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	HAL060158	A. BUILDING: _____ B. WING _____	R-C 11/09/2018

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THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 Mecklenburg County Department of Social Services conducted a follow-up survey and a complaint investigation on November 6th -9th, 2018. The complaint investigations were initiated by the county on 09/20/18, 09/27/18, 10/05/18, 10/18/19, 10/25/18 and on 10/29/18.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure 3 storage rooms (janitor's closet, a storage closet, and kitchen supply room) containing hazardous chemicals were locked and not accessible to residents. The findings are: Observation of the first floor back hall door on 11/09/18 from 12:15pm to 12:45pm revealed: -The door to the back hall was located at the end of the assisted living (AL) hallway for resident	D 056		

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rooms #100 - #108.
-The back hall door was located approximately 15 to 20 feet from the main entrance of the resident dining room.
-The back hall door was unlocked and opened by pushing on the horizontal door release bar running across the front of the door.
-No staff member was observed standing at the back hall door.
-No resident was observed opening the back hallway door or trying to enter into the back hallway.

Observation of the first floor back hall on 11/09/18 from 12:15pm to 12:45pm revealed:
-The janitor storage room, a storage room, and the kitchen supply room were all located on the back hall.
-No staff member was observed in the first floor back hall.
-No resident was observed in the first floor back hall.

Observation of the AL resident dining room at 12:25pm revealed:
-There were 15 residents in the dining room eating lunch.
-The dining room doors that lead into the hall by the back hall door were open while the residents ate lunch.

Observation of the janitor's closet on 11/09/18 between 12:15pm to 12:45pm revealed:
-There was a sign beside the door labeled "Janitor's Closet".
-There was a paper sign taped to janitor's closet door labeled "Dietary dept. Chemical".
-The door was unlocked and opened with one single motion turn of the door handle.
-There was no staff present on the hall where the

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janitor's closet was located.
-There was no staff present inside the janitor's closet.
-There was a 3/4 full 2.5-gallon container of Antimicrobial Fruit and Vegetable Treatment inside the closet with ingredients of Dodecylbenzenesulfonic acid and with a hazard warning label, "Causes substantial but temporary eye injury. Harmful if absorbed through skin.".
-There was a full gallon container of Special Rinse Additive for High Solids Water inside the closet with a caution/first aide label, "Do not ingest or allow to come in contact with skin or eyes.", and "Get medical attention immediately.".
-There was a full 2.5-gallon container of disinfectant-sanitizer-deodorizer-cleaner inside the closet with a hazard label, "Danger; Corrosive; Causes irreversible eye damage and skin burns." and "Harmful if swallowed.".
-There were eight 17 ounce containers of Stainless Steel Cleaner and Polish inside the closet with ingredients of aliphatic petroleum distillates, propane, n-Butane, and a warning label "May cause drowsiness and dizziness.".

Observation of the storage room closet on 11/09/18 between 12:20pm to 12:45pm revealed:
-There was a sign beside the door labeled "Storage".
-The door was unlocked and opened with one single motion turn of the door handle.
-There was no staff present on the hall where the storage room was located.
-There was no staff present inside the storage room closet.
-There were two - 1 gallon containers of a "No Thaw Freezer Cleaner" inside the closet that were each approximately ¼ to ½ full and with a caution label, "My Cause Respiratory, Tract, Eye, and Skin Irritation", "Can cause central nervous

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D 056	Continued From page 3 system depression.". Observation of the kitchen supply room door on 11/09/18 at 12:45pm revealed: -The door to the closet had a paper sign taped to the outside of the door labeled "Keep Door Locked". -The door was unlocked and opened with one single motion turn of the door handle. -There was no staff present in the hall where the kitchen supply room was located. -There was no staff present inside the kitchen supply room. -There were six - 1 gallon containers of liquid "disinfectant bleach" inside the room. Interview with first floor medication aide (MA) on 11/09/18 at 12:55pm revealed: -She identified 3 residents (Residents # 18, #12, #11) who lived on the first floor of the AL side that were disoriented or confused. -Resident #18 ambulated by walking with assistance from staff. -Resident #12 ambulated by wheel chair with assistance from staff and sometimes tried to ambulate by herself with her wheel chair. -Resident #11 ambulated by wheel chair. Interview with first floor AL personal care aide (PCA)on 11/09/18 at 1:22pm revealed: -She identified 2 residents (Residents #12, # 18) who lived on the first floor of the AL side that were disoriented or confused. -Resident #12 was the most disoriented resident on the hall and was confused on some days. -Resident #18 walked with assistance from staff, was confused on some days, and needed a lot of redirection from staff. -The back hallway was housekeeping area. -She did not know if there were any chemicals or	D 056		

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cleaning supplies stored in the back hall area.
-She did not have any keys to the doors in the back hall area.
-That back hall door was always unlocked.
-She did not usually go back there on that hall.

Interview with the lead housekeeper on 11/09/18 at 1:10pm revealed:
-All storage rooms with chemicals on the back hall were supposed to be locked.
-"All staff" were responsible for assuring the storage rooms on the back halls were locked. She stated, "Everyone is to lock the doors behind them.".
-The master key to the janitor's closet was kept in the kitchen so that housekeeping staff and kitchen staff could open them.
-She did not have a key for the storage closet and thought that only maintenance had the key for that closet.
-Only the kitchen staff kept a key for the kitchen supply room in the back hall.
-The kitchen supply closet had the sign on it to keep the door lock because "the kitchen supply is in there".
-"Everybody" is trained on keeping the storage supply closet doors locked and "maintenance goes over it" with staff.

Interview with the food service staff member on 11/09/18 at 1:15pm revealed:
-She was not aware there were containers of bleach in the kitchen supply closet.
-There "used to be a sign" on the janitor's closet to keep it locked, but somebody had taken it down in the past so she was not sure if staff were supposed to leave the janitor's closet unlocked or locked.

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D 075	Continued From page 5	D 075		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; 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 assure the facility was maintained without chronic odors of urine. The findings are: 1. Observation of resident room 201 on 11/06/18 at 8:35am revealed the room had a strong pungent odor of urine that permeated throughout the room and into the hallway outside of the room. Second observation of resident room 201 on 11/07/18 at 4:07pm revealed: -The room had a strong pungent odor of urine that permeated throughout the room. -The flooring in the room was sticky and made a suction noise when walked on. Third observation of resident room 201 on 11/09/18 at 2:30pm revealed the room had a strong pungent odor of urine that permeated throughout the room. Fourth observation of resident room 201 on 11/09/18 at 4:38pm revealed: -The room had a strong pungent odor of urine.	D 075		

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D 075	Continued From page 6 Interview with a personal care aide (PCA) on 11/07/18 at 4:15pm revealed: -Resident #2 in room 201 had a hand held urinal the he would sometimes spill it onto the floor. Interview with Resident #2 on 11/06/18 at 2:05pm revealed: -He was not sure the last time he had a shower. -"Last night I slept in urine, and no one came to change me". -Staff came "sometimes" to change brief throughout the night. Observation of Resident #2 on 11/08/18 at 5:04am revealed: -Resident #2 was lying in bed with an empty urinal hanging from his wheelchair. -There was a blue towel on the floor next to Resident #2's bed that was covering urine. -Resident #2 could not recall being changed within the past 2 hours, he attempted to use his urinal and had an "accident". Refer to interview with housekeeping staff on 11/06/18 at 11:35am. Refer to interview with lead housekeeper on 11/08/18 at 2:00pm. Refer to additional interview with the lead housekeeper on 11/09/18 at 2:45pm. Refer to interviews with 5 residents on 11/09/18 between 4:30pm to 5:00pm. 2. Observation of resident room 324A on 11/08/18 between 5:02am revealed: -A strong urine odor that permeated throughout the suite area of the bedroom.	D 075		

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D 075	Continued From page 7 Second observation of resident room 324 A on 11/08/18 at 5:43am revealed: -The 324 suite door was opened and there was a strong urine odor that permeated throughout the bedroom suite and out into the third floor common hallway outside of the room. Third observation of resident room 324 A on 11/09/18 at 2:25pm revealed a strong odor of urine that permeated throughout the 324 suite. Fourth observation of resident room 324 A on 11/09/18 at 4:38pm revealed the room had a strong pungent odor of urine permeating throughout the bedroom and throughout the suite area of the bedroom. Refer to interview with housekeeping staff on 11/06/18 at 11:35am. Refer to interview with lead housekeeper on 11/08/18 at 2:00pm. Refer to additional interview with the lead housekeeper on 11/09/18 at 2:45pm. Refer to interviews with 5 residents on 11/09/18 between 4:30pm to 5:00pm. 3. Observation of vacant resident room 307 on 11/08/18 at 5:25am revealed: -A strong pungent stale urine odor permeated throughout the bedroom and the entire bedroom suite. -The flooring throughout the room was sticky causing a suction noise when walked on. Second observation of vacant resident room 307 on 11/09/18 at 2:24pm revealed the room had a	D 075		

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D 075	Continued From page 8	D 075		

very strong odor that permeated throughout the entire 307 suite.

Refer to interview with housekeeping staff on 11/06/18 at 11:35am.

Refer to interview with lead housekeeper on 11/08/18 at 2:00pm.

Refer to additional interview with the lead housekeeper on 11/09/18 at 2:45pm.

Refer to interviews with 5 residents on 11/09/18 between 4:30pm to 5:00pm.

4. Observation of resident room 224 on 11/08/18 between 4:45am and 6:30am revealed:
-The room had a strong odor of urine.
-There was feces and urine on the toilet in the resident's bathroom.
-There were old dark yellow urine stains on the resident's bed sheets.

Refer to interview with housekeeping staff on 11/06/18 at 11:35am.

Refer to interview with lead housekeeper on 11/08/18 at 2:00pm.

Refer to additional interview with the lead housekeeper on 11/09/18 at 2:45pm.

Refer to interviews with 5 residents on 11/09/18 between 4:30pm to 5:00pm.

5. Observation of second floor hallways on the assisted living side of the facility on 11/09/18 between 2:30pm to 3:00pm revealed a strong urine in the hallway between resident rooms 201 to 210.

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D 075	Continued From page 9 Refer to interview with housekeeping staff on 11/06/18 at 11:35am. Refer to interview with lead housekeeper on 11/08/18 at 2:00pm. Refer to additional interview with the lead housekeeper on 11/09/18 at 2:45pm. Refer to interviews with 5 residents on 11/09/18 between 4:30pm to 5:00pm. 6. Observation of resident room 107 on 11/08/18 at 5:00am revealed: -The resident was sitting in a chair with a soiled brief around her ankles. -The resident was confused and attempted to look for her "panties" -There was a strong odor of urine that permeated throughout the suite. Based on interview is was determined the resident in room 017 was not interviewable. Refer to interview with housekeeping staff on 11/06/18 at 11:35am. Refer to interview with lead housekeeper on 11/08/18 at 2:00pm. Refer to additional interview with the lead housekeeper on 11/09/18 at 2:45pm. Refer to interviews with 5 residents on 11/09/18 between 4:30pm to 5:00pm. 7. Observation of Resident #3's facility room on 11/08/18 at 10:13am revealed an empty room with a strong urine smell.	D 075		

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D 075	Continued From page 10 Interview with a medication aide (MA) on 11/07/18 at 8:38am and 11/08/18 at 8:35am revealed she had not noticed Resident #3 smelling like urine. Interview with the Resident Care Coordinator (RCC) on 11/07/18 at 10:15am revealed: -She was not aware that Resident #3 had any problems with a leaking catheter bag. -"It was normal," for Resident #3 to smell like urine even after he had received a shower. Refer to interview with housekeeping staff on 11/06/18 at 11:35am. Refer to interview with lead housekeeper on 11/08/18 at 2:00pm. Refer to additional interview with the lead housekeeper on 11/09/18 at 2:45pm. Refer to interviews with 5 residents on 11/09/18 between 4:30pm to 5:00pm. _____ Interview with housekeeping staff on 11/06/18 at 11:35am revealed: - She used a sanitizer/virucidal cleaner to mop the bathroom floors in the facility, which was mixed with water. - She used the light duty sanitizer/crucial solution to clean the floors in resident rooms and she used the heavy duty sanitizer/crucial solution to clean any bathroom floors and showers that had grout. -For urine odors, she used "Clorox" and then said she could not locate the Clorox and that she thought it was "all gone".	D 075		

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D 075	Continued From page 11 Interview with lead housekeeper on 11/08/18 at 2:00pm revealed: -She was responsible for ordering cleaning supplies. -Housekeeping staff was responsible for cleaning the floors in resident rooms. -The flooring in resident rooms was mopped every other day. -Housekeeping staff checked all resident bathrooms every day and were responsible for cleaning the resident bathrooms. -When housekeeping staff were not working, the caregivers were responsible for cleaning the resident bathrooms. Additional interview with the lead housekeeper on 11/09/18 at 2:45pm revealed: -She used a "urine odor remover" or bleach for removing urine odors in resident rooms. -She sometimes found urine on the floor in resident bathrooms. -Care aides "should be cleaning urine up" in resident bathrooms and then "housekeeper comes behind and sanitizes". -The facility was out of urine odor remover. -She was unsure how long the facility had been out of urine odor remover and she had told staff to use a bleach/water spray solution for urine odors. Interviews with 5 residents on 11/09/18 between 4:30pm to 5:00pm revealed: -No resident revealed problems with chronic odors in the facility.	D 075		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings	D 076		

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D 076	Continued From page 12 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; 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 assure the chairs in the resident hallways on the 2nd and 3rd floors were kept clean and in good repair. The findings are: Observation of 3rd floor resident hallways on 11/06/08 from 9:00am to 9:30am and on 11/08/18 from 5:25am to 5:30am revealed: -There were 4 fabric upholstered wing back chairs located on the 3rd floor hallways. -The chair arms of the chairs were ripped and splitting at the end of the chair arms exposing the -The chair arms of the chairs were ripped and splitting at the end of the chair arms exposing the foam cushion underneath the fabric. -The fabric on the arms of the chairs appeared to have a brownish grimy staining. -One of the chairs had a dried brown clumpy matter stain and also white residue staining on the edge of the seat cushion. Observations of the wing back chairs in the hallways on the 2nd floor on 11/09/18 at 1:59pm revealed cloth table napkins spread out on 2 of the 4 upholstered chairs covering the seat cushions that had dark staining. Interview with lead housekeeper on 11/09/18 between 1:00pm to 2:30pm revealed: -The facility had a steam cleaner to clean the	D 076		

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D 076	Continued From page 13 upholstered chairs in the facility and she stated it "had been in the shop". -She did not know how long the facility had been without a steam cleaner.	D 076		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure staff provided personal care assistance for 6 of 6 sampled residents (Residents #3, #2, #8, #18, #22 and #23) regarding a resident not receiving foley catheter care or showers and presented to physician appointments covered in urine and feces (#3), residents not receiving assistance with incontinence care and an open perineal wound that was not assessed (#2, #8, #18 and #22), and a resident not receiving bed linen changes (#23). The findings are: 1. Review of Resident #3's current FL2 current dated 11/02/17 revealed: -Diagnoses included dementia without behavioral disturbances, atrial fibrillation, diabetes, and	D 269		

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edema.
-Resident #3 was incontinent of bladder.
-Resident #3 was intermittently disoriented and was semi-ambulatory.

Review of Resident #3's Resident Register revealed he was admitted to the facility on 10/31/17.

Review of Resident #3's urologist's visit notes dated 06/26/18 revealed:
-Resident #3 was referred to the urologist for urinary incontinence.
-Resident #3 had a Foley catheter placed during the office visit.
-The facility was instructed to assist the resident in emptying the catheter bag.
-Resident #3 was given extra catheter supplies to allow the catheter bag to be changed weekly.
-Resident #3 was scheduled to return to the urologist's office in 4 weeks to exchange the catheter.

Review of a Licensed Health Professional Support (LHPS) evaluation dated 10/12/18 revealed:
-Resident #3 had a Foley catheter that was followed up by a home health agency.
-The staff had been LHPS competency validated in catheter care.
-Catheter care for Resident #3 included positioning and emptying the urinary catheter bag and cleaning around the urinary catheter.

Interview with the Adult Home Specialist on 10/31/18 at 3:50pm revealed Resident #3 was emptying his own catheter bag and was having no discomfort from his catheter.

Review of Resident #3's Personal Care Record

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for October 2018 revealed no documentation the resident received catheter care or showering assistance from 10/01/18 to 10/31/18.

Observation of Resident #3's room on 11/08/18 at 10:13am revealed an empty room with no furnishings with a strong urine smell.

Telephone interview with Resident #3's Power of Attorney (POA) on 11/07/18 at 4:52pm revealed:
-She would meet Resident #3 at his physician appointments.
-Resident #3 was covered in feces on his clothes when she met him for the urologist appointment on 09/24/18.
-Resident #3 had "a plastic bag from the kitchen strapped to his leg holding his catheter bag."
-"Facility should clean and change the catheter bag," for Resident #3.

Interview with a first shift personal care aide (PCA) on 11/08/18 at 9:15am revealed:
-She had worked at the facility for "about 1 year."
-She was responsible for Resident #3's showers and catheter care.
-Resident #3 was scheduled to have 3 showers weekly.
-She had never received catheter care training at the facility.
-She was a nurse assistant (NA) and "knew how to care for a resident with a catheter."
-She would clean the area around Resident #3's catheter and the catheter tubing with alcohol swabs.
-The facility was not responsible for changing the catheter bag and never had supplies to change the bag.

Interview with a medication aide (MA) on 11/07/18 at 8:38am and 11/08/18 at 8:35am revealed:

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-The PCA was responsible for catheter care and showering the residents.
-She had not noticed Resident #3 smelling like urine.
-There were no extra catheter supplies in storage at the facility.

Interview with the Resident Care Coordinator (RCC) on 11/07/18 at 10:15am revealed:
-The PCA's were responsible for catheter care for Resident #3.
-The PCA's were instructed to empty Resident #3's catheter bag and shower the resident.
-She did not know that Resident #3 had any problems with a leaking catheter bag.
-"It was normal," for Resident #3 to smell like urine even after he had received a shower.

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:45pm revealed:
-She worked from 12:00pm to 12:00am.
-The PCA's were responsible for catheter care for Resident #3.
-The PCA was responsible for emptying the catheter bag and using soap and water to wash the resident.
-Each resident with a catheter had a home health agency that was responsible for cleaning the catheter and doing daily checks at the facility.
-The MA was responsible for checking the catheter bag to determine if it needed to be emptied.
-She did not know of any problems Resident #3 had with his catheter or the catheter bag leaking.
-Resident #3 was supposed to be showered twice weekly during first shift.
-The second shift PCA would report that Resident #3 was "left in a mess" when they checked on him.
-The first shift PCA's would report on a regular

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basis that Resident #3 refused his showers.
-"The first shift staff was lazy and didn't want to give him a shower."

Review of Resident #3's hospital admission summary on 10/31/18 and 11/01/18 revealed:
-Resident #3 reported to the hospital that he had not been feeling well for the last several days and had a fever and chills.
-Resident #3's urine in his catheter bag was cloudy, foul smelling, and contained a sediment.
-Resident #3 was at "high risk for clinical death and decline" and was admitted with urosepsis.

Telephone interview with a nurse from Resident #3's urologist's office on 11/09/18 at 9:24am revealed:
-Resident #3 was scheduled for catheter changes every 4 to 5 weeks.
-Resident #3 had arrived to his appointment on 09/24/18 with a rip in his catheter bag.
-The catheter bag was placed in a plastic bag but was leaking urine on the resident.
-"The clinic gave each patient catheter supplies until they could be mailed directly to the patient."
-Resident #3 was "saturated in urine down to his ankles with a tremendous amount of feces covering his front and back groin area."
-"It took 2 nurses more than 30 minutes to clean all the dried feces and urine off the patient."
-She gave Resident #3 surgical pants to wear to return to the facility.
-She contacted a social worker to recommend a higher level of care for Resident #3 because of the condition he presented to his appointment.
-The facility should not manipulate the catheter but was responsible for emptying the catheter bag, basic bathing, and washing the area around the catheter with soap and water.
-The catheter bag needed to be changed out

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weekly.
-Resident #3 was not able to care for himself and needed "total care for showering and catheter care."
-The amount of feces and urine on Resident #3 could lead to the resident developing urosepsis.
-The facility should have contacted the urology office immediately if there was a problem with the catheter or if the facility noticed signs and symptoms of an infection.

Telephone interview with the social worker from Resident #3's primary care physician's (PCP) office on 11/09/18 at 3:37pm revealed:
-She had been notified by the nurse from Resident #3's urologist's office that the resident had presented to the office "covered in urine and feces."
-Resident #3's catheter changes were being followed by the urologist and not home health.
-The facility staff should be providing personal care to the resident.
-She had called Resident #3's POA to discuss moving the resident to a higher level of care and offer additional personal care services for the resident at the facility.
-The POA did not want to move the resident.
-A nurse from the physician's office had contacted the facility on 10/04/18 regarding offering additional personal care services to Resident #3, including weekly baths.
-The facility staff stated "they provided this service already" to Resident #3.

Review of Resident #3's charting notes on 11/06/18 revealed:
-Resident #3 was sent out of the facility to the hospital for evaluation on 10/31/18 at 11:17pm.
-The MA had documented that Resident #3 had a "blood looking color" in his catheter bag on

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D 269	Continued From page 19 10/31/18 at 5:30pm. Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed: -He was responsible for providing training on LHPS tasks to the facility staff and completing resident assessments. -He had not provided any "recent catheter training" and could not remember the last time he provided an "in-service training on catheters." -The facility was only responsible for emptying the catheter bag and cleaning the resident. -He instructed the staff to wash the resident with soap and water to keep the catheter area clean. -The PCA or MA should notify the nurse if they notice any "discoloration or sediment in the catheter bag." -The facility staff should visibly "lay eyes" on each resident every 2 hours and should document in the personal care notebook -The PCA was responsible for showering the resident and providing personal care assistance. -The PCA should follow the schedule for showers and other personal care activities. -The PCA should notify the nurse supervisor if a resident refused any personal care activities. -Resident #3 was followed by a home health agency. -He did not know Resident #3 had any problems with his catheter, including any leaking of the catheter bag. -He was not aware that Resident #3 was not getting proper personal care and had presented to the urologist covered in feces and urine. Attempted telephone interview with Resident #3's home health nurse on 11/09/18 at 9:16am was unsuccessful. 2. Review of Resident #23's current FL-2 dated	D 269		

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D 269	Continued From page 20 10/24/17 revealed: -Diagnoses included vascular dementia, bipolar disorder, diabetes, chronic renal disease, and post-traumatic stress disorder (PTSD). -Resident #23 was constantly disoriented. -Resident #23 needed assistance with bathing, feeding, and dressing. -Resident #23 had functional limitations with sight and hearing. Review of Resident #23's Care Plan dated 10/23/17 revealed he was not motivated to complete personal care tasks and must be reminded by staff to complete task such as showering, shaving, and brushing teeth. Observation of Resident #23's room on 11/08/18 at 5:06am revealed: -Resident #23 was in the bed asleep. -Room had a strong body odor and urine smell. -Urine and feces were on the seat of the toilet. Review of Resident #23's Caregiver Information Record located on the back of his bathroom door on 11/08/18 at 5:06am revealed resident's bed should be changed once weekly during first shift from 7:00am to 3:00pm. Observation of Resident #23's room on 11/08/18 at 5:46am revealed: -Resident #23 was out of the bed in the restroom. -Resident #23's bed sheet had a large, yellow stain that appeared to be wet urine. Review of Resident #23's Shower Schedule located on the back of his bathroom door on 11/08/18 at 5:46am revealed: -Resident #23's Caregiver Information Chart on the back of the bathroom door had been replaced with a shower schedule.	D 269		

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D 269	Continued From page 21 -Resident #23's bed linens should be changed "on 1st shift weekly on scheduled shower day and as needed." -Resident #23 was scheduled for showers on Tuesday, Thursday, and Saturday. Observation of Resident #23's room on 11/08/18 at 2:09pm revealed: -The bed linens on Resident #23's bed had been straightened. -The sheet was stained with a large yellow permanent stain that appeared to be dried urine. -The toilet seat was raised and had feces on the seat. Review of Resident #23's November 2018 Personal Care Record revealed that Resident #23 had his bed made daily from 11/01/18 to 11/08/18 but there was no documentation that the bed linens had been changed. Interview with a housekeeper on 11/08/18 at 2:11pm revealed the personal care aides were responsible for changing the resident's bed linens at least weekly and as needed. Interview with a PCA on 11/09/18 at 4:26pm revealed: -Resident #23 was independent with bathing. -The PCA's that worked on first shift was responsible for changing a resident's bed linens. -Each resident's bed linens should be changed weekly and as needed. -She only changed a resident's bed linens if the sheets were dirty. -She did not know if first shift was changing the resident's bed linens. -Housekeeping was responsible for the cleaning the resident's bathrooms.	D 269		

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Interview with a medication aide (MA) on 11/09/18 at 12:57pm revealed:
-Resident #23 was able to take care of himself but needed reminders.
-The PCA was responsible for changing the resident's bed linens on shower days and as needed.

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm revealed:
-PCAs on first shift should be providing showers and bed linen changes.
-PCAs on second shift would often report the residents were "left in a mess" when they checked on the residents when "starting their rounds."

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed:
-The PCA was responsible for showering the resident and providing personal care assistance.
-The PCA should follow the schedule for showers and other personal care activities.
-The PCA should notify the Nurse Supervisor if a resident refused any personal care activities.
-The RCC was responsible for monitoring the personal care logs for each resident.

