resident #3's room had still not be treated for bed bugs. -Resident #3 stayed in the dining/television room in the Special Care Unit (SCU) during the day and slept in resident room #114 on the assisted living side of the facility at night. Review of Resident #3's progress note dated 09/04/18 revealed Resident #3's room was treated for bed bugs at the beginning of the 3:00pm - 11:00pm shift and Resident #3 was allowed to return to her room at 7:00pm after her room was treated. Telephone interview with a former staff member on 02/28/19 at 8:48am revealed: -She wrote the progress notes regarding Resident #3 and bed bugs for 09/01/18, 09/03/18, and 09/04/18. -She normally worked second shift in the SCU. -She caught live bed bugs before 09/01/18 in Resident #3's room. -She had taken the bed bugs and slipped them under the Administrator's office door. -She could not remember when she did this. -She was concerned that Resident #3's kept getting bed bug bites. -The Administrator denied there was any problems with bed bugs in Resident #3's room or any bite marks. -She notified the on-call staff during second shift	{D 079}		

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{D 079}	Continued From page 4	{D 079}		

on 09/01/18 when she found the bed bugs again in Resident #3's room.
-She could not remember who the on-call person was for 09/01/18.
-The on-call person told her to remove Resident #3 from her room, shower Resident #3, and bag up all of Resident #3's clothing.
-This was the facility's protocol when bed bugs were found in a resident's room and she followed it on 09/01/18.

Interview with the Special Care Unit Coordinator on 02/27/19 at 2:45pm revealed:
-There had been some problems with bed bugs in the SCU since May 2018 or June 2018.
-Residents rooms #209, #211, and #214 had been treated multiple times in that time frame which included Resident #3's room.
-Resident #3 had some bug bites in August 2018 but they were treated.
-She did not know of any other residents having any bedbug bites.
-She notified the Administrator to call the exterminator whenever staff reported seeing bed bugs.
-Residents were removed from their rooms, showered, and staff bagged up all the resident's clothing.

Interview with the Administrator on 02/25/19 at 11:15am revealed:
-She did not know about Resident #3 being bitten by bed bugs on 09/01/18 because no staff notified her.
-She knew Resident #3's room had been treated for bed bugs late last summer but she was not be sure of the date.
-She remembered a former staff member had put a dead bedbug on her office desk when bed bugs were supposedly found in the SCU.

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{D 079}	Continued From page 5	{D 079}		

-The staff were supposed to follow the facility's protocol when bed bugs were found in a resident room by removing the resident from the room, shower the resident, bag up the resident's clothing, and notify the Resident Care Coordinator or the Special Care Unit Coordinator.
-She along with the Resident Care Coordinator or the Special Care Unit Coordinator were responsible to make sure staff followed the facility's protocol.
-The staff were following the facility's protocol and residents' were treated.

Confidential interview with a staff member revealed:
-The bedbug problems had been ongoing in the facility since last summer.
-Several rooms throughout the facility had been treated for bed bugs but the bed bugs kept coming back.
-She did not know how many times the residents' rooms had been treated.
-The facility's protocol when bed bugs were found in a resident's room was to move the resident from the room, shower the resident, bag up the resident's clothing, and notify the Resident Care Coordinator or the Special Care Unit Coordinator.
-The staff member followed the facility's protocol.

Interview with the Administrator on 02/28/19 at 3:20pm revealed:
-She was aware that several residents' rooms had been treated for bed bugs.
-She thought family members were bringing the bed bugs inside the facility when they brought in residents' clothing.
-She called the pest control provider whenever a staff member or a resident reported seeing bed bugs.
-It had been "back in the summer" when she had

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{D 079}	Continued From page 6 last had the pest control provider do a room to room inspection for bed bugs.	{D 079}		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an adequate supply of washcloths, towels, and bed linens for residents' use at all times. The findings are: Review of the facility's current license effective 01/01/19 through 12/31/19 revealed a maximum capacity of 88 residents. Observation of the facility's linen closet on 02/19/19 at 11:30am revealed: -There were 4 fitted sheets, 33 flat sheets and 21 blankets on the shelves. -There were no washcloths or towels on the shelves. A second observation of the facility's linen closet on 02/27/19 at 8:45am revealed 11 bath towels and 6 washcloths were in the linen closet.	D 080		

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D 080	Continued From page 7 Interview with the special care coordinator (SCC) on 02/19/19 at 3:50am revealed a current census of 68 residents. Interview with the laundry supervisor on 02/27/19 at 8:50am revealed: -She was the only laundry staff at the facility and she did all of the laundry. -All the bath linens had been laundered and placed in the linen closet. -There were no dirty bath linens in the laundry room. -All the towels and washcloths were in the linen closet. A third observation of the facility's linen closet on 02/28/19 at 4:15pm revealed 6 bath towels and 5 washcloths were in the linen closet. Confidential interview with a former staff member revealed: -The supply of linens in the facility had been scarce for over a year. -The staff never had enough washcloths, towels, sheets, pillowcases, or bed spreads. -Staff had to search of washcloths and towels when it was time to bathe the residents or do personal care. -Sometimes staff were not able to give residents baths because there were not enough washcloths or staff had to use chux pads to bathe the residents. -The staff member had complained to the Administrator several times about not having enough linens but nothing was ever done. Confidential interview with a second former staff member revealed: -Staff "never had enough linens to work with".	D 080		

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-This was especially a problem during second shift.
-The staff member had to use chux pads sometimes to provide perineal care for the residents.
-The staff member used one chux pad to clean, a second chux pad to rinse, and the third chux pad to dry the residents during bathing when there were no washcloths and towels available.
-"It was a hit or miss" [may or may not have clean bed linens] in staff trying to find sheets to change the residents' beds and residents' bed linens were not being changed.
-The linen supply had been scarce at the facility for about a year.
-She had last complained to Administrator about four months ago, but there had not been any new linens at the facility.

Confidential interview with a staff member revealed:
-The linen supply had been scarce in the facility since last summer.
-Staff did not have enough washcloths, towels, or sheets for use with the residents.
-The staff member did not know why the linen supply was low.
-The staff member had complained once to the Administrator last summer.
-The Administrator told the Business Office Manager to order more linen for the facility.
-The staff member never saw an increase in the supply of linens after complaining to the Administrator.

Confidential interview with two additional staff members revealed:
-One staff member would bring in her own washcloths and towels to bathe residents and then take them home to launder them and return

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them.
-When the bed linens were laundered, they had to be immediately put back on the beds because there was not enough extra in supply.

Review of facility's purchasing invoices revealed:
-On 02/22/18, an order was placed for 10 dozen washcloths and 6 dozen pillowcases; and paid in full on 05/16/18.
-On 06/15/18, an order was placed for 6 dozen flat sheets and 6 dozen fitted sheets; and paid in full on 08/18/18.
-On 06/21/18, an order was placed for 2 bed comforters; and paid in full on 08/18/18.
-On 09/07/18, an order was placed for 10 dozen washcloths and 10 dozen towels; and paid in full on 10/25/18.

Interview with the Business Office Manager on 02/20/19 at 10:15am revealed:
-She ordered towels, washcloths and bed linens when she was told by staff that the linen was low.
-She would send an email to the owner to get approval for the purchase.
-When the orders arrived, she would put out only a portion of the towels and washcloths.
-She had one towel and one washcloth left in her office from the last order of linens.
-She had not been informed by any staff that additional towels, washcloths or bed linens were needed.

Interview with the Administrator on 02/28/19 at 4:20pm revealed:
-The Administrator did not know the facility did not have enough bath linens for resident use at all times.
-The Administrator did not know that residents were being washed and dried using chux pads.
-The Administrator thought staff had "squirreled

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D 080	Continued From page 10 away" [hid] towels and wash cloths for their use and this is why the supply was low in the linen closet. -The Office Manager kept the new bath linens and floor staff in her office and staff could get them as needed. -The Administrator did not know how many new bath linens were on hand.	D 080		
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	D 188		

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resident census). (For staffing chart, see Rule .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 observations, interviews and record reviews, the facility failed to assure there were staff on duty to meet the needs of the residents with a minimum of 20 aide hours on 1st and 2nd shift and 16 aide hours on 3rd shift for 4 of 24 shifts sampled.

The findings are:

Interview with the Special Care Coordinator (SCC) on 02/19/19 at 3:50am revealed:
-There were 45 residents on the assisted living (AL) side.
-There were two personal care aides (PCAs) working on the back (300) hall and one PCA working on the front (100) hall on the AL side.
-She was covering the building as the medication aide (MA)/Supervisor until 7:00am on 02/19/19.
-She had come in to work at 3:30am to cover a call in and would be working her normal hours as the SCC after 7:00am on 02/19/19.

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D 188	Continued From page 12 Observations on the 100 hall on 02/19/19 at 4:06am revealed: -There was a chair pulled into the doorway of resident room #102. -The chair had blankets in it and a hair wrap lying across the back of the chair. -There was a wheeled walker with a sheet on it in front of the chair. Interview with a PCA on 02/19/19 at 4:06am revealed she had been sitting in resident room #102 because the resident was on every 15 minute checks. Interview with the SCC on 02/27/19 at 3:00pm revealed: -There had been problems with staff sleeping on 3rd shift. -She had not been told of any problems with the PCA on duty for the 100 hall on 02/19/18 at 4:00am. -If the PCA was sitting in resident room #102 monitoring that resident, then the PCA was not monitoring the residents on the rest of the 100 hall unless a call bell went off. -It was hard for staff to keep up with every 15 minute checks if there was just one PCA working on a hall. -When she worked as a MA on the medication cart, she was just on the cart and did not cover as SCC or Resident Care Coordinator (RCC). -It was not that often that she had to come in at 3:30am like on 02/19/19. -The facility had been short staffed especially on the weekends since approximately October 2018. -The shift times were from 7:00am to 3:00pm for 1st shift, 3:00pm to 11:00pm for 2nd shift and 11:00pm to 7:00am for 3rd shift. Interview with a resident on 02/26/19 at 11:53am	D 188		

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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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revealed:
-If her BP was high and she did not feel good, the staff did not come and check on her.
-She felt like her room was not part of the rest of the hall because staff did not check on her or come to the room and see if she needed help.
-She needed help; she had a dialysis catheter in her right arm and could not use the arm well to put on shirts and jackets.
-The facility did not have enough help; "they train them and then they leave."
-Some nights there was no MA; the MA left before the next one got there.

Interview with a MA on 02/20/19 at 5:25pm revealed:
-The facility was mostly short of staff on the weekends.
-Over the past weekend (02/16/19), there was one PCA for the back (300) hall; they really needed two PCAs.
-There was one PCA for the front (100) hall.

Confidential interview with a staff member revealed:
-There had been a problem with short-staffing at the facility for several months.
-It was a common practice for a MA to work all of three halls, especially at night.
-There would be one MA and two personal care aides to work the entire facility.
-The staff member had complained to the Administrator about it because it was "stressful" because the staff felt like working short-staffed compromised the residents' care and the quality of the staff's work performance.
-When the staff called out for a shift after hours or on the weekend, the staff called the on-call person to find a fill-in staff.
-Sometimes the on-call person just said "yeah,"

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but did not find any help for the staff.
-Sometimes, the on-call person did not answer the phone and the facility was still short staffed.
-The Administrator did not do anything about the staff working short-staffed.

Review of the facility's census revealed the census for 11/10/18 was 66; the special care unit (SCU) and AL census were not specified.

Review of staff time cards and assignment sheets for 11/10/18 revealed there were 11.75 aide hours for the AL side for 3rd shift.

Review of the facility census for 02/15/19 revealed the AL census was 45.

Review of staff time cards and schedule for 02/15/19 revealed there were 15 aide hours for the AL side for the 3rd shift, resulting in a shortage of 1 hour.

Review of the facility census for 02/16/19 revealed the AL census was 45.

Review of staff time cards and schedule for 02/16/19 revealed there were 15 aide hours for the AL side for the 3rd shift resulting in a shortage of 1 hour.

Review of the facility census for 02/17/19 revealed the AL census was 45.

Review of staff time cards and schedule for 02/17/19 revealed there were 10.75 aide hours for the AL side for the 3rd shift resulting in a shortage of 5.25 hour.

Interview with the Administrator on 02/28/19 at 5:10pm revealed:

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D 188	Continued From page 15 -"The facility had been short staffed for a while." -She did not know what "a while" was and "short staffed" meant. -The facility had a lot of turn-over and she had to fire a few employees. -She tried to make sure the facility was covered but sometimes staff called out from work. -If staff called out, the staff were supposed to call the on-call person (the SCC or RCC) to arrange for coverage of the shift. -It was her expectation that if staff called out from work that staff person "was really supposed to find someone to cover their shift and if they could not find anyone, then staff was supposed to come to work." -"Nine out of ten times though" the SCC came and worked the shift if staff called out because the SCC "liked working the extra hours". _____ The facility failed to assure there were personal care staff on duty to meet the needs of residents for 4 of 24 shifts resulting in the inability to assist residents with personal care tasks and provide supervision which was detrimental to the health, safety and welfare of all residents on the assisted living side and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/26/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2019.	D 188		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	{D 273}		

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{D 273}	Continued From page 16 to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 violation is abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the primary care provider (PCP) was notified of changes in condition and acute health care needs for 3 of 15 sampled residents (#3, #7 and #17), including Resident #3 who had bedbug bites to her left cheek and jaw; Resident #7 who had symptoms of aspiration resulting in hospital admission for aspiration pneumonia 4 days after the onset of symptoms; and Resident #17 who had 11 out of 12 systolic blood pressures (SBPs) greater than 160 in January and February 2019 that were not reported to the PCP as ordered and did not have a hospital follow up appointment with her PCP for more than six weeks. The findings are: 1. Review of Resident #17's current FL-2 dated 03/01/18 revealed: -Diagnoses included end stage renal disease on hemodialysis, hypertension, osteoarthritis, gastro esophageal reflux disease and aortic aneurysm. -There was an order to monitor blood pressure (BP) daily and call the primary care provider (PCP) for systolic blood pressure (SBP) greater than 160 and/or diastolic blood pressure (DBP) greater than 110.	{D 273}		