3. Review of Resident #2's current FL2 dated 01/16/18 revealed:
-Diagnoses included history of malignant neoplasm of prostate, type 1 diabetes, heart disease, and hyperlipidemia.
-Resident #2 was incontinent of bladder and bowel, with a note listed "frequent".
-Resident #2 was non-ambulatory.

Review of Resident #2's Care Plan dated 10/10/18 revealed he was totally dependent on staff for bathing, toileting, grooming, and

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D 269	Continued From page 23 dressing. Review of Resident #2's record revealed no documentation of a personal care log with documented refusals of personal care or showers. Observation of Resident #2 on 11/06/18 at 2:00pm revealed: -Resident #2 was dressed and sitting in his wheelchair in his room. -Resident #2 had his right leg amputated. -There was a sit to stand Hoyer lift present in his bedroom. -Resident #2's room smelled of strong urine odor. -Resident #2 was wearing a yellow shirt and blue sweatpants. -Resident #2 had thick tan colored residue inside of his ears, that appeared to be dirt. Interview with Resident #2 on 11/06/18 at 2:05pm revealed: -He was not sure the last time he had a shower. -"Last night I slept in urine, and no one came to change me". -Staff came "sometimes" to change the incontinent brief throughout the night. -He had been in bed some nights and it had taken a long time for a caregiver to change him. -He was experiencing irritation and bleeding around his perineal area. Observation of Resident #2 with staff present on 11/07/18 at 10:46am revealed: -Resident #2 was dressed in a yellow shirt and blue sweatpants. -Resident #2 had thick tan colored residue inside of his ears. -Resident #2's room smelled of strong urine odor. -Resident #2 had wound on his perineal about the	D 269		

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size of a nickel that was red and raw.
-Resident #2 had skin breakdown and redness at the base of perineal area, with a two and one-half inch open area in the skin.
-Resident #2 stated his perineal area was "irritated and uncomfortable".

Observation of Resident #2 on 11/08/18 at 5:04am revealed:
-Resident #2 was lying in bed with an empty urinal hanging from his wheelchair.
-There was a blue towel on the floor next to Resident #2's bed that was covering urine on the floor.
-Resident #2 could not recall incontinence care being provided within the past 2 hours, he attempted to use his urinal and had an "accident".

Interview with a third shift personal care aide (PCA) on 11/08/18 at 5:04am revealed:
-She and another PCA was responsible for caring for the residents on the second floor.
-She did not know who put the towel on the floor in Resident #2's room.
-She came throughout the night and provided incontinent care for Resident #2, but could not remember the times.
-She was getting ready to get Resident #2 dressed for the day.
-She provided Resident #2 with a bed bath daily, and assisted him with grooming and dressing.
-She had not noticed the residue in Resident #2's ear.

Interview with a first shift PCA on 11/08/18 at 8:42am revealed:
-She assisted residents with bathing, grooming, dressing, and transfers.
-Resident #2 usually received his bath during third shift.

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D 269	Continued From page 25 -Resident #2 was up and dressed when she arrived for her shift at 7:00am. -She thought Resident #2 appeared clean when she came in for her shift. -Resident #2 never refused care. -Resident #2's showers were scheduled Monday, Wednesday, and Friday. -She had never assisted Resident #2 with a shower because he received his showers during 3rd shift. -Resident #2 was totally dependent on staff for showering, dressing, and incontinent care. Review of the facility shower schedule updated on 11/07/18 revealed Resident #2 was scheduled to receive a shower on Mondays, Wednesdays, and Fridays. Review of Resident #2's record and the facility's activities of daily living (ADL) records revealed there were no personal care records for September 2018. Review of Resident #2's Personal Care Record for October 2018 revealed: -Sponge baths, skin care (wash hands, face, and foot care), dressing, transfer, and mobility was documented as completed twice for October 2018. -Toileting/incontinence was documented completed once for October 2018. -There was no documentation Resident #2 had received showers, dressing, or assistance with incontinence care. Interview with a PCA on 11/06/18 at 5:20pm revealed: -She had worked as a PCA for about 3 months. -She would go to the medication aide (MA) if she had any concerns with the residents.	D 269		

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-She was not aware of the daily personal care record shower log for the residents.
-She had not documented any showers or baths she had given to the residents.
-She had not been trained on using the personal care record book and did not know what the book was.

Interview with the Resident Care Coordinator (RCC) on 11/09/18 at 3:00pm revealed:
-Resident #2 was totally dependent with all ADLs.
-PCAs were responsible for providing assistance with ADLs and tasks were listed in the ADL book.
-PCAs were supposed to document their tasks completed in the ADL book daily.
-She was responsible for ensuring PCAs completed ADL tasks.
-She thought Resident #2 was receiving assistance with bathing, incontinence care, and grooming.
-She had not smelled body odor or urine on Resident #2.
-She was responsible for reviewing the ADL book weekly.
-She had not had the chance to review the ADL book for completeness as she had been functioning as a MA for multiple shifts.

Interview with the Assisted Living (AL) Nurse Supervisor on 11/08/18 at 4:19pm revealed:
-Residents were supposed to receive assistance with ADLs daily and document in the ADL book.
-The ADL book was supposed to be reviewed weekly by the RCC.
-She personally came into the facility on weekends to give residents' showers because they had an odor.
-She had never smelled body odor or urine on Resident #2.
-She felt that the care provided "could be better"

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THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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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for the residents.
-She expressed her concerns with the Administrator and nothing had been done.

Interview with the Administrator on 11/09/18 at 2:00pm revealed:
-PCAs were responsible for providing personal care to residents.
-He expected showers to be completed according to the schedule and to notify the RCC, and the facility nurse if showers were missed.
-Completed ADL tasks should be documented in the ADL book for each resident.
-The RCC was responsible for reviewing the ADL book for accuracy.

4. Review of Resident #22's current FL2 dated 08/08/17 revealed:
-Diagnoses included open reduction and internal fixation of left hip, osteoporosis, hypothyroidism, atrial fibrillation, and osteoarthritis.
-Resident #22 was continent of bladder and bowel.

Review of Resident #22's Care Plan dated 06/30/18 revealed she required limited assistance by staff with toileting with occasional incontinence.

Review of Resident #22's record revealed no documentation of refusals of toileting.

Observation of Resident #22 on 11/08/18 at 5:00am revealed:
-Resident #22 was sitting in her wheelchair attempting to put on an incontinence brief.
-Resident #22 was unsteady as she stood to pull up her incontinence brief while holding on to her dresser.
-Resident #22's wheelchair was wet and soiled

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with urine.
-Resident #22 assisted herself to the bed.

Interview with Resident #22 on 11/08/18 at 5:05am revealed:
-She woke up to change her own soiled incontinence brief.
-She always changed her incontinence brief at night because she tried to do it alone.
-"I could use some help, I am afraid of falling".
-She had not pressed her call button for help, she was not sure anyone would come to assist.
-No one came to her bedroom to check on her throughout the night.

Observation of the second floor on 11/08/18 from 5:10am-5:53am revealed:
-Resident #22 pressed her call button to request assistance.
-No staff came to check on Resident #22 after she pressed her call button.
-The computer on the second floor in the wellness center showed an alert on the screen that Resident #22 had pressed her call button.
-There was no staff available in the wellness center to acknowledge call button requests.
-At 5:53am, Resident #22's call button had still not been responded to by staff.

Interview with a third shift personal care aide (PCA) on 11/08/18 at 5:04am revealed:
-She thought Resident #22 was independent with incontinence care.
-She did not know incontinence care was a task that Resident #22 required assistance with.
-She referred to the assignment sheet and Resident #22 was not listed as requiring assistance with incontinence care.
-Resident #22 never pressed her call button to request assistance with incontinence care.

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D 269	Continued From page 29 -She would expect someone from the front desk to alert her when a resident pressed the call button. Interview with a first shift PCA on 11/08/18 at 8:42am revealed: -She assisted residents with bathing, grooming, dressing, incontinence care, and transfers. -Resident #22 never requested assistance with incontinence care. -She assisted Resident #22 with showers three times per week. -Resident #22 never refused care. -She thought Resident #22 was independent with incontinence care, but would assist if she asked. Review of Resident #22's record and the facility's activities of daily living (ADL) records revealed there were no personal care records for September, October, or November 2018. Interview with the Resident Care Coordinator (RCC) on 11/09/18 at 3:00pm revealed: -She would have to see Resident #22's care plan to determine if she required assistance with toileting. -PCAs were responsible for providing assistance with ADLs and tasks were listed in the ADL book. -PCAs were supposed to document their tasks completed in the ADL book. -She was responsible for reviewing the ADL book weekly. -She had not had the chance to review the ADL book for completeness as she had been functioning as a medication aide (MA) for multiple shifts. Interview with the AL Nurse Supervisor on 11/08/18 at 4:19pm revealed: -Residents were supposed to receive assistance	D 269		

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with ADLs daily and document in the ADL book.
-The ADL book was supposed to be reviewed weekly by the RCC.
-She felt that the care provided "could be better" for the residents.
-She expressed her concerns with the Administrator and nothing had been done.

Interview with the Administrator on 11/09/18 at 2:00pm revealed:
-PCAs were responsible for providing personal care to residents.
-He expected personal to be provided according to the residents needs.
-Completed ADL tasks should be documented in the ADL book for each resident.
-The RCC was responsible for reviewing the ADL book for accuracy.

5. Review of Resident #18's FI-2 dated 08/01/18 revealed:
-Diagnoses included: dementia; unspecified peripheral insufficiency; unspecified essential hypertension; syncope and collapse; PAC; anxiety; depression; lung nodule; diverticulosis of colon; dizziness; esophageal reflux; hair loss; and edema.
-She was intermittently disoriented.
-She was semi-ambulatory with a walker.

Review of Resident #18's care plan dated 10/17/18 revealed:
-Resident #18 required extensive assistance with bathing and grooming.
-She needed minimal assistance with dressing.
-She required supervision for eating, toileting; ambulation, and transfers.

Observation of Resident #18 in her room on 11/08/18 at 5:15am revealed:

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D 269	Continued From page 31 -She was sitting in a high-back living room chair with a pull-up around her ankle in front of the television. -The pull-up had a strong odor with yellowish urine stains inside. -Resident #18 stated she did not have any new panties to put on. Observation of Resident #18 in her room on 11/09/18 at 10:48am: -She was sitting in her high-back living room chair in front of the television. -She stated, "it's squishy, if I move, I will pee." -She did not have a pendant to call for assistance to go to the bathroom. Staff had to be located by a survey team member to find a staff member to assist Resident #18 to go to the bathroom. Interview with a medication aide (MA) on 11/09/18 at 10:55am revealed: -Resident #18 required assistance from staff to go to the bathroom for safety reasons. -Resident #18 would sometimes get confused when going to the bathroom alone and fall. -She did not know if resident had a pendant to call for assistance to go to bathroom. Interview with the Maintenance Director (MD) on 11/09/18 at 11:00am revealed: -Resident #18 was assigned a call bell pendant. -The resident sometimes misplaced the pendant. -She did not always keep the pendant on or remember to call for assistance when she needed to go to the bathroom. -MD checked Resident #18's room for her call bell pendant and could not locate the pendant. -MD said he would issue her a new pendant today.	D 269		

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D 269	Continued From page 32 Telephone interview with Resident #18's Power-of-Attorney, POA, on 11/09/18 at 11:35am revealed: -Resident #18 was supposed to be getting assistance with toileting. -When Resident #18 had to go to the bathroom, she would "need to go all of a sudden and have an accident." -Resident #18 has had several pendants, but she keeps removing the pendants. -POA has spoken with the administrator about the personal care service her mother was supposed to receive due to concerns of other family members that had visited her mother at the facility and found her wet. -POA reported that since she had the conversation with the administrator, the staff was more responsive to ensuring her mother is toileted more frequently with staff assistance. _____ The facility failed to assure staff provided personal care assistance for 6 residents including Resident #3's Foley catheter bag leaking, smelled of urine, arrived at the physician's office covered in feces and wet from urine, facility staff not providing care to the Foley catheter and incontinent care, Resident #2 had a wound and redness around his perineal area, and slept in urine due to staff not changing his brief, Resident #23 had feces and urine on the toilet seat and had been sleeping on a urine stained sheet, Resident #22 was in a wheelchair attempting to provide personal care to herself, her incontinent brief was saturated and soiled, the wheelchair cushion was saturated, she was fearful of falling and pushed her call bell pendant for staff assistance with no response after 50 minutes. Resident #18 found in a soiled incontinent brief, providing personal care to herself and did not	D 269		

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D 269	Continued From page 33 have a call bell pendant to call for assistance. This failure placed residents at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 8, 2018.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure staff provided supervision for 1 of 6 sampled residents (Resident #19) related to Resident #19 unlocking the special care unit (SCU) door, and exiting the facility unsupervised in the dark.	D 270		

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D 270	Continued From page 34 The findings are: Observation of the SCU on 11/08/18 between 4:55am and 5:30am revealed: -Resident #19 was sitting in a chair in the common area awake. -There were 8 residents asleep in their rooms. -The medication aide (MA) exited the SCU at 5:00am leaving one personal care assistant (PCA) on the unit who was providing personal care for a resident in room 122. -The MA was off the SCU from 5:00am until 5:04am at which during this time Resident #19 rose from her chair without her walker, cane or wheelchair, walked to the courtyard door, opened the lock(that did not alarm) at the top of the door and walked into the courtyard onto uneven pavement, where a flower pot was in her pathway, and stood in a tee-shirt, warm-up pants, and tennis shoes saying "I heard you knocking on the door and you can come inside now." -The courtyard door opened to the courtyard that was enclosed with a fence secured with a gate that led to the parking lot that was locked only by a simple hook and eye latch lock with not alarm, and easily opened when lifted. -The temperature in the courtyard was 55 degrees Fahrenheit, and Resident #19 remained outside from 5:00am until 5:02am when she returned inside after being prompted to return. -The PCA was not alerted when Resident #19 exited the locked door to the courtyard and continued providing care to the resident in room 122. Review of Resident #19's current FL2 dated 09/10/18 revealed: -Her level of care was documented as SCU. -Her diagnoses included pneumonia, emphysema, left rib fracture, dementia, diabetes	D 270		

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mellitus type 2, and hypothyroid.
-Resident #19 was constantly disoriented.

Review of Resident #19 Care Plan dated 10/11/18 revealed:
-Resident #19 personal care tasks included standby assistance by staff, and ambulation using assistive devices that required physical assistance.
-Resident #19's activities of daily living for transferring the performance code documented she was totally dependent.
-Resident #19 was documented as a high elopement risk.
-Resident #19's social and mental history statement was "resident continue to be followed by behavioral health provider and continues paranoid and hallucinations, resident has to be re-directed throughout the day, and needs supervision when ambulating and transferring."

Review of Resident #19's fall assessment dated 09/18/18 revealed a score of 32 points requiring use of chair and bed alarm to prevent falls.

Interview with the PCA on 11/08/18 at 5:30am revealed:
-The MA had left to take a drink to another PCA who was on a smoke break in her car.
-She did not know Resident #19 had walked outside to the courtyard because she was in room 122 and had not heard her leave.
-"She's had went out and sat in the courtyard before."
-She was aware Resident #19 required constant supervision.
-She was aware Resident #19 needed to use her walker when ambulating.

Interview with the MA on 11/08/18 at 5:40am

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revealed:
-She had left the SCU to get something out of her car outside, and she had told the PCA she was leaving and she would be right back.
-She knew Resident #19 was a high risk for falls, and she was to have a chair alarm.
-"She won't keep a chair alarm on, and she had figured out how to take it off herself."
-She knew Resident #19 required constant reminders to use her walker or cane.
-She knew Resident #19 was able to open the SCU door.
-She thought Resident #19 was probably capable of unlocking the gate's simple hook and eye latch lock.

Interview with the SCU Nurse Supervisor on 11/08/18 at 2:00pm revealed:
-She did not know Resident #19 had been left unsupervised to exit the SCU to the courtyard.
-She expected 2 of the 3 staff members scheduled to work on the SCU would remain on the SCU at all times.
-After Resident #19 had a recent fall the staff was expected to keep one staff member in the common area to supervise Resident #19 to prevent any recurrent falls.

Interview with Resident #19's Behavioral Health doctor on 11/09/18 at 12:16pm revealed the resident required constant supervision because her behavior could lead to an injury.

Interview with the Administrator in Charge on 11/09/18 at 1:00pm revealed:
-She did not know Resident #19 had been left unsupervised to walk outside into the courtyard.
-The SCU was supposed to be staffed with 2 people at all times.

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D 270	Continued From page 37 Interview with the Administrator on 11/09/18 at 2:00pm revealed: -He expected the "staff to keep eyes on the residents at all times." -Staff were allowed to take breaks without leaving the SCU understaffed. _____ The facility failed to assure staff provided supervision for 1 of 6 residents (Resident #19) regarding a resident who resided in the SCU left unsupervised in the common area, she locked the SCU door which did not alarm that led outside on to the patio, she went outside without her walker or cane. 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 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 8, 2018.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Non-compliance continues with increased severity. THIS IS A TYPE A1 VIOLATION	D 273		

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D 273	Continued From page 38 Based on observations, interviews and record reviews, the facility failed to notify the physician for 5 of 6 sampled residents (Residents #1, #2, #3, #6, and #15) regarding blood pressure and edema medications not being available and not referring a resident for treatment for an illness in a timely manner (#3), high blood sugars and diabetic medications not administered (#1), a perineal wound with bleeding and discomfort (#2), fentanyl patch not being available then administered without an order after discontinued (#15) and refusals for three medications and with an order for a psychological evaluation and treatment for a resident who displayed aggressive behaviors (#6). The findings are: 1. Review of Resident #3's current FL2 dated 11/02/17 revealed diagnoses included dementia without behavioral disturbances, atrial fibrillation, diabetes, and edema. a. Review of Resident #3's current FL2 dated 11/02/17 revealed: -Diagnoses included dementia without behavioral disturbances, atrial fibrillation, hypertension, diabetes, and edema. -Resident #3 was incontinent of bladder. -Resident #3 was intermittently disoriented and was semi-ambulatory. Review of a Licensed Health Professional Support (LHPS) evaluation dated 10/12/18 revealed: -Resident #3 had a Foley catheter that was followed by a home health agency. -The staff had been competency validated in catheter care.	D 273		

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D 273	Continued From page 39 -Catheter care for Resident #3 included positioning and emptying the urinary catheter bag and cleaning around the urinary catheter. Telephone interview with Resident #3's Power of Attorney (POA) on 11/07/18 at 4:52pm revealed: -Resident #3 had called her "early in the morning" on 10/31/18 and reported "he felt terrible and did not know what was going on." -She told Resident #3 to "press his call button to get someone to come help him." -Resident #3 told her it took "someone an hour and a half to come check on him." Interview with the facility receptionist on 11/08/18 at 2:32pm revealed: -She sat at the front desk and monitored the call bell monitoring system during first shift from 6:00am to 2:00pm. -When a resident pressed their call bell, she would get an alert on her computer. -She would use a "walkie-talkie" to alert the staff working on the floor that a resident needed something. -The facility staff that responded to the alert would use an "acknowledger" to silence the alert once they had reached the resident. -She would call the staff until she could reach someone to make sure the alert had been responded to because sometimes the "acknowledger" would not work. -She kept the "acknowledgers" that did not work at her desk for the maintenance team to fix. -She had never been trained based on a facility policy on the call bell system. -She was not sure the procedure that other staff used to monitor the call bell system. -She was not aware of Resident #3's call bell not being answered.	D 273		

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Telephone interview with Resident #3's family member on 11/09/18 at 7:55am revealed:
-She visited Resident #3 on the morning of 10/31/18.
-She arrived before Resident #3 was served breakfast and left before lunch.
-Resident #3 was "sick and not feeling good."
-She spoke with the Administrator before she left to make sure he knew that Resident #3 was not feeling well.

Interview with a personal care aide (PCA) on 11/08/18 at 9:15am revealed:
-She had worked as Resident #3's PCA on 10/31/18.
-Resident #3 was "out of it and had a fever all day" on 10/31/18.
-She had delivered all 3 meals to Resident #3 in his room because the resident did not want to leave his room.
-She had notified the medication aide (MA) about Resident #3 "not feeling good" but she was not sure what care was provided by the MA.

Interview with a MA on 11/07/18 at 10:15am and 11/08/18 at 5:15am revealed:
-She worked third shift on 10/31/18 when Resident #3 had been sent out to the hospital.
-Resident #3 "seemed fine before he left to go to the hospital."
-Resident #3 was "joking like he normally did."
-She noticed no change in Resident's #3's behavior.
-"If no one was sitting at the front desk then no one was monitoring the call bell system."

Interview with a MA on 11/08/18 at 8:35am and at 9:34am revealed:
-If a resident reported not feeling well, she checked vital signs and assessed the resident for

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symptoms.
-She would notify the RCC or nurse about the resident if she could not provide care to the resident.
-She was responsible for checking on the residents every 2 hours.

Interview with the Resident Care Coordinator (RCC) on 11/07/18 at 10:15am revealed:
-The MA had informed her that Resident #3 was not feeling well and had a fever prior to being sent to the hospital on the evening of 10/31/18.
-Resident #3 had been "fine all day up until he was sent out to the hospital."

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:45pm revealed:
-She was notified by the MA on the evening of 10/31/18 that Resident #3 had a fever and was not feeling well.
-She or the Special Care Unit Nurse Supervisor should be notified if a resident is "having a problem."
-She was responsible for assessing the resident if they needed to be sent out of the facility to the hospital.
-She was responsible for checking the resident's vital signs, including blood pressure, pulse, blood sugar, and if the resident was in pain.
-The MA's should not be assessing residents but should notify the nursing supervisors.
-"There was no one available to make these decisions if both of the nurses were out of the building."
-The PCAs and MAs were responsible for answering the alerts from the call bell system.

Review of Resident #3's charting notes for 10/31/18 revealed:
-The MA documented that Resident #3 had a

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"blood looking color" in his catheter bag at 5:30pm.
-The MA documented that Resident #3 was complaining of not feeling well and had a fever of 103.6 at 9:40pm.
-She had given Resident #3 medication for the fever, diarrhea, and vomiting.
-The Assisted Living Nurse Supervisor was notified at 9:40pm.
-The Assisted Living Nurse Supervisor documented at 11:17pm that Resident #3 "looked weak" and was observed with nausea, vomiting, fever, and diarrhea.
-Resident #3 was sent out of the facility to the hospital for evaluation at 11:17pm.
-Resident was out of the facility at 11:25pm.

Telephone interview with a nurse from Resident #3's urologist's office on 11/09/18 at 9:24am revealed:
-Resident #3 was not able to care for himself and needed "total care for showering and catheter care."
-"The urologist would treat a patient with a catheter for a urinary tract infection only if they showed symptoms."
-The facility should have contacted the urology office immediately if there was a problem with the catheter or if the facility noticed signs and symptoms of an infection.
-Signs and symptoms of an infection included fever, abdominal pain, nausea, vomiting, and diarrhea.
-It was important for Resident #3 to get care immediately if he developed symptoms to prevent a serious infection.

Review of Resident #3's hospital admission summary on 10/31/18 and 11/01/18 revealed:
-Resident #3 reported to the hospital that he had

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not been feeling well for the last several days and had a fever and chills.
-Resident #3's urine in his catheter bag was cloudy, foul smelling, and contained a sediment.
-Resident #3 was at "high risk for clinical death and decline" and was admitted with urosepsis and pulmonary edema.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed he did not know Resident #3 was not feeling well and was having nausea, vomiting, diarrhea, and a fever until the night of 10/31/18 when Resident #3 was sent out of the hospital.

b. Review of Resident #3's signed physician's orders dated 03/08/18 revealed there was a physician's order for hydrochlorothiazide 25mg take 1 tablet daily (used to treat high blood pressure).

Review of Resident #3's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was a computer generated entry for hydrochlorothiazide 25mg take 1 tablet daily scheduled to be administered at 9:00am.
-Hydrochlorothiazide was documented as unavailable for 17 of 31 opportunities from 10/01/18 to 10/31/18.

Observation of Resident #3's medications on hand on 10/31/18 at 3:58pm revealed hydrochlorothiazide was not available to be administered.

Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed hydrochlorothiazide was not listed as an active medication for the resident.

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D 273	Continued From page 44 Interview with the Medication Aide (MA) on 11/08/18 at 9:34am revealed: -The physician should be notified if a resident refuses a medication or misses a dose of medication for 3 consecutive days. -"There is no reason that a medication would not be available." -She had not contacted Resident #3's physician about the resident being out of some of his medications. Interview with the Resident Care Coordinator (RCC) on 11/07/18 at 10:15am revealed: -She could not remember when she was first notified by an MA about Resident #3 being out of medications. -She had called Resident #3's pharmacy multiple times during October to get medications refilled. -Resident #3's pharmacy told her that all of Resident #3's "medications had been discontinued because the prescriptions were only good for 1 year." -The pharmacy or the PCP's office had not contacted the facility to let them know the medications had been discontinued because Resident #3 needed an office visit. -She had not contacted Resident #3's physician about the resident being out of medications and missing multiple doses. Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm revealed: -The resident's physician needed to be notified if the resident missed more than 3 doses of medication on consecutive days. -If she was not at the facility, it was the MA's responsibility to contact the physician for missed doses of medications. -All refusals or missed doses should be	D 273		

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documented on the eMAR.
-She did not know Resident #3 had missed multiple doses of medication in October.
-Resident #3's primary care physician's (PCP) office had contacted the RCC to let her know that Resident #3's medication would be mailed from the pharmacy.
-She did not know when Resident #3's physician had contacted the RCC.

Telephone interview with a nurse from Resident #3's urologist's office on 11/09/18 at 9:24am revealed:
-"Patients with an indwelling catheter are encouraged to dilute their urine as much as possible to reduce the risk of infection."
-"Diuretics dilute a patient's urine and can reduce the risk of infection."
-Resident #3 was at an increased risk of infection due to missing multiple doses of his fluid medications.

Telephone interview with the Social Worker from Resident #3's PCP office on 11/09/18 at 3:37pm revealed:
-The facility had not notified Resident #3's PCP that he had missed multiple doses of hydrochlorothiazide.
-Resident #3's cardiologist had discontinued the hydrochlorothiazide on 08/30/18 due to "significant edema in the resident's lower extremities."
-The cardiologist had started metolazone 2.5mg take 1 tablet on Monday, Wednesday, and Friday to help with the swelling in Resident #3's legs to replace the hydrochlorothiazide.
-The cardiologist had not been notified that Resident #3 had not received the metolazone but continued receiving the hydrochlorothiazide when available.

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D 273	Continued From page 46 Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed the MA's or the Assisted Living Nurse Supervisor were responsible for notifying the physician if a resident missed a medication for 3 consecutive days. Attempted telephone interview with Resident #3's cardiologist on 11/09/18 at 11:03am was unsuccessful. c. Review of Resident #3's signed physician's orders dated 03/08/18 revealed there was a physician's order for doxazosin 8mg take 1 tablet daily (used to treat high blood pressure). Review of Resident #3's October 2018 eMAR revealed: -There was a computer generated entry for doxazosin 8mg take 1 tablet daily scheduled to be administered at 9:00am. -Doxazosin was documented as unavailable for 25 of 31 opportunities from 10/01/18 to 10/31/18. Observation of Resident #3's medication on hand on 10/31/18 at 3:58pm revealed doxazosin was not available to be administered. Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed: -Doxazosin was last dispensed to the resident on 07/26/18 for a 90 day supply. -Resident #3's most recent physician's order for doxazosin was written on 11/02/18 and was received from the physician. -Resident #3's medications were mailed from the pharmacy to the facility when a refill was requested. -If a prescription was expired, the pharmacy was	D 273		

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responsible for contacting the physician for a new order.
-Resident #3 "should not be out of doxazosin based on refill dates."

Interview with the MA on 11/08/18 at 9:34am revealed the physician should be notified if a resident refused a medication or missed a dose of medication for 3 consecutive days.

Interview with the RCC on 11/07/18 at 10:15am revealed:
-She could not remember when she was first notified about Resident #3 being out of medications.
-She had called Resident #3's pharmacy multiple times during October to get medications refilled.
-Resident #3's pharmacy told her that all of Resident #3's "medications had been discontinued because the prescriptions were only good for 1 year."
-The pharmacy or the PCP's office had not contacted the facility to let them know the medications had been discontinued because Resident #3 needed an office visit.
-She had not contacted Resident #3's physician about the resident being out of medications and missing multiple doses.

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm revealed:
-The resident's physician needed to be notified if the resident missed more than 3 doses of medication on consecutive days.
-If she was not at the facility, it was the MA's responsibility to contact the physician for missed doses of medications.
-All refusals or missed doses should be documented on eMAR.
-She was not aware that Resident #3 had missed

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multiple doses of medication in October.
-Resident #3's primary care physician's (PCP) office had contacted RCC to let her know that Resident #3's medication would be mailed from the pharmacy.
-She did not know when Resident #3's physician had contacted the RCC.
-She assumed Resident #3 had all his medications available to be administered.

Telephone interview with the Social Worker from Resident #3's PCP office on 11/09/18 at 3:37pm revealed:
-The facility had not notified Resident #3's PCP he had missed multiple doses of doxazosin.
-Resident #3's prescription for doxazosin had expired but the medication was not discontinued.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed the MA's or the Assisted Living Nurse Supervisor were responsible for notifying the physician if a resident missed a medication for 3 consecutive days.

d. Review of Resident #3's signed physician's orders dated 03/08/18 revealed there was a physician's order for hydralazine 50mg take 1 tablet 3 times daily (used to treat high blood pressure).

Review of Resident #3's October 2018 eMAR revealed:
-There was a computer generated entry for hydralazine 50mg take 1 tablet 3 times daily scheduled to be administered at 9:00am, 3:00pm, and 9:00pm.
-Hydralazine was documented as unavailable or not documented as administered for 27 of 93 opportunities from 10/01/18 to 10/31/18.

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D 273	Continued From page 49 Observation of Resident #3's medications on hand on 10/31/18 at 3:58pm revealed hydralazine was available to be administered. Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed: -Hydralazine was last dispensed to Resident #3 on 09/28/18 for a 90 day supply. -Resident #3's recent physician's order for hydralazine was written on 11/02/18 and was received from the physician. -Resident #3's medications were mailed from the pharmacy to the facility when a refill was requested. -If a prescription was expired, the pharmacy was responsible for contacting the physician for a new order. Interview with the MA on 11/08/18 at 9:34am revealed: -The physician should be notified if a resident refuses a medication or misses a dose of medication for 3 consecutive days. -"There is no reason that a medication would not be available. -She had told the RCC that Resident #3 was out of multiple medications. -She had not contacted Resident #3's physician about the resident missing multiple doses of medication. Interview with the RCC on 11/07/18 at 10:15am revealed: -She could not remember when she was first notified about Resident #3 being out of medications. -She had called Resident #3's pharmacy multiple times during October to get medications refilled. -Resident #3's pharmacy told her that all of	D 273		

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Resident #3's "medications had been discontinued because the prescriptions were only good for 1 year."
-The pharmacy or the PCP's office had not contacted the facility to let them know the medications had been discontinued because Resident #3 needed an office visit.
-She had not contacted Resident #3's physician about the resident missing multiple doses of medication.

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm revealed:
-The resident's physician needed to be notified if the resident missed more than 3 doses of medication on consecutive days.
-If she was not at the facility, it was the MA's responsibility to contact the physician for missed doses of medications.
-All refusals or missed doses should be documented on eMAR.
-She did not know that Resident #3 had missed multiple doses of medication in October.
-Resident #3's PCP office had contacted RCC to let her know that Resident #3's medication would be mailed from the pharmacy.
-She did not know when Resident #3's physician had contacted the RCC.
-She assumed Resident #3 had all his medications available to be administered.

Telephone interview with the Social Worker from Resident #3's PCP office on 11/09/18 at 3:37pm revealed:
-The facility had not notified Resident #3's PCP that he had missed multiple doses of hydralazine.
-Resident #3's prescription for hydralazine had expired but the medication was not discontinued.

Telephone interview with the Administrator on

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11/09/18 at 2:00pm revealed the MA's or the Assisted Living Nursing Supervisor were responsible for notifying the physician if a resident missed a medication for 3 consecutive days.

e. Review of Resident #3's signed physician's orders dated 03/08/18 revealed there was a physician's order for loratadine 10mg take 1 tablet daily (used to treat allergies).

Review of Resident #3's October 2018 eMAR revealed:
-There was a computer generated entry for loratadine 10mg take 1 tablet daily scheduled to be administered at 9:00am.
-Loratadine was documented as unavailable for 19 of 31 opportunities from 10/01/18 to 10/31/18.

Observation of Resident #3's medications on hand on 10/31/18 at 3:58pm revealed loratadine was not available to be administered.

Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed:
-Loratadine was last dispensed to Resident #3 on 02/01/18 for a 90 day supply.
-Resident #3's recent physician's order for loratadine was written on 11/02/18 and was received from the physician.
-Resident #3's medications were mailed from the pharmacy to the facility when a refill was requested.
-If a prescription was expired, the pharmacy was responsible for contacting the physician for a new order.

Interview with the Medication Aide (MA) on 11/08/18 at 9:34am revealed:
-The physician should be notified if a resident

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refuses a medication or misses a dose of medication for 3 consecutive days.
-She had told the RCC that Resident #3 was out of multiple medications.
-She had not contacted Resident #3's physician about the resident missing multiple doses of medications.

Interview with the RCC on 11/07/18 at 10:15am revealed:
-She could not remember when she was first notified about Resident #3 being out of medications.
-She had called Resident #3's pharmacy multiple times during October to get medications refilled.
-Resident #3's pharmacy told her that all of Resident #3's "medications had been discontinued because the prescriptions were only good for 1 year."
-The pharmacy or the PCP's office had not contacted the facility to let them know the medications had been discontinued because Resident #3 needed an office visit.
-She had not contacted Resident #3's physician about the resident missing multiple doses of medication.

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm revealed:
-The resident's physician needed to be notified if the resident missed more than 3 doses of medication on consecutive days.
-If she was not at the facility, it was the MA's responsibility to contact the physician for missed doses of medications.
-All refusals or missed doses should be documented on eMAR.
-She was not aware that Resident #3 had missed multiple doses of medication in October.
-Resident #3's primary care physician's (PCP)

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office had contacted RCC to let her know that Resident #3's medication would be mailed from the pharmacy.
-She did not know when Resident #3's physician had contacted the RCC.
-She assumed Resident #3 had all his medications available to be administered.

Telephone interview with the Social Worker from Resident #3's PCP office on 11/09/18 at 3:37pm revealed:
-The facility had not notified Resident #3's PCP that he had missed multiple doses of loratadine.
-Resident #3's prescription for loratadine had expired but the medication was not discontinued.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed the MA's or the Assisted Living Nurse Supervisor were responsible for notifying the physician if a resident missed a medication for 3 consecutive days.

2. Review of Resident #1's current FL2 dated 01/16/18 revealed diagnoses included dementia, hypertension, and diabetes.

Review of Resident #1's subsequent physician orders revealed:
-There was a physician's order dated 06/20/18 for Levemir Flexpen (a long acting insulin to treat hyperglycemia) 100u/ml inject 20 units subcutaneous every morning.
-There was a physician's order dated 07/31/18 for Humalog Kwikpen (a short acting insulin to treat hyperglycemia) 100u/ml check finger stick blood sugars (FSBS) three times a day with meals and give insulin according to the following sliding scale insulin subcutaneous if FSBS less than 100 no insulin, FSBS 101-150 give 2 units, FSBS 151-200 give 4 units, FSBS 201-250 give 6 units,

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FSBS 251-300 give 8 units, FSBS 301-350 give 10 units, FSBS 351-400 give 12 units, FSBS 401-450 give 14 units, FSBS 451-500 give 16 units, and FSBS >500 give 18 units and notify the doctor.

Review of Resident #1's September 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Levemir Flexpen 100u/ml inject 20 units scheduled for administration at 9:00am every morning.
-The Levemir was documented as refused on 09/03/18, 09/04/18 and 09/06/18 at 9:00am.
-There was no documentation of the refusal of Levemir reported to the physician.
-There was an entry for Humalog Kwikpen 100u/ml check (FSBS) three times a day with meals and administer sliding scale insulin if FSBS less than 100 no insulin, FSBS range 101-150 give 2 units, FSBS 151-200 give 4 units, FSBS 201-250 give 6 units, FSBS 251-300 give 8 units, FSBS 301-350 give 10 units, FSBS 351-400 give 12 units, FSBS 401-450 give 14 units, FSBS 451-500 give 16 units, and FSBS >500 give 18 units and notify the doctor.
-It was documented Resident #1 refused to have his FSBS taken three times a day on 09/02/18 at 12:00pm through 09/05/18 at 7:30am
-It was documented Resident #1 refused to take his Humalog Kwikpen started on 09/02/18 at 12:00pm through 09/05/18 at 7:30am.
-There was no documentation the physician was notified about Resident #1 refusing the FSBS or the Humalog insulin.
-On 09/05/18 at 7:30am the FSBS was documented as 593 at 7:30am, and documented administration of 18 units of Humalog.
-There was no documentation the physician was notified about Resident #1's FSBS greater than

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D 273	Continued From page 55 500. Review of electronic progress notes for Resident #1 revealed: -There was an electronic entry by the medication aide (MA) on 09/02/18 at 4:57pm "resident refused to have blood sugar taken x 3." -There was an electronic entry by the MA on 09/05/18 at 9:09pm "refuse." -There was an electronic entry by the MA on 09/06/18 at 12:46pm "resident refused every med and b/s check." -There was an electronic entry by the facility nurse dated 09/06/18 at 10:22pm "resident was responsive and was very lethargic with an unsteady gait upon assessment vital signs done." -"The resident was sent to the emergency room for further evaluation, responsible party and Administrator made aware." Review of Resident #1's discharge summary from the local hospital dated 09/10/18 revealed: -Resident #1 had been admitted to the hospital on 09/07/18 at 12:16am and discharged from the hospital on 09/10/18 at 12:11pm. -Resident #1's Urine glucose level result on 09/06/18 in the emergency room was 500 normal result < 130 according to lab result sheet reference range and urine Kenton level result was 15 normal result 0 according to lab result sheet reference range. -The attending physician assessment and plan included treatment for acute encephalopathy (a disorder caused by buildup of toxins in the brain), dementia, acute kidney infection, hypertension, and diabetes mellitus type 2. Interview with a MA on 11/08/18 at 2:00pm revealed: -The MA knew if Resident #1 refused his	D 273		

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medications, blood sugars or vitals for 3 days it was to be reported to the resident care coordinator (RCC) or the Assisted Living (AL) Nurse Supervisor.
-The MA knew if Resident #1's FSBS was greater than 500 the doctor was to be notified.
-It was the responsibility of the RCC or the AL Nurse Supervisor to contact the physician.
-The MA had administered Resident #1's Humalog Kwikpen 100u/ml 18 units of insulin.
-The MA had not documented and was not able to remember who or when he notified the RCC or AL Nurse Supervisor about Resident #1's FSBS on 09/05/18, but knew he told someone.
-The MA had not documented what happened on 09/05/18 when Resident #1's FSBS was 593.
-The MA checked Resident #1's FSBS on 09/05/18 at 12:00pm, it was 244 and gave him Humalog Kwikpen 100u/ml 8 units of insulin.

Interview with a second MA on 11/06/18 at 11:00am revealed:
-The MA knew Resident #1 refused his medication frequently.
-The MA had told the RCC about his frequent refusals but did not document she told the RCC because when it happened during her shift it was not for 3 days.
-It was the responsibility of the RCC and the AL Nurse Supervisor to notify the physician about medication refusals.
-The MA had not contacted the physician and did not know if the RCC or the AL Nurse Supervisor contacted the physician.

Interview with the RCC on 11/06/18 at 4:00pm revealed:
-She had not called Resident #1's doctor because the Administrator wanted to be the one to contact the physician about his elevated FSBS.

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D 273	Continued From page 57 -She did not know if the Administrator was told about Resident #1's FSBS on 09/05/18 was 593. -She did not know Resident #1 had refused his FSBS and insulin 09/02/18 through 09/05/18 because she was not in the facility on those days. Interview with Assisted Living Nurse Supervisor on 11/06/18 at 4:15pm revealed: -She did not know Resident #1 had been refusing his blood sugar checks and insulin 09/02/18-09/05/18. -She did not know Resident #1's FSBS on 09/05/18 at 7:30am was 593 because no one had told her about it. -She was to call the physician's office after Resident #1 had refused his medications for 3 days, and when his blood sugar was greater than 500. -On 09/06/18, at 10:22pm Resident #1 very lethargic, with an unsteady gait and she sent him to the emergency room at that time. Interview with Resident #1's Nurse Practitioner on 11/07/18 at 5:00pm revealed: -She was not told by anyone at the facility Resident #1 had refused his FSBS checks, his Levemir insulin and Humalog insulin from 09/02/18-09/05/18. -The staff at the facility had contacted her at different times, but not consistently when Resident #1 had changes in his condition and refusals of medications. -She knew he had a history of non-compliance and did not feel comfortable with not being notified of Resident #1's FSBS and medication refusal until after his hospitalization. -She increased visits with Resident #1 to weekly or every other week to check on him more frequently after his hospitalization. -She had placed a referral for home health	D 273		

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services on 10/29/18 to assist with management of Resident #1 diabetes and hyperglycemia, and they are coming this week.

Interview with the Administrator in Charge on 11/09/18 at 12:30pm revealed:
-She knew Resident #1 had a history of non-compliance in regards to his medications and FSBS.
-She did not know Resident #1 had been refusing his blood sugar checks and insulin from 09/02/18-09/05/18.
-She did not know about Resident #1's FSBS result on 09/05/18 at 7:30am was 593 because no one had told her about it.
-When Resident #1 had refused his medications for 3 days the physician was to be notified by the RCC and the AL Nurse Supervisor.
-The RCC and AL Nurse Supervisor should have notified the doctor about Resident #1's refusals.

Review of the medication refusal policy on 11/09/18 at 12:30pm revealed:
-"Respect the resident right's to choose not take medications."
-"Document the time, date and medication the resident did not take."
-"Notify the physician after the 3 days of refusal and follow any instructions provided."

3. Review of Resident #2's current FL2 dated 01/16/18 revealed diagnoses included history of malignant neoplasm of prostate, type 1 diabetes, heart disease, and hyperlipidemia.

a. Interview with Resident #2 on 11/06/18 at 2:05pm revealed:
-Resident #2 complained of irritation in his perineal area.
-Resident #2 stated that he had been bleeding in

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his perineal area and was not sure where it was coming from.
-Resident #2 stated he told the personal care aide (PCA) and they had been putting cream around his perineal area.
-He could not remember how long the irritation had lasted.
-The physician had not seen or treated his perineal area.

Observation of Resident #2's perineal area on 11/07/18 at 10:46am revealed:
-Resident #2 had a wound around his perineal area about the size of a nickel that was red and raw.
-Resident #2 had skin breakdown and redness at the base of his perineal area, with a two and one-half inch open area in the skin.
-Resident #2 stated his perineal area was "irritated and uncomfortable".

Interview with a second shift personal care aide (PCA) on 11/06/18 at 4:59pm revealed:
-She noticed redness around Resident #2's perineal area.
-She notified the second shift medication aide (MA) of the redness and put barrier cream on the area.
-She notified the MA about Resident #2's skin "a few days ago".
-She had not notified the Resident Care Coordinator (RCC), of the Assisted Living (AL) Nurse Supervisor.

Interview with a personal care aide (PCA) on 11/07/18 at 11:00am revealed:
-He noticed Resident #2 had irritation and redness around his perineal area "a couple of days ago"
-He told a home health nurse on 11/06/18 when

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she was present.
-He could not remember if he told a MA, the RCC, or the AL Nurse Supervisor.
-He had not notified the physician about the condition of Resident #2's perineal area.
-He did not document the condition of Resident 2's perineal area.
-He put barrier cream around Resident #2's perineal area to prevent skin breakdown.

Interview with a MA on 11/08/18 at 6:07am revealed:
-She was notified by a PCA on 11/06/18 about Resident #2's skin breakdown around his perineal area.
-She observed Resident #2's perineal area and notified the RCC on the same day that she was notified.
-She was not sure if the physician had been notified about Resident #2's skin.
-The RCC and AL Nurse Supervisor were responsible for notifying the primary care provider (PCP).

Interview with the contracted home health nurse on 11/07/18 at 11:21am revealed:
-Resident #2 was currently receiving home health services for diabetes management.
-She had not completed a skin assessment for Resident #2.
-She was notified by a PCA about redness in the perineal area, she did not know Resident #2 was bleeding.
-The irritation around Resident #2's perineal area could be caused lack of prompt incontinence care but she had not completed an assessment.

Interview with the RCC on 11/07/18 at 4:15pm revealed:
-She did not know about the redness, irritation,

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and skin breakdown around Resident #2's perineal area.
-PCAs should be doing a skin assessments when providing personal care.
-PCAs and MAs should be notifying her, MAs, and the AL Nurse Supervisor of any changes.
-PCAs and MAs were to notify her verbally of any changes with residents.
-She had not notified the PCP, because she was not aware.

Interview with the AL Nurse Supervisor on 11/07/18 at 2:09pm revealed:
-She did not know Resident #2 was experiencing redness, irritation, skin breakdown around his perineal area.
-She would have expected the PCA's and MAs to notify her or the RCC, so the physician could be notified.
-She had not notified the PCP about Resident #2's perineal area.

Interview with Resident #2's PCP on 11/07/18 at 9:10am revealed:
-She did not know that Resident #2 had skin breakdown, redness, and irritation around his scrotum.
-She would have expected the RCC or AL Nurse Supervisor to notify her of any changes with the resident's skin.
-She would want to be notified so that she could assess Resident #2's skin and order medication if needed.

Interview with the Administrator on 11/09/18 at 2:00pm revealed:
-He did not know Resident #2's skin breakdown around the perineal area.
-He would have expected the MAs to notify the RCC and AL Nurse Supervisor.

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-The RCC and AL Nurse Supervisor were responsible for notifying the PCP.
-He expected the PCP to be notified of any changes with residents' skin.

b. Review of Resident #2's record revealed a physician's order dated 07/24/18 revealed there was an order for fingerstick blood sugars (FSBS) to be checked twice daily and notify primary care provider (PCP) if less than 50 and greater than 300.

Review of Resident #2's September 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS to be checked at 9:00am and 5:00pm, notify PCP if blood sugar is lower than 50 or greater than 300.
-Resident #2's FSBS ranged from 136 to 437.
-Resident #2's FSBS was documented as 301 or greater 4 times with examples as follows:
-On 09/04/18, FSBS was documented as 437 at 5:00pm; there was no documentation Resident #2's PCP had been called.
-On 09/05/18, FSBS was documented as 313 at 5:00pm; there was no documentation Resident #2's PCP had been called.
-On 09/16/18, FSBS was documented as 347 at 5:00pm, there was no documentation Resident #2's physician had been called.

Review of a subsequent physician's order dated 10/17/18 revealed an order for FSBS to be checked three times daily and notify PCP if less than 70 or greater than 400.

Review of Resident #2's October 2018 eMAR revealed:
-There was an entry for FSBS to be checked at 9:00am and 5:00pm, notify PCP if blood sugar is

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lower than 50 or greater than 300 from 10/1/18-10/17/18.
-There was an entry for FSBS to be checked at 7:00am, 12:00pm, and 5:00pm, notify PCP if blood sugar is lower than 70 or greater than 400 from 10/17/18-10/31/18.
-Resident #2's FSBS ranged from 116-519.
-Resident #2's FSBS was documented as 301 or greater 10 times with examples as follows:
-On 10/16/18, FSBS was documented as 411 at 9:00 am; there was no documentation Resident #2's PCP had been called.
-On 10/26/18, FSBS was documented as 500 at 7:00 am; there was no documentation Resident #2's physician had been called.
-On 10/31/18, FSBS was documented as 519 at 5:00pm; there was no documentation Resident #2's physician had been called.

Review of Resident #2's November 2018 eMAR revealed:
-There was an entry for FSBS to be checked at 7:00am, 12:00pm, and 5:00pm, notify PCP if blood sugar is lower than 70 or greater than 400.
-Resident #2's FSBS ranged from 174-411.
-On 11/04/18, FSBS was documented as 411 at 7:00am; there was no documentation Resident #2's PCP had been called.

Review of Resident #2's record revealed there were no progress notes indicating the PCP had been notified about high blood sugar readings.

Interview with a first shift medication aide (MA) on 11/08/18 at 9:35am revealed:
-Resident #2 had an order for FSBS checks three times daily.
-She documented Resident #2's FSBS on the eMAR after it was checked.
-She had contacted the PCP when Resident #4's

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D 273	Continued From page 64 FSBS was greater than 301, but did not document it anywhere. -When she contacted the PCP she would leave a message and sometimes she would receive a call back from office staff and sometime she would not. Interview with the Resident Care Coordinator (RCC) on 11/07/18 at 4:15pm revealed: -She knew Resident #2 had orders for FSBS checks and parameters for notifying the physician. -She had not been notified of any high blood sugar levels. -MAs were supposed to notify the physician of high blood sugars. -She had not notified the physician about high blood sugars for Resident #2. Interview with the Assisted Living (AL) Nurse Supervisor on at 7:05 pm revealed: -She did not know Resident #2's blood sugars of 301 or greater were not reported to the physician. -The other Nurse Supervisor was responsible for reviewing the eMAR to check FSBS and ensure the PCP was notified. -No one reviewed Resident #2's documented FSBS other than the PCP when he visited the facility every week. -The MAs should have followed the physician's order to contact the PCP for FSBS greater than 301. -The MAs should have documented in the progress notes in the eMAR system when the PCP was contacted. Interview with Resident #2's PCP on 11/07/18 at 9:10am revealed: -The facility staff did not notify her regularly of Resident #2's high blood sugars.	D 273		

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-Resident #2's FSBS normally ran high and she wanted to be notified as listed on the order.
-She expected to be contacted by the facility when blood sugars were greater than 400.
-She ordered home health for Resident #2 to help educate and manage diabetes.
-Resident #2 was at risk for kidney failure if his blood sugars were not maintained.

Interview with the Administrator on 11/19/18 at 2:00pm revealed Resident #2's physician should have been contacted if his FSBS were over the parameters.

4. Review of Resident #15's current FL-2 dated 07/04/18 revealed:
Diagnoses included depression, anxiety and chronic pain.
-There were medication orders that included Fentanyl (an opioid narcotic used to treat severe pain) 50mcg patch every 72 hours.

Review of Resident #15's electronic medication administration (eMAR) record for October 2018 reveled:
-There was an entry for fentanyl 50mcg patch every 72 hours.
-On 10/03/18, 10/06/18 and on 10/09/18 the fentanyl 50mcg patch was not administered "medication not available."
-There were "holes" on the eMAR the fentanyl patch was not administered from 10/10/18 to 10/20/18, there was no reason documented.