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{D 273}	Continued From page 17 Review of a vital signs report dated 01/01/19 through 01/31/19 for Resident #17 revealed: -There were 29 BP results documented. -There were seven SBP documented greater than 160 ranging from 164 to 173. Review of Resident #17's January 2019 electronic medication administration record (eMAR) revealed there was no documentation the PCP was notified in the medication notes. Review of Resident #17's February 2019 electronic treatment administration record (eTAR) revealed: -There were 21 BP results documented. -There was no BP result documented for 02/20/19. -There were three SBP documented greater than 160 ranging from 167 to 175. Review of Resident #17's February 2019 eMAR revealed: -There was documentation an as needed medication was administered on 02/20/19 at 6:40am for SBP of 199. -There was no documentation the PCP was notified in the medication notes. Review of "Nurse's Notes" for Resident #17 revealed there were no entries in the months of January or February 2019. Review of a Physician Communication Report for Resident #17 dated 02/21/19 revealed: -The Resident Care Coordinator (RCC) sent a fax notification to the PCP for a BP of 190/80 on 02/21/19. -There was no documentation staff notified the PCP at any other time Resident #17's SBP	{D 273}		

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{D 273}	Continued From page 18 exceeded the ordered parameter. Interview with a medication aide (MA) on 02/26/19 at 11:19am revealed: -She documented Resident #17's BP was 169/86 on 02/07/19. -There was no documentation, so she probably did not notify the PCP Resident #17 SBP was 169. -It would have been documented on the eMAR in medication notes. Interview with a second MA on 02/27/19 at 11:32am revealed: -She documented Resident #17's BP was 173/75 on 01/12/19. -She documented Resident #17's BP was 187/85 on 02/18/19. -When Resident #17 laid down her BP went down, and when the resident got up her BP went back up. -She did not know if the PCP had been notified Resident #17's SBP was 173 on 01/12/19 and 187 on 02/18/19; she could not remember if she had notified the PCP. -She would have documented calling the PCP on the 24 hour reporting sheet or in Resident #17's record. -She could not find the 24 hour reporting sheet for 01/12/19 and 02/18/19. Upon request on 02/27/19, the 24 hour reporting sheet for 01/12/19 and 02/18/19 were not available for review. Interview with Resident #17 on 02/26/19 at 11:53am revealed: -She was "not feeling so great," her blood pressure (BP) was bothering her and "just making me sick."	{D 273}		

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{D 273}	Continued From page 19 -She felt like she "could not hardly stand up." -The staff did not check her BP unless she asked them to. -She had not asked the staff to check her BP on 02/26/19. -She just took her scheduled BP medication, laid down and "hoped it went down." -Her SBP was 200 yesterday (02/25/19) before she went to her PCP's office and her heart rate was 105. Telephone interview with Resident #17's PCP's Nurse on 02/25/19 at 2:07pm revealed: -The PCP's office received a faxed notification from the facility on 02/21/19 that Resident #17's BP was 190/80 and the resident's heart rate was 100. -The PCP's office received a fax from the facility on 02/22/19 at 12:00pm, that Resident #17's BP medications were still not right. -Resident #17's BP was a concern. -Resident #17's BP tended to "run high" and the resident would get worked up because her BP was high which made her BP even higher. Second telephone interview with Resident #17's PCP's Nurse on 02/26/19 between 12:00pm and 5:00pm revealed there were no notifications prior to 02/21/19 about Resident #17's SBP being over 160. Interview with the Resident Care Coordinator (RCC) on 02/26/19 at 4:09pm revealed: -The staff had not been documenting reporting SBP to the PCP; she could not say if the staff had reported the SBP greater than 160 to the PCP and just did not document it. -She had started working at the facility in December 2018 and was working on learning the facility's existing processes and implementing	{D 273}		

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improvements where needed.
-She implemented a new process for reporting and documenting on 02/14/19; the MAs should know the new process because she told the MAs on 02/14/19.
-The Physician Communication Report was completed and faxed to the PCP by the MA; the form was filed with the fax confirmation in the resident's record after being faxed.
-She could not say exactly what the MAs had done, as far as reporting concerns to the PCP and documenting the contact, prior to the new process.

b. Review of hospital discharge instructions for Resident #17 dated 01/31/19 revealed:
-Resident #17 was seen in the emergency room (ER) for dizziness, end stage renal disease and near syncope.
-There were instructions to follow up with the PCP in two days.

Interview with Resident #17 on 02/26/19 at 11:53am revealed:
-She missed one appointment with her doctor because the doctor was not in his office when she went there; then another appointment was canceled.
-She did not know who canceled the appointment.
-She had to end dialysis early yesterday to go to her doctor's appointment so he could get her BP medications right.

Telephone interview with Resident #17's PCP's Nurse on 02/25/19 at 2:07pm revealed:
-Resident #17 was hospitalized in January 2019 and had changes made to her medications.
-The PCP liked to have a follow up appointment after hospitalizations to reconcile the resident's

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{D 273}	Continued From page 21 medications. -Resident #17 had appointments on 01/21/19 and 02/13/19 that were rescheduled. -She did not know any details about the missed appointments, only that the appointments were in the scheduling system as missed appointments. -Resident #17 had an appointment scheduled on 02/25/19 at 2:45pm. Second telephone interview with Resident #17's PCP's Nurse on 02/26/19 between 12:00pm and 5:00pm revealed: -Resident #17 was seen on 02/25/19 by the PCP. -She did not know anything about the PCP not being in the office because she was not working on 02/13/19 and the computer just showed the appointment was rescheduled. -Prior to being seen on 02/25/19, Resident #17 was seen on 12/04/18 by the PCP. Interview with the Resident Care Coordinator (RCC) on 02/26/19 at 4:09pm revealed: -Resident #17 was discharged from the hospital on 01/20/19; she had been seen by the PCP a couple of times since then. -She would have to check the appointment book. -The transportation staff had the appointment schedule book; the transportation staff made all of the appointments. Interview with the transportation staff on 02/27/19 at 11:19am revealed: -Resident #17 scheduled and canceled some of her own appointments and then gave the transportation staff the appointment information. -There were no appointments scheduled with the PCP for Resident #17 in January or February 2019 prior to 02/25/19. -There was no appointment scheduled for Resident #17 with the PCP on 01/21/19 or	{D 273}		

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{D 273}	Continued From page 22 02/13/19. -She got follow up appointment cards whenever she took residents for their appointments. -She wrote the appointment in the book or gave the card to the RCC or Special Care Coordinator (SCC) to write in the book. -For hospital follow up appointments either she, the RCC or SCC scheduled the appointment. Attempted interview with Resident #17's Primary Care Provider on 02/25/19 at 2:07pm was unsuccessful. 2. Review of Resident #7's current FL-2 dated 03/30/18 revealed diagnoses included anxiety, dementia, diabetes mellitus, hypertension, Parkinson's disease and gastro esophageal reflux disease. Review of a 72 hour report for Resident #7 dated 11/11/18 revealed: -The third shift staff documented Resident #7 returned from the emergency room (ER) with no new orders. -Resident #7 had a laceration on the right side of her ear with "skin glue". -The first shift staff documented Resident #7 was not feeling her best and wanted to lay in bed. -There were no further entries on the 72 hour report. Review of a Special Care Unit (SCU) communication log dated 11/11/18 for first shift revealed: -Staff documented Resident #7 was "not feeling too well." -There was no documentation the Primary Care Provider (PCP) was notified of the change in condition.	{D 273}		

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{D 273}	Continued From page 23 Telephone interview with a medication aide (MA) on 02/22/19 at 10:33am revealed: -She had documented the note about Resident #7 on 11/11/18. -Resident #7 was having a lot of problems at that time. -Resident #7 usually got around and did things, but she wasn't her normal self. -Resident #7 was laying around all of the time and was more disoriented, it just seemed like she wasn't herself. -Resident #7 had pain, she was not talking very much and had stopped eating. -She reported her concerns to the Special Care Coordinator (SCC). -The SCC would "deal with things in her own way by saying the resident would be okay or it might be because of medications." -Resident #7 "was going through some things for a couple of weeks, but they just blew it off." -The SCC and Administrator did not want staff just sending residents to the emergency room (ER); staff had to go through the SCC and Administrator first. Review of a primary care provider (PCP) visit note for Resident #7 dated 11/13/18 revealed: -Resident #7 was seen follow up visit for a fall; the resident fell out of her wheelchair on both Saturday and Sunday the previous weekend. -Resident #7 had old blood matted in her hair, had been very quiet, not walking around, not talking and not eating much since the falls. -Staff would "watch her (Resident #7) closely." -The hospital "suggested" and Resident #7 did have multiple small bruises on her arms; staff did not know how the resident "got so many bruises." Review of a PCP "Imaging Order" for Resident #7 dated 11/15/18 revealed:	{D 273}		

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{D 273}	Continued From page 24 -There was an order for an MRI (magnetic resonance image) of the head for an unspecified head injury. -There were orders for an x-ray of the chest and ribs for contusion of breasts. Upon request, on 02/20/19 and 02/21/19, the results of the MRI and chest x-ray ordered on 11/15/18 were not available for review. Review of PCP visit notes for Resident #7 dated 11/13/18 through 11/20/18 revealed there was no visit note dated 11/15/18. Interview with a second MA on 02/21/19 at 11:15am revealed whenever a resident had a change in condition she would let the SCC know and the SCC contacted PCP. Review of SCU communication logs dated 11/12/18 through 11/13/18 revealed: -On 11/12/18 for first shift staff documented Resident #7 complained of pain due to previous falls. -On 11/12/18 for second shift staff documented Resident #7 was agitated more than normal, confused and had to be redirected by staff. -On 11/13/18 for first shift staff documented Resident #7 had "aspiration, congestion behavior." -There was no documentation the PCP had been notified of an episode of aspiration or of the increased congestion. Interview with the second MA on 02/22/19 at 2:29pm revealed: -She had written the notes on the communication log dated 11/12/18 first and second shift and 11/13/18 first shift. -Aspiration behavior as documented in her	{D 273}		

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communication log note on 11/13/18, meant Resident #7 "had phlegm in her throat and could hardly breathe."
-Usually, if she wrote "something like that", the PCP had been at the facility that day or had seen the resident.
-In response to what was done for Resident #7's aspiration behavior she said, "If it was that serious, I'm sure it had already been passed on to the doctor."
-She did not report these symptoms to the PCP herself.

Review of a SCU communication log dated 11/13/18 for second shift revealed:
-Staff documented Resident #7 refused all evening medications and was not responding.
-There was no documentation the physician was notified about Resident #7 refusing the medications and not responding to staff.

Attempted interview on 02/22/19 at 10:08am, with the MA who documented the communication log note dated 11/13/18 2nd shift, was unsuccessful.

Review of SCU communication logs dated 11/14/18 through 11/17/18 revealed:
-On 11/14/18 for second shift staff documented Resident #7 "seemed to be in pain, refused meals, appetite poor and eyes closed."
-There was no documentation Resident #7's complaints of pain, decreased nutritional intake or change in behavior was reported to the physician.
-On 11/15/18 for first shift staff documented Resident #7 complained of pain, congestion and aspiration; Resident #7 needed assistance with total care due to behavior change with congestion, aspiration when swallowing food and drinking and the PCP was aware of the matter.
-On 11/16/18 for third shift staff documented

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Resident #7 complained of hip pain; staff would keep watch on her during the night.
-On 11/17/18 for first shift staff documented Resident #7 was sent to the hospital due to aspiration and Resident #7 was on no fluids or food for 24 hours per (name of PCP) and staff orders.
-On 11/17/18 for second shift staff documented Resident #7 was admitted to the hospital due to acute kidney injury and hypernatremia.

Interview with the second MA on 02/22/19 at 2:29pm revealed:
-She had written the note on the communication log dated 11/14/18 for second shift; the concern had been reported to the SCC and the SCC reported to the PCP.
-She had written the note on the communication log dated 11/15/18 for first shift; staff were expected to alert the PCP and she (the MA) did;" she did not remember what, if any instructions were given by the PCP.
-On 11/17/18 1st shift, that was when Resident #7 was "real bad," she could not remember the specifics of the order to keep the resident without food and water for 24 hours.
-She documented any concerns about residents and reported the concerns to the SCC and PCP.
-No one instructed her to send Resident #7 to the hospital on 11/17/18, but she could not remember why she sent the resident.
-She had been sent to the hospital "so many times then from the falls and for her health."
-In response to hospital records indicating Resident #7 was sent 11/10/18 and 11/17/18, she said, "She (Resident #7) had been seeing the doctor all that week; I kept telling them (SCC and Administrator)."
-Resident #7 had been having a hard time swallowing her medications the last three days

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

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{D 273}	Continued From page 27 (11/15/18, 11/16/18 and 11/18/18). Review of hospital records for Resident #7 dated 10/15/18 through 12/02/18 revealed: -Resident #7 was brought the ER by emergency medical services (EMS) on 11/10/18 for a right ear laceration; the resident had bruises on both hips and a skin tear to her right elbow. -Resident #7 was brought to the ER by EMS on 11/17/18 with altered mental status and report of aspirating on Thursday (11/15/18). -Resident #7 was admitted to the hospital on 11/17/18 with aspiration pneumonia, hypernatremia, acute kidney injury and abnormally elevated troponin levels (which can be an indicator of cardiac injury). Interview with the SCC on 02/22/19 at 02/22/19 at 10:50am revealed she was unable to locate a communication log sheet for 11/16/18. Review of PCP visit notes for Resident #7 dated 11/13/18 through 11/20/18 revealed: -There was no PCP visit documented on 11/15/18. -There was no documentation of PCP assessment and evaluation of Resident #7 for symptoms of aspiration. -There was no documentation Resident #7 experienced episodes of being unresponsive. Review of "Progress Notes" for Resident #7 revealed there were no entries after 11/11/18 and no documentation the PCP was made aware Resident #7 complained of pain and had increased agitation and confusion on 11/12/18; had symptoms of aspiration and was not responding on 11/13/18; evidenced pain, had a poor appetite and her eyes remained closed on 11/14/18; and complained of hip pain on 11/16/18.	{D 273}		

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{D 273}	Continued From page 28 Interview with a third MA on 02/21/19 at 5:35pm revealed: -He was working on 11/16/18 and had documented administering medications to Resident #7. -Resident #7 had been "very sharp," she knew where her room was, had a good appetite and went to the bathroom by herself. -Staff could lay Resident #7's pajamas out and the resident would put them on by herself. -Resident #7 changed over the last week and half to two weeks before she left the facility (11/17/18); he did not know if the fall Resident #7 had on 11/10/19 led to the changes in Resident #7. -Resident #7 was having difficulty swallowing, but he had not noticed any symptoms of aspiration. -If he had observed a resident having trouble swallowing and breathing and the PCP was at the facility, he would get the PCP. -If the PCP was not at the facility, he would send the resident to the hospital. -He had not contacted the PCP in regards to the changes he observed in Resident #7. Interview with a fourth MA on 02/22/19 at 1:25pm revealed: -Resident #7 was not herself the week before she left the facility (11/12/19). -Resident #7 did not verbally respond when staff greeted her the way she normally would. -Resident #7 was not walking and was "hardly eating". -She could "hardly get her (Resident #7) to take her medications; she (Resident #7) would take some, but not all." -She could not remember if Resident #7 was having trouble swallowing. -She "could not say" whether the PCP had been	{D 273}		

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{D 273}	Continued From page 29	{D 273}		

notified of the changes in Resident #7 because she did not normally work on the SCU.
-The MAs who worked in the SCU would let the SCC know and the SCC let the PCP know; unless it was something like a high blood sugar result, then she would contact the PCP herself.
-She had not contacted the PCP about Resident #7.