Observation on 11/07/18 at 1:35pm of medications on hand for Resident #15 revealed there were no fentanyl 50 mcg patches available for administration.

Interview with the Home Health (HH) Nurse on

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D 273	Continued From page 66 11/07/18 at 11:30am revealed: -She had seen Resident #15 for pain control. -She had reviewed Resident #15's eMAR and found missed doses of the fentanyl 50mcg patch on 10/03/18, 10/06/18 and on 10/09/18. -She found "holes" in the October 2018 eMAR without an entry of documentation the reason the fentanyl patch was not administered to Resident #15. -The HH Nurse contacted Resident #15's Nurse Practitioner to inform her of the missed fentanyl doses. -The HH Nurse had informed the facility nurse Resident #15 was not administered the fentanyl patch on 10/03/18, 10/06/18 and on 10/09/18 and there were "holes" in eMAR for missed administration of the fentanyl patch. Interview with a MA on 11/08/18 at 2:00pm revealed: -She worked as a MA first and second shift administering medications to the residents. -"If it's not here you cannot give it." -She had not notified the physician Resident #15 had not received the fentanyl 50mcg patch. -She could not recall if she had informed the facility nurse or the oncoming shift in regards to contacting the physician about the fentanyl patch not available for administering to Resident #15. Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 5:30pm revealed: -She was responsible for overseeing the clinical staff which included the MAs. -She did not know the fentanyl 50 mcg patch was not administered as ordered on 10/01/18 through 10/20/18. -She had not contacted Resident #15's physician to inform her the fentanyl patch was not available for administration.	D 273		

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-The MAs should contact the physician if a resident missed 3 days of receiving their medications.
-The MAs were responsible for reporting to her if a medication had not been administered for 3 days and she would contact the physician.

Interview with Resident #15's Nurse Practitioner on 11/07/18 at 9:25am revealed:
-She had reviewed Resident #15's eMAR and found no documentation the Fentanyl patch had been administered 10/01/18 through 10/17/18.
-The facility had not contacted her in regard to Resident #15's missing applications of fentanyl patch on 10/03/18, 10/06/18 and on 10/09/18.
-The Home Health (HH) agency nurse had contacted her in regards to Resident #15 not receiving the fentanyl patch on 10/03/18, 10/06/18 and on 10/09/18.
-She expected the facility to contact her of missed medications especially pain management medications.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed:
-He relied on the facility nurse to oversee the MAs.
-He was not aware the fentanyl patch was not administered as ordered to Resident #15 on 10/03/18, 10/06/18 and on 10/09/18.
-The MAs and the Assisted Living Nurse Supervisor were responsible for contacting the physician if a medication is missed for three day.
-He expected the MAs and the facility nurse to follow the policy for medication refusal.

Review of the medication refusal policy revealed:
a. Respect the resident right's to choose not take medications.
b. Document the time, date and medication the

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resident did not take.
c. Notify the physician after the 3 days of refusal and follow any instructions provided.
d. Facility will continue to document any medication refusal after physician notification.

5. Review of Resident #6's current FL2 dated 09/26/18 revealed diagnoses included Wernicke's encephalopathy, history of ethanol alcohol abuse, cerebellar stroke, history of osteoporosis, vertebral compression fractures and remote history of intracerebral hemorrhage.

Review of Resident #6's record revealed:
-A physician's order dated 09/12/18 for a "psych eval and treat pt for behavior disturbance" was issued by the nurse practitioner that treated Resident #6.
-There was no documentation that the psychological referral and evaluation was completed.
-There were no treatment notes by the facility psychologist in the record.

Review of Resident #6's progress notes revealed:
-Documentation dated 10/16/18 that the "resident was very agitated and verbally abusive with staff and [administrator], resident made several attempts to be physically aggressive with assault on [administrator].".
-Documentation dated 10/16/18 "resident will not allow anyone to touch him, medic and police called, upon their arrival resident became a perfect gentleman and consented to be transferred to [hospital] for[evaluation]".

Interview on 11/09/18 at 2:00pm with the AL Nurse Supervisor revealed:
-She did not know of a psychological evaluation order for Resident #6.

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D 273	Continued From page 69 -The medical office that treated Resident #6 always sent a fax to the facility with physician orders. -The faxed orders were pulled off the fax machine by management and placed in the "box" labeled for either herself, the RCC or the AL Nurse Supervisor. -There were three staff members who followed-up on the physician's orders (RCC or herself). -She was unable to provide an explanation as to why the psychological evaluation for Resident #6 was not completed. Interview on 11/09/18 at 10:50am with the RCC revealed: -The nurse practitioner who provided care for Resident #6 communicated her orders via a fax to the facility. -The fax machine was located in her office. -Various staff members checked the fax daily for incoming faxes and filed the paperwork in "box" based on which side of the facility the named resident resided in such as assisted living (AL) or Special Care Unit (SCU). -The faxes for AL residents should have been placed in the AL nurse supervisor's box. -The faxes for the SCU residents should have been placed in the SCU manager's box. -She did not know Resident #6 had a physician's order to have a psychological evaluation. -She expected her staff to follow physician's orders. -The AL Nurse Supervisor was responsible for scheduling and following up on physician's orders to assure they were implemented. -If a resident was seen by the facility psychologist there would be documentation filed in the resident's record.	D 273		

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Interview on 11/09/18 at 1:40pm with AL Nurse Supervisor revealed:
-The front desk receptionist was responsible for monitoring the fax machine and placing incoming faxes in the appropriate management's (RCC, AL Nurse Supervisor or SCU coordinator box).
-The AL Nurse Supervisor was responsible for implementing treatment orders.

Interview on 11/09/18 at 8:40am with the front desk receptionist revealed:
-She monitored the facility fax machine.
-She placed the incoming physician's orders in the corresponding management's box based on whether the named resident resided in AL or SCU.
-She was responsible for making appointments for the residents who needed healthcare appointments.
-The management staff (RCC, AL Nurse Supervisor, SCU or Administrator) gave her a copy of the physician order and then she scheduled the appointment.
-She maintained a medical appointment calendar.
-She reviewed her scheduling calendar for September 2018 and October 2018 and noted no outside appointments were made for Resident #6.

Interview on 11/08/18 at 9:30am with Resident #6's Nurse Practitioner revealed:
-She ordered a psychological evaluation and treatment for Resident #6 on 9/12/18 due to his "behavior disturbance".
-She did not know if the referral was completed.
-She could not recall seeing any documentation that the facility psychologist had evaluated Resident #6.

Attempted telephone interview with the facility

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D 273	Continued From page 71 psychologist on 11/09/18 at 2:24pm was unsuccessful. Review of Resident #6's hospital discharge summary dated 09/28/18 revealed: -New physician's orders for aspirin 81mg, 1 tablet by mouth every day and atorvastatin 40mg, 1 tablet by mouth each night at bedtime. -Continued physician's order for lisinopril 10mg, 1 tablet by mouth every day. Review of Resident #6's October 2018 eMAR revealed: -Resident # 6 refused the aspirin 81mg 4 times during the month. -Resident # 6 refused the atorvastatin 40mg a total of 6 times, with two consecutive days, 10/12/18 - 10/13/18 and then three consecutive days, 10/19/18 - 10/21/18 -Resident # 6 refused the lisinopril 10mg 4 times during the month. Review of Resident #6's November 2018 eMAR on 11/06/18 revealed: -Resident # 6 refused the aspirin 81mg, atorvastatin 40mg and lisinopril 10mg on 11/05/18. Review of Resident #6's record revealed: -There was no written documentation that the facility notified the resident's physician about his refusal to take his medications in the month of October 2018 nor the time in November 2018. Interview on 11/6/18 at 9:10am with Resident #6 revealed: -He was unsure how many medications he was supposed to take each day. -He did not know his medical diagnoses nor why he was prescribed medications.	D 273		

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-He admitted that he refused to take the medications on some days but gave no reason why he refused them.
-He could not recall why he went to the hospital twice in September 2018 or once in October 2018.

Interview on 11/08/18 at 2:00pm with the AL Nurse Supervisor revealed:
-She expected the MA to document any medication refusals in the resident's record and notify the prescribing physician of the refusal.
- If the MA was unable to notify the prescribing physician of medication refusal, they were to make her aware of the situation.
-The MA could call the main office for the nurse practitioner (NP) and leave a message, but were not allowed to call the NP's private number.

Interview on 11/07/18 at 11:30 am with MA revealed:
-Resident #6 did refuse his medications.
-She was to notify the AL Nurse Supervisor when any resident refused medication for three days.
-She stopped informing her supervisor about Resident #6's refusal because his behavior was unpredictable.
-Often times she had to ask him more than once to take his medications during her shift.

Interview with personal care aide (PCA) on 11/07/18 at 11:00am revealed:
-She provided care services such as help with transfers, showers, dressing, and grooming for Resident #6.
-She described Resident #6 as being unpredictable with his moods. He could be cooperative with care in the morning and yelling and cussing at you by lunch time.
-Her way of dealing with him was to use a calm

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tone with "sweet talk" to get him to allow her to provide care services.
-She never reported his behaviors to the MA because she thought this was just a part of his personality.

Interview with a second PCA on 11/07/18 at 12:30pm revealed:
-She provided care for Resident #6.
-He often refused care.
-Today he refused to be shaved, but did allow her to comb his hair.
-She described Resident #6 as someone who "had good days" and allowed the staff to assist him with care but "the other days were hard" because he used "harsh words" that were offensive toward the staff and sometimes toward other residents.
-She never asked the MA for assistance with him and did not report his "mood swings" because she thought this was his normal behavior.

Interview on 11/08/18 at 9:30am with Resident #6's Nurse Practitioner (NP) revealed:
-She preferred to be informed whenever Resident #6 missed any dose of the aspirin, atorvastatin and Lisinopril.
-She did not know Resident #6 had missed any doses of the aspirin, atorvastatin and lisinopril.
-She reviewed the eMAR during her weekly visits to the facility if a copy was placed in her communication book.
-When a resident refused a medication she considered other options such as could the medication be injectable or an oral suppressant.
-She wanted Resident #6 to take these three medications as prescribed because he recently suffered a major stroke.

_____

The facility failed to notify the physician Resident

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D 273	Continued From page 74 #3 regarding not referring resident to a physician for treatment for an illness in a timely manner and blood pressure medications not being available which put the resident at risk for infection and was admitted to the hospital with urosepsis and pulmonary edema; Resident #1 documented high blood sugars over 500 with an ER visit and hospital admission and diabetic medications not administered; Resident #2 had an abrasion around his scrotum with a two and a half inch split in the skin which was bleeding and painful; Resident #15's fentanyl patch not being available then administered without an order after discontinued, and Resident # 6's refusals for three medications aspirin 81mg, atorvastatin 40mg and lisinopril 10mg and with an order for a psychological evaluation and treatment for aggressive behaviors. This failure placed residents at substantial risk of serious harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 8, 2018.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.	D 296		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for 3 of 6 sampled residents with a mechanical soft ground diet (Resident #2), mechanical soft, no added salt (MS-NAS) diet (Resident #12), and no menu for a pureed carbohydrate controlled diet (Resident #14).

The findings are:

1. Review of Resident #2's current FL2 dated 01/16/18 revealed diagnoses included history of malignant neoplasm of prostate, type 1 diabetes, heart disease, and hyperlipidemia.

Review of a physician's order dated 10/10/18 revealed Resident #2 was ordered a mechanical soft ground diet.

Review of diet list provided by the Administrator-In-Charge (AIC) revealed Resident #2 was to be served a pureed, CCHO, nectar thickened liquid diet.

Review of notebook in the dining room that included diet orders revealed Resident #2 was listed to receive a LCS diet.

There were no therapeutic diet menus available to guide staff in the preparation of a mechanical soft ground diet.

Without a theraputic diet menu, it could not be determined if Resident #2 was served a mechanical soft ground diet as ordered by the

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D 296	Continued From page 76 physician. Interview with Resident #2 on 11/06/18 at 2:15pm revealed: -He was served what was listed on the menu in the kitchen. -His food was not normally chopped or ground. -He had no issues eating his food and had not experienced choking. -He did not know his current diet order. Refer to the interview with the cook 11/06/18 at 11:30am. Refer to the interview with the AIC on 11/09/18 at 10:17am. Refer to the telephone interview with the Administrator on 11/09/18 at 2:00pm. 2. Review of Resident #12's current FL2 dated 03/14/18 revealed diagnoses included atrial fibrillation, dementia, and basal cell carcinoma. Review of a signed physician's order dated 07/24/18 revealed a diet order for a MS-NAS diet. Observation of kitchen on 11/06/18 revealed there was no diet list for the Assisted Living (AL) unit posted for food service staff to reference. Review of diet list provided by the Administrator-In-Charge (AIC) revealed Resident #12 was to be served a MS-NAS diet. There were no therapeutic diet menus available to guide staff in the preparation of a MS-NAS diet. Without a theraputic diet menu, it could not be determined if Resident #12 was served a	D 296		

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D 296	Continued From page 77 MS-NAS diet as ordered by the physician. Refer to the interview with the cook 11/06/18 at 11:30am. Refer to the interview with the AIC on 11/09/18 at 10:17am. Refer to the telephone interview with the Administrator on 11/09/18 at 2:00pm. Based on record review, observation, and interview Resident #12 was not interviewable. Attempted interview with Resident #12's responsible party on 11/09/18 at 10:51am was unsuccessful. 3. Review of Resident #14's current FL2 dated 06/12/18 revealed diagnoses included dementia, type 2 diabetes, and peripheral vascular disease. Review of signed subsequent physician's orders for Resident #14 dated 07/25/18 revealed: -There was an order on the first page for pureed meats, controlled carbohydrate diet and cardiac diet. -On the second page, there was an order for pureed meats, controlled carbohydrate diet. Review of Resident #14's record revealed no clarification of diet orders. Review of diet list provided by the AIC revealed Resident #14 was to be served a pureed, CCHO (carbohydrate controlled), and cardiac diet. Observation of kitchen on 11/06/18 revealed a diet list for the Special Care Unit (SCU) listed Resident #14 was to be served a pureed diet.	D 296		

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D 296	Continued From page 78 There were no therapeutic diet menus available to guide staff in the preparation of a pureed meats, controlled carbohydrate diet. Without a theraputic diet menu, it could not be determined if Resident #14 was served a pureed meats, controlled carbohydrate diet as ordered by the physician. Interview with the Resident Care Coordinator (RCC) on 11/06/18 at 3:52pm revealed: -She thought the carbohydrate controlled diet was the same as a Low Concentrated Sweets (LCS) diet. -She did not know there was no menu available for a carbohydrate controlled diet. Refer to the interview with the cook 11/06/18 at 11:30am. Refer to the interview with the AIC on 11/09/18 at 10:17am. Refer to the telephone interview with the Administrator on 11/09/18 at 2:00pm. Based on observation, interview, and record review Resident #14 was not interviewable. Attempted interview with Resident #14's responsible party on 11/09/18 at 11:00am was unsuccessful. _____ Interview with the cook on 11/06/18 at 11:30am revealed: -The Administrator and the AIC were responsible for overseeing the kitchen because there was no	D 296		

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D 296	Continued From page 79 dietary manager. -She worked at the facility for 11 years and knew how to prepare mechanical soft and pureed diets from memory. -The only menu she referred to for preparing and serving food to the residents was the regular/NAS diet menu. -She did not have a menu to refer for mechanical soft or pureed. -She thought the carbohydrate controlled diet was the same as Low Concentrated Sweets (LCS). -She was trained on how to prepare a mechanical soft and pureed diet by the dietary manger 11 years ago when she was first employed. -She had not received a menu for mechanical soft or pureed for this cycle and used what menus the Administrator and AIC provided. Interview with the AIC on 11/09/18 at 10:17am revealed: -She and the Administrator oversaw the kitchen because there was no dietary manager. -She was responsible for printing and providing the menus to the cooks. -She thought she provided the cook with the menu for mechanical soft and pureed diets. -The facility did not offer the carbohydrate controlled diet, but they offered a LCS diet. -The cook had not informed her that she did not have a mechanical soft or pureed menu to reference for this cycle. Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed: -He knew the facility needed to have a matching therapeutic menu for each therapeutic diet offered. -He did not know the cook was not using therapeutic menus as guidance for preparing and serving therapeutic diets.	D 296		

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D 296	Continued From page 80 -He thought therapeutic menus were available to the cook for this cycle. -He did not realize Resident #14's diet order did not match the diets they offered, "It should have been clarified". -He expected the cook to reference the therapeutic menus.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 3 of 6 sampled residents with physician ordered therapeutic diets were served as ordered for a mechanical soft ground diet (Resident #2), mechanical soft no added salt (MS-NAS) diet (Resident #12), and pureed meats, controlled carbohydrate diet (Resident #14). The findings are: 1. Review of Resident #2's current FL2 dated 01/16/18 revealed diagnoses included history of malignant neoplasm of prostate, type 1 diabetes,	D 310		

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D 310	Continued From page 81 heart disease, and hyperlipidemia. Review of a physician's order dated 10/10/18 revealed Resident #2 was ordered a mechanical soft ground diet. Review of a diet list provided by the Administrator-In-Charge (AIC) revealed Resident #2 was to be served a pureed, CCHO, nectar thickened liquid diet. Review of a notebook in the dining room which included diet orders, revealed Resident #2 was listed to receive a LCS diet. There were no therapeutic diet menus available to guide staff in the preparation of a mechanical soft ground diet. Observation of the lunch meal service on 11/06/18 from 2:00pm-2:15pm revealed: -Resident #2 was served his lunch meal in his bedroom. -A dietary aide attempted to serve Resident #2 Salisbury steak, unaltered in its consistency, sweet potatoes, and a roll. -After redirection by the surveyor, Resident #2 was served a ham salad sandwich, a soft baked cookie, and diet cranberry juice. -Resident #2 consumed 100% of his meal without difficulty. Without a therapeutic diet menu, it could not be determined if Resident #2 was served a mechanical soft ground diet as ordered by the physician. Observation of the lunch meal service on 11/07/18 from 12:00pm-12:49pm revealed: -Resident #2 was served barbequed beef which	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 310	Continued From page 82	D 310		

was coarse cut but not ground, chopped green beans, rice, a roll, a cup of unsweetened tea, a cup of water, a cup of milk, and orange sherbet.
-Resident #2 consumed 100% of his meal without difficulty.

Without a therapeutic diet menu, it could not be determined if Resident #2 was served a mechanical soft ground diet as ordered by the physician.

Interview with Resident #2 on 11/06/18 at 2:15pm revealed:
-He was served what was listed on the menu in the kitchen.
-His food was not normally chopped or ground.
-He did not know his current diet order.

Interview with Resident #2's Primary Care Provider (PCP) on 11/08/18 at 1:41pm revealed:
-Resident #2 was ordered a mechanical soft ground diet because it was recommended by speech therapy.
-She followed the recommendation of speech therapy and wrote an order for a mechanical soft ground diet.
-She expected Resident #2 to continue to receive mechanical soft diet as ordered.

Attempted telephone interview with speech therapy on 11/09/18 at 10:55am was unsuccessful.

Interview with a dietary aide on 11/06/18 at 2:30pm revealed:
-She provided Resident #2 the plate that was already prepared in the kitchen.
-She thought Resident #2 was ordered a Low Concentrated Sweets (LCS) diet as it was listed in the diet book.

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D 310	Continued From page 83 -She did not know Resident #2 was to be served a mechanical soft ground diet. -Resident #2 was previously on pureed, but the order changed "a while ago". Interview with the Resident Care Coordinator (RCC) on 11/06/18 at 3:52pm revealed: -She thought Resident #2 was on a LCS diet. -She was responsible for updating the notebook in the dining room with diet updated diet orders. -She did not know Resident #2's diet order changed to mechanical soft ground on 10/10/18. -She would have updated the notebook with the current diet order if she knew that it changed. -She updated the notebook in the dining room whenever there was a new diet order. Interview with the cook on 11/06/18 at 11:30am revealed: -The only menu she referred to for preparing and serving food to the residents was the regular/NAS diet menu. -She did not have a menu to refer to for preparing mechanical soft ground. -She worked at the facility for 11 years and knew how to prepare mechanical soft ground and pureed diets from memory. -She was trained on how to prepare a mechanical soft ground and pureed diet by the dietary manger 11 years ago when she was first employed. -She had not received a menu for mechanical soft ground for this cycle from the Administrator or AIC. -Diet orders were kept in a notebook in the dining room area for servers to refer to when taking orders. -Servers were responsible for taking orders and referring to the notebook to record the diet order before taking to the cook.	D 310		

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D 310	Continued From page 84	D 310		

-The RCC was responsible for updating the notebook with most recent diet orders.
-She did not Resident #2 was ordered a mechanical soft ground diet.

Refer to interview with another cook on 11/07/18 at 11:47am.

Refer to interview with the Administrator on 11/09/18 at 2:00pm.

2. Review of Resident #12's current FL2 dated 03/14/18 revealed diagnoses included atrial fibrillation, dementia, and basal cell carcinoma.

Review of a signed physician's order dated 07/24/18 revealed a diet order for a MS-NAS diet.

Observation of kitchen on 11/06/18 revealed there was no diet list posted for food service staff to reference for the assisted living unit.

Review of a diet list provided by the AIC revealed Resident #12 was to be served a MS-NAS diet.

There were no therapeutic diet menus available to guide staff in the preparation of a MS-NAS diet.

Observation of the lunch meal service on 11/06/18 from 12:15pm to 1:00pm revealed:
-A dietary aide served Resident #12 Salisbury steak (not mechanically altered), succotash, whipped sweet potatoes, tea, and water.
-After redirection by the surveyor, the server went to the kitchen to obtain another plate for Resident #12.
-At 12:40pm, Resident #12 was served ground Salisbury steak, succotash, whipped sweet potatoes, tea, and water.
-Resident #12 consumed 100% of her meal

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D 310	Continued From page 85 without difficulty. Without a therapeutic diet menu, it could not be determined if Resident #12 was served the MS-NAS as ordered by the physician. Observation of the lunch meal service on 11/06/18 from 12:00pm to 12:49pm revealed: -Resident #12 was served ground chicken, rice, a roll, tea, water, and orange sherbet. -Resident #12 consumed 100% of her meal without difficulty. Without a therapeutic diet menu, it could not be determined if Resident #12 was served the MS-NAS diet as ordered by the physician. Telephone interview with Resident #12's primary care provider (PCP) 11/08/18 at 1:41pm revealed: -Resident #12 was ordered a mechanical soft diet as a precaution due to a previous brain injury. -She was waiting on an evaluation to be completed by speech therapy to determine if another diet needed to be ordered. -She was not aware of any swallowing difficulties for Resident #12. -She expected Resident #12 to receive a mechanical soft diet as ordered. Interview with the cook on 11/06/18 at 11:30am revealed: -She knew Resident #12 was ordered a mechanical soft diet. -She don't know why Resident #12 received a regular plate. -Diet orders were kept in a notebook in the dining room area for servers to refer to when taking orders. -The only menu she referred to for preparing and serving food to the residents was the regular/NAS	D 310		

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D 310	Continued From page 86	D 310		

diet menu.
-She did not have a menu to refer to for preparing mechanical soft.
-She worked at the facility for 11 years and knew how to prepare mechanical soft and pureed diets from memory.
-She was trained on how to prepare a mechanical soft and pureed diet by the dietary manger 11 years ago when she was first employed.
-She had not received a menu for mechanical soft for this cycle from the Administrator or AIC.
- The servers were responsible for taking orders and referring to the notebook to record the diet order before taking to the cook.

Based on record review, observation, and interview Resident #12 was not interviewable.

Attempted interview with Resident #12's responsible party on 11/09/18 at 10:51am was unsuccessful.

Refer to interview with another cook on 11/07/18 at 11:47am.

Refer to the telephone interview with the Administrator on 11/09/18 at 2:00pm.

3. Review of Resident #14's current FL2 dated 06/12/18 revealed diagnoses included dementia, type 2 diabetes, and peripheral vascular disease.

Review of signed subsequent physician's orders for Resident #14 dated 07/25/18 revealed:
-There was an order on the first page for pureed meats, controlled carbohydrate diet and cardiac diet.
-On the second page, there was an order for pureed meats, controlled carbohydrate diet.