Interview with the SCC on 02/21/19 at 3:54pm revealed:
-Resident #7 was sent to the emergency room (ER) on 11/17/18 because she was not eating or walking.
-The PCP was the one who told staff to send Resident #7 to the ER for x-rays.
-Staff normally documented in the resident notes section of the resident's record whenever a resident was sent to the ER.

Interview with Resident #7's PCP on 02/20/19 at 4:30pm revealed:
-She was a Nurse Practitioner and saw most of the residents at the facility and visited the facility two days each week.
-She remembered seeing Resident #7 on 11/13/18 after the resident fell the previous weekend.
-Resident #7 had a large bruise on her right hip and a bruise on her left upper arm.
-Resident #7 seemed to decline after the fall over the weekend of 11/10/18.
-She did not know that Resident #7 was experiencing symptoms of aspiration; it had not been reported to her.
-Resident #7 had been sent to the hospital several times; the last time Resident #7 did not come back.
-She believed Resident #7 was sent out that last time for a fall.

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{D 273}	Continued From page 30	{D 273}		

-Staff did not usually report changes in condition, falls or concerns about residents until she arrived at the facility.
-She had always told the staff to call anytime day or night; she did not get many calls from the facility staff.
-The SCC called if it was "really bad".
-She expected staff to contact her immediately so she could "start the ball on what needed to be done".

Second interview with Resident #7's PCP on 02/22/19 at 1:43pm revealed:
-She had seen Resident #7 on 11/13/18 and 11/15/18; no one had reported Resident #7 was aspirating or she would have documented that in her visit note.
-She did not why there was no PCP visit note for 11/15/18.
-She remembered Resident #7 having a large bruise on her hip, but no bruising on her chest.
-She could not recall why she ordered a chest x-ray for breast contusions on 11/15/18 and an MRI for a head injury on 11/15/18.
-She could not remember if Resident #7 had experienced another fall after 11/11/18.
-She had not given an order for Resident #7 not to eat or drink for 24 hours (11/17/18).
-She expected staff to call her immediately if there was a concern; if a resident was a concern for aspiration she expected staff to send the resident immediately to the emergency room (ER) especially if the resident had a cough and a rattle like sound.

Second interview with the SCC on 02/22/19 at 2:50pm revealed:
-Whenever the staff told her of any concerns related to Resident #7 she would call the PCP and ask what to do.

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{D 273}	Continued From page 31 -The PCP would say that she would see Resident #7 when she came to the facility. -The staff did not call her and tell her Resident #7 was not responsive or that the resident had aspiration symptoms so she did not know to report those symptoms to the PCP. -During daytime hours she would call the PCP's office and after 5:00pm she would send a fax. -For something like aspiration, congestion and falls, she would send the resident to the ER and then call the PCP. -If Resident #7 was not responding staff should have called EMS. -She did not routinely review notes made in the communication log; the log was for MA to MA communication. -She normally got an update when she arrived at work at 8:00am or 8:30am from the first shift MA on what was going on from third shift. Interview with the Administrator on 02/21/19 at 10:05am revealed: -The last week (11/12/18) Resident #7 had gotten to be where she was in the bed a lot; Resident #7 was too sore to walk. -Resident #7 then got to the point of being in a wheelchair, then she was mostly in bed and then not responding. -Resident #7 was more confused; staff were used to Resident #7 being active. -Staff were getting Resident #7 up for meals and she was eating. -The PCP was seeing Resident #7 during the last week (11/12/18); whatever was discussed by the PCP was between the PCP and the SCC. -The times that Resident #7 needed to go to the ER, staff sent the resident. -Resident #7 was sent to the ER on 11/17/18 because she was not responding.	{D 273}		

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{D 273}	Continued From page 32 Second interview with the Administrator on 02/22/19 at 4:50pm revealed: -She did not know Resident #7 had symptoms of aspiration on 11/13/18 until 02/21/18. -She expected the MA to have reported the concern for aspiration to the SCC and send Resident #7 to the ER; staff should not have waited until the PCP was at the facility to report concerns. Attempted interview with Resident #7's family member on 02/20/19 at 9:38am and 02/22/19 at 10:19am were unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #7 was not interviewable. Refer to interview with the facility's contracted primary care provider (PCP) on 02/27/19 at 4:48pm. 3. Review of Resident #3's current FL-2 dated 08/21/18 revealed: -Diagnoses included Parkinson's disease, vascular dementia, seizure disorder, seizures, uncontrolled hypertension, cerebral vascular accident with right sided weakness, osteoarthritis, chronic obstructive pulmonary disease, and gout. -Resident #3 was semi-ambulatory and constantly disoriented. Review of Resident #3's progress note dated 09/01/18 with no time documented for entry revealed: -Staff documented Resident #3 was lying in bed and had 3 fresh, reddened, raised bedbug bite marks along her left jawline and one bite mark on the left cheek. -Staff took a flashlight and tape and pulled back a corner of Resident #3's fitted sheet.	{D 273}		

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{D 273}	Continued From page 33 -She found a bedbug in the seam of Resident #3's mattress, removed it with the tape, and killed the bedbug. -Staff documented this was the third time Resident #3 had been bitten by bedbugs or had to move out of her room because of bedbugs found in her room (there was no specification of how this time span took place). -There was no documentation Resident #3's primary care provider (PCP) was notified of Resident #3's bedbug bites. Telephone interview with a previous staff on 02/28/19 at 8:48am revealed: -She wrote the progress notes regarding Resident #3 on 09/01/18. -She caught live bedbugs before 09/01/18 in Resident #3's room. -She had taken these bedbugs taped to a sheet of paper and slipped them under the Administrator's office door and she could not remember when she did this on 09/01/18. -She notified the on-call staff during second shift on 09/01/18 when she found the bedbugs again in Resident #3's room. -She could not remember who the on-call staff was for 09/01/18. -The on-call staff told her to remove Resident #3 from her room, shower Resident #3, and bag up all of Resident #3's clothing. -This was the facility's protocol when bedbugs were found in a resident's room. -She did not notify Resident #3's PCP because that was the responsibility of the on-call staff since it was the weekend. Interview with the Special Care Unit Coordinator on 02/27/19 at 2:45pm revealed: -Resident #3 had some bug bites in August 2018 but they were treated.	{D 273}		

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{D 273}	Continued From page 34 -She was not sure if Resident #3's bedbug bites in September 2018 were reported to Resident #3's PCP. -If Resident #3's PCP was notified of the bedbug, it should have been documented in her record. Review of medication orders for Resident #3 dated 08/10/18 revealed: -There was a medicaton order for triamcinolone acetonide 0.1% topical cream to apply to the affected areas topically twice a day (Triamcinolone acetonide 0.1% topical cream is a topical steroid used to treat skin inflammation caused by allergic reactions, eczema, and psoriasis). -There was a medication order for Keflex 300mg take one capsule twice a day for 7 days (Keflex is a antibiotic used to treat respiratory, ear, urinary, and skin infections). Review of a progress note for Resident #4 dated 08/11/18 revealed: -Resident #4 was seen for complaints of bug bites under her right eye that were resolved. -There was a medication order to discontine triamcinolone cream. Interview with the Resident #4's PCP on 02/22/19 at 2:36pm revealed: -No one reported to her about that Resident #3 had bedbugs from 09/01/18. -She had treated Resident #3's for suspected bedbug bites in August 2018, but she had not treated Resident #3 for bedbugs since then. -She remembered that she had ordered some type of cream and an antibiotic. -She expected the facility to report to her when Resident #3 had the new bite marks so she could look at the areas and treat them if needed.	{D 273}		

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{D 273}	Continued From page 35 Interview with the Administrator on 02/25/19 at 11:15am revealed: -She did not know about Resident #3 being bitten by bedbugs on 09/01/18 because no staff notified her. -She knew Resident #3's room had been treated for bedbugs late last summer but she was not be sure of the date. -If Resident #3 had any bedbug bites on 09/01/18, it should have been the responsibility of the on-call staff to call Resident #3's PCP and the on-call staff should have notify her. -There must have been a breakdown of communication because she did not remember getting any notification that Resident #3 had new bite marks. Interview with the facility's contracted primary care provider (PCP) on 02/27/19 at 4:48pm revealed: -She did not receive fax notifications or calls from staff regarding concerns about residents. -Staff would wait until she came to the facility on her next visit day to the facility which was sometimes days after a fall or an incident. _____ The facility failed to assure the primary care provider (PCP) was notified of changes in condition and acute health care needs for 3 of 15 sampled residents (#3, #7, and #17). The facility's failure resulted in Resident #3 suffering bedbug bites marks to her left cheek and jaw; Resident #7, who had symptoms of aspiration that were not reported to the PCP, being admitted to the hospital for aspiration pneumonia; and Resident #17 having 11 out of 12 systolic blood pressures (SBPs) greater than 160 in January 2019 and February 2019 that were not unreported to the PCP as ordered and no post hospitalization follow-up appointment for more than six weeks.	{D 273}		

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{D 273}	Continued From page 36 The facility's failure to report and follow up on the health care needs of Residents #3, #7, and #17 resulted in serious risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/22/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 30, 2019.	{D 273}		
{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 is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on interviews, observations, and record reviews, the facility failed to assure 3 of 19 sampled residents were free of verbal, and physical abuse as evidenced by one resident (#2) who was assaulted by another resident on the Assisted Living (AL), and two residents (#1, #8) who were handled roughly by staff. The findings are:	{D 338}		

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{D 338}	Continued From page 37 1. Review of Resident #8's FL-2 dated 08/23/18 revealed diagnoses included anemia, orthostatic hypotension, ventricular fibrillation, congestive heart failure, type II diabetes, hypertension, atrial fibrillation and aortic valve stenosis. Review of Resident #8's care plan dated 03/03/18 revealed: -Resident #8 ambulated with a walker and had limited strength in his upper extremities. -Resident #8 required extensive assistance from staff with toileting, bathing and dressing. -Resident #8 was totally dependent on staff for grooming/personal hygiene. Review of an Accident/Incident report for Resident #8 dated 10/22/18 at 6:50am revealed: -Resident #8 had skin tears on his right forearm and thumb. -The areas were cleaned and bandaged. -There was no documentation regarding how the skin tears occurred. Review of Progress Notes for Resident #8 dated 11/19/18 revealed: -Resident #8 was seen by the home health nurse. -Resident #8 received wound care to a skin tear on his arm. Attempted interview with Resident #8 on 02/21/19 at 11:30am was unsuccessful; Resident #8 was no longer a resident of the facility. Interview with Resident #8's family member on 02/21/10 at 11:35am revealed: -Resident #8 often had skin tears because his skin was so tender. -She had not asked Resident #8 how he got the skin tears. -Resident #8 had not complained to her about the	{D 338}		

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{D 338}	Continued From page 38	{D 338}		

staff at the facility.

Interview with Resident #8's home health nurse on 02/22/19 at 2:50pm revealed:
-She provided wound care for Resident #8's skin tears while he was in the facility.
-When she first began taking care of him in November 2018, he told her that he had fallen in the shower and that was how he got the skin tear.
-She had asked the staff on duty that day if they knew about Resident #8's fall or if there was a fall report, and the staff told her no.
-Before she left that day, she asked the Administrator if she was aware of Resident #8's fall and the Administrator said no and there was no fall report done.
-At the end of November (she thought it was on or around 11/19/18), she had asked Resident #8 why he kept getting skin tears.
-Resident #8 then told her there was staff with a really strong accent that worked in the evening that was rough with him while helping him with his shower.
-Resident #8 told her the staff made the residents shower early and go to bed early.
-Resident #8 told her the night he fell in the shower, the staff was very rough with him and rushed him and made him fall and that was when he got the current skin tear.
-The home health nurse told the primary care provider (PCP) what Resident #8 had told her, immediately after she had been informed.
-The PCP said she would report it to the staff.
-The home health nurse never heard anything further and Resident #8 was discharged a few days later.
-The home health nurse thought it was Staff A (medication aide) who was rough with Resident #8, because she fit the description that Resident #8 gave her.

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{D 338}	Continued From page 39 Interview with Resident #8's PCP on 02/26/19 at 2:00pm revealed: -She could not remember being told Resident #8 was injured by a staff. -A couple of months ago, the staff on the special care unit (SCU) were talking about being concerned that a staff had been rehired that was known to have been rough with residents. -She had told the staff to report it to the Special Care Unit Coordinator (SCC). -She recently found out the staff no longer worked at the facility. Interview with the Administrator on 02/22/19 at 4:50pm revealed: -She did not know Resident #8 had a skin tear in November 2018. -She did not remember the home health nurse telling her about Resident #8's fall in the shower. -She did not know Resident #8 fell in the shower. -She did know of any staff being rough with Resident #8 or any other residents in November 2018. -She fired Staff A about 2-3 weeks ago for being rough with a resident. -Staff A had a very strong accent. Interview with a personal care aide (PCA) on 02/26/19 at 3:50pm revealed: -There was one staff recently that had been rough and heavy handling residents. -That staff was a larger person and heared that she was rough with the residents when she bathed them or turned them in bed. -She did not report it to anyone because she had heard someone else had. -That staff was fired. 2. Review of Resident #2's current FL-2 dated 04/17/18 revealed diagnoses included anxiety	{D 338}		

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disorder, dipolar disorder depression, diabetes mellitus (unspecified), hypertension and mental disorder (unspecified).

Interview with Resident #2 on 02/27/19 at 4:05pm revealed:
-On 12/17/18 she was standing at the nurse's station on the back hall waiting for her bedtime medication.
-Several people were in the general location.
-She was struck twice in the back, once in the lower back and once just below her shoulders.
-The resident was hit with enough force to "almost lose her breath."
-She looked around quickly but didn't see who had struck her.
-While she continued to wait for her medication, someone reached under her left arm and twisted her left breast causing her pain.
-At this point she realized it was a male resident (named) who had attacked her.
-The resident told the medication aide (MA) that someone had attacked her and "the MA just blew me off."
-The resident tried several times to report the incident to the Administrator but "she [the Administrator} was always busy."
-The resident reported the incident to the Administrator on 12/18/18 who also "blew her off."
-The resident was upset because the staff did not address her concerns and that she was physically hurt by the incident.
-The resident had spoken with family members about the incident and how she didn't think the staff was concerned.
-After a family member called the facility to question what had been done about the incident, the Administrator called the local police on 12/21/19 to investigate the assault.
-The resident reported what had happened during

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the incident to the police officer who filed a report.
-She refused to go to the hospital for a physical exam because of the length of time after the accident; she did not think any bruising would be evident a week later.
-She did not file charges but wanted the report on file.

Telephone interview with Resident #2's family member on 03/01/19 at 8:00am revealed:
-She understood the resident's medical conditions and she knew the resident could get confused at times.
-The resident had told her that she (resident) was waiting in-line for her medication and was struck from behind by another resident and a few minutes later the same resident twisted or pinched her (the resident's) left breast.
-The family member believed the resident had been assaulted because she had reported it to different family members at different times.
-The family members concern was for the resident's safety and she did not feel the facility had responded appropriately.

Interview with the Administrator on 02/28/19 at 3:20pm revealed:
-She had reported the incident to the local police and Department of Social Services as soon as she was aware of it on 12/21/18.
-The resident had refused to go to the hospital for exam.
-The resident had refused to press charges against the male resident.

3. Review of Resident #1's FL2 dated 10/04/18 revealed a diagnoses of dementia, dehydration, metabolic encephalopathy, hypertension, gastro

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esophageal reflux disease (GERD), severe protein calorie malnutrition and osteoporosis.

Review of Resident #1's Care Plan dated 02/19/18 revealed the resident was totally dependent on staff for all of her Activities of Daily Living (eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, transferring).

Interview with Resident #1's roommate on 01/29/19 at 3:25pm revealed:
-They (residents) were treated badly
-Resident #1 was unable to turn herself over.
-It was bad the way they (staff) turned her and it happened on a regular basis.
-The medication aide (MA) handled Resident #1 "very roughly".
-The roommate wished she could record it.
-Resident #1 had bruises on her arm from the way she was being handled.
-The roommate told Resident #1's family member and the family member spoke with the Administrator but she could not specify when.

Observation of Resident #1 on 01/30/19 revealed a medium sized, purple-colored bruise on Resident #1's on the right forearm.

Interview with Resident #1's family member on 01/30/19 at 9:00am revealed when she saw the bruise on Resident #1's arm last week (01/22/19) and it was very black.

Based on observation, record review, and interview, it was determined Resident #1 was not interviewable.

Telephone interview with Resident #1's family member on 02/27/19 at 4:10pm revealed:

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{D 338}	Continued From page 43 -She had been visiting Resident #1 when she pulled the covers back and found the bruise on the resident's right forearm. -Staff had not reported the bruise to her; she found the bruise and reported it to the head lady in the front office (Administrator). -The Administrator did an investigation and the staff that caused the bruise no longer worked at the facility. -She could not remember when she had found the bruise, it was in January 2019. Interview with a MA on 01/30/19 at 11:50am revealed: -Resident # 1 had a bruises and no one seemed to know how the resident got the bruise. -Resident #1 was totally bed bound and had not fallen. -A 3rd shift personal care aide (PCA) told the MA and the MA said no one knew how Resident #1 got the bruise. -Resident #1 was not sent to the hospital, but the communication log located at the nurses' station had documentation of the bruise. Interview with the Administrator at 12:25 p.m. on 1/30/19 revealed: -She always investigated when a staff was accused of abusing or neglecting any resident and a verbal warning was given to the staff person. -She interviewed residents and staff whenever a staff was accused of abuse or neglect. -A staff's "tone could be misconstrued and a resident could accuse staff of yelling or talking ugly to the resident". -She wrote up staff on their first incident and staff were terminated for their second time. -Staff who do not get along "play the blame game," meaning staff who do not get along with	{D 338}		

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{D 338}	Continued From page 44 other staff blame other staff for anything that may happen to residents._____ _ The facility failed to assure three residents (#1, #2 and #8) were protected from physical abuse. This failure resulted in Resident #8 and Resident #1, sustaining bruises and skin tears from being handled roughly by staff and Resident #2 being assaulted by another resident which was detrimental to the safety and welfare of these residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/28/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 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 A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated.	{D 358}		

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{D 358}	Continued From page 45 Based on observations, interviews and record reviews, the facility failed to assure 4 of 16 residents (#1, #10, #15 and #17) observed during the medication pass received their medication as ordered by the primary care provider (PCP) including errors with an antacid (#1), antidepressant (#10), an antibiotic eye ointment (#15), and an antihypertensive (#17); and for 2 of 7 residents sampled for record review (#15 and #17) including missed doses of an antibiotic eye ointment (#15), and missed doses of an as needed (PRN) antihypertensive for SBP greater than 160 for (#17). The findings are: with 4 errors out of 25 observations for an error rate of 16%. The medication error rate was 16% as evidenced by the observation of 4 errors out of 25 opportunities during the 6:00am medication pass on 02/19/19, the 12:00pm medication pass on 02/21/19, and the 8:00am medication pass on 02/26/19. 1. Review of Resident #17's current FL-2 dated 03/01/18 revealed diagnoses included end stage renal disease, hypertension, osteoarthritis, gastro esophageal reflux disease and aortic aneurysm. a. Review of Resident #17's current FL-2 dated 03/01/18 revealed there was an order for clonidine 0.2mg three times daily. (Clonidine is used to treat high blood pressure.) Review of physician's orders for Resident #17 dated 10/25/18 revealed an order for clonidine 0.3mg four times daily.	{D 358}		

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{D 358}	Continued From page 46 Review of physician's orders for Resident #17 dated 12/04/18 revealed an order for clonidine 0.2mg four times daily. Observation of the morning medication pass on 02/19/18 at 6:00am revealed: -The medication aide (MA) entered Resident #17's room to administer a 6:00am medication. -Resident #17 looked in the medication cup and asked where her clonidine was. -The MA told Resident #17 the clonidine was discontinued. Review of physician's orders and Provider Order Request/Clarification/Concern notification forms for Resident #17 dated 12/04/18 through 02/19/19 revealed there was no order to discontinue clonidine for Resident #17. Review of Resident #17's February 2019 electronic medication administration record (eMAR) revealed: -There was an entry for clonidine 0.3mg four times daily which was discontinued on 02/18/19 at 9:45am. -There was an entry for clonidine 0.2mg three times daily and the first dose was documented as administered on 02/21/19 at 8:00am. -There was an entry for clonidine 0.2mg four times daily; one dose was documented as administered on 02/20/19 at 12:00pm. -There was documentation the order was discontinued on 02/20/19 at 2:22pm. -Clonidine 0.3mg was documented as administered once on 02/18/19 at 6:00am and there were no further doses of clonidine administered on 02/18/19 resulting in 3 missed doses. -There were no doses of clonidine documented	{D 358}		

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{D 358}	Continued From page 47 as administered on 02/19/19 resulting in 3 missed doses. -Clonidine 0.2mg was documented as administered once on 02/20/19 at 12:00pm and there were no further doses of clonidine administered on 02/20/19 resulting in 2 missed doses. Interview with the Special Care Coordinator (SCC) on 02/27/18 at 3:00pm revealed: -She was responsible for checking to make sure PCP orders were entered correctly by the pharmacy. -Before the new Resident Care Coordinator (RCC) came to the facility in December 2018, the MAs would just approve the orders entered by the pharmacy on the eMAR without checking the entry against the primary care provider (PCP) order. -When a medication was discontinued, the order was faxed to the pharmacy and the pharmacy entered the discontinue order on the eMAR. -She or the RCC had to approve the order on the eMAR before the medication was discontinued on the eMAR. -If an order to discontinue a medication remained pending for approval on the eMAR then the medication remained on the eMAR unchanged. -PCP orders had to be sent to the pharmacy before 5:00pm or the pharmacy did not enter the order until the next day. Interview with a MA on 02/19/19 at 7:49am revealed: -The order to discontinue Resident #17's clonidine was on the eMAR. -The RCC was waiting for the pharmacy to open to get a copy of the order to discontinue the clonidine for Resident #17.	{D 358}		

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{D 358}	Continued From page 48 Interview with the RCC on 02/21/19 at 9:27am revealed: -She did not find an order to discontinue Resident #17's clonidine; she got a clarification order on 02/19/19. -The order for Resident #17's clonidine should not have been discontinued and taken off the eMAR by the pharmacy. -The pharmacy staff may have been in the process of discontinuing one order and entering another order for Resident #17's clonidine. -When a primary care provider (PCP) wrote an order, she faxed the order to the pharmacy and waited until the pharmacy entered the order on the eMAR. -There had been some issues with pharmacy entering the orders correctly on eMARs, so once the order was correct on the eMAR she approved the order. -Once the order was correct on the eMAR, the medication was in the facility and everything was complete, she put her initials and the date on the corner of the order page. -The RCC, the SCC or sometimes a MA if the RCC or SCC was not there, approved orders once they were entered correctly. -She had recently started taking care of the orders; before she started (12/12/18) it was "just whoever" that took care of the orders. Review of a Provider Order Request/Clarification/Concern notification form for Resident #17 dated 01/07/19 revealed: -There was an unsigned notation, "Please write new/correct clonidine order?" -There was a notation signed by the PCP and dated 02/04/19 which read, "What clonidine order do they have now?" Review of a Provider Order	{D 358}		

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Request/Clarification/Concern notification form for Resident #17 dated 02/05/19 revealed:
-The RCC documented Resident #17's current clonidine order was 0.3mg four times daily.
-The PCP documented an order for clonidine 0.2mg three times daily; signed and dated for 02/19/19.

Interview with the RCC on 02/22/19 at 11:30am revealed:
-The pharmacy had taken the order for Resident #17's clonidine off of the eMAR.
-She was waiting for a clarification from Resident #17's PCP because the resident had requested a dosage change.
-Resident #17 missed 3 doses on 02/18/19 and on 02/19/18 and 2 doses on 02/20/19 while the order was being clarified.
-There was another order from a hospital discharge which the pharmacy took off the eMAR so there were not two orders for clonidine.
-The orders for Resident #17's clonidine were all mixed up between the hospital order and the resident calling the PCP to change the dose.
-She was unable to find the order from the hospital discharge.

Review of orders from the facility's contracted pharmacy for Resident #17 revealed:
-There was a hospital medication list of continued medications dated 12/17/18 which listed clonidine 0.3mg four times daily; there was no licensed prescriber's signature or electronic signature.
-There was a physician's visit form dated 01/17/19 with a medication list which included clonidine 0.2mg four times daily; there was no licensed prescriber's signature or electronic signature.
-There was a copy of the Provider Order Request/Clarification/Concern notification dated

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02/05/19 and signed by the PCP on 02/19/19 with an order for clonidine 0.2mg three times daily.

Interview with Resident #17 on 02/22/19 at 11:35am revealed:
-Her blood pressure (BP) had been high morning, noon and night.
-"It (BP) finally came down yesterday (02/21/19) because they (staff) finally got my medicine right."
-Her BP had started going up when her clonidine was changed to 0.2mg three times daily.
-At hemodialysis over the last week, her BP had been 194/87, 196/92 and 198/88.
-The staff were giving her clonidine at 5:00am, then it was changed to 8:00am.
-It was better at 6:00am because her BP went up in the morning before she got out of the bed.
-Her BP "did not run like most peoples by going down overnight;" by 8:00am her systolic BP would be 196.
-She could feel when her BP was high; it made her get headaches and feel dizzy.

Observation on 02/22/19 at 11:35am revealed:
-The MA checked Resident #17's BP using a digital BP cuff on the resident's wrist.
-Resident #17's BP was 168/96 and her heart rate was 83.

Observation of medications on hand for Resident #17 on 02/22/19 at 11:50am revealed:
-There was a prescription bottle with a pharmacy label from a local pharmacy.
-The pharmacy label had Resident #17's name, instructions for clonidine 0.2mg three times daily and a notation that 42 tablets were dispensed on 02/22/19.

Telephone interview with the Hemodialysis Clinical Coordinator on 02/26/19 at 11:38am

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revealed:
-Resident #17 received hemodialysis treatments every Monday, Wednesday and Friday at 12:00pm.
-Scheduled medications were administered at the facility prior to Hemodialysis.
-Most of the time Resident #17's BP was within range; if the resident's BP was elevated at Hemodialysis, they gave the resident medication for her BP.
-On Wednesday 02/20/19 at 12:25pm, Resident #17's BP was 177/79.
-On Friday 02/22/19 at 12:40pm, Resident #17's BP was 194/78.
-On Monday 02/25/19 at 12:26pm, Resident #17's BP was 179/74.
-Resident #17 got anxious about her BP and when she did her BP would go up.

Interview with the RCC on 02/22/19 at 11:45am revealed:
-The problem with Resident #17's clonidine orders was Resident #17 contacted her PCP and requested her clonidine be changed and then the facility staff did not have the orders for any changes communicated to the resident.
-She had spoken with Resident #17's PCP's Nurse several times since December 2018, about sending all orders to the facility.