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D 310	Continued From page 87 Review of Resident #14's record revealed no clarification of diet orders. Review of a diet list provided by the AIC revealed Resident #14 was to be served a pureed, CCHO (carbohydrate controlled), and cardiac diet. Observation of kitchen on 11/06/18 revealed a diet list for the Special Care Unit (SCU) listed Resident #14 was to be served a pureed diet. There were no therapeutic diet menus available to guide staff in the preparation of a pureed meats, carbohydrate controlled diet. Observation of the lunch meal service on 11/06/18 from 12:15pm-1:00pm revealed: -Resident #14 was served pureed ham, pureed mixed vegetables, pureed sweet potatoes, diet cranberry juice, water, and chocolate pudding. -Resident #14 consumed 100% of her meal without difficulty. Without a therapeutic diet menu, it could not be determined if Resident #14 was served the pureed meats, carbohydrate controlled diet as ordered by the physician. Observation of the lunch meal service on 11/07/18 from 12:00pm-12:49pm revealed: -Resident #14 was served pureed chicken, mashed potatoes, a pureed dinner roll, diet cranberry juice, a cup of water, and sugar free pudding. -Resident #14 consumed 100% of her meal without difficulty. Without a therapeutic diet menu, it could not be determined if Resident #14 was served the pureed meats, carbohydrate controlled diet as	D 310		

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D 310	Continued From page 88 ordered by the physician. Interview with the Resident Care Coordinator (RCC) on 11/06/18 at 3:52pm revealed: -She thought the carbohydrate controlled diet was the same as a Low Concentrated Sweets (LCS) diet. -She did not know there was no menu available for a carbohydrate controlled diet. Refer to the interview with the cook 11/06/18 at 11:30am. Refer to the interview with the AIC on 11/09/18 at 10:17am. Refer to the telephone interview with the Administrator on 11/09/18 at 2:00pm. Based on observation, interview, and record review Resident #14 was not interviewable. Attempted interview with Resident #14's responsible party on 11/09/18 at 11:00am was unsuccessful. _____ Interview with another cook on 11/07/18 at 11:47am revealed: -A mechanical soft menu was not available for guidance in the kitchen. -She used her memory to prepare the mechanical soft meal. -She was trained by a previous dietary manager "years ago" when she first began working at the facility. -She referred to the diet orders in the notebook located in the dining hall to prepare meals for the residents.	D 310		

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D 310	Continued From page 89 -She did not know Resident #2 was to be served a mechanical soft diet. Interview with the Administrator on 11/09/18 at 2:00pm revealed: -The cooks was responsible for making sure diets were served as ordered by the physician. -The dietary staff had a notebook with therapeutic menus in the kitchen to use as a guide. -The RCC was responsible for making sure the notebook had the most current diet orders. -He did not know Resident #2 was served mechanical soft ground diet. -He expected residents to be served according to the diet ordered by the physician. _____ The facility failed to assure therapeutic diets were served as ordered including Resident #2 with a physician's order for a mechanical soft ground diet and Resident with #12 with a physician's order for a mechanical soft no added salt diet, for which menus were not available to reference which resulted in Resident #2 and Resident #12 being served a meal that was not mechanically altered, requiring redirection from the surveyor. Resident #14 with a physician's order for a pureed meats, controlled carbohydrate diet for which a menu was not available to reference. Without menus available to guide staff, it could not be determined if Resident #2, Resident #12, and Resident #14 were served diets as ordered by physician. This failure was detrimental to health of the residents and constitutes a Type B violation. _____ A Plan of Protection in accordance with G.S. 131D-34 was requested on November 28, 2018, for this violation.	D 310		

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D 310	Continued From page 90 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 8, 2018.	D 310		
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: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 4 of 6 sampled residents (#3, #4, #5, and #8) were free of neglect and physical abuse related to not providing Foley catheter care and supplies to 2 residents with Foley catheters, resulting in one resident being hospitalized for urosepsis (Resident #3) and one resident having to carry his uncovered, urine-filled Foley catheter bag in one hand while walking with his cane in the other hand (Resident #8); not providing personal care assist with toileting, showers, transfers, and positioning while in bed, resulting in 2 residents receiving injuries of unknown origin related to multiple skin tears and bruising to his right forearm and left hand (Resident #5) and dislocated right shoulder (Resident #4). The findings are: 1. Review of Resident #3's current FL2 dated 11/02/17 revealed: -Diagnoses included dementia without behavioral disturbances, atrial fibrillation, diabetes, and	D 338		

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edema.
-Resident #3 was incontinent of bladder.
-Resident #3 was intermittently disoriented and was semi-ambulatory.

Review of Resident #3's Resident Register revealed he was admitted to the facility on 10/31/17.

a. Review of Resident #3's urologist's notes dated 06/26/18 revealed:
-Resident #3 was referred to the urologist for urinary incontinence.
-Resident #3 had a Foley catheter placed during the office visit.
-The facility was instructed to assist the resident in emptying the catheter bag.
-Resident #3 was given extra catheter bags to allow the catheter bag to be "changed weekly."
-Resident #3 was scheduled to return to urologist's office in 4 weeks to change catheter.

Review of a Licensed Health Professional Support (LHPS) evaluation dated 10/12/18 revealed:
-Resident #3 was followed by a home health agency.
-The staff had been competency validated for a Foley catheter in catheter care.
-Catheter care for Resident #3 included positioning and emptying the urinary catheter bag and cleaning around the urinary catheter.

Review of Resident #3's Personal Care Record for October, 2018 revealed there were no entries documented for changing or emptying catheter bag or showering the resident from 10/01/18 to 10/31/18.

Observation of Resident #3's facility room on

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D 338	Continued From page 92 11/08/18 at 10:13am revealed an empty room with a strong urine smell. Telephone interview with Resident #3's Power of Attorney (POA) on 11/07/18 at 4:52pm revealed: -Resident #3 was covered in feces on his clothes when she met him for the urologist appointment on 09/24/18. -Resident #3 had "a plastic bag from the kitchen strapped to his leg with his catheter bag inside." -"The Facility should clean and change the catheter bag," for Resident #3. Interview with a personal care aide (PCA) on 11/08/18 at 9:15am revealed: -She was responsible for Resident #3's showers and catheter care. -Resident #3 was scheduled to have 3 showers weekly. -She had never received catheter care training at the facility. -She was a certified nurse assistant (CNA) and "knew how to care for a resident with a catheter." -She would clean Resident #3's catheter with alcohol swabs. -The facility was not responsible for changing the catheter bag and never had supplies to change the bag. -Resident #3's home health agency was responsible for providing catheter supplies. Interviews with a medication aide (MA) on 11/07/18 at 8:38am and 11/08/18 at 8:35am revealed: -The PCA's were responsible for catheter care and showering the residents. -She had not noticed Resident #3 smelling like urine. -There were no extra catheter supplies in storage. -The Resident Care Coordinator (RCC) or the	D 338		

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Assisted Living Nurse Supervisor was responsible for ordering supplies.

Interview with the RCC on 11/07/18 at 10:15am revealed:
-The PCA's were responsible for providing catheter care.
-She was not aware that Resident #3 had any problems with a leaking catheter bag.
-"It was normal," for Resident #3 to smell like urine even after he had received a shower.

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:45pm revealed:
-The PCA's were responsible for catheter care for Resident #3.
-Each resident with a catheter had a home health agency that was responsible for "cleaning the catheter and doing daily checks."
-She was not aware of any problems Resident #3 had with his catheter or the catheter bag leaking.
-Resident #3 was supposed to be showered twice weekly during first shift.
-The second shift PCAs would report that Resident #3 was "left in a mess" with feces covering his groin area when they checked on him.
-The first shift PCAs would report that Resident #3 refused his showers but the "staff was just lazy and didn't want to give him a shower."
-The second shift PCAs would report they had to shower and clean Resident #3 at the beginning of their shift.

Telephone interview with a nurse from Resident #3's urologist's office on 11/09/18 at 9:24am revealed:
-Resident #3 had arrived to his appointment on 09/24/18 with a rip in his catheter bag.
-The catheter bag was in a plastic bag and was

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leaking urine on the resident.
-"The clinic gave each patient catheter supplies until they could be mailed directly to the patient."
-Resident #3 was "saturated in urine down to his ankles and a tremendous amount of feces covering his front and back."
-"It took 2 nurses more than 30 minutes to clean all the dried feces and urine off the patient."
-She gave Resident #3 surgical pants to wear to return to the facility.
-The facility should not manipulate the catheter but was responsible for emptying the catheter bag, basic bathing, and washing the area around the catheter with soap and water.
-The catheter bag needed to be changed out weekly.
-Resident #3 was not able to care for himself and needed "total care for showering and catheter care."
-The amount of feces and urine on Resident #3 could lead to the resident developing urosepsis.

Telephone interview with the social worker from Resident #3's primary care physician's office on 11/09/18 at 3:37pm revealed:
-She had been notified by the nurse from Resident #3's urologist's office that the resident had presented to the office "covered in urine and feces."
-Resident #3's catheter changes were being followed by the urologist and not home health.
-The facility should be providing personal care to the resident.
-A nurse from the physician's office had contacted the facility on 10/04/18 regarding offering additional personal care services to Resident #3, including weekly baths.
-The facility stated "they provided this service already" to Resident #3.

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Review of Resident #3's charting notes on 11/06/18 revealed Resident #3 was sent out of the facility to the hospital for evaluation for a fever, nausea, vomiting, diarrhea, and weakness on 10/31/18 at 11:17pm.

Review of Resident #3's hospital admission summary dated 10/31/18 and 11/01/18 revealed:
-Resident #3's urine in his catheter bag was cloudy, foul smelling, and contained a sediment.
-Resident #3 was at "high risk for clinical death and decline" and was admitted with urosepsis.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed:
-He had not provided any "recent catheter training" and could not remember the last time he provided an "in-service training on catheters."
-The facility was only responsible for emptying the catheter bag and cleaning the resident.
-He instructed the staff to wash the resident with soap and water to keep the catheter area clean.
-The resident's home health agency was responsible for changing catheter bags.
-The facility staff should visibly check on each resident every 2 hours and should document in the personal care notebook.
-The PCA was responsible for showering the resident and providing personal care assistance.
-He was not aware that Resident #3 had any problems with his catheter, including any leaking.
-He was not aware that Resident #3 was not getting proper personal care and had presented to the urologist covered in feces and urine.

b. Telephone interview with Resident #3's Power of Attorney (POA) on 11/07/18 at 4:52pm revealed:
-Resident #3 had called her "early in the morning" on 10/31/18 and reported "he felt terrible and did

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not know what was going on."
-She told Resident #3 to "press his call button to get someone to come help him."
-Resident #3 had short term memory loss.

Review of the facility's call bell monitoring system from 10/30/18 to 10/31/18 revealed:
-Resident #3 had pressed his call bell at 5:28am on 10/31/18 and the alert was never responded to.
-The alert timed out and turned off at 8:05am.
-Resident #3 had pressed his call bell at 7:50pm on 10/31/18 and the alert was never responded to.
-The alert timed out and turned off at 10:54pm.

Telephone interview with Resident #3's family member on 11/09/18 at 7:55am revealed:
-She visited Resident #3 on the morning of 10/31/18.
-She arrived before Resident #3 was served breakfast and left before lunch.
-Resident #3 was "sick and not feeling good."
-She spoke with the Administrator before she left to make sure he knew that Resident #3 was not feeling well.
-The Administrator had assured her that Resident #3 would be cleaned.

Interview with a MA on 11/07/18 at 10:15am and 11/08/18 at 5:15am revealed:
-She worked third shift on 10/31/18 when Resident #3 had been sent out to the hospital for a fever, nausea, vomiting, and diarrhea.
-Resident #3 was "fine all day until he was sent out to the hospital."
-"If no one was sitting at the front desk then no one was monitoring the call bell system."

Interview with the Resident Care Coordinator

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(RCC) on 11/07/18 at 10:15am revealed:
-The MA had informed her that Resident #3 was not feeling well and had a fever prior to being sent to the hospital on the evening of 10/31/18.
-Resident #3 had been "fine all day up until he was sent out to the hospital."

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:45pm revealed:
-She was notified by the MA on the evening of 10/31/18 that Resident #3 had a fever and was not feeling well.
-The PCA's and MA's were responsible for answering the alerts from the call bell system.

Review of Resident #3's charting notes for 10/31/18 revealed:
-The MA documented that Resident #3 had a "blood looking color" in his catheter bag at 5:30pm.
-The MA documented that Resident #3 was complaining of not feeling well and had a fever of 103.6 at 9:40pm.
-The Assisted Living Nurse Supervisor was notified at 9:40pm.
-The Assisted Living Nurse Supervisor documented at 11:17pm that Resident #3 "looked weak" and was observed with nausea, vomiting, fever, and diarrhea.
-Resident #3 was sent out of the facility to the hospital for evaluation at 11:17pm.

Telephone interview with a nurse from Resident #3's urologist's office on 11/09/18 at 9:24am revealed:
-The facility should have contacted the urology office immediately if there was a problem with the catheter or if the facility noticed signs and symptoms of an infection.
-Signs and symptoms of an infection included

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fever, abdominal pain, nausea, vomiting, and diarrhea.
-It was important for Resident #3 to get care immediately if he developed symptoms to prevent a serious infection.

Review of Resident #3's hospital admission summary on 10/31/18 and 11/01/18 revealed:
-Resident #3 reported to the hospital that he had not been feeling well for the last several days and had a fever and chills.
-Resident #3's urine in his catheter bag was cloudy, foul smelling, and contained a sediment.
-Resident #3 was at "high risk for clinical death and decline" and was admitted with urosepsis and pulmonary edema.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed he did not know Resident #3 was not feeling well and was having nausea, vomiting, diarrhea, and a fever until the night of 10/31/18 when Resident #3 was sent out of the hospital.

2. Review of Resident #5's current FL-2 dated 08/01/18 revealed:
-Diagnoses included dementia, cerebral vascular accidents x2, chronic obstructive and pulmonary disease.
-Resident #5 had no documented mood indicators or behavioral symptoms with wandering, being physically abusive; being verbally abusive, or being a danger to self, others, or property.

Review of Resident #5's care plan dated 07/03/18 revealed:
-Resident #5 was evaluated as "totally dependent" on staff to assist with toileting, dressing, grooming and personal hygiene.

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-He required extensive assistance with bathing.
-He was independent with eating.
-He required supervision with ambulation and locomotion.
-He required limited assistance with transferring.
-The care plan did not reflect any documentation of resident being resistant to care or being physically or verbally abusive.

Review of Resident #5's subsequent care plan dated 10/03/18 revealed:
-Resident #5 was evaluated as "totally dependent" on staff to assist with toileting, bathing, dressing, transferring, grooming and personal hygiene.
-He required extensive assistance with eating.
-He required supervision with self-propelling his wheelchair.
-The care plan did not reflect any documentation of resident being resistant to care or being physically or verbally abusive.

Review of the Licensed Health Professional Support (LHPS) dated 07/30/18 revealed:
-Resident #5 was transferred daily by staff to his wheelchair.
-He used a wheelchair for ambulation.

Review of Resident #5's Hospice documentation dated 08/17/18 revealed, "He is wheelchair bound but able to self-propel with the use of his feet, incontinent of bowel and bladder."

Review of Resident #5's charting notes by the Medication Aide (MA) dated 09/24/18 at 7:07am revealed:
-Resident #5 was found in bed.
-MA was going to provide morning care to Resident #5.
-MA observed blood in the bed with Resident #5's

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right forearm and the back of his left hand was leaking from "blood blisters."

Review of an Incident-Occurrence Report and Investigation form on Resident #5 dated 09/22/18 at 10:30pm revealed:
-The location of the occurrence was in Resident #5's room.
-The type of occurrence was circled as staff to resident.
-The clinical assessment (ROM-range of motion) was documented as "completed and assessed," and there were no further documented details. The nature of the injury was checked as a bruise.
-The right upper forearm was identified as the location of the injury.
-The description of the occurrence documented, "CNA, (Certified Nursing Assistant), used resident's arm to reposition in bed instead of the pad. Resident able to move extremity and no redness or bruising noted."
-There was no change in environment.
-Resident was found in bed wearing T-shirt and brief.
-Hospice was made aware when bruise was reported on 09/24/18.
The facility documented, "Educated staff member on the spot on proper repositioning."
There was no documentation to show who was trained and what techniques was demonstrated on proper repositioning residents in the bed.
-The Incident-Occurrence Report and Investigation was filed by SCU nurse supervisor who was also the Licensed Practical Nurse who reviewed the report on 09/26/18.
-The administrator signed the Incident-Occurrence Report and Investigation on 09/26/18.

Review of an Incident-Occurrence Report and

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D 338	Continued From page 101 Investigation form on Resident #5 dated 09/24/18 at 7:07am revealed: -The location of the occurrence was in Resident #5's room. -The type of occurrence was unknown. -The nature of the injury was a skin tear and a bruise. -The right upper and lower forearm was identified as the location of the injury. -The back of the left hand was also identified as having an injury. -The injury or the significance the injury was not documented. -Hospice was notified of the injury. -The description of the occurrence was documented as, "On duty Med Tech stated she saw blood in the bed on his right forearm and ball of left hand. This was leaking from blood blisters. This was observed when she went to do am care." -The victim's statement as to the cause was documented as, "Resident when initially asked what happened stated repeatedly he didn't know. When asked if he resisted care from staff he said yes. When resident asked by Hospice nurse, and administer, resident state he didn't know what happened. Bruise to right forearm due to repositioning." -There was no change in the environment. -There was blood (dried) and dried skin found on resident's wheelchair and pad. -"Resident was found in the bed per med tech on duty. Resident uses a wheelchair that he self-propels." -Resident was in bed without shoes. -Staff education on personal care and repositioning was provided to prevent further occurrences. -There was no documentation to indicate what further occurrences mean.	D 338		

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-The Incident-Occurrence Report and Investigation was filed by SCU nurse supervisor who was also the Licensed Practical Nurse who reviewed the report on 09/26/18.
-The administrator signed the Incident-Occurrence Report and Investigation form on 09/26/18.

Review of Resident #5's charting notes revealed:
-A note dated 09/24/18 at 7:07am by Medication Aide, MA, "med tech went to do morning care for resident saw blood in the bed his right forearm and the back of left hand was leaking from the blood blisters."
-A note dated 09/24/18 at 3:07pm by SCU nurse supervisor, "Received report this morning that resident needed to be seen. Resident observed with two bandage wraps on, one on his right forearm and the other to his left hand. Resident states he did know what happen when initially asked. Resident asked if he was fighting the staff during personal care, resident stated yes. Call placed third shift med tech who wrote chart noted, med tech stated when she went to do her round she noticed leaking blood from blisters and did not know what happened. Med tech also stated that the resident did resist care after having a large bowel movement. Resident has two large skin tears which observed after dressing was taken off. Chart note from third shift med tech stated he had blood leaking from blood blisters which was cleaned and dressed. Facility administrator called to the resident's room regarding skin tears. Hospice contacted regarding condition and hospice nurse in to see resident to assess. Resident's wounds redressed by hospice nurse. VM left for resident's daughter to return to the facility. Daughter returned call, made aware.
-A note dated 09/24/18 at 3:37pm by the SCU

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nurse supervisor, "Received report that resident has a bruise to the right upper arm. Resident assessed this morning and a large bruised area noted. Resident did not complain of pain to the area and was able to extend his arm. Caregiver addressed by nurse supervisor about improper positioning resident while in bed on the spot when the caregiver did not use the pad to pull up in bed. No redness or bruising noted or documented on the following day. Hospice and Administrator aware. VM left for resident's {family member} to return call to the facility. {Family member} returned call made aware."
-A note dated 09/24/18 at 4:34pm by the Administrator, "Called in by LPN to observe residents hands, resident had what appears to be skin tear or rupture of hematoma under skin, resident alert however, not oriented, resident unable to state how injury occurred, LPN spoke with med tech from previous shift who stated collection of blood under skin that had ruptured and she applied basic first aid, pt has hx per staff of self-injury to arms and hands accidental. Pt is known to resist care, staff backs off and attempts to approach again to provide ADL care. LPN notified family and hospice in regards to wounds, staff informed to provide frequent safety checks on resident. Further investigation of resident's w/c revealed blood on breaking mechanism, appears that resident may have injured hand while self-propelling."

Review of charting notes from 8/30/18-09/22/18 revealed no documentation of resident being resistant to care or having any self-injuries.

Review of the communication note from the hospice nurse for Resident #5 dated 09/24/18 revealed:
-"SNV: pt lying in bed, awake, alert. Stated he

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didn't want to get up today. Pt has bandages on Rt arm, left hand. Assessment reveals a large ST {skin tear} Rt {right} forearm 8x2cm with 2cm additional bruising above wound. Lt hand (dorsum) has a large wound/skin tear that covers 75% of hand from pinky finger to near index finger. Significant bleeding still, despite tegaderm and gauze bandage. Visual white structure below ring finger, unsure if this is tendon or bone.
-Wound is very painful to touch and pt was premeditated with morphine 5mg prior wound care.
-Wound on left is an avulsion injury of unknown origin. Wounds cleaned, polymer and dressing applied. During wound care, pt was having labored breathing. Pulse 82, resp 20, PO2 98% on O2 at 2lpm. Diffuse rales, wet breathing in all lobes. Observed med tech giving prn Levsin - administered only 1 dropper (0.25 ml) - education on proper dosing is 4 droppers full to total 1ml dose."

Review of hospice note dated 09/24/18 revealed:
-"Staff report patient has two skin tears."
-"BP deferred due to painful wounds."
-Current location "right forearm and left hand".

Interview with a medication aide (MA) on 09/26/18 at 4:40pm revealed:
-Resident #5 used only his legs to self-propel his wheelchair.
-She never observed Resident #5 using his hands to self-propel his wheelchair.
-Resident #5's hands were usually in his lap when self-propelling his wheelchair.
-Resident #5 had never "lashed out at staff."
-Resident #5 was able verbalize his response when asked questions prior to the incident.
-Resident #5 required a 2-person assist with transferring and personal care.

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D 338	Continued From page 105 -She overheard the third-shift medication aide, MA, say, "I am tired of fighting with Resident #5," upon arriving on the unit at the start of her shift. -When completing morning rounds on 09/24/18, she observed blood on Resident #5's bed sheets, and she observed he was wearing only a tee-shirt and briefs. -She was never informed about any health care concerns concerning Resident #5. -Resident #5's arms and hands were bandaged with blood seeping through the gauzes. -She did not know what had happened to Resident #5 because when she left work on 09/23/18. -Resident #5 was in the bed with no dressings on his arm and hands with no visible signs of bleeding. -When her shift ended on 09/23/18, Resident #5 was dressed in his "PJs." -She notified the SCU nurse supervisor of Resident #5's condition when SCU nurse supervisor arrived to work on 09/24/18. -The SCU nurse supervisor then assessed Resident #5 and notified the Administrator of resident's condition. -The SCU nurse supervisor and she cleaned up Resident #5 and rewrapped his "arms and hands." -The hospice nurse came in later that day on 09/24/18 to provide care to Resident #5's injuries. -She spoke to SCU nurse supervisor about the care that was provided to Resident #5 on 09/23/18, and the condition she found Resident #5 in when she returned to work the morning of 09/24/18. Interview with another MA on 09/28/18 at 11:00am revealed: -She described Resident #5 as a "sweet resident who was never combative."	D 338		

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-Resident #5 was known to crack jokes before he was injured.
-Resident #5 had a change in "his spirit" after his injuries.
-Resident #5 no longer wanted to get out of bed, and he did not eat his meals on 09/25/18 after his injuries.
-She had never observed Resident #5's hands hanging down beside the wheels of his wheelchair.
-Resident #5 kept his hands in his lap with the arms resting on the wheelchair arm rest when self-propelling his wheelchair using his feet.
-She did not know how Resident #5 sustained the injuries on his hands and arms.
-She had not worked since 09/20/18.

Interview with a personal care aide (PCA) on 09/28/18 at 11:46am revealed:
-She always observed Resident #5 self-propelling his wheelchair with his feet with his hands in his lap.
-Resident #5 never used his hands to self-propel the wheelchair.
-Resident #5 was never combative with staff.
-When assisting Resident #5, "if he told you No, staff would just need to come back later."
-She did not know the cause of injuries to Resident #5 arms or hand.

Interview with another PCA on 09/28/18 at 4:10pm revealed:
-Resident #5 used his feet to self-propel his wheelchair around the special care unit with his arms/hands crossed in his lap.
-Resident #5 had propelled himself to his room on Sunday night (09/23/18).
-She and the MA assisted Resident #5 to bed on 09/23/18 by "wiping him down and putting on his pajamas sometime between 9:00pm to 9:30pm.

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D 338	Continued From page 107 -Upon assisting him to bed, she took off the Geri sleeve Resident #5 wore on his right arm. -She observed no blood blisters, bruises, bleeding, or any broken skin on Resident #5 when she assisted him to bed on 09/23/18 sometime between 9:00pm to 9:30pm. -During rounds on the evening of 09/23/18, she heard Resident #5 moaning. -She went into his room and asked if everything was alright. Resident #5 responded by saying "nope." -She turned on the bathroom light and pulled his pillow out and used the draw sheet to pull him up in the bed to turn him on his left side. -Resident #5 had no visible signs of blood on the sheets or his body. -She last checked on Resident #5 around 10:30pm on 09/23/18 and observed Resident #5 was sleeping in his bed. -Her shift ended around 11:00pm on 09/23/18. -She did not return to work until 09/24/18 to work second shift (3:00pm to 11:00pm) -On 09/24/18, she observed Resident #5 in his bed with bandages on both arms and hands. -When she touched Resident #5 on his shoulder, "he jumped and looked scared." -The MA on duty was responsible for completing incident/accident reports and charting the information about the incident/accident in the progress notes. -Written incident/accident report would go to both the SCU nurse supervisor and the administrator. -The MA was responsible for notifying the doctor and the family member as well. Interview with a third PCA on 09/28/18 at 4:10pm revealed: -She worked first shift on 09/23/18 (7:00am-3:00pm). -She observed no markings on Resident #5	D 338		

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hands and arms during her shift on 09/23/18.
-She next worked first shift on 09/24/18 and worked a double shift (7:00am-11:00pm).
-When she arrived to the facility in the morning of 09/24/18, she heard the MA from 3rd shift say, -"I am tired of fighting with Resident #5, he had **** all over him."
-She did not understand what the MA meant because Resident #5 was not combative.
-If Resident #5 said No, just walk away and come back later.
-Resident #5 was in bed when during her rounds.
-She observed bruising on Resident #5's arms and hands on 09/24/18.
-Resident #5's arms and hands were wrapped, with blood coming through the wrappings.
-Resident #5 could not get up without 2-person assist for transferring.
-Resident #5 was total care.
-Resident #5 would propel his wheelchair with his feet.
-Resident #5 would not use his hands to propel the wheelchair.
-She had never observed Resident #5's arms hanging over the arm of the wheelchair. His hands were always in his lap.
-The MA notified the SCU nurse supervisor concerning the condition of Resident #5 when the SCU nurse supervisor arrived at work.
-The SCU nurse supervisor rewrapped Resident #5 arms and hands after she removed the previous wrapping to assess the condition of his skin.
-She assisted the SCU nurse supervisor with giving Resident #5 a bath to clean up the dried blood on his arms and hands.
-While bathing Resident #5, he would call out like he was in pain.
-There was blood all over the sheets.
-There was bowel movement on the comforter.