Telephone interview with Resident #17's PCP's Nurse on 02/25/19 at 2:07pm revealed:
-Resident #17 called the PCP office requesting changes to her BP medications on 02/22/19.
-Resident #17 was taking clonidine 0.3mg four times daily; the resident requested a decreased dose because 0.3mg four times a day was too much.
-Resident #17 was in the hospital for her BP and the hospital decreased the clonidine to 0.2mg

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 52 TID. -The PCP's office tried to get Resident #17 to have the facility staff to contact the PCP's office. -If the PCP wrote a prescription order, she faxed the order to the pharmacy and the RCC. -Last week (02/19/19) the PCP changed clonidine from 0.3mg four times daily to 0.2mg TID; the clonidine was not discontinued. -Clonidine was a medication the PCP wanted Resident #17 to take to manage the resident's BP. -Resident #17's BP was a concern; the PCP would be concerned Resident #17 missed seven doses of clonidine from 02/18/19 through 02/20/19. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 02/26/19 at 2:55pm revealed: -The original order for clonidine for Resident #17 was dated 12/17/18 for 0.3mg four times daily. -On 02/18/19 the clonidine order for Resident #17 was changed to 0.2mg four times daily following a hospital readmission. -On 02/19/19 the clonidine order for Resident #17 was clarified to 0.2mg three times daily. -The order was clarified twice and the start date automatically went to 02/20/19. -The facility staff had to approve orders to discontinue a medication on the eMAR after pharmacy entered the discontinue order. Interview with the Resident Care Coordinator (RCC) on 02/26/19 at 4:09pm revealed: -The medication list dated 01/17/19 came from an eye doctor visit for Resident #17. -Resident #17 was discharged from the hospital on 01/31/19. -The PCP's requested clarification on Resident #17's clonidine dose on 02/04/19.	{D 358}		

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{D 358}	Continued From page 53 -She responded to the PCP on 02/05/19 by fax that Resident #17's current clonidine order was 0.3mg four times daily. -The PCP did not replied on 02/19/19 with a new order for clonidine 0.2mg three times daily. Attempted interview with Resident #17's Primary Care Provider on 02/25/19 at 2:07pm was unsuccessful. b. Review of Resident #17's current FL-2 dated 03/01/18 revealed there was an order for amlodipine 5mg daily as needed (PRN) for systolic blood pressure (SBP) greater than 170. Review of Physician's Orders for Resident #17 dated 10/25/18 revealed an order for amlodipine 5mg daily PRN for SBP greater than 160. Interview with Resident #17 on 02/21/19 at 4:00pm revealed: -She asked a medication aide (MA) to give her the PRN blood pressure medication and the MA would not give it to her (when her clonidine order was changed). -She was feeling dizzy and could not get up; around 6:30am she asked the MA to give the PRN blood pressure medication. -The MA told her she was not going back and forth with her, sat down at the desk and looked at her phone. -She told the MA she was going to stay at the desk until the MA gave her something for her blood pressure. -The MA did not know anything about the PRN order; the MA had not checked her chart to see that she could have amlodipine 5mg PRN. -The MA had the personal care aide check her blood pressure and it was high. -The MA told her she could not give her anything	{D 358}		

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because it was too close to 8:00am.
-She told the MA if she did not get her blood pressure medications, she was going to call the police.
-She finally received her clonidine.
-This past Monday at hemodialysis, her blood pressure was 198/92.

Review of vital signs report dated 01/01/18 through 01/31/19 for Resident #17 revealed:
-There were 29 BP results documented with seven SBP documented greater than 160.
-On 01/11/19 at 9:11am, the BP was documented as 172/82.
-On 01/12/19 at 8:59am, the BP was documented as 173/75.
-On 01/20/19 at 8:33am, the BP was documented as 164/78.
-On 01/23/19 at 8:24am, the BP was documented as 169/81.
-On 01/24/19 at 9:04am, the BP was documented as 171/71.
-On 01/29/19 at 8:09am, the BP was documented as 167/72.
-On 01/31/19 at 8:33am, the BP was documented as 171/71.

Review of Resident #17's January 2019 electronic medication administration record (eMAR) revealed there was an entry for amlodipine 5mg daily PRN for SBP greater than 160 and there were no doses documented as administered.

Review of Resident #17's February 2019 electronic treatment administration record (eTAR) revealed:
-There were 21 BP results documented with three SBP documented greater than 160.
-On 02/02/19, the BP was documented as

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167/74.
-On 02/07/19, the BP was documented as 169/86.
-On 02/18/19, the BP was documented as 175/77.
-There was no BP result documented for 02/20/19.

Review of Resident #17's February 2019 eMAR revealed:
-There was an entry for amlodipine 5mg daily PRN for SBP greater than 160.
-There was documentation amlodipine 5mg daily PRN was administered on 02/20/19 at 6:40am for SBP of 199.

Interview with a MA on 02/26/19 at 11:19am revealed:
-She had documented Resident #17 BP of 169/86 on 02/07/19.
-If the medication was a PRN medication, she did not give it unless the resident asked for it.

Interview with a second MA on 02/26/19 at 11:46am revealed:
-Resident #17 had a scheduled and PRN dose of amlodipine; she initialed on the eMAR whenever she administered a dose.
-If she administered a PRN dose she would enter a comment the amlodipine was given for the resident's BP and she would enter the BP.
-Resident #17 should have gotten a dose of amlodipine on 02/02/19 because the resident's SBP was over 160.
-She notified Resident #17's PCP, but the PCP was hard to get in touch with.
-She documented calling Resident #17's PCP in her own notes.
-She kept a notebook, but she did not have it with her.

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{D 358}	Continued From page 56 Interview with a third MA on 02/27/19 at 11:32am revealed: -On 01/12/19, Resident #17's BP was 173/75; she gave a PRN medication and forgot to document the PRN was given. -She was sure she gave Resident #17 the PRN medication because the resident would not let MAs forget to give it; the resident would come to the desk to get the PRN medication. Interview with Resident #17's PCP's Nurse on 02/25/19 at 2:07pm revealed: -Resident #17 was on scheduled and as needed (PRN) amlodipine. -Resident #17 was ordered to receive amlodipine PRN for a systolic blood pressure (SBP) greater than 160. -Resident #17's BP was a concern. -Resident #17's BP tended to "run high" then the resident would get worked up because her BP was high which made her BP even higher. Interview with Resident #17 on 02/26/19 at 11:53am revealed: -The staff did not check her BP unless she asked them to. -If her SBP was over 162, the staff was supposed to give her a PRN (as needed medication), but the staff did not know if it was over 162 because they did not check it. -She had not asked the staff to check her BP. -She just took her scheduled BP medication, laid down because she "felt so sick and hoped it went down." Interview with the Resident Care Coordinator (RCC) on 02/26/19 at 4:09pm revealed: -The BP may be different on the eMAR and the eTAR because the MA may have rechecked the	{D 358}		

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BP.
-Even if the BP had been rechecked the original BP should have been documented and the recheck documented in the notes section on the eMAR.
-A resident did not have to ask for PRN blood pressure medication when there were written parameters.
-Resident #17's amlodipine PRN order was clear to give if the SBP was greater than 160 without the resident having to ask for the medication.

Attempted interview with Resident #17's Primary Care Provider on 02/25/19 at 2:07pm was unsuccessful.

Refer to interview with the Administrator on 02/22/19 at 4:50pm.

2. Review of Resident #15's current FL-2 dated 01/22/19 revealed:
-Diagnoses included Alzheimer's dementia.
-Medication orders included erythromycin ointment 1 centimeter (cm) to the left lower eye lid four times daily. (Erythromycin is an antibiotic used to treat infection.)

Review of a Provider Order Request/Clarification/Concern notification form for Resident #15 dated 01/17/19 revealed there was a primary care provider (PCP) order for erythromycin ointment 1 cm to the right lower eye lid with meals and at bedtime until there was no redness in the left lower eye lid.

a. Observation of the noon medication pass on 02/21/18 at 11:45am revealed the medication aide (MA) administered erythromycin ointment on the right lower eye lid of Resident #15.

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{D 358}	Continued From page 58 Review of Resident #15's February electronic treatment administration record (eTAR) revealed there was an entry for erythromycin ointment 1cm to right lower eye lid four times daily and documented as administered at 8:00am, 12:00pm, 6:00pm and 8:00pm 02/01/19 at 8:00am through 02/21/19 at 12:00pm. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 02/26/19 at 2:55pm revealed: -The pharmacy received the order for Resident #15's erythromycin ointment on 01/18/19; the order would have been added to the resident's eTAR the same day. -The only order the pharmacy had for erythromycin ointment for Resident #15 was dated 01/17/19 for the right lower eye lid four times daily. Interview with Resident #15's PCP on 02/22/19 at 1:43pm revealed: -The erythromycin ointment was ordered to treat an infection on Resident #15's left lower lid. -The staff could not have missed that the ointment was for her left eye because the resident's left eye was big, red and puffy. -If staff were administering the erythromycin ointment in the wrong eye, the infection could "linger". Interview with the Special Care Coordinator (SCC) on 02/22/19 at 2:50pm revealed: -She had just gotten a copy of the original order for the erythromycin ointment for Resident #7. -The PCP sent a lot of orders directly to the pharmacy that the facility did not have. -She did not approve some orders because she did not have a copy of the order. -She would have to call the pharmacy and get a	{D 358}		

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copy of the order before she could approve it.
-When the FL-2 was updated, it was not reviewed by anyone to assure the orders were accurate on the eTAR.
-The only time the FL-2 and eTAR were reviewed was when a resident returned from a hospital admission.
-She was in the process of reviewing all of the charts on the Special Care Unit (SCU) to assure all of the orders were accurate on the eTAR.

b. Interview with Resident #15's primary care provider (PCP) on 02/22/19 at 1:43pm revealed:
-The erythromycin ointment was ordered to treat an infection on Resident #15's left lower lid.
-She had originally wrote the order in January 2019, but the staff had not been administering the ointment; it had been weeks before she found out the medication was not being given.
-She found out on a follow up visit with Resident #15.
-Seeing no improvement, she asked the medication aide (MA) if the erythromycin ointment was being given; the MA said the ointment had not been given.
-She wrote a second order for erythromycin ointment for Resident #15's left eye.

Review of Resident #15's January 2019 electronic treatment administration record (eTAR) revealed:
-There was an entry for erythromycin ointment 1cm to right lower eye lid four times daily scheduled at 8:00am, 12:00pm, 6:00pm and 8:00pm.
-There was documentation that the 12:00pm, 6:00pm and 8:00pm doses on 01/19/19, the 6:00pm dose on 01/20/19, the 6:00am and 12:00pm doses on 01/21/19 and the 6:00am and 12:00pm doses on 01/23/19 were not

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administered.
-There was documentation the doses were not administered due to, "meds from another pharmacy, in route, awaiting, awaiting pharmacy, awaiting order and new order in route."
-All other scheduled doses between 01/19/19 at 6:00am and 01/23/19 at 8:00pm were documented as administered.

Interview with a MA on 02/26/19 at 10:47am revealed:
-She had documented the erythromycin ointment was not available for Resident #15 on 01/19/19, 01/21/19 and 01/23/19 on the eTAR.
-Resident #15 got her medications filled at a different pharmacy from the facility's contracted pharmacy and staff were waiting for the erythromycin ointment to be delivered to the facility.
-She did not know how other staff documented administering the medication unless the ointment was borrowed from another resident.

Telephone interview with a second MA on 02/27/19 at 9:46pm revealed she had documented administering Resident #15's erythromycin ointment on 01/19/19, 01/20/19, 01/22/19 and 01/23/19; the ointment was on the medication cart and had been administered.

Interview with the Special Care Coordinator (SCC) on 02/26/19 at 11:00am revealed:
-Resident #15's erythromycin ointment was delivered on 01/19/19.
-The pharmacy label on the package indicated when the ointment arrived in the facility.
-Resident #15's pharmacy delivered the medication and facility staff signed for the medication.
-She was not sure why some staff documented

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administering the erythromycin ointment between 01/19/19 and 01/23/19, and other staff documented the medication was not available.

Observation of medications on hand for Resident #15 on 02/26/19 at 11:03am revealed:
-There was a prescription box with a label from a local pharmacy.
-The pharmacy label had Resident #15's name, instructions for erythromycin ointment and indicated it had been dispensed on 01/19/19.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 02/26/19 at 2:55pm revealed:
-The pharmacy received the order for Resident #15's erythromycin ointment on 01/18/19; the order would have been added to the resident's eTAR the same day.
-The only order the pharmacy had for erythromycin ointment for Resident #15 was dated 01/17/19 for the right lower eye lid four times daily.

Based on observations, interviews and record reviews, it was determined Resident #15 was not interviewable.

Refer to interview with the Administrator on 02/22/19 at 4:50pm.

3. Review of Resident #10's current FL-2 dated 07/16/18 revealed:
-Diagnoses included dysphagia oropharyngeal phase, chronic obstructive pulmonary disease, essential hypertension, muscle weakness, hyperlipidemia and cerebral hemorrhage.
-Medication orders included Wellbutrin XL 150mg daily. (Wellbutrin in used to treat depression and XL indicates extended release.)

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{D 358}	Continued From page 62 Observation of the morning medication pass on 02/26/18 at 8:59am revealed: -The medication aide (MA) removed a Wellbutrin XL 150mg tablet from a bubble pack with a pharmacy label with Resident #10's name and instruction written, "DO NOT CRUSH". -The MA placed the tablet in a plastic sleeve with a second tablet and the contents of a capsule, placed the plastic sleeve in the pill crusher on the medication cart and crushed the medications together. -The MA mixed the crushed medications including the Wellbutrin XL with pudding in a medication cup. -The MA administered the pudding with the crushed medications to Resident #10. Interview with the MA on 02/26/18 at 8:59am revealed: -Resident #10 had an order to crush all of her medications; the resident was not able to take her medications whole. -Tablets were crushed and capsules were pulled apart. -There should have been an order to crush all medications in Resident #10's record. Review of a Provider Order Request/Clarification/Concern notification for Resident #10 dated 02/21/19 revealed an order to crush medications. Review of Resident #10's February 2019 electronic medication administration record (eMAR) revealed there was an entry for Wellbutrin XL 150mg daily with a notation, "DO NOT CRUSH". Second interview with the MA on 02/26/19 at	{D 358}		

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{D 358}	Continued From page 63 11:19am revealed: -She had not come across the situation of a do not crush order with an extended release capsule. -Most of the time the medication package and the eMAR says DO NOT CRUSH". -Resident #10's Wellbutrin was a capsule that did not need to be crushed so the medicine was fine by opening the capsule and pouring the contents out. -She thought the Wellbutrin was the capsule she administered and not a tablet. -Resident #10 "had an order to crush her medications, so we crush her meds." Telephone interview with the Pharmacist from the facility's contracted pharmacy on 02/26/19 at 2:55pm revealed: -Extended release tablets could not be crushed. -The clinical response was not conducive to a therapeutic effect. Interview with Resident #10's primary care provider (PCP) on 02/26/19 at 2:42pm revealed: -The staff had told her on 02/26/19, Resident #10's Wellbutrin XL had been crushed for administration. -Wellbutrin XL was an extended release tablet and by crushing the tablet, the resident probably got all of the medication at once instead of the smooth delayed effect intended. Interview with the Administrator on 02/26/19 at 10:55am revealed: -There was no list of medications not to crush available on medication carts for the MAs. -MAs knew not to crush medications because the pharmacy labeled the packaging and the eMAR "do not crush". -If a resident had difficulty swallowing a	{D 358}		

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medication that could not be crushed, staff were expected not to crush the medication, notify the PCP and get a new order.

Refer to interview with the Administrator on 02/22/19 at 4:50pm.

4. Review of Resident #1's current FL-2 dated 10/04/18 revealed:
-Diagnoses included dementia, dehydration, metabolic encephalopathy, hypertension, gastroesophageal reflux disease, severe protein calorie malnutrition and osteoporosis.
-Medication orders included rantidine 150mg daily. (Rantidine is used to treat gastroesophageal reflux disease.)

Observation of the morning medication pass on 02/19/18 at 5:27am revealed:
-The Special Care Coordinator (SCC) removed a rantidine tablet from an over the counter bottle for Resident #1.
-The SCC placed the tablet in a plastic sleeve, placed the plastic sleeve in the pill crusher on the medication cart and crushed the rantidine tablet.
-The SCC mixed the crushed rantidine with pudding in a medication cup and administered the pudding to Resident #1.

Interview with the SCC on 02/19/19 at 5:27am revealed:
-Resident #1 got all of her medications crushed.
-She was unable to locate the order to crush medications on the electronic medication administration record (eMAR).
-There was no list of crushable medications on the medication cart.

Review of Resident #1's February 2019 eMAR revealed:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 65 -There was an entry for rantidine 150mg daily at 6:00am and there was documentation it had been administered 02/01/19 through 02/19/19. -There was no order to crush medications. Review of Provider Order Request/Clarification/Concern notification forms and physician orders for Resident #1 dated 10/01/19 through 02/19/19 revealed there was no order to crush medications. Interview with a medication aide (MA) on 02/19/19 at 7:42am revealed: -She crushed all of Resident #1's prior to administering. -She had seen the order on the medication cart to crush Resident #1's medications. -The other MAs were looking for the order. Interview with the Special Care Coordinator (SCC) on 02/19/19 at 7:42am revealed: -There was a primary care provider (PCP) order to crush Resident #1's medications. -There was a copy of the order on the medication cart for the 100 hall. -The pharmacy labeled the bubble packs when a medication could not be crushed. -Staff would not know if a medication in an over the counter bottle could be crushed. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 02/26/19 at 2:55pm revealed: -It did not affect the drug availability to crush rantidine. -Rantidine has a bitter taste and that was why it was not recommended to be crushed. Interview with Resident #1's PCP on 02/22/19 at 1:43pm revealed:	{D 358}		

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{D 358}	Continued From page 66 -Rantidine was prescribed to help Resident #1's stomach with acid reflux symptoms. -Crushing the rantidine would probably not be harmful. -The pharmacy would know more about the effect of crushing medications. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to interview with the Administrator on 02/22/19 at 4:50pm. _____ Interview with the Administrator on 02/22/19 at 4:50pm revealed: -The facility had been through three Resident Care Coordinators (RCCs) since August 2018. -One of the RCCs was at the facility for approximately two weeks, a second for approximately one month and a third was borrowed from another facility for one month. -The Special Care Coordinator (SCC) helped, and there were two medication aides that helped. -The facility hired a new RCC in December 2018 and was in the process of improving systems with primary care provider (PCP) orders. -The Pharmacist would be at the facility on 02/25/19 to review medication processes. _____ The facility failed to assure 4 residents (#1, #10, #15 and #17) observed during various medication passes and 2 of 7 sampled residents (#15 and #17) received their medication as ordered by the primary care provider (PCP). The facility's failure to administer medications as ordered by the PCP resulted in Resident #17, who had a history of hypertension and end stage renal disease and was receiving hemodialysis, missing 7 doses of an antihypertensive medication (clonidine) and	{D 358}		

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{D 358}	Continued From page 67 missing 9 of an as needed (PRN) antihypertensive medication (amlodipine) for SBP greater than 160; Resident #5 having an antibiotic eye ointment administered in her right eye when the order was for the left eye and missing 8 doses of the erythromycin eye ointment upon order by the PCP placing the resident at risk for a prolonged infection of the eye. This failure resulted in neglect and substantial risk of harm which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/22/19 for this violation.	{D 358}		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to report bruises of unknown origin to the Health Care Personnel Registry (HCPR) within 24 hours, conduct an investigation of the injuries and submit a 5 day report to the HCPR for 2 of 4 sampled residents (#1 and #11) with documented injuries of possible physical abuse by staff. The findings are:	D 438		

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Interview with the facility's primary care provider (PCP) on 02/22/19 at 1:43pm revealed:
-Around November 2018, there had been concerns about a resident having bruises and a staff rough handling residents.
-The staff who was rough handling residents was someone who had worked at the facility before, left and then came back.
-The staff did not want to tell the PCP the name of the staff.
-She told the staff to report the staff who was rough handling residents to the Special Care Coordinator (SCC).

1. Review of Resident #11's FL2 dated 10/02/18 revealed diagnoses included dementia, depression, hypothyroidism, arthritis, abnormal gait, bipolar disorder and acute kidney failure.

Review of Resident #11's Care Plan dated 10/02/18 revealed:
-Resident #11 used a wheelchair for ambulation and had limited strength to her upper extremities due to muscle weakness.
-Resident #11 required extensive assistance from staff with bathing and ambulation.
-Resident #11 was totally dependent upon staff for toileting, bathing, dressing, grooming, and transferring.
-Resident #11 was incontinent of bowel and bladder.
-Resident #11 was sometimes disoriented, forgetful and needed reminders.

Review of a care note dated 12/15/18 for Resident #11's revealed:
-A personal care aide (PCA) notified the medication aide (MA) of bruising on Resident #11's right thigh.
-The MA notified the doctor by voice message of

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the bruising to Resident #11's right thigh.

Review of documentation on the facility communication log dated 01/17/19 revealed:
-Resident #11 had bruising on the outer right hip area and inner left thigh area.
-Resident #11 was unable to say what happened.
-The MA did not see any fall reports for Resident #11.
-A PCA noticed it as she was getting Resident #11 dressed on 01/17/19 at 5:35am and reported the bruising to the MA.

Review of a facility accident/incident report for Resident #11 dated 01/17/19 revealed:
-Staff noted bruising to Resident #11's lower body at 5:30am.
-Bruising was noted on Resident #11's lower right hip and left inner thigh.
-Staff saw Resident #11's bruises when she was changing the resident.
-Resident #11 was not able to say how she got the bruises.

Review of documentation on the facility communication log dated 01/22/19 revealed a PCA reported an "anonymous bruise on Resident #11's left of forehead (small knot) at 5:30am."

Observation on 01/30/19 at 10:51am revealed:
-Resident #11 had two pea sized purplish bruises coupled on her forehead.
-Resident #11 had a dime sized purple bruise on her right upper leg.
-Resident #11 had a boomerang shaped dark purple bruise approximately one inch in length on her left inner thigh.

Interview with the Administrator on 01/30/19 at 10:51 revealed:

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-She knew Resident #11 had some bruises.
-She had not seen the bruise on the Resident #11's left inner thigh.

Interview with a MA on 01/30/19 at 11:50am revealed:
-She had written the communication log note dated 01/22/19.
-Resident #11 had bruises no one seemed to know how the resident got the bruises.
-Resident #11 had not had a recent fall when the bruises showed up.
-Resident #11 had bruises on her thigh and on the left side of her forehead.
-A 3rd shift PCA told the MA and said no one knew how Resident #11 got the bruises.
-Resident #11 was not sent to the hospital, but the communication log (01/17/19) located at the nurses' station had documentation on the bruise.

Interview with the Administrator on 01/30/19 at 12:25pm revealed:
-She did not know there was documentation on the communication log note dated 01/17/19 of Resident #11 having bruises of unknown origin.
-She was informed by the Department of Social Services (DSS) worker on 01/29/19 that Resident #11 had the bruises.

Review of a facility 24-Hour Report dated 01/22/19 revealed:
-A second shift staff person reported that Resident #11 had a bruise on her left upper arm
-The third shift staff person reported that Resident #11 has a knot on the left side of her head.

Review of a facility accident/incident report for Resident #11 dated 01/30/19 revealed:
-Resident #11 had bruising of unknown origin on

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her inner and outer right thigh and behind her right knee.
-The Administrator reported the bruising to DSS and investigated Resident #11's bruising by questioning pertinet staff.

Based on observations, interviews and record reviews, it was determined Resident #11 was not interviewable.

A 24-Hour Health Care Personnel Registry Report for Resident #11 was not available for review upon request on 02/28/19.

Interview with Administrator 02/28/19 at 5:00pm revealed:
-She was informed by the DSS worker on 01/29/19 about the communication log dated 01/17/19 and 01/22/19 that documented bruises of unknown origin for Resident #11.
-She took disciplinary action against an employee once she saw the bruises on Resident #11 after DSS inquired on it.

Refer to interview with the Administer on 01/30/19 at 12:25pm.

2. Review of Resident #1's FL2 dated 10/4/18 revealed diagnoses included dementia, dehydration, metabolic encephalopathy, hypertension, gastro esophageal reflux disease (GERD), severe protein calorie malnutrition and osteoporosis.

Review of Resident #1's Care plan dated 02/19/18 revealed that she is totally dependent for all of her activities of daily living (ADLs) including eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring.

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D 438	Continued From page 72 Interview with Resident #1's roommate on 01/29/19 at 3:25pm revealed: -Resident #1 had bruises on her arm from the way she was being rough handled by a staff (Staff A). -The roommate told Resident #1's family member and the family member spoke with the Administrator. -The Administrator came and looked at the bruise on Resident #1's right arm and said that she wanted Resident #1 to be a 2-person assist. Interview with Resident #1's family member on 01/30/19 at 9:00am revealed: -When she saw the bruise on Resident #1's arm last week (01/23/19) it was very black. -The family member had seen Resident #1 being assisted by one staff person on more than one occassion. -Resident #1 was supposed to have two staff assisting because the resident was immobile. -The family member had helped tuen Resident #1 when she saw only one staff person come into the resident's room. Second telephone interview with Resident #1's family member on 02/27/19 at 4:10pm revealed: -She had been visiting Resident #1 when she pulled the covers back and found the bruise on the resident's right forearm. -Staff had not reported the bruise to her; she found the bruise and reported it to the Administrator. -The Administrator did an investigation and the staff person that caused the bruise no longer worked at the facility. -She could not remember when she had found the bruise, but it was in January 2019.	D 438		

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D 438	Continued From page 73 Observation of Resident #1 on 01/30/19 at 9:00am revealed there was a purple oval shaped bruise approximately the diameter of a tennis ball on Resident #1's on the right forearm. Review of a communication log note dated 01/22/19 revealed staff documented Resident #1 had a bruise on her right arm above the wrist which was found when incontinence care was provided. Interview with a personal care aide (PCA) on 02/28/19 at 11:18am revealed: -She had written the communication log note dated 01/22/19. -When she, another PCA and a medication aide (MA) had seen the bruise on Resident # 1's arm, it looked new like the resident had just gotten the bruise. -She and the two other staff members reported it to the Administrator the same day they saw it (01/22/19). -She did not know if it had been addressed by the Administrator, but noticed that she no longer saw certain people working, i.e. Staff A, working any more. -Not long after the bruise incident, Staff A was not working anymore. Interview with a MA on 01/30/19 at 11:50am revealed: -Resident # 1 had a bruise and no one seemed to know how the resident got on the bruise. -Resident #1 was totally bed bound and had not fallen. -A third shift personal care aide (PCA) told the MA and said no one knew how Resident #1 got the bruise. Interview with the Resident Care Coordinator	D 438		

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(RCC) on 01/30/19 at 11:01am revealed:
-The only reason she knew about Resident #1's bruise was because she just happened to be in the Administrator's office when a medication aide (MA) brought it to the Administrator's attention (01/22/19).
-She and the Administrator went to look at the bruise on Resident #1's arm.
-She left the Administrator in the resident's room.

Interview with the Administrator on 01/30/19 at 12:25pm revealed:
-She talked with Resident #1's family member at least 2 times a day and the family member had not reported any issues.
-She had been informed by the Department of Social Services (DSS) worker on 01/29/19 that Resident #1 had bruises of an unknown origin documented on the communication log on 01/22/19.
-A staff person was accused by another resident of bruising Resident #1 during 2nd shift.

Review of an incident/accident report for Resident #1 dated 01/22/19:
-There was a notation of a bruise of unknown origin on the right forearm.
-The report was signed by the Administrator and dated 01/30/19.

Review of the 24 Hour Initial Report to the HCPR for Resident #1 revealed:
-The incident date was documented as 01/22/19 for a bruise on Resident #1's right forearm.
-The report was signed 02/01/19 by the Administrator.

Review of the 5 Day Working Report to the HCPR for Resident #1 revealed:
-Resident #1's roommate reported a named PCA

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(Staff A) was very rough with the Resident #1 when changing and repositioning the resident.
-The named PCA (Staff A) was terminated from employment at the facility on 02/06/19.

Interview with Administrator at 5:00 p.m. on 02/28/19 revealed:
-She did not send the HCPR Initial 24 hour report for Resident #1 until 02/01/19 because she did not know it was bruised until 1/29/19 when the DSS worker inquired.
-She was informed that it was documented in the communication log that bruises from an unknown origin were seen on Resident #1 on 01/22/19.
-On 01/22/19, staff informed her and the RCC of bruises on Resident #1 when the bruise was first seen by staff.
-She did not take any type of action when she was informed of Resident # 1's bruise on her arm because she did not know which staff member was involved.

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

Refer to interview with the Administrator on 1/30/19 at 12:25pm.