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D 338	Continued From page 109 -She observed Resident #5 with bowel movement on his fingers and some on his thighs when giving him a bath. -Resident #5 was not the same since he had the injuries to his arms and hand. -Resident #5 no longer wanted to get out of bed or eat his meals. -There was no incident report written by the 3rd shift MA regarding Resident #5 injuries. -The MA on duty was responsible for writing up the incident/accident reports before leaving the facility. -The MA was also responsible for completing a chart note on the computer and faxing the doctor about the incident/accident. -Resident #5 was under Hospice care. Telephone interview with MA on 10/22/18 at 5:30pm revealed: -She was the MA that worked 3rd shift on 09/23/18 (11:00pm to 7:00am). -Resident #5 was already in bed when she started her shift on 09/23/18. -She never assisted Resident #5 out of the bed during the shift on 09/23/18. -During her shift, she checked on residents about every 2-hours. -She changed Resident #5 in his bed around 2:00am the morning of 09/24/18. -Resident #5 had no visible signs of blood on the sheets or his body at the time she changed him. -Between 6:00am-6:30am on 09/24/18, she observed Resident #5 in bed with a large bowel movement and blood all over the resident's arms and hand and the sheets. -The bleeding was coming from Resident #5's arms and hands. -She could not clean the bowel movement on Resident #5 until she cleaned the blood. -She heard no yelling during that shift coming	D 338		

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from Resident #5.
-Resident #5 required a 2-person assist to get up from the bed.
-Resident #5 could use his feet to proper his wheel chair and used his hands to turn the wheelchair.
-She used a draw-sheet to move Resident #5 to keep from pulling on him when changing him in bed.
-Resident #5 was on his left side.
-There was a "lot of blood" coming from the purple areas on his arm and hands.
-She did not look at Resident #5's wheelchair.
-She did not look at the wheelchair because Resident #5 was in the bed the entire shift and the wheelchair was in the bathroom.
-She reported that morning about Resident #5's condition at shift change.
-She documented a quick note in the computer.
-She did not call Hospice or the SCU nurse supervisor about Resident #5's condition.
-She did not fill out an incident report.

Interview with the MA/PCA on 11/08/18 at 4:30pm revealed:
-She worked 3rd shift the night of 09/23/18 (11:00pm-7:00am).
-She worked the hall from 119 to 127, and the other MA worked the other hall in the SCU.
-She was not assigned to Resident #5.
-Resident #5 was asleep throughout the shift.
-Resident #5 did not get out of bed during the shift.
-Resident #5 was a "turn and dry."
-Resident #5 could stand and pivot, but he could not walk alone.
-She was not aware of Resident #5 having protective sleeves for his arms.
-She heard the MA reporting to first shift prior to leaving the facility around 7:00am, but she was

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not aware of the information reported to the first shift MA.
-If an accident/incident occurred, the MA was responsible for completing incident/accident reports.
-The MA would call the medical doctor or nurse to report the incident/accident of a resident.
-The MA would fax the medical doctor about the incident/accident of a resident.
-There was a Body Audit form that the MA would fill out when a resident suffered an incident/accident.
-The SCU nurse supervisor called and asked her what happened to Resident #5 when he was found with injuries to his arms and hand.
-She was not aware of any injuries regarding Resident #5.
-She had never known Resident #5 to be aggressive with personal care.

Telephone interview with the hospice Registered Nurse (RN) on 09/26/18 at 4:15pm revealed:
-She received a telephone call from the SCU nurse supervisor late morning on 09/24/18 about Resident #5 having skin tears on the right arm and left hand.
-When she arrived to the facility on 09/24/18, Resident #5 was observed in bed with gauzes wrapped around his right arm and his left hand.
-The SCU nurse supervisor assisted her with removing the gauze.
-Resident #5 had an 8 cm skin tear that she cleaned with wound cleaner and reapplied the bandage.
-Resident #5 had an injury that covered the back of his left hand from below the pinky finger over to the area that almost reached the index finger.
-Resident #5's index finger skin was "pushed back" towards the index finger.
-The area on Resident #5's left hand was a

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"bloody mess."
-She cleaned the left hand with wound cleanser.
-The facility staff had put an adhesive dressing over Resident #5's wounds to the arms and left hand.
-When she removed the adhesive dressing, Resident #5's left hand continued to bleed.
-Resident #5's wound was cleaned with polymer over the wound and covered with a non-adhesive pad wrapped in gauze.
-Resident #5 said that his hand hurts.
-Resident #5 had to be pre-medicated with morphine to ease the pain of cleaning and dressing his wounds.
-Resident #5 did not know how the injury occurred.
-Resident #5 had "poor skin" and always had "bruising somewhere."
-She told by the SCU nurse supervisor that 3rd shift found him lying in blood before the end of shift around 7:00am on 09/24/18.
-She was told that no staff knew what caused the injuries to Resident #5's arms and hands.
-She was also told by the SCU nurse supervisor that Resident #5 had some "blood blisters."
-SCU nurse supervisor reported that the MA was attempting to provide personal care, but Resident #5 was resistant to care.
-Resident #5 was always corporative.
-Resident #5 was not resistant to care when she provided wound care to him on 09/24/18.
She received a telephone call from the facility's director who stated that the he had found blood on Resident #5's wheelchair.
-She did not see Resident #5 until after lunch on 09/24/18.
-She did not have an explanation of what happened to Resident #5's arms and hand.
-A different hospice nurse saw Resident #5 on 9/22/18 with no documentation of any injuries

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noted.
-Prior to 09/24/18, she last saw Resident #5 on 09/21/18 with no of the injuries observable on his body.
-A nurse saw him today 09/26/18 and documented that Resident #5's dressings were intact.

Telephone interview with the Responsible Party (RP) for Resident #5 on 11/08/18 at 8:38am revealed:
-Resident #5 would propel his wheelchair with his feet.
-She had never known him to use his hands to propel the wheelchair.
-She was told by the SCU nurse supervisor and administrator that Resident #5's injuries was caused by his wheelchair.
-RP reported Resident #5's hands were hard to fit in the wheelchair where the injuries allegedly occurred, plus the injuries occurred while Resident #5 was already in bed.
-RP was told by SCU nurse supervisor that no one could really determine what happed to Resident #5.
-Resident #5 had behavior changes after he sustained the injuries to his arms and hands.
-Resident #5 no longer wanted to get out of bed or eat his meals.
-Resident #5 would flinch when she touched him until he recognized who she was.
-Resident #5 was never aggressive with anyone.

Interview with SCU nurse supervisor on 09/26/18 at 5:05pm revealed:
-She had never experienced Resident #5 being combative with care.
-She described Resident #5 being "easy going and cooperative."
-Resident #5 had prescribed sleeves for both

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arms which covered the area from the top of his hand to his elbow.
-She was informed about Resident #5 injuries when she came to work on 09/24/18 around 9:30am.
-She unwrapped the gauze from both hands/arms and requested that the Administrator come to see the injuries on 09/24/18 before lunch.
-She observed the cut on Resident #5's left hand to be very deep, and the injuries on his arms looked more like skin tears.
-She contacted Hospice to come and assess Resident #5's injuries 09/24/18 before lunch after the Administrator came into assess Resident #5's injuries to his arms and hands.
-The Administrator looked around the room to see what could have caused the injuries when he came to assess Resident #5.
-The Administrator determined the Resident #5's injuries were caused by the resident's wheelchair because he observed dried blood and skin on Resident #5's wheelchair.
-SCU nurse supervisor was told by the Administrator that she did not have to do a 24-hour report because Resident #5 had hurt himself on his wheelchair.

Interview with Administrator regarding Resident #5 on 09/28/18 at 1:53pm revealed:
-SCU nurse supervisor contacted him on 09/24/18 around 10:30am to assess Resident #5's injuries on his arms and hands.
-He observed the braking mechanism on the resident's wheelchair and saw blood on the wheelchair rail with dried skin.
-He thought the injuries may have caused Resident #5 to sustain blood blisters or a hematoma.
-He did not think Resident #5 had large amounts of blood, just droplets.

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-He personally had never seen Resident #5 propel his wheelchair.
-Staff told him that Resident #5 propel his wheelchair with his hands.
-He had not interviewed staff on 2nd shift about Resident #5's injuries because he had found the source of the injuries to come from his wheelchair.
-He was told Resident #5 had Geri sleeves, but had never seen them.
-He would expect staff to report injuries to him or the SCU nurse supervisor.
-The injuries to Resident #5's arms and hand observed on the morning of 09/24/18 appeared to be like a flesh wound.
-He had not heard from staff that worked on 3rd shift as of 09/28/18.
-The MA who worked on third shift had not worked since the incident or returned any phone calls.
-He had not completed and submitted a 24-hour or 5-day working report to the Health Care Personnel Registry, HCPR, because he thought he had determined the cause of Resident #5's injuries.

Review of the 24-hour Initial Report for Resident #5 on 11/09/18 revealed:
-The 24-hour report was signed and dated on 10/02/18 for Resident #5 and reflected the incident date as 10/01/18 at 2:30pm.
-The description of the physical harm was documented as "skin tear to left forearm".
-There was no documentation on the 24-hour report regarding Resident #5's injury to the left hand.

Review of 5-day Working Report for Resident #5 on 11/09/18 revealed.
-The 5-day Working Report signed by the

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administrator on 10/05/18 reflected the incident as 10/01/18 at 2:30pm with an allegation type checked as injury of unknown source.
-The attached summary to the 5-day working report stated, "Hospice nurse in to visit resident to perform wound care dressing change on resident's left arm, dressing initially wrapped from left elbow to finger tips, however resident apparently worked dressing down to around wrist area per statement from hospice nurse. Resident noted to have small skin tear per measurements noted o left arm under initial dressing where are not visible to staff. Dressing changed by different hospice nurse on 09/30/18 with documentation stating multiple skin tears to resident's bilateral forearms, resident continues to pull at dressing per staff, due to disease process, pt. is currently a hospice pt., pt. has history of fragile skin with orders to ear Geri sleeves for skin protection, areas of concern are areas that are normally exposed to possible trauma. During investigation I have no reason to suspect neglect or abuse, this is a normal disease progression with resident history.
-Resident is transitioning with hospice, being restless in bed per hospice staff."

3. Review of Resident #4's current FL-2 dated 01/16/18 revealed diagnoses included dementia, osteoarthritis, depression and status post/fall hip replacement.

Observation of Resident #4 on 11/06/18 at 9:00am revealed:
-Her room was located at the beginning of the second floor hallway.
-The door to her room was opened.
-She was in her room sitting in a wheelchair, her head was in a downward position.
-Both arms were down by her side with her hands

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folded in her lap.
-She opened her eyes with verbal response.
-She was alert to sound but was not oriented to time or place.
-She had a facility call bell pendant around her neck but was not aware what it was for or how to push the pendant call bell if she needed assistance.
-It was determined Resident #4 was not interviewable.

Interview with Resident #4's Power of Attorney (POA) on 11/06/18 at 2:12pm revealed:
-He was in the facility today to take Resident #4 out of the facility "for her safety."
-The facility had contacted him in October 2018 in regard to Resident #4 had a right arm injury.
-The ER physician had contacted him and explained Resident #4 did not have a blood clot but a dislocated right shoulder and possible fractured clavicle.
-He had emailed the facility Nurse Practitioner on 11/17/18 in regard to Resident #4's dislocated shoulder.

Interview with the second shift Nurse Supervisor on 11/06/18 at 12:35pm revealed:
-She had worked on 10/16/18.
-She had sent Resident #4 to the ER for evaluation of the right arm and shoulder on 10/16/18.
-She was unsure if the MA had contacted the nurse practitioner on 10/16/18 or was waiting till morning to call her.

Interview with Resident #4's Nurse Practitioner (NP) on 11/07/18 at 9:20am revealed:
-The facility had not contacted her about Resident #4's ER visit on 10/16/18.
-She was unaware of the incident until 10/17/18

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when Resident #4's POA had sent her an email.
-She had seen Resident #4 in the facility on 10/17/18.
-Resident #4's right arm from the top of the shoulder to the middle of her arm was swollen, red and bruised.

Review of Resident #4's incident reports dated 10/16/18 at 7:30pm revealed:
Type of occurrence was documented as "other resident drooling and not responding to stimuli, skin clammy.
-The facility documented 911 was called.
-Vital signs were obtained.
-Resident #4 was sitting on a rollator walker with her head down drooling.
-Resident #4 not responding to basic stimuli and her skin clammy.
-The family was notified on 10/16/18.
-The physician had a time and date of 11/17/18 at 9:00am to be notified.
-The incident report was signed by the RCC, the nurse supervisor, and the Administrator.

Review of a second incident report dated 10/16/18 at 8:54pm for Resident #4 revealed:
-"No visible injury, the right arm with redness."
-There was documentation 911 was called and vital signs were obtained.
-Description of the occurrence was documented as "upon arrival on 3-11 shift [Resident #4] was observed with swelling to her right forearm, [Resident #4] c/o pain, I could not touch her right arm. I notified MA."
-There was documentation the family, the Nurse Supervisor and the administrator were notified.
-There was documentation Resident #4 was assessed and 911 called to transport to the ER for evaluation.
-The incident report was signed and dated by the

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MA, the facility nurse and the Administrator.

-Review of a third incident report dated 10/16/18 at 9:00pm for Resident #4 revealed:
-The nature of the injury was documented as "other, caregivers observed [Resident #4] arm swollen and red."
-There was documentation Resident #4 was sent to the ER.
-There was documentation Resident #4's right arm was red, swollen and warm to touch.
There was documentation the family was notified and the physician was to be notified on 10/17/18 at 9:00 am.
-The incident report was signed and dated by the RCC, the Nurse Supervisor, and the Administrator.

Interview with the Assistant Administrator on 11/09/18 at 8:55am revealed:
-Incident reports were completed by the MAs when the incident occurred.
-The Nurse Supervisor reviewed the incident report and signs off, then the report were given to the Administrator.
-The MAs were responsible for contacting the family, responsible person, physicians and the Nurse Supervisor.
-The physician's office had a 24 hour on call service that the MAs could call and leave a message if an incident happens at night.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed:
-He was not working the evening of 10/16/18 when Resident #4 was sent to the ER for the right shoulder injury.
-He was not aware of the incident report dated 10/16/18 at 7:00pm concerning Resident #4 drooling, non-responsive and her skin was

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clammy prior to the ER admission on 10/16/18 at 9:31pm for the right shoulder dislocation.

4. Review of Resident #8's current FL2 dated 07/03/18 revealed:
-Diagnoses included urinary tract infection (UTI), depression, and hypertension.
-Resident #8 had a Foley catheter.
-Resident #8 was incontinent of bowel.

Observation on 11/06/18 at 8:50am revealed:
-Resident #8 was in the hallway walking with his catheter bag in one and his cane in the other hand.
-The medication aide (MA) told Resident #8 that he was getting ready to find a leg bag to put on him, and to wait in his room.

Interview with Resident #8 on 11/06/18 at 8:50am revealed:
-He was not sure how long he had been holding his catheter bag.
-Staff would empty the bag when needed.

Interview with a MA on 11/06/18 at 9:20 am revealed:
-He was trying to find Resident #8 a leg bag but there were none on the cart.
-He would check the supply room for supplies to see if he could find leg bag.

Observation on 11/07/18 at 12:15pm revealed:
-Resident #8 entered the dining hall holding his cane in one hand and his catheter bag in another hand.
-No one found a leg bag for him so he had to carry the bag around.
-Resident #8 did not have a leg bag.
-The staff were still trying to find him a leg bag.

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D 338	Continued From page 121 Observation on 11/08/18 at 5:19pm revealed: -Resident #8 was lying in bed watching television with his catheter bag placed in small garment bag with a zipper to cover the catheter bag which was attached to his cane. -Resident #8 did not have a leg bag. Interview with Resident #8 on 11/08/18 at 5:19pm revealed: -A caregiver told him they ran out of leg bags for him. -He "would rather have a leg bag, I am embarrassed". -He thought he had been carrying around the catheter bag for about a week. Interview on 11/07/18 at 12:30pm with personal care aide (PCA) revealed: -She provided personal care for Resident #8 with toileting which included emptying his catheter bag. -She looked in Resident #8's closet and room for a leg bag but was unable to locate one so the resident had to use his catheter bag when he left his room. -She reported to the MA on duty the previous weekend that Resident #8 was out of leg bags and was told the MA would order some for him but three days later he was still without the supplies. Interview on 11/07/18 at 1:30pm with the MA assigned to the 3rd floor revealed: -She was told today by a PCA that Resident # 8 did not have catheter leg bags. -She planned to place an order for the catheter leg bags with Resident #8's home health agency. -She created a cover to help conceal the catheter bag that Resident #8 was carrying until the leg bags arrived.	D 338		

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D 338	Continued From page 122 Interview with a MA on 11/08/18 at 8:40am revealed: -Resident #8's leg bag began leaking on 11/05/18. -Resident #8 then received a regular catheter bag as they tried to find a leg bag. -She had not notified anyone of the need for a leg bag, "it slipped my mind". -Resident #8's leg bags were moved and they could not be found. Telephone interview with the Nurse Supervisor at the contracted home health agency on 11/09/18 at 10:30am revealed: -Resident #8 had received catheter care from agency since 01/25/18. -The agency was responsible for providing leg bags as needed. -She could not find any documentation of catheter leg bags being requested for Resident #8. -They provided catheter bags based on the request of the facility and the resident. -The catheter bag may be used for Resident #8 because leg bags needed to be cleaned more frequently. Interview with the Resident Care Coordinator (RCC) on 11/09/18 at 10:00am revealed: -She had not seen Resident #8 as she had been working as a MA on the second floor. -She did not know Resident #8 was walking around holding his leg bag. -She would expect PCAs and MAs to notify her if they are out of leg bags for Resident #8. -She would have contacted the contracted home health agency to be contacted to request additional leg bags. Interview with Assisted Living (AL) Nurse	D 338		

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D 338	Continued From page 123 Supervisor on 11/08/18 at 4:19pm revealed: -No one notified her that Resident #8 was out of catheter leg bags. -She expected the PCAs and MAs to notify her if a resident ran out of leg bags. -Resident #8's catheter supplies were provided by contracted home health agency. Interview with the Administrator on 11/09/18 at 2:00pm revealed: -He expected staff to notify the RCC or AL Nurse Supervisor if there was a need for catheter supplies. -He expected the RCC or the AL Nurse Supervisor to contact the contracted home health agency for additional catheter supplies if needed. Attempted telephone interview with Resident #8's primary care provider (PCP) on 11/09/18 at 10:49am was unsuccessful. Attempted telephone interview with Resident #8's responsible party on 11/09/18 at 10:51am was unsuccessful. _____ The failure of the facility to assure 4 of 6 residents were free of neglect resulted in one resident not receiving Foley catheter care as ordered, placing the resident at high risk for "clinical death and decline"and was admitted to the hospital with a diagnosis of urospesis and pulmonary edema as well as being sent to the physician appointment wearing clothes soiled with urine and feces (Resident #3); two residents sustained injuries of unknown origin, one with multiple skin tears and bruising to the right foreman and left hand, requiring pre-medication with morphine for wound care (Resident #5) and a second resident with a dislocated right shoulder (Resident #4); not maintaining a supplies of Foley catheter leg bags	D 338		

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D 338	Continued From page 124 for a resident who had to carry the urine filled Foley bag in one hand while walking with a cane in the other hand (Resident #8). These failures resulted in serious physical harm and serious neglect to Residents #3, #4, #5 and #8 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 8, 2018.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 6 sampled residents (#2, #3, #6, #15, and #19) related to unavailable medications for blood pressure that led to a hospitalization (Resident #3), not completing a dose titration for a medication for agitation for a resident in the Special Care Unit	D 358		

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(Resident #19), applying narcotic pain patches to a resident after the order had been discontinued (Resident #15), an order for anxiety medication not being available to administer (Resident #6) and incorrect administration of an insulin preparation (Resident #2).

The findings are:

1. Review of Resident #3's most current FL2 dated 11/02/17 revealed:
-Diagnoses included dementia without behavioral disturbances, atrial fibrillation, hypertension, diabetes, and edema.
-There was a physician's order for hydrochlorothiazide 25mg take 1 tablet daily (used to reduce excess fluid and high blood pressure).
-There was a physician's order for doxazosin 8mg take 1 tablet daily (used to treat high blood pressure).
-There was a physician's order for hydralazine 50mg take 1 tablet 3 times daily (used to treat high blood pressure).
-There was a physician's order for loratadine 10mg take 1 tablet daily (used to treat allergies).

Review of Resident #3's progress notes on 11/06/18 revealed Resident #3 was sent out of the facility to the hospital for evaluation on 10/31/18 at 11:17pm.

Review of Resident #3's hospital admission summary on 10/31/18 and 11/01/18 revealed:
-Resident #3 had severe lower extremity edema.
-Resident #3 was at "high risk for clinical death and decline" and was admitted with urosepsis and pulmonary edema.

a. Review of Resident #3's signed physician's

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orders dated 03/09/18 revealed an order for hydrochlorothiazide 25mg take 1 tablet daily.

Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed hydrochlorothiazide was not listed as an active medication for the resident.

Review of Resident #3's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was a computer generated entry for hydrochlorothiazide 25mg take 1 tablet by mouth daily scheduled to be administered at 9:00am.
-Hydrochlorothiazide was documented as unavailable for 17 out of 31 opportunities from 10/01/18 to 10/31/18.

Observation of Resident #3's medications on hand on 10/31/18 revealed hydrochlorothiazide was not available to be administered.

Telephone interview with the Social Worker from Resident #3's primary care physician's (PCP) office on 11/09/18 at 3:37pm revealed:
-The facility had not notified Resident #3's PCP that he had missed multiple doses of hydrochlorothiazide.
-Resident #3's cardiologist had discontinued the hydrochlorothiazide on 08/30/18 due to "significant edema in the resident's lower extremities."

Telephone interview with a nurse from Resident #3's urologist's office on 11/09/18 at 9:24am revealed:
-"Patients with an indwelling catheter are encouraged to dilute their urine as much as possible to reduce the risk of infection."
-Medications used to remove fluid "dilute a

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patient's urine and can reduce the risk of infection."
-Resident #3 was at an increased risk of infection due to missing multiple doses of his fluid medication.

Review of Resident #3's hospital admission summary on 10/31/18 and 11/01/18 revealed:
-Resident #3 had severe lower extremity edema.
-Resident #3 was at "high risk for clinical death and decline" and was admitted with urosepsis and pulmonary edema.

Attempted telephone interview with Resident #3's cardiologist on 11/09/18 at 11:03am was unsuccessful.

Refer to telephone interview with Resident #3's Power of Attorney (POA) on 11/07/18 at 4:52pm.

Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/07/18 at 12:38pm.

Refer to telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am.

Refer to interview with the medication aide (MA) on 11/06/18 at 11:54am.

Refer to interview with the MA on 11/07/18 at 8:38am.

Refer to interview with the Resident Care Coordinator (RCC) on 11/07/18 at 10:15am.

Refer to interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm.

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Refer to telephone interview with the Administrator on 11/09/18 at 2:00pm.

b. Review of Resident #3's October 2018 eMAR revealed there was no computer generated entry for metolazone on the eMAR.

Observation of Resident #3's medications on hand on 10/31/18 revealed metolazone was not available to be administered.

Review of a medication delivery ticket from Resident #3's pharmacy dated 09/03/18 revealed 24 tablets of metolazone 2.5mg was mailed to the facility.

Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed:
-Resident #3 had a physician's order for metolazone 2.5mg (used to reduce excess fluid) take 1 tablet daily on Monday, Wednesday and Friday written on 08/31/18 and was last dispensed on 10/18/18 for a 56 day supply.
-"New physician's orders were automatically filled and mailed to the patient but refills had to be ordered when needed."
-Resident #3 "should not be out of medication based on refill dates."

Interview with the medication aide (MA) on 11/07/18 at 8:38am revealed she did not know Resident #3 had a physician's order for metolazone.

Interview with the RCC on 11/07/18 at 10:15am revealed she did not know that Resident #3 had a physician's order for metolazone.

Telephone interview with the Social Worker from

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Resident #3's PCP office on 11/09/18 at 3:37pm revealed:
-The cardiologist had started metolazone 2.5mg take 1 tablet on Monday, Wednesday, and Friday at an office visit on 08/30/18 to help with the swelling in Resident #3's legs.
-There was no documentation that the facility had notified the cardiologist that Resident #3 was not taking the metolazone.

Telephone interview with a nurse from Resident #3's urologist's office on 11/09/18 at 9:24am revealed:
-"Patients with an indwelling catheter are encouraged to dilute their urine as much as possible to reduce the risk of infection."
-Medications used to remove fluid "dilute a patient's urine and can reduce the risk of infection."
-Resident #3 was at an increased risk of infection due to missing multiple doses of his fluid medication.

Review of Resident #3's hospital admission summary on 10/31/18 and 11/01/18 revealed:
-Resident #3 had severe lower extremity edema.
-Resident #3 was at "high risk for clinical death and decline" and was admitted with urosepsis and pulmonary edema.

Refer to telephone interview with Resident #3's POA on 11/07/18 at 4:52pm.

Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/07/18 at 12:38pm.

Refer to telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am.

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D 358	Continued From page 130 Refer to interview with the MA on 11/06/18 at 11:54am. Refer to interview with the MA on 11/07/18 at 8:38am. Refer to interview with the RCC on 11/07/18 at 10:15am. Refer to interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm. Refer to telephone interview with the Administrator on 11/09/18 at 2:00pm. c. Review of Resident #3's signed physician's orders dated 03/09/18 revealed an order for doxazosin 8mg take 1 tablet daily. Review of Resident #3's October 2018 eMAR revealed: -There was a computer generated entry for doxazosin 8mg take 1 tablet daily scheduled to be administered at 9:00am. -Doxazosin was documented as unavailable for 25 out of 31 opportunities from 10/01/18 to 10/31/18. Observation of Resident #3's medications on hand on 10/31/18 revealed doxazosin was not available to be administered. Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed: -Doxazosin was last dispensed to resident on 07/26/18 for a 90 day supply. -Resident #3's current physician order for doxazosin was written on 11/02/18.	D 358		

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D 358	Continued From page 131 Telephone interview with the Social Worker from Resident #3's PCP office on 11/09/18 at 3:37pm revealed: -The facility had not notified Resident #3's PCP that he had missed multiple doses of doxazosin. -Resident #3's prescription for doxazosin was written 10/03/17 and was renewed on 11/02/18. -Doxazosin was never discontinued for Resident #3. Attempted telephone interview with Resident #3's cardiologist on 11/09/18 at 11:03am was unsuccessful. Refer to telephone interview with Resident #3's POA on 11/07/18 at 4:52pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/07/18 at 12:38pm. Refer to telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am. Refer to interview with the MA on 11/06/18 at 11:54am. Refer to interview with the MA on 11/07/18 at 8:38am. Refer to interview with the RCC on 11/07/18 at 10:15am. Refer to interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm. Refer to telephone interview with the Administrator on 11/09/18 at 2:00pm.	D 358		

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d. Review of Resident #3's signed physician's orders dated 03/09/18 revealed an order for hydralazine 50mg take 1 tablet 3 times daily.

Review of Resident #3's October 2018 electronic Medication Administration Record (eMAR) revealed
-There was a computer generated entry for hydralazine 50mg take 1 tablet 3 times daily scheduled to be administered at 9:00am, 3:00pm, and 9:00pm.
-Hydralazine was documented as unavailable or not documented as administered for 27 of 93 opportunities from 10/01/18 to 10/31/18.

Observation of Resident #3's medications on hand on 10/31/18 revealed no hydralazine was available to be administered to the resident.

Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed:
-Hydralazine was last dispensed to Resident #3 on 09/28/18 for a 90 day supply.
-Resident #3's medications were mailed from the pharmacy to the facility.
-Resident #3's current physician order for hydralazine was written on 11/02/18.

Telephone interview with the Social Worker from Resident #3's PCP office on 11/09/18 at 3:37pm revealed:
-The facility had not notified Resident #3's PCP that he had missed multiple doses of hydralazine.
-Resident #3's prescription for hydralazine was written on 10/03/17 and renewed on 11/02/18.
-Hydralazine was never discontinued for Resident #3.

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D 358	Continued From page 133 Attempted telephone interview with Resident #3's cardiologist on 11/09/18 at 11:03am was unsuccessful. Refer to telephone interview with Resident #3's POA on 11/07/18 at 4:52pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/07/18 at 12:38pm. Refer to telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am. Refer to interview with the MA on 11/06/18 at 11:54am. Refer to interview with the MA on 11/07/18 at 8:38am. Refer to interview with the RCC on 11/07/18 at 10:15am. Refer to interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm. Refer to telephone interview with the Administrator on 11/09/18 at 2:00pm. e. Review of Resident #3's signed physician's orders dated 03/09/18 revealed an order for loratadine 10mg take 1 tablet daily. Review of Resident #3's October 2018 electronic Medication Administration Record (eMAR) revealed -There was a computer generated entry for loratadine 10mg take 1 tablet daily scheduled to be administered at 9:00am.	D 358		

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-Loratadine was documented as unavailable for 19 out of 31 opportunities from 10/01/18 to 10/31/18.

Observation of Resident #3's medications on hand on 10/31/18 revealed no loratadine was available to be administered to the resident.

Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed:
-Loratadine was last dispensed to Resident #3 on 02/01/18 for a 90 day supply.
-Resident #3's medications were mailed from the pharmacy to the facility.
-Resident #3's recent physician order for loratadine was written on 11/02/18.

Telephone interview with the Social Worker from Resident #3's PCP office on 11/09/18 at 3:37pm revealed:
-The facility had not notified Resident #3's PCP that he had missed multiple doses of loratadine.
-Resident #3's prescription for loratadine was written on 10/03/17 and renewed on 11/02/18.
-Loratadine was never discontinued for Resident #3.

Refer to telephone interview with Resident #3's POA on 11/07/18 at 4:52pm.

Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/07/18 at 12:38pm.

Refer to telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am.

Refer to interview with the MA on 11/06/18 at

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D 358	Continued From page 135 11:54am. Refer to interview with the MA on 11/07/18 at 8:38am. Refer to interview with the RCC on 11/07/18 at 10:15am. Refer to interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm. Refer to telephone interview with the Administrator on 11/09/18 at 2:00pm. _____ Telephone interview with Resident #3's POA on 11/07/18 at 4:52pm revealed: -The facility was responsible for refilling medications for Resident #3. -She did not know Resident #3 had ran out of some of his medications and needed refills. -In the past, she had been contacted by Resident # 3's physician's office if there was a problem with medications. -She had not received any phone calls about resident needing medications from the physician's office or the facility. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/07/18 at 12:38pm revealed: -The pharmacy only filled medication for Resident #3 on an emergency basis. -The pharmacy last dispensed medication to Resident #3 on 08/23/18 and it was a refill on his insulin. -The RCC or the Assisted Living Nurse Supervisor must call the pharmacy to request refills for Resident #3. -The facility was responsible for faxing all orders	D 358		

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to the pharmacy.
-The pharmacy was responsible for inputting orders into the eMAR software for the facility to approve but did not dispense Resident #3's medications.

Telephone interview with a pharmacist from Resident #3's pharmacy on 11/09/18 at 8:42am revealed:
-Resident #3's medications were mailed from the pharmacy to the facility.
-If a prescription was expired, the pharmacy was responsible for contacting the physician for a new order.
-A nurse would follow up with the facility or resident if there was a problem refilling medications.
-The pharmacy was not responsible for automatically sending out medication refills.
-"All medication refills had to be called and requested by the patient or representative."
-Resident #3 "should not be out of medication based on refill dates of medications."

Interview with the MA on 11/06/18 at 11:54am revealed:
-The MA, RCC, or the Administrator was responsible for contacting Resident #3's pharmacy to refill medications.
-She would verbally tell the RCC, the Administrator, or the MA coming on duty about Resident #3 needing medications.
-Resident #3's pharmacy needed to be contacted at least 15 days prior to the resident running out of medication.
-If the facility had not received medications after 3 days, she would contact the resident's family to assist the facility to receive the medications.
-She had not contacted Resident #3's family regarding needing medication refills because she

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D 358	Continued From page 137 thought the RCC was working to get medications. Interview with the MA on 11/07/18 at 8:38am revealed: -The MA was responsible for making sure the medications received from the pharmacy matched the orders on the eMAR. -The RCC or the MA must approve the medication order before it appeared on the eMAR. -She would contact the RCC or Assisted Living Nurse Supervisor if the orders did not match or if she got a medication she did not have an order on the eMAR. -The Administrator went to the pharmacy "sometime in October" to pick up Resident #3's medications and was told that Resident #3 needed an office visit with his primary care physician (PCP) to refill medications. Interview with the RCC on 11/07/18 at 10:15am revealed: -The MA was responsible for refilling each resident's medications. -The MA should pull the refill stickers for each medication Resident #3 needed refilled and call the pharmacy at least 10 to 15 days before the resident was out of medications. -If the MA was running out of medication for a resident, the MA was responsible for calling the back-up pharmacy for an emergency fill and contacting the family. -She could not remember when she was first notified about Resident #3 being out of medications. -She had called Resident #3's pharmacy multiple times during October to get medications refilled. -Resident #3's pharmacy told her that all of Resident #3's "medications had been discontinued because the prescriptions were only	D 358		

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good for 1 year."
-The pharmacy or the PCP's office had not contacted the facility and let them know the medications had been discontinued because he needed an office visit.

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 4:05pm revealed:
-She did not know that Resident #3 had missed multiple doses of medication in October.
-Resident #3's PCP's office had contacted the RCC to let her know that Resident #3's medication would be mailed from the pharmacy.
-She assumed Resident #3 had all his medications available to be administered.
-She did not know that Resident #3 had a physician's order for metolazone.
-All new orders had to be faxed to the facility's contracted pharmacy to be entered on the eMAR.
-She, the Administrator, or RCC was responsible for approving new orders.
-A designated MA or RCC was responsible for auditing the eMARs and medication carts for any discrepancies weekly.
-She or the Administrator should be notified verbally of any discrepancies with the medications or the physician's orders.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed:
-Medications should be administered based on physician's orders.
-The RCC or the Assisted Living Nurse Supervisor was responsible for faxing physicians' orders to the pharmacy to be entered on the eMAR.

2. Review of Resident #6's current FL2 dated 09/26/18 revealed:
-Diagnoses included Wernicke's encephalopathy,

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history of ethanol alcohol abuse, cerebellar stroke, history of osteoporosis, vertebral compression fractures and remote history intracerebral hemorrhage.

Review of the physician signed hospital discharge summary dated 09/28/18 revealed:
-A principal diagnosis as cerebella infarct.
-The discharge medications to continue taking included lorazepam 0.5mg, two times a day as needed for anxiety/agitation.

Review of the facility's progress notes for Resident #6 revealed:
-There was documentation dated 10/16/18 the "resident was very agitated and verbally abusive with staff and [administrator] resident made several attempts to be physically aggressive with assault on [administrator]."
-There was documentation dated 10/16/18 that "resident will not allow anyone to touch him, medic and police called, upon their arrival resident became a perfect gentleman and consented to be transferred to [redacted] hospital for [evaluation]."

Review of Resident #6's emergency department discharge summary dated 10/16/18 revealed:
-Discharge diagnosis of "aggressive outburst; penile pain".
-Documentation to continue taking Lorazepam 0.5 mg as needed for anxiety/agitation.

Review of Resident #6's September 2018 electronic medication administration records (eMAR) revealed:
-An entry for lorazepam 0.5 mg to be administered by mouth twice a day as needed for anxiety/agitation with a notation "need new script".

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D 358	Continued From page 140 -There was no documentation that reflected the medication was needed nor administered during the month of September 2018. Review of Resident #6's October 2018 eMAR revealed: -An entry for lorazepam 0.5 mg to be administered by mouth twice a day as needed for anxiety/agitation with a notation "need new script". -There was no documentation that the medication was needed nor administered during the month of October 2018. Review of Resident #6's November 2018 eMAR revealed: -An entry for lorazepam 0.5 mg to be administered by mouth twice a day as needed for anxiety/agitation with a notation "need new script". -There was no documentation between 11/01/18 to 11/06/18 that the medication was needed nor administered. Observation of medication on hand on 11/07/18 at 11:25am revealed Lorazepam 0.5 mg, was not available for administration for Resident #6. Interview with facility pharmacy on 11/07/18 at 9:20am revealed: -The pharmacy had provided medications for Resident #6 since April 2017. -The pharmacy had never filled lorazepam 0.5mg for Resident #6. -The facility faxed a copy of Resident #6's discharge summary dated 09/28/18 to the pharmacy on 09/28/18. -The hospital discharge summary included an order for lorazepam PRN medication for Resident #6 to be given two times a day for	D 358		

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anxiety/agitation.
-The pharmacy did not have a hard script for lorazepam so they faxed a control letter to the facility on 09/28/18 at 4:44pm requesting a signature from Resident #6's physician which would allow the pharmacy to fill the order for lorazepam and would allow refills of the controlled medication to be completed without a monthly hard script.
-The facility never returned the control letter to the pharmacy so they could fill the prescription.

Interview with a medication aide (MA) on 11/07/18 at 11:30am revealed:
-She did not know Resident #6 had an order for PRN Lorazepam because there was no card of Lorazepam on the cart.
-She pulled up the November 2018 eMAR for Resident #6 and saw the medication, Lorazepam 0.5mg, documented as a PRN with a written note "need new script".
-She was "puzzled" as to how she had missed the prescribed medication and that no other MA had brought it to her attention.
-"Only the regularly scheduled medications for Resident #6 showed on the computer screen" and thought all of Resident #6's PRN medications were standing house orders for over-the-counter medicines.
-Resident #6 could be difficult to deal with because his behaviors were unpredictable.

Interview with personal care aide (PCA) on 11/07/18 at 11:00am revealed:
-She provided care services such as help with transfers, showers, dressing, and grooming for Resident #6.
-She described Resident #6 as being unpredictable with his moods. He could be cooperative with care in the morning and yelling

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and cussing at you by lunch time.
-Her way of dealing with him was to use a calm tone with "sweet talk" to get him to allow her to provide care services.
-She never reported his behaviors to the MA because she thought this was just a part of his personality.

Interview with a second PCA on 11/07/18 at 12:30pm revealed:
-She provided care for Resident #6.
-He often refused care.
-Today he refused to be shaved, but did allow her to comb his hair.
-She described Resident #6 as someone who "had good days" and allowed the staff to assist him with care but "the other days were hard" because he used "harsh words" that were offensive toward the staff and sometimes toward other residents.
-She never asked the MA for assistance with him and did not report his "mood swings" because she thought this was his normal behavior.

Interview on 11/08/18 at 2:00pm with the AL Nurse Supervisor revealed:
-The medication carts were audited weekly by the AL Supervisor.
-The audit included ordering medications, removing expired medications and matching new medication with physician's orders.
-If an error was found the staff member was directed to let her or the administrator know.
-Discharge papers were received by the facility from the hospital, were reviewed by either the Resident Care Coordinator (RCC), the Administrator, or herself.
-Whomever reviewed the hospital discharge summary was responsible for acting on newly prescribed medications, therapies, follow up visits

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and reviewing medications listed on the discharge since this was electronically signed by a doctor.
-The person reviewing the hospital discharge summary was to fax a copy of the hospital discharge summary to the facility pharmacy which allowed the pharmacy to upload the medications to the current eMAR.
-Either she or the AL Supervisor were responsible for obtaining the hard copy of a medication script or getting the physician to sign the pharmacy letter.
-She could not recall who reviewed Resident #6's discharge summaries.
-She did not know that the medication, lorazepam, was on eMAR as a PRN medication for Resident #6 and not available for administration.

Interview on 11/09/18 with the RCC at 10:50am revealed:
-The AL Nurse Supervisor was the staff member assigned to audit the AL medication carts and responsible for making sure the medications were ordered for all AL residents.
-She was responsible for auditing the Special Care Unit medication cart.
-She audited the medication cart by printing the current month's eMAR and comparing the written list of medications to medications on the cart.
-Audits of the medication carts were to be completed weekly.
-She did not know that Resident #6 had an order for lorazepam 0.5mg.
-She worked the AL medication carts by administering medications to the residents including Resident #6 but never noticed that Resident #6 had lorazepam documented on his eMAR.
-She explained that she missed seeing lorazepam on the eMAR because the "system"

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populated scheduled medications due administering, but not PRN medications.

Interview on 11/09/18 at 1:40pm with AL Supervisor revealed:
-The facility had been "short staffed" for MAs for 2 to 3 months and other staff members in the facility like herself and the RCC had to "work the carts" sometimes 16 hours on the weekends instead of being able to complete their other duties like auditing the medication carts.
-When she was able to, she audited the medication carts by printing the eMAR and using it as a checklist to make sure the prescribed medications were on the cart.
-If a medication was not available, she faxed an order or verbally called the pharmacy to get it filled. -This process included the PRN medications.
-She had no explanation as to why Resident #6's PRN medication, lorazepam 0.5mg, was not on the medication cart other than it was "missed" during the audit.
-She did not know when the last audit of his medications took place.

Interview on 11/08/18 at 9:30am with Resident #6's Nurse Practitioner revealed:
-The facility staff verbally told her about his behaviors.
-She did not know of the order for Lorazepam since she did not prescribe it.
-She preferred the facility contacted her for clarification which had not happened.
-No one called her and requested a hard copy.
-When her signature was required on an order, the facility placed a copy of the document she was to sign in a communication notebook that she reviewed during every facility visit.
-She did not know the facility pharmacy had sent

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a control form, which required her signature, for the Lorazepam 0.5mg because it was not filed in her facility communication notebook.

3. Review of Resident #15's current FL-2 dated 07/04/18 revealed:
Diagnoses included depression, anxiety and chronic pain.
-There were medication orders that included Fentanyl (an opioid narcotic used to treat severe pain) 50mcg patch every 72 hours.

Review of Resident #15's electronic medication administration (eMAR) record for October 2018 revelaed:
-There was an entry for fentanyl 50mcg patch every 72 hours.
-There was documentation on 10/03/18, 10/06/18 and on 10/09/18 the fentanyl 50mcg patch was not administered "medication not available."
-There were "holes" on the eMAR the fentanyl patch was not administered from 10/10/18 to 10/20/18, there was no reason documented.

Observation on 11/07/18 at 1:35pm of medications on hand for Resident #15 revealed there were no fentanyl 50 mcg patches available for administration.

Interview with the home health nurse on 11/07/18 at 11:30am revealed:
-She had seen Resident #15 for pain control.
-She had reviewed Resident #15's eMAR and found missed doses of the fentanyl 50mcg patch on 10/03/18, 10/06/18 and on 10/09/18.
-She found "holes" in the October 2018 eMAR without an entry of documentation the reason the fentanyl patch was not administered to Resident #15.
-The HH Nurse contacted Resident #15's Nurse

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Practitioner to inform her of the missed fentanyl doses.
-The HH Nurse had informed the facility nurse Resident #15 was not administered the fentanyl patch on 10/03/18, 10/06/18 and on 10/09/18 and there were "holes" in eMAR for missed administration of the fentanyl patch.

Interview with a MA on 11/08/18 at 2:00pm revealed:
-She worked as a MA first and second shift administering medications to the residents.
-"If it's not here you cannot give it."
-She had not notified the physician Resident #15 had not received the fentanyl 50mcg patch.
-She could not recall if she had informed the facility nurse or the oncoming shift in regards to contacting the physician about the fentanyl patch not available for administering to Resident #15.

Interview with the Assisted Living Nurse Supervisor on 11/08/18 at 5:30pm revealed:
-She was responsible for overseeing the clinical staff which included the MAs.
-She did not know the fentanyl 50 mcg patch was not administered as ordered on 10/01/18 through 10/20/18.
-She had not contacted Resident #15's physician to inform her the fentanyl patch was not available for administration.
-The MAs should contact the physician if a resident missed 3 days of receiving their medications.
-The MAs were responsible for reporting to her if a medication had not been administered for 3 days and she would contact the physician.

Interview with Resident #15's Nurse Practitioner on 11/07/18 at 9:25am revealed:
-She had reviewed Resident #15's eMAR and

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found no documentation the Fentanyl patch had been administered 10/01/18 through 10/17/18.
-The facility had not contacted her in regard to Resident #15's missing applications of fentanyl patch on 10/03/18, 10/06/18 and on 10/09/18.
-The Home Health (HH) agency nurse had contacted her in regards to Resident #15 not receiving the fentanyl patch on 10/03/18, 10/06/18 and on 10/09/18.
-She expected the facility to contact her of missed medications especially pain management medications.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed:
-He relied on the facility nurse to oversee the MAs.
-He was not aware the fentanyl patch was not administered as ordered to Resident #15 on 10/03/18, 10/06/18 and on 10/09/18.
-The MAs and the Assisted Living Nurse Supervisor were responsible for contacting the physician if a medication is missed for three day.
-He expected the MAs and the facility nurse to follow the policy for medication refusal.

Review of the medication refusal policy revealed:
a. Respect the resident right's to choose not take medications.
b. Document the time, date and medication the resident did not take.
c. Notify the physician after the 3 days of refusal and follow any instructions provided.
d. Facility will continue to document any medication refusal after physician notification.

4. Review of Resident #2's current FL2 dated 01/16/18 revealed diagnoses included history of malignant neoplasm of prostate, type 1 diabetes, heart disease, and hyperlipidemia.

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D 358	Continued From page 148 Review of Resident #2's record revealed a physician's order dated 10/24/18 revealed an order for Lantus 100 unit/mL 12 units twice per day. Review of a subsequent physician's order dated 10/29/18 revealed an order for Lantus 100 unit/mL 16 units twice per day. Review of Resident #2's October 2018 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Lantus 100 unit/mL 12 units to be administered daily at 8:00am and 8:00pm. -There was documentation Lantus 100 unit/mL 12 units had been administered every day from 10/24/18 through 10/31/18 at 8:00am and 8:00pm. -There was no entry for Lantus 100 unit/mL 16 units. -Resident #2's FSBS ranged from 116-519. Review of Resident #2's November 2018 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Lantus 100 unit/mL 12 units to be administered daily at 8:00am and 8:00pm. -There was documentation Lantus 100 unit/mL 12 units had been administered every day from 11/01/18 through 11/05/18 at 8:00am and 8:00pm, and 11/06/18 at 8:00am. -There was an electronic entry for Lantus 100 unit/mL 16 units to be administered daily at 8:00am and 8:00pm. -There was documentation Lantus 100 unit/mL 16 units had been administered 11/06/18 at 8:00pm and 11/07/18 at 8:00am.	D 358		

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D 358	Continued From page 149 -The 16 units of Lantus was not documented as administered from 11/01/18-11/05/18 as ordered. -Resident #2's FSBS ranged from 174-411. Observation of Resident #2's medications available for administration on 11/07/18 at 2:15pm revealed Lantus 100 unit/mL was available for administration. Interview with a first shit medication aide (MA) on 11/08/18 at 9:35am revealed: -The Assisted Living (AL) Nurse Supervisor and Resident Care Coordinator (RCC) were responsible for receiving new medications orders and faxing to the pharmacy. -MAs administered medications as they appeared on the eMAR. -She began administering 16 units on 11/07/18 as it appeared on the eMAR. -She did not know Resident #2's Lantus 100 unit/mL order changed to 16 units on 10/29/18. Interview with the AL Nurse Supervisor on 11/08/18 at 4:19pm revealed: -She and the RCC were responsible for accepting new orders and faxing to the pharmacy to be entered on the eMAR. -The other AL Nurse Supervisor was responsible for completing a weekly audit of new medication orders and a weekly audit of the eMAR. -She did not know what happened with Resident #2's Lantus 100 unit/mL order change to 16 units. -The Lantus 100 unit/mL 16 units should have been administered beginning 10/29/18 as ordered by the primary care provider (PCP). Interview with the RCC on 11/09/18 at 9:04am revealed: -Medication orders from the PCP were received via fax.	D 358		

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-Medication orders received via fax were placed in the AL Nurse Supervisor's box to be faxed to the pharmacy to be included on the eMAR.
-She did not know Resident #2's order for Lantus 100 unit/ML had changed on 10/29/18.
-The Lantus 100 unit/mL was now on the eMAR beginning 11/06/18.
-She had not been functioning as the RCC as she had been working as a MA for multiple shifts.
-There was a breakdown in communication between management staff, "I am not sure what happened".

Telephone interview with the pharmacist at Resident #2's contracted pharmacy on 11/09/18 at 9:04am revealed:
-Physician orders were received via fax from the facility.
-They received a medication order dated 10/29/18 for Resident #2 for 16 units of Lantus 100 unit/mL on 11/06/18.
-She did not know why the order for Lantus was received on 11/06/18.
-The start date for the order was entered on the eMAR as 11/06/18 because that's when the order was received.
-The Lantus 100 unit/mL was filled on 10/17/18, 11/06/18, and 11/12/18.

Telephone interview with Resident #2's PCP on 11/08/18 at 1:41pm revealed:
-She wrote an order on 10/29/18 for Lantus 100 unit/mL 16 units to be administered twice per day and faxed it to the facility.
-It was crucial that the facility follow the order to prevent the risk of diabetic ketoacidosis (a serious complication of diabetes that causes the body to produce ketones).
-She attempted a plan to get the residents blood sugars regulated, and it could not be

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implemented because the order for Lantus 16 units was not followed as ordered.

Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed:
-It was the responsibility of the RCC and AL Nurse Supervisor that received the medication order to fax to the pharmacy to be included on the eMAR.
-He did not know Resident #2 did not receive the 16 units of Lantus as ordered.
-He expected medication orders to be followed as written by the PCP.

Attempted interview with the second AL Nurse Supervisor was unsuccessful as she was unavailable.

5. Review of Resident #19's current FL2 dated 09/10/18 revealed diagnoses included pneumonia, emphysema, left rib fracture, dementia, diabetes mellitus type 2, and hypothyroid.

Review of Resident #19's physician's orders revealed:
-There was a physician's order dated 10/08/18 to discontinue haldol (a medication used to treat psychosis) 0.5mg by mouth three times daily, and to start haldol 1mg three times daily at 6:00am, 2:00pm, and 6:00pm.
-There was a physician's order dated 11/03/18 to discontinue haldol 1mg and start haldol 1mg(1-1/2 tablets, 1.5mg) three times daily at 6:00am, 2:00pm and 8:00pm.