_____

Interview with the Administrator on 1/30/19 at 12:25pm revealed:
-She always investigated when a staff person was accused of abusing or neglecting a resident and a verbal warning was given to the staff person.
-Staff and residents were interviewed when a staff person was accused of abuse or neglect.
-Staff would be written up if it was their first and time and terminated if it was their second time.
-No physical abuse by staff had been brought to her attention and there was no hospice note

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D 438	Continued From page 76 reported anything. -Staff who do not get along "play the blame game," meaning staff who do not get along with other staff blame other staff for anything that may happen to residents. _____ The facility failed to report bruises of an unknown origin related to possible abuse to the Health Care Personnel Registry within 24 hours for 2 residents (#1 and #11), conduct an investigation of the injuries and submit a 5 day report to the HCPR for 2 sampled residents (#1 and #11) which placed the residents at risk of further harm. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/28/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2019.	D 438		
{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. This Rule is not met as evidenced by:	{D 451}		

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{D 451}	Continued From page 77 Based on observations, interviews and record reviews, the facility failed to assure incidents resulting in injury and emergency room evaluation were reported to the Department of Social Services within 48 hours for 1 of 4 sampled residents (#16). The findings are: Review of Resident #16's current FL-2 dated 01/15/19 revealed: -Diagnoses included dementia, major depression, abnormal posture, benign prostatic hyperlesion, and hemiplegia left dominant side. -Resident #16 was non-ambulatory and constantly disoriented. -Resident #16 was injurious to others and property, verbally abusive, and a wanderer. Review of Resident #16's care plan dated 10/11/18 revealed: -Resident #16 was physically abusive and injurious to others. -Resident #16 fought with the staff and was very agitated. -Resident #16 was non-ambulatory but was able to ambulate with a wheelchair. -Resident #16 was always disoriented, forgetful and needed reminders. -Resident #16's speech was slurred. -Resident #16 was incontinent of bowel and bladder. Review of an Accident/Incident Report for Resident #16 dated 02/10/19 at 3:30pm revealed: -Resident #16 slid down in his wheelchair and refused staff assistance. -Resident #16 became agitated, was yelling, and hit a staff member on her legs. -EMS was called and Resident #16 was	{D 451}		

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{D 451}	Continued From page 78 transferred to the Emergency Department (ED). -Resident #16's PCP was notified. -The report was signed by a medication aide. -The report was not signed by the Administrator. -There was no documentation on the report that DSS was notified. Review of an EMS report for Resident #16 dated 02/10/19 at 3:23pm revealed: -Upon arrival, Resident #16 was found lying on the floor next to his wheelchair. -Resident #16 was transported to the ED. Interview with the county DSS Supervisor on 02/27/19 at 2:40pm revealed the facility had not faxed an incident/accident report to DSS for Resident #16 for the 02/10/19 incident in which he was transported and admitted to the hospital. Interview with the Administrator on 02/28/19 at 4:20pm revealed: -She had not received a copy of the Accident/Incident report dated 02/10/19 for Resident #16. -She had been out of town during that time and was not aware of the incident. -The process for DSS notificaiton was that the MA on duty at the time an incident/accident occurred was responsible for completing an incident/accident report, putting a copy in the Administrator's box, and faxing a copy to DSS, if applicable.	{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	D 453		

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D 453	Continued From page 79	D 453		

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 observations, interviews and record reviews, the facility failed to assure the county Department of Social Services was notified of incidents of suspected physical and verbal abuse for 2 of 5 sampled residents (#1 and #11) who sustained bruises of unknown origin.

The findings are:

1. Review of Resident #1's current FL2 dated 10/04/18 revealed diagnoses included dementia, dehydration, metabolic encephalopathy, hypertension, gastro esophageal reflux disease (GERD), severe protein calorie malnutrition and osteoporosis.

Interview with Resident #1's roommate on 01/29/19 at 3:25pm revealed:
-Resident #1 had bruises on her arm from the way she was being rough handled by a staff (Staff A).
-The roommate told Resident #1's family member and the family member spoke with the Administrator.
-The Administrator came and looked at the bruise on Resident #1's right arm.

Observation of Resident #1 on 01/30/19 at 9:00am revealed there was a purple oval shaped bruise approximately the diameter of a tennis ball on Resident #1's on the right forearm.

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D 453	Continued From page 80 Interview with Resident #1's family member on 01/30/19 at 9:00am revealed: -When she saw the bruise on Resident #1's arm last week (01/23/19) it was very black. -The family member had seen Resident #1 being assisted by one staff person on more than one occassion. -Resident #1 was supposed to have two staff assisting because the resident was immobile. Second telephone interview with Resident #1's family member on 02/27/19 at 4:10pm revealed: -She had been visiting Resident #1 when she pulled the covers back and found the bruise on the resident's right forearm. -Staff had not reported the bruise to her; she found the bruise and reported it to the Administrator. -The Administrator did an investigation and the staff person that caused the bruise no longer worked at the facility. -She could not remember when she had found the bruise, but it was in January 2019. Review of a communication log note dated 01/22/19 revealed staff documented Resident #1 had a bruise on her right arm above the wrist which was found when incontinence care was provided. Interview with a personal care aide (PCA) on 02/28/19 at 11:18am revealed: -She had written the communication log note dated 01/22/19. -When she, another PCA and a medication aide (MA) had seen the bruise on Resident # 1's arm, it looked new like the resident had just gotten the bruise. -She and the two other staff members reported it	D 453		

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to the Administrator the same day they saw it (01/22/19).

Interview with the Resident Care Coordinator (RCC) on 01/30/19 at 11:01am revealed:
-The only reason she knew about Resident #1's bruise was because she just happened to be in the Administrator's office when a medication aide (MA) brought it to the Administrator's attention (01/22/19).
-She and the Administrator went to look at the bruise on Resident #1's arm.
-She left the Administrator in the resident's room.

Interview with the Administrator on 01/30/19 at 12:25pm revealed:
-She talked with Resident #1's family member at least 2 times a day and the family member had not reported any issues.
-She had been informed by the Department of Social Services (DSS) worker on 01/29/19 that Resident #1 had bruises of an unknown origin documented on the communication log on 01/22/19.

Interview with the Administrator on 02/21/19 at 10:05am revealed:
-The medication aides (MAs) completed accident and incident reports and then gave the report to the Resident Care Coordinator (RCC) or Special Care Coordinator (SCC).
-The RCC or SCC kept up with making sure accident and incident reports were completed by MAs.

Review of an incident/accident report for Resident #1 dated 01/22/19 (no time) revealed:
-There was a notation of a bruise of unknown origin on the right forearm.
-The report was completed by the RCC and

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D 453	Continued From page 82 signed and dated 01/30/19 by the Administrator. Interview with Administrator on 02/28/19 at 5:00pm revealed she did not send an incident report to DSS for Resident #1 until 01/30/19 because she did not know it was bruised until 01/29/19 when the DSS worker inquired. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #11's current FL2 dated 10/02/18 revealed diagnoses included dementia, depression, hypothyroidism, arthritis, abnormal gait, bipolar disorder and acute kidney failure. Review of Resident #11's Care Plan dated 10/02/18 revealed: -Resident #11 used a wheelchair for ambulation and had limited strength to her upper extremities due to muscle weakness. -Resident #11 required extensive assistance from staff for bathing and ambulation. -Resident #11 was totally dependent upon staff for toileting, bathing, dressing, grooming, and transferring. -Resident #11 was incontinent of bowel and bladder. -Resident #11 was sometimes disoriented, forgetful and needed reminders. Review of a care note dated 12/15/18 for Resident #11's revealed: -A personal care aide (PCA) notified the medication aide (MA) of bruising on Resident #11's right thigh. -The MA notified the doctor by voice message of the bruising to Resident #11's right thigh.	D 453		

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D 453	Continued From page 83 Review of documentation on the facility communication log dated 01/17/19 revealed: -Resident #11 had bruising on the outer right hip area and inner left thigh area. -Resident #11 was unable to say what happened. -The MA did not see any fall reports for Resident #11. -A PCA noticed it as she was getting Resident #11 dressed on 01/17/19 at 5:35am and reported the bruising to the MA. Review of documentation on the facility communication log dated 01/22/19 revealed a PCA reported an "anonymous bruise on Resident #11's left of forehead (small knot) at 5:30am." Observation on 01/30/19 at 10:51am revealed: -Resident #11 had two pea sized purplish bruises coupled on her forehead. -Resident #11 had a dime sized purple bruise on her right upper leg. -Resident #11 had a boomerang shaped dark purple bruise approximately one inch in length on her left inner thigh. Interview with the Administrator on 01/30/19 at 10:51 revealed: -She knew Resident #11 had some bruises. -She had not seen the bruise on the Resident #11's left inner thigh. Interview with a MA on 01/30/19 at 11:50am revealed: -She had written the communication log note dated 01/22/19. -Resident #11 had bruises no one seemed to know how the resident got the bruises. -Resident #11 had not had a recent fall when the bruises showed up.	D 453		

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D 453	Continued From page 84 -Resident #11 had bruises on her thigh and on the left side of her forehead. -A 3rd shift PCA told the MA and said no one knew how Resident #11 got the bruises. -Resident #11 was not sent to the hospital, but the communication log (01/17/19) located at the nurses' station had documentation on the bruise. Review of incident/accident reports for Resident #11 revealed: -There was documentation the incident/accident reports dated 01/17/19 and 01/22/19 were faxed to Department of Social Services (DSS) on 01/30/19. -There were no incident/accident reports for Resident #11 dated 12/15/18 for bruises of unkown origins. Interview with the Administrator on 1/30/19 at 12:25pm revealed she was informed by DSS on 01/29/19 Resident #11 had bruises of an unknown origin documented on the communication log on 01/17/19. Interview with Administrator 02/28/19 at 5:00pm revealed she was informed that it was documented in the communication log that bruises from an unknown origin were seen on Resident #11 on 01/22/19. Refer to interview with the Administrator on 01/30/19 at 12:25pm.	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	D 465		

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one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

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

Based on observations, interviews and record reviews, the facility failed to assure there were staff on duty to meet the needs of the residents on the Special Care Unit (SCU) with a minimum of 8 aide hours for every 8 residents on 1st and 2nd shift and 8 aide hours for every 10 residents on 3rd shift for 5 of 24 shifts sampled.

The findings are:

Interview with the Special Care Coordinator (SCC) on 02/19/19 at 3:50am revealed:
-There were 23 residents on the Special Care Unit (SCU).
-There were two personal care aides (PCAs) working on the SCU.
-She was covering the building as the medication aide (MA)/Supervisor until 7:00am on 02/19/19.
-She had come in to work at 3:30am to cover a call in and would be working her normal hours as the SCC after 7:00am on 02/19/19.

Interview with a PCA on 02/19/19 at 3:56am revealed:
-There were two staff working on the SCU for 3rd shift on 02/19/19.
-There were about 25 residents on the SCU.
-There were usually three staff on the SCU for 3rd shift.

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D 465	Continued From page 86 -Staff "just quit" about a week ago. Interview with a MA on 02/20/19 at 5:25pm revealed: -The facility was mostly short of staff on the weekends. -Over the past weekend (02/16/19), there were two PCAs in the SCU. Confidential interview with a staff member revealed: -The entire facility had a problem with shorting staffing for at least the last two months. -The staff first noticed short staffing problems in the SCU about a year ago. -The SCC often worked three consecutive shifts as the medication aide and there were only two PCAs in the SCU. -When the SCU was short staffed, staff could not bathe or change the clothes of the residents as they needed. -The SCU staff felt rushed to try to get all of the things done that the residents needed like feeding assistance or providing perineal care. -There was not enough staff so the residents had to wait until the staff was able to get to them. -The staff member had last complained about the short-staff to the SCC and the Administrator sometime in September 2018. Interview with the SCC on 02/27/19 at 3:00pm revealed: -The shift times were from 7:00am to 3:00pm for 1st shift, 3:00pm to 11:00pm for 2nd shift and 11:00pm to 7:00am for 3rd shift. -On 11/16/18, she worked 16 hours on as a MA. -She was still covering regularly as an MA on the medication cart because she was "about the only one who could work the cart." -Last weekend was the first weekend she did not	D 465		

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have to cover as a MA.
-The facility had been short staffed especially on the weekends since approximately October 2018.
-It was not that often that she had to come in at 3:30am like on 02/19/19.

Review of the facility's census revealed the census for 11/11/18 was 66; the SCU and AL census were not specified.

Review of staff time cards and assignment sheets for 11/11/18 revealed:
-There were 23.25 aide hours for the SCU for 2nd shift.
-There were 20.25 aide hours for the SCU for 3rd shift.
-A PCA scheduled for 3rd shift on the SCU punched in at 12:23pm and a second PCA scheduled for 3rd shift on the SCU punched in at 11:42pm.
-There was no staff from the 2nd shift after 11:18pm resulting in a shortage of 2.25 aide hours at the change of shift on the SCU.

Review of the facility census for 02/03/19 revealed the SCU census was 22.

Review of staff time cards and schedule for 02/03/18 revealed:
-There were 7.5 aide hours for the SCU for 1st shift resulting in a shortage of 14.5 aide hours.
-A PCA punched in at 10:45am on 02/03/19 and punched out at 7:00am on 02/04/19 for 19.25 of continuous work hours on the SCU.

Review of the facility census for 02/15/19 revealed the SCU census was 22.

Review of staff time cards and schedule for 02/15/19 revealed there were 15.75 aide hours

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for the SCU for the 3rd shift resulting in a shortage of 1.85 hours.

Review of the facility census for 02/16/19 revealed the SCU census was 22.

Review of staff time cards and schedule for 02/16/19 revealed there were 15 aide hours for the SCU for the 3rd shift resulting in a shortage of 2.6 hours.

Review of the facility census for 02/17/19 revealed the SCU census was 22.

Review of staff time cards and schedule for 02/17/19 revealed there were 14.5 aide hours for the SCU resulting in a shortage of 3.1 hours.

Interview with the Administrator on 02/28/19 at 5:10pm revealed:
-"The facility had been short staffed for a while."
-She did not know what "a while" was and "short staffed" meant.
-The facility had a lot of turn-over and she had to fire a few employees.
-She tried to make sure the facility was covered but sometimes staff called out from work.
-If staff called out, the staff were supposed to call the on-call person (the SCC or RCC) to arrange for coverage of the shift.
-It was her expectation that if staff called out from work that staff person "was really supposed to find someone to cover their shift and if they could not find anyone, then staff was supposed to come to work."
-"Nine out of ten times though" the SCC came and worked the shift if staff called out because the SCC "liked working the extra hours".

The facility failed to assure there were personal

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D 465	Continued From page 89 care staff on duty to meet the needs of residents for 4 of 24 shifts resulting in the inability to assist residents with personal care tasks and provide supervision which was detrimental to the health, safety and welfare of all residents on the special care unit and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/26/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2019.	D 465		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there was a Special Care Coordinator (SCC) on duty eight hours a day for five days each week for the Special Care unit. The findings are: Interview with the Special Care Coordinator (SCC) on 02/19/19 at 3:50am revealed:	D 466		

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-There were 23 residents on the Special Care Unit (SCU).
-She was covering the building as the medication aide (MA)/Supervisor until 7:00am on 02/19/19.
-She had come in to work at 3:30am to cover a call in and would be working her normal hours as the SCC after 7:00am on 02/19/19.

Review of staff time cards and schedules for the week of 11/11/18 through 11/17/18 revealed:
-There were no punch times for the SCC on 11/11/18, 11/12/18 and 11/13/18.
-The SCC worked 9.25 hours on 11/14/18, 6.25 hours on 11/15/18, 16 hours on 11/16/18 and 6 hours on 11/17/19.

Interview with the SCC on 02/27/19 at 2:47pm revealed:
-She had worked as the SCC since May 2018 and covered the Resident Care Coordinator (RCC) position together with a couple of the MAs and the Administrator from August through December 2018.
-She was responsible for assuring staff were providing direct care assistance to residents, keeping up with resident records, completing new FL-2's and care plans when residents returned from hospital admissions, clarifying doctor's orders and making sure the Administrator, family member and doctor were notified when a resident was sent to the hospital.
-On 11/16/18, she worked 16 hours on as a medication aide (MA).
-When she worked as a MA on the medication cart, she was just on the cart and did not cover as SCC/RCC.
-She did not work as the SCC on 11/12/18 and 11/13/18; the 1st shift MA would have been the Supervisor.
-She had not had to cover as the RCC since the

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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 466	Continued From page 91 middle of December 2018. -She was still covering regularly as an MA on the medication cart because she was "about the only one who could work the cart." -Last weekend was the first weekend she did not have to cover as a MA. -The facility had been short staffed especially on the weekends since approximately October 2018. -It was not that often that she had to come in at 3:30am like on 02/19/19. Interview with the Administrator on 02/27/19 at 5:25pm revealed there was a Supervisor on duty, but no one covered the role of SCC when the SCC was not in. Interview with the Administrator on 02/22/19 at 4:50pm revealed: -The facility had been through three RCCs since August 2018. -One of the RCCs was at the facility for approximately two weeks, a second for approximately one month and a third was borrowed from another facility for one month. -The SCC helped, and there were two medication aides that helped with completing RCC duties when there was no RCC on staff at the facility. -The facility hired a new RCC in December 2018.	D 466		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	{D912}		

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{D912}	Continued From page 92	{D912}		

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to healthcare referral and follow-up, medication administration, personal care and other staffing and special care unit staffing.

The findings are:

1. Based on observations, interviews and record reviews, the facility failed to assure the primary care provider (PCP) was notified of changes in condition and acute health care needs for 3 of 15 sampled residents (#3, #7, #17), including Resident #3 who had bedbug bites to her left cheek and jaw; Resident #4, who had intermittent disorientation and wandering behaviors; Resident #7 who had symptoms of aspiration resulting in hospital admission for aspiration pneumonia 4 days after the onset of symptoms; and Resident #17 who had 11 out of 12 systolic blood pressures (SBPs) greater than 160 in January and February 2019 that were not reported to the PCP as ordered and did not have a hospital follow up appointment with her PCP for more than six weeks [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to assure 4 of 16 residents (#1, #10, #15 and #17) observed during the medication pass received their medication as ordered by the primary care provider (PCP) including errors with an antacid (#1), antidepressant (#10), an antibiotic eye ointment (#15), and an antihypertensive (#17); and for 2 of 7 residents sampled for record review (#15 and

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{D912}	Continued From page 93 #17) including missed doses of an antibiotic eye ointment (#15), and missed doses of an as needed (PRN) antihypertensive for SBP greater than 160 for (#17). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure there were staff on duty to meet the needs of the residents on the Special Care Unit (SCU) with a minimum of 8 aide hours for every 8 residents on 1st and 2nd shift and 8 aide hours for every 10 residents on 3rd shift for 5 of 24 shifts sampled. [Refer to Tag 465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)]. 4. Based on observations, interviews and record reviews, the facility failed to assure there were staff on duty to meet the needs of the residents with a minimum of 20 aide hours on 1st and 2nd shift and 16 aide hours on 3rd shift for 4 of 24 shifts sampled. [Refer to Tag 188, 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)].	{D912}		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are	{D914}		

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{D914}	Continued From page 94 protected from harm and neglect and in compliance with federal and state laws and rules and regulations related to resident rights, health care personal registry and implementation. The findings are: 1. Based on interviews, observations, and record reviews, the facility failed to assure 5 of 19 sampled residents were in an environment free of verbal, and physical abuse and received adequate care and services as evidenced by one resident (#2) assaulted by another resident on the Assisted Living (AL), one resident (#5) verbally abused by staff, one resident (#10) being robbed of $300, and two residents (#1, #8) being handled roughly by staff [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to report bruises of unknown origin to the Health Care Personnel Registry (HCPR) within 24 hours, conduct an investigation of the injuries and submit a 5 day report to the HCPR for 2 of 4 sampled residents (#1 and #11) with documented injuries of possible physical abuse by staff. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personal Registry (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator failed to assure the overall management, operations, and policies and procedures of the facility were developed and implemented to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, personal care and supervision, medication administration, resident rights, personal care and staffing, health care personnel registry, and special care unit	{D914}		

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{D914}	Continued From page 95 staffing. [Refer to Tag 980, G.S. 131D-25 - Implementation (Type A2 Violation)].	{D914}		
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. (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	D935		

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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.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled medication aides (Staff F) had completed their 5, 10, or 15 hour state approved medication training.

The findings are:

Review of the personnel record for Staff F, medication aide (MA) on 02/27/19 revealed:
-Staff F's date of hire was documented as 12/17/18.
-Staff F successfully passed the state written medication administration exam on 10/14/15.
-There was documentation of a completed Medication Administration Clinical Skills Validation Checklist dated 12/26/18.
-There was no documentation of verification of previous employment as MA within the last 24 months prior to employment at the facility for Staff F.
-There was no documentation of completion of the 15-Hour State-approved Medication Administration Training Course for Adult Care Homes for Staff F.

Review of the facility's December 2018 electronic Medication Administration Record (eMAR) revealed Staff F documented administering medications on 12/28/18 at 8:00am, 9:00am, 12:00pm, and 2:00pm and on 12/31/18 at

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D935	Continued From page 97 8:00am. Review of the facility's January 2019 eMAR revealed Staff F documented administering medications on 01/01/19, 01/05/19, 01/06/19, 01/08/19, 01/09/19, 01/10/19, 01/11/19, 01/14/19, 01/18/19, 01/19/19, 01/20/19, 01/22/19, 01/24/19, 01/25/19, 01/28/19, 01/29/19, 01/30/19, and 01/31/19 at 8:00am. Review of the facility's February 2019 eMAR revealed Staff F documented administering medications on 02/02/19, 02/05/19, 02/08/19, 02/11/19, 02/15/19, 02/16/19, 02/17/19, 02/18/19, and 02/19/19 at 8:00am. Telephone interview with Staff F on 02/28/19 at 6:45pm revealed: -She had worked as a MA at a previous facility. -She had completed the 15 hour state approved medication administration courses training at that facility on 02/28/19. -She had not completed any of the 15 hour state approved medication administration courses training at the facility prior to 02/28/19. -Her prior employer refused to give her documentation she had completed the 15 hours of state approved medication administration courses training when she left. -She did not complete the 15 hour state approved medication administration courses training until 02/28/19 when the Administrator told her about it. -She had administered medications to the residents since she started working at the facility in December 2018. Interview with the Administrator on 02/27/19 at 3:50pm revealed: -She believed Staff F had worked previously as a MA but she was not sure where.	D935		

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D935	Continued From page 98 -She thought Staff F had a copy of completion of the 15 hour medication administration training courses in her personnel file. -She did not know if Staff F had completed the 15 hour medication administration training courses since Staff F started working in December 2018. -She had not verified if Staff F had previously been employed as a MA within 24 months prior to working at the facility.	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 A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the overall management, operations, and policies and procedures of the facility were developed and implemented to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, medication administration, resident rights, personal care and staffing, health care personnel registry, and special care unit staffing. The findings are: Confidential interview with a staff revealed: -The Administrator addressed issues that staff brought to her but it usually took 2 or 3 days for	D980		

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any type of response.
-The facility had an ongoing bedbug problems since last summer and several rooms throughout the facility had been treated for bedbugs but the bedbugs kept coming back.
-The linen supply had been scarce in the facility since last summer and staff did not have enough bath cloths, towels, or sheets for use with the residents.
-The staff had complained once to the Administrator last summer and the Administrator told the Business Office Manager to order more linen for the facility.
-The staff never saw an increase in the supply of linens after complaining to the Administrator.
-The facility also had a problem with being short-staffed and it was a common occurrence for there to be one medication aide and two personal care aides to work the entire facility especially at night.
-The staff did not think staff was able to perform their job well because there was not enough staff to work.

Interview with a resident on 02/21/19 at 4:00pm revealed:
-The facility was an assisted living facility, but there was not much assistance.
-She could not seem to talk with anyone at the facility about any concerns she had, particularly the Resident Care Coordinator (RCC).
-Speaking to the Administrator about any concerns was like "speaking to the man on the moon."

Confidential telephone interview with a staff revealed:
-Staff was afraid of reporting things to the Administrator; afraid there would be

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"repercussions".
-If staff said anything, they might get fired.

Interview with a primary care provider (PCP) on 02/20/19 at 4:30pm revealed:
-For many months between July and December 2018, there was no RCC.
-It was hard for her to keep up with things because there was no one person in charge.
-It was hard for staff to keep up.
-She had spoken with the Administrator related to concerns for falls, injuries and residents with aggressive and violent behaviors.
-She was "chastised" and told she was wrong about the falls and wrong about the aggression.

Interview with the Special Care Coordinator (SCC) on 02/27/19 at 3:00pm revealed:
-There was supposed to be a meeting every morning with the Administrator, RCC and the SCC.
-The meeting was to discuss what was going on in the facility, but there had not been a meeting in approximately four to five months.

Non-compliance was identified at violation level in the following rule areas:

1. Based on observations, interviews and record reviews, the facility failed to assure the primary care provider (PCP) was notified of changes in condition and acute health care needs for 5 of 15 sampled residents (#3, #4, #7, #13, #17), including Resident #3 who had bedbug bites to her left cheek and jaw; Resident #4, who had intermittent disorientation and wandering behaviors; Resident #7 who had symptoms of aspiration resulting in hospital admission for aspiration pneumonia 4 days after the onset of symptoms; Resident #13 who had symptoms of

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generalized illness resulting in hospital admission for a urinary tract infection and pneumonia 8 days after the onset of symptoms; and Resident #17 who had 11 out of 12 systolic blood pressures (SBPs) greater than 160 in January and February 2019 that were not reported to the PCP as ordered and did not have a hospital follow up appointment with her PCP for more than six weeks [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

2. Based on interviews, observations, and record reviews, the facility failed to assure 5 of 19 sampled residents were in an environment free of verbal, and physical abuse and received adequate care and services as evidenced by one resident (#2) assaulted by another resident on the Assisted Living (AL), one resident (#5) verbally abused by staff, one resident (#10) being robbed of $300, and two residents (#1, #8) being handled roughly by staff [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].

3. Based on observations, interviews and record reviews, the facility failed to assure 4 of 16 residents (#1, #10, #15 and #17) observed during the medication pass received their medication as ordered by the primary care provider (PCP) including errors with an antacid (#1), antidepressant (#10), an antibiotic eye ointment (#15), and an antihypertensive (#17); and for 2 of 7 residents sampled for record review (#15 and #17) including missed doses of an antibiotic eye ointment (#15), and missed doses of an as needed (PRN) antihypertensive for SBP greater than 160 for (#17). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type A2 Violation)].

4. Based on observations, interviews and record

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D980	Continued From page 102 reviews, the facility failed to assure there were staff on duty to meet the needs of the residents on the Special Care Unit (SCU) with a minimum of 8 aide hours for every 8 residents on 1st and 2nd shift and 8 aide hours for every 10 residents on 3rd shift for 5 of 24 shifts sampled. [Refer to Tag 465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to report bruises of unknown origin to the Health Care Personnel Registry (HCPR) within 24 hours, conduct an investigation of the injuries and submit a 5 day report to the HCPR for 2 of 4 sampled residents (#1 and #11) with documented injuries of possible physical abuse by staff. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personal Registry (Type B Violation)]. 6. Based on observations, interviews and record reviews, the facility failed to assure there were staff on duty to meet the needs of the residents with a minimum of 20 aide hours on 1st and 2nd shift and 16 aide hours on 3rd shift for 4 of 24 shifts sampled. [Refer to Tag 188, 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)]. _____ The Administrator failed assure the primary care provider (PCP) was notified of changes in condition and acute health care needs for 5 sampled residents (#4, #7, #13, and #17) Resident #4, who had intermittent disorientation and a known history of alcohol abuse who had wandering behaviors, Resident #7 who had symptoms of aspiration and resulted in a hospital admission for aspiration pneumonia 4 days after the onset of symptoms, Resident #13 who had generalized symptoms of illness and resulted in	D980		

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WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 103 hospital admission for a urinary tract infection and pneumonia 8 days after the onset of symptoms, Resident #17 who had 11 out of 12 systolic blood pressures (SBPs) greater than 160 in January and February 2019; failed to report bruises of unknown origin to the Health Care Personnel Registry, conduct an investigation of the injuries and submit a 5 day report to the HCPR for 2 sampled residents (#1 and #11); failed to assure there was adequate staffing to meet the needs of the residents and the facility's census; failed to protect the residents' rights of 6 of 19 sampled residents. The failure of the Administrator to oversee the overall management of the facility resulted in substantial risk to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/28/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 30, 2019.	D980		