Review of Resident #19's electronic Medication Administration Record (eMAR) for October 2018 revealed:
-There was an entry for haldol 0.5mg three times

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daily scheduled and documented as administered 6:00am, 2:00pm and 6:00pm from 10/01/10 to 10/08/18 and was discontinued on 10/08/18.
-There was no entry for haldol 1mg three times daily at 6:00am, 2:00pm and 8:00pm.

Review of Resident #19's eMAR for November 2018 revealed there was an entry for haldol 1.5mg which was documented as administered 11/05/18 at 8:00pm and 11/06/18 6:00am, 2:00pm and 8:00pm.

Observation of Resident #19's medications on hand on 11/08/18 at 12:30pm revealed:
-There were fifteen doses of haldol 0.5mg tablets available for administration with instructions to administer haldol 0.5mg tablet three times daily, dispensed on 09/30/18.
-There was a bottle of haldol lactate 2mg/ml liquid with a label with instructions to give 0.75ml (1.5mg) three times a day at 6:00am, 2:00pm, and 8:00pm with 60ml remaining in the bottle, 120ml was dispensed on 11/05/18.
-There was no haldol 1mg tablets available for Resident #19.

Telephone interview on 11/08/18 at 12:50pm with the Resident #19's pharmacy revealed:
-The pharmacy had received a physician's order by facsimile on 10/08/18 to discontinue haldol 0.5mg three times daily, and start haldol 1mg three times daily at 6:00am, 2:00pm, and 6:00pm.
-They had discontinued the order for haldol 0.5mg three times daily on the eMAR and they did not enter the new order for haldol 1mg three times daily at 6:00am, 2:00pm, and 6:00pm.
-The pharmacy had received a physician's order by facsimile on 11/03/18 to discontinue Haldol 1mg, and start haldol 1mg(1-1/2 tablets) (1.5mg) three times daily at 6:00am, 2:00pm and 8:00pm.

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-On 11/05/18, they entered the order to discontinue haldol 1mg, and to start haldol 1mg(1-1/2 tablets,1.5mg) three times daily at 6:00am, 2:00pm and 8:00pm.
-When they entered physician orders it was the responsibility of the facility to verify the orders were entered correctly.

Interview with the medication aide (MA) on 11/08/18 at 12:30pm revealed:
-She knew Resident #19's haldol 0.5mg tablet had been discontinued on 10/08/18.
-She did not know Resident #19 had received a new order for haldol 1mg tablet three times daily on 10/08/18.
-She did not know Resident #19 had not received haldol 1mg, three times a day from 10/08/18 through 11/05/18.
-When physician orders were received they should be faxed to the resident's pharmacy and then entered the electronic physician's orders into the eMAR.
-The Special Care Unit (SCU) Nurse Supervisor was responsible for checking the new physician orders against the eMAR entries.
-The MAs were not responsible for comparing new orders against the eMAR.

Interview with the SCU Nurse Supervisor on 11/09/18 at 11:45am revealed:
-She knew Resident #19's haldol 0.5mg tablet had been discontinued on 10/08/18.
-She did not know Resident #19 had not received haldol 1mg tablet three times daily from 10/08/18 through 11/05/18.
-When physician orders were received they were faxed to the pharmacy and entered into the eMAR by the pharmacy.
-All new order entries were flagged but orders to discontinue a medication were not flagged by the

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computer system.
-The nurses and/or the Administrator were responsible to verify the orders entered by the pharmacy were correct and complete.
-The order dated 10/08/18, was partially entered by the pharmacy and because it was a discontinued order in the system it did not cue the nurses or the Administrator to check the order entered for accuracy.
-There was no system in place to check each physician's order to verify the order had been entered into the eMAR correctly and completely.
-She had printed the eMAR monthly and compared each month.
-She did not compare the new months entries against the original physician's orders.

Interview with Resident #19 Behavioral Health Physician on 11/09/18 at 12:16pm revealed:
-She had intended to increase the haldol gradually because Resident #19 had been oversensitive to medications in the past which had led to negative outcomes, such as over sedation.
-She did not know Resident #19 had not received haldol 1mg tablet three times daily from 10/08/18 through 11/03/18.
-She would not have increased the haldol to 1.5mg three times daily on 11/03/18 if she had known Resident #19 had not been administered the 1mg dose three times daily from 10/08/18 through 11/03/18, because of Resident #19's oversensitivity and history of falls.
-She planned to monitor the Resident #19 closely because of the abrupt increase in haldol.

_____

The facility failed to assure medications were administered as ordered by the physician for 5 of 6 sampled residents related to Resident #3's medications for blood pressure and edema not

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D 358	Continued From page 155 being available which led to a hospitalization which placed Resident #3 at a "high risk for clinical death and decline" and diagnosis of urospesis and pulmonary edema, Resident #6's medications not available for administration which included anxiety medications. Resident #15 who had an order for Fentanyl 50mcg patch and was not administered the medication for 20 days and the physician had discontinued the fentanyl patch the facility applied the fentanyl patch without and order for 3 doses, Resident #19 not completing a dose titration for haldol 1mg for a month, the haldol was to be tapered and incorrect administration of an insulin preparation to Resident #2. The failure of the facility to assure medications were administered was neglect and caused serious harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 8, 2018.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	D 371		

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D 371	Continued From page 156 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 medication aides (MAs) observed during the medication passes implemented infection control measures related to failing to properly clean nebulizer equipment between uses (Resident #20), and 2 of 2 MAs accessing insulin pens using insulin syringes in place of pen needles for 2 of 2 residents (Resident #1 & #9) The findings are: 1. Observation of the 9:00am medication pass on the Special Care Unit (SCU) on 11/06/18 at 9:53am revealed -The MA had administered a nebulizer treatment via mask to Resident #20 and left the mask on the window sill beside the resident's bed. -The mask was soiled with yellow dried secretions. Observations on 11/08/18 at 1:25pm and 11/09/18 at 12:00pm revealed Resident #20's nebulizer mask remained in the same location and soiled. Review of Resident #20's current FL2 dated 09/26/18 revealed: -Diagnoses included dementia with behavioral disturbances, falls, chronic kidney disease, hypertension, chronic pain, and abnormality of gait. -There were physician orders for ipratropium-albuterol (0.5 mg-3mg/3ml) one vial solution for nebulizer every morning routinely scheduled daily at 9:00am, and give one vial by nebulizer every six hours as needed for wheezing or shortness of breath.	D 371		

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D 371	Continued From page 157 Review of the facility's Medication Administration Policy on 11/08/18 at 5:55pm revealed instructions that following the medication pass clean all equipment and set up for the next medication pass. Review of manufacturer's package insert for Resident #20's nebulizer equipment on 11/09/18 at 8:00am revealed: -"Do not use disposable nebulizer masks longer than recommended, even if they seem fine, they are meant to be thrown away after 5 to 7 uses." -"Plastics degrade over time and treatment benefits may decrease with mask used longer than directed." -"To ensure your safety and increase the effectiveness of treatment, it's very important to keep you nebulizer system clean." -"After each treatment: rinse the mask or mouthpiece with warm water for at least half a minute." -"Shake off excess water and place part on a clean towel for air-drying." -"Make sure all part and accessories are clean and completely dry after use." Interview with the MA on 11/06/18 at 10:15am revealed: -When administering nebulizer treatments she would wash her hands with soap and water or use hand sanitizer, squeeze the medication from the vial into the cup reservoir of the nebulizer, turn the machine and allow completion of the medication in the reservoir. -She had not rinsed the reservoir or cleaned the mask because they were not dirty. -She could not recall the last time the mask, reservoir, or the tubing had been replaced. -She had wiped the mask with a paper towel if it became wet after the treatment from the mist of	D 371		

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the medication.
-She had not routinely rinsed the reservoir or cleaned the mask because she had not been told to do so.
-She had changed out the equipment if it had become clogged, but she could not recall the last time she had done it.
-There was no schedule or system in place to change out the nebulizer mask or tubing.

Interview with the Nurse for SCU on 11/08/18 at 2:00pm revealed:
-She had trained the MAs on the SCU to cleanse nebulizers after each use and change the tubing.
-She did not know why they had not been cleansed properly.
-She did not know the nebulizers were not being cleaned by the MAs after each use.
-They had not put any reminders in place to remember to replace the tubing and masks for the nebulizer's.

Telephone interview with Resident #20's Nurse Practitioner (NP) on 11/07/18 at 12:00pm revealed:
-Without taking appropriate measures to prevent infection, the resident could acquire mouth sores, bacterial infections or fungal lung infections.
-The resident had not acquired any of these infections.

Interview with the Administrator in Charge on 11/09/18 at 9:00am revealed the MAs had all been trained on the policy and completed infection control training provided, and they had failed to do what they had been trained to prevent possible contamination of the nebulizers.

Refer to interview with the Administrator in Charge on 11/09/18 at 9:10am.

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D 371	Continued From page 159 2. Observation MA on 11/06/18 at 11:43am during medication pass he used an insulin syringe to draw insulin out from Humalog Kwikpen (to treat hyperglycemia) and administered it subcutaneous to Resident #1. Review of Resident #1's current FL2 dated 01/16/18 revealed: -Diagnoses included dementia, hypertension, and diabetes. -There was a physician's order for Humalog Kwikpen 100u/ml check blood sugars three times a day with meals and give insulin according to the following sliding scale insulin subcutaneous if finger stick blood sugar (FSBS) less than 100 no insulin, FSBS 101-150 give 2 units, FSBS 151-200 give 4 units, FSBS 201-250 give 6 units, FSBS 251-300 give 8 units, FSBS 301-350 give 10 units, FSBS 351-400 give 12 units, FSBS 401-450 give 14 units, and FSBS 451-500 give 16 units. Telephone interview with Resident #1's responsible party on 11/09/18 at 9:05am revealed: -The resident has insulin pen needles supplied by his pharmacy and she did not know he had ran out of pen needles. -The facility was responsible for ordering his insulin and supplies. Interview with MA on 11/06/18 at 4:02pm revealed: -He had been shown by the Administrator to draw insulin from an insulin pen using an insulin syringe a long time ago when they ran out of pen needles for the insulin pens. -Another MA was responsible for taking inventory of and ordering the facility supplies for the	D 371		

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medication carts, which included the insulin pen needles, but when she was absent they had ran out of the supply of pen needles.
-The MA placing the order for supplies was the only one who knew how to re-order supplies.
-The MA who placed the orders had told him she placed an order for pen needles about a week ago.

Interview with the pharmacy on 11/06/18 at 9:30am revealed:
-Resident #1 had insulin pen needles supplied when insulin pens had been ordered.
-Using a syringe to draw insulin from a pen could contaminate the insulin inside the pen.
-They had not instructed the facility to use syringes to draw insulin from insulin pens.

Interview with the Facility Nurse on 11/06/18 at 4:00pm revealed:
-She knew they had ran out of pen needles at times.
-The pen needles for Resident #1 should have come from the pharmacy and been reordered when they ran out of them.
-She had not instructed the MAs to use a syringe to draw insulin out of the insulin pens.

Interview with Resident #1's Nurse Practitioner on 11/07/18 at 9:15am revealed:
-It was not appropriate to use a syringe to draw insulin from an insulin pen because it could cause contamination of the insulin, and an accidental needle stick to the person performing the technique.
-She was not comfortable with MAs drawing insulin from insulin pens because they could give the incorrect dose of insulin.
-She did not know the staff had been using a syringe to draw up Resident #1's insulin from his

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insulin pen.

Interview with the Administrator in Charge on 11/09/18 at 9:05am revealed:
-The MAs who had used syringes to draw insulin from insulin pens were being lazy.
-The MAs had failed to do what they had been trained to prevent possible contamination of the insulin pens.

Refer to interview with the Administrator in Charge on 11/09/18 at 9:10am.

3. Observation MA on 11/06/18 at 8:56am during medication pass she used an insulin syringe to draw insulin out of a Levemir Flexpen (to treat hyperglycemia) 100u/ml and administered it subcutaneous to Resident #9.

Review of Resident #9's current FL2 dated 10/10/18 revealed:
-Diagnoses included morbid obesity, non-rheumatic aortic stenosis, diabetes mellitus type 2, anemia, left bundle branch block, cellulitis right lower limb, hypertension, osteoporosis, multiple sclerosis, and neuromuscular dysfunction of the bladder.
-There was a physician's order for Levemir Flexpen (to treat hyperglycemia) 100u/ml give 45units twice daily.

Interview with the MA on 11/06/18 at 11:43am revealed:
-She had no insulin pen needles available on her cart to use to administer Resident #9's insulin.
-"No one had instructed her to draw insulin from the Levemir Flexpen with a syringe, she just did it".

Interview with the Assisted Living Nurse

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D 371	Continued From page 162 Supervisor on 11/06/18 at 4:00pm revealed: -She knew they had ran out of pen needles at times. -She did not know the MAs had used syringes to draw insulin from insulin pens. -She was not certain Resident #9's insulin pen supply had come from the pharmacy, but the facility stocked a supply for the medication carts. -She had not instructed the MAs to use a syringe to draw insulin out of the insulin pens. Interview with the Administrator in Charge on 11/09/18 at 9:05am revealed: -The MAs who had used syringes to draw insulin from insulin pens were being lazy. -The MAs had failed to do what they had been trained to prevent possible contamination of the insulin pens. Refer to interview with the Administrator in Charge on 11/09/18 at 9:10am. _____ Interview with the Administrator in Charge on 11/09/18 at 9:10am revealed: -Staff were expected to use appropriate infection control measures. -She expected the MAs to follow the medication administration policy and use appropriate infection control measures when administering medication according to their training provided. -The MAs had all been trained on the policy and completed infection control training provided.	D 371		
D 377	10A NCAC 13F .1006(a) Medication Storage 10a NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult	D 377		

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care home's medication storage policy and procedures.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure that the residents' medications were stored in a safe and secure manner for 3 of 6 sampled residents (Resident #10, #11 and #12) who self-administer medications.

The findings are:

Review of the facility's medication storage policy revealed residents who self-administer medications must have medications stored in a lock box. Medications may not be left unattended at any time in the resident's room.

Interview with the Administrator on 11/09/18 at 2:00pm revealed there were no residents in the facility who had physician orders for self-administration of medications.

1. Review of Resident #10's current FL-2 dated 03/22/18 revealed:
-Diagnoses included depression and anxiety.
-There were no orders on the FL2 for Tylenol (used to treat minor aches and pain) or pepto-bismol (used to treat nausea and upset stomach).

Observation of Resident #10's room on 11/06/18 at 8:45am revealed:
-The resident's room door was open and the resident was sitting in a chair.
-There was a bottle of Tylenol 325mg on the table

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near the television.
-There was a bottle of pepto-bismol on the table near the television.
-Neither bottle was labeled with the resident name, strength or directions for usage.

Interview with Resident #10 on 11/06/18 at 8:45am revealed:
-She administered the Tylenol 325mg tablets as needed for headaches and body aches.
-She administered two Tylenol tablets mostly at night about 3 times weekly.
-She administered the pepto-bismol as needed for her "upset stomach".
-Staff came into her room every day.
-She did not have a secure area that she could place medications in her room.
-No one had ever taken her medications out of the room.

Interview with the RCC on 11/07/18 at 11:10am revealed:
-A MA told her on 11/06/18 Resident #10 had medications in her room, Tylenol and pepto-bismol.
-She had removed the medications on 11/06/18 after a MA brought to her attention.
-The medications were not secured or locked in Resident #10's room, they were on the shelf near the television.
-Resident #10 had told the RCC a family member had brought the medications to her.
-The RCC had not contacted the physician in regard to the medications located in Resident #10's room.

Observation of Resident #10's room with the RCC on 11/07/18 at 11:15am revealed the Tylenol and the pepto-bismol were not in Resident #10's room.

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D 377	Continued From page 165 Interview with the facility Nurse Practitioner on 11/07/18 at 9:20am revealed: -She did not know Resident #10 had unsecured medications in her room. -Resident #10 had diagnoses depression and anxiety and was not able to self-administer her medications. -She did not have orders to self-administer medications or to have medications in her room. -She expected the facility to be responsible for administering Resident #10's medications and to secure all medications from Resident #10. Refer to interview with a MA on 11/07/18 at 10:30am. Refer to interview with the RCC on 11/07/18 at 11:10am. 2. Review of Resident #12's current FL-2 dated 03/14/18 revealed: -Diagnoses included dementia. -There were no orders on the FL2 for isopropyl rubbing alcohol 70% (used as an antiseptic to clean wounds) or Neosporin ointment (used as an antiseptic to prevent infection). Observation of Resident #12's room on 11/06/18 at 9:00am revealed: -The resident's room door was open. -The resident was not in the room. -The was a 16 ounce bottle of rubbing alcohol 70% located in the bathroom on a shelf in the cabinet. -There was a tube of Neosporin ointment located in the bathroom on a shelf in the cabinet. Based on observation, interviews, and record review it was determined Resident #12 was not	D 377		

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interviewable.

Interview with the facility Nurse Practitioner on 11/07/18 at 9:20am revealed:
-She did not know Resident #12 had unsecured medications in her room.
-Resident #12 had diagnosis of dementia and was not able to self-administer any of her medications.
-Resident #12 did not have orders to self-administer medications or to have medications in her room.
-She expected the facility to be responsible for administering Resident #12's medications and to secure all medications from Resident #12.

Observation of Resident #12's room with the RCC on 11/07/18 at 11:15am revealed:
-The alcohol 70% and the Neosporin ointment were in Resident #12's bathroom in a cabinet on a shelf.
-The RCC removed the alcohol and the Neosporin from the cabinet shelf located in Resident #12's bathroom.

Refer to interview with a MA on 11/07/18 at 10:30am.

Refer to interview with the RCC on 11/07/18 at 11:10am.

3. Review of Resident #11's current FL-2 dated 01/1618 revealed:
-Diagnoses included dementia, anxiety and muscle weakness.
-There were no orders on the FL2 for sweet oil ear drops (used as a herb to treat infections) or blink eye drops (used to treat dry eyes).

Observation of Resident #11's room on 11/06/18

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at 9:05am revealed:
-The resident's room door was open.
-The resident was resting in a wheelchair in the room.
-There was a bottle of sweet oil ear drops and a plastic dispenser on the shelf near the microwave in the kitchen area.
-There was a bottle of blink eye drops on the shelf near the microwave in the kitchen area.

Interview with Resident #11 on 11/06/18 at 9:05am revealed based on interview and record review Resident #11 was not interviewable.

Interview with the facility Nurse Practitioner on 11/07/18 at 9:20am revealed:
-She did not know Resident #11 had unsecured medications in her room.
-Resident #11 had diagnosis of dementia and anxiety and was not able to self-administer any of her medications.
-Resident #11 did not have orders to self-administer medications or to have medications in her room.
-She expected the facility to be responsible for administering Resident #11's medications and to secure all medications from Resident #11.

Observation of Resident #11's room with the RCC on 11/07/18 at 11:20am revealed:
-The sweet oil ear drops and the blink eye drops were in Resident #11's room near the microwave in the kitchen area.
-The RCC removed the sweet oil ear drops and Blink eye drops from Resident #11's room.

Refer to interview with a MA on 11/07/18 at 10:30am.

Refer to interview with the RCC on 11/07/18 at

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D 377	Continued From page 168 11:10am. _____ Interview with a MA on 11/07/18 at 10:30am revealed: -There were no residents in the facility who self-administered medications. -The MAs were to check rooms for medications weekly. -The personal caregivers (PCA) were to check the resident's room for medications when they go into the rooms to provide personal care. -The last time the facility conducted a room to room sweep for medications was about 2 weeks ago. -If the PCA's find medications in the resident's rooms they were to tell the MAs. -The MAs were to tell the Resident Care Coordinator (RCC) or the facility nurse when they find medications in a resident room. Interview with the RCC on 11/07/18 at 11:10am revealed: -There were no residents in the facility who self-administered medications. -There was a room sweep conducted about 45 days ago to remove any medications from the resident's rooms. -The PCA's and the MAs were to tell her if a resident had medications in their rooms.	D 377		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.	D911		

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D911	Continued From page 169 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were treated with respect, consideration, dignity, and full recognition of his or her individuality related to Resident Rights. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure 4 of 6 sampled residents (#3, #4, #5, and #8) were free of neglect and physical abuse related to not providing Foley catheter care and supplies to 2 residents with Foley catheters, resulting in one resident being hospitalized for urosepsis (Resident #3) and one resident having to carry his uncovered, urine-filled Foley catheter bag in one hand while walking with his cane in the other hand (Resident #8); not providing personal care assist with toileting, showers, transfers, and positioning while in bed, resulting in 2 residents receiving injuries of unknown origin related to multiple skin tears and bruising to his right forearm and left hand (Resident #5) had a dislocated right shoulder (Resident #4). [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation).]	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 170 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to implementation, food and nutrition, personal care and supervision. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to assure the management and overall operations of the facility by failing to meet and monitor rules related to personal care and supervision, medication administration and storage, resident rights, nutrition and food storage, housekeeping furniture, unpleasant odors and chemical storage. [Refer to Tag 980 G.S. 131D-25 Implementation (Type A1 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to assure staff provided personal care assistance for 6 out of 6 sampled residents (#3, #2, #8, #18, #22 and #23) including 1 residents not receiving Foley catheter care (#3), 3 residents not receiving assistance with incontinence care (#2, #8 and #22), 1 resident with an open wound that was not assessed (#2), and 1 resident not receiving bed linen changes (#23). [Refer to Tag 269,10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to assure staff provided supervision for 3 out of 6 sampled residents (Resident #19, #3 and #22) related to Resident	D912		

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D912	Continued From page 171 #19 had unlocked the SCU door, walked into the patio courtyard unsupervised in the dark, Resident #3 was sent to the hospital with a "high risk for clinical death and decline" and was admitted with urosepsis and pulmonary edema, and (Resident #22) who attempted to seek staff assistance with ADLs unsuccessfully placing her at high risk for falls. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).] 4. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 6 sampled residents with physician ordered therapeutic diets were served as ordered for a mechanical soft ground diet (Resident #2), mechanical soft no added salt (MS-NAS) diet (Resident #12), and pureed meats, controlled carbohydrate diet (Resident #14). [Refer to Tag 210, 10A NCAC 13F .0904(e)(4) Nutrition and Food Services (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 free of neglect in compliance with federal and state laws and rules and regulations related to resident rights, medication administration and health care.	D914		

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D914	Continued From page 172 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure 4 of 6 sampled residents (#3, #4, #5, and #8) were free of neglect and physical abuse related to not providing Foley catheter care and supplies to 2 residents with Foley catheters, resulting in one resident being hospitalized for urosepsis (Resident #3) and one resident having to carry his uncovered, urine-filled Foley catheter bag in one hand while walking with his cane in the other hand (Resident #8); not providing personal care assist with toileting, showers, transfers, and positioning while in bed, resulting in 2 residents receiving injuries of unknown origin related to multiple skin tears and bruising to his right forearm and left hand (Resident #5) had a dislocated right shoulder (Resident #4). [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 6 sampled residents (#2, #3, #6, #15, and #19) related to unavailable medications for blood pressure that led to a hospitalization (Resident #3), not completing a dose titration for a medication for agitation for a resident in the Special Care Unit (Resident #19), applying narcotic pain patches to a resident after the order had been discontinued (Resident #15), an order for anxiety medication not being available to administer (Resident #6) and incorrect administration of an insulin preparation (Resident #2). [Refer to Tag 358, 10A NCAC 13F.1004(a) Medication Administration (Type A1 Violation).]	D914		

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D914	Continued From page 173 3. Based on observations, interviews and record reviews, the facility failed to notify the physician for 5 of 6 sampled residents (Residents #1, #2, #3, #6, and #15) regarding blood pressure and edema medications not being available and not referring a resident for treatment for an illness in a timely manner (#3), high blood sugars and diabetic medications not administered (#1), a perineal wound with bleeding and discomfort (#2), fentanyl patch not being available then administered without an order after discontinued (#15) and refusals for three medications and with an order for a psychological evaluation and treatment for a resident who displayed aggressive behaviors (#6). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).]	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Non-compliance continues with increased severity resulting in serious physical harm and neglect. THIS IS A TYPE A1 VIOLATION The findings are: Based on observations, interviews, and record	D980		

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reviews, the Administrator failed to assure the management and overall operations of the facility by failing to meet and monitor rules related to personal care and supervision, medication administration and storage, resident rights, nutrition and food storage, housekeeping furniture, unpleasant odors and chemical storage.

Observation during the survey from 11/06/18 to 11/09/18 revealed the Administrator was not in the facility.

Observations of the facility staff on 11/08/18 between 4:45am and 6:30am revealed:
-The supervisor had opened the front door for the survey team.
-There was no staff person at the front desk.
-There was one staff person on the first floor who was sitting in a recliner in an unoccupied room with her feet propped up, a scarf around her head and the television was on.
-There was a residents' room on the first floor the survey team could not enter because the resident had tied the door from the inside with a scarf.
-There was a strong urine odor in room 107 with the resident in a soiled brief attempting to complete incontinent care by herself.
-There was a staff person sitting in another unoccupied room with her shoes off.
-There was feces and urine on the toilet, old dark brownish yellow urine stains on the sheets, and the room had a strong odor of urine in Resident room 224.
-On the second floor room 213, the resident's room had a strong smell of urine, when the survey team entered the room the resident was sitting in her wheelchair attempting to provide personal care to herself. The survey team had the resident push her call bell pendant for assistance at 5:10am. The call bell went unanswered for 50

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minutes (5:53am) and was still going off at the computer on the second floor with no staff responding to the call bell or assisting the resident.
-On the third floor in an occupied resident room 304, the survey team found a staff person asleep and snoring on the residents couch. Another staff person was coming out of the resident's bathroom in the same room 304.
-There were two staff in Special Care Unit (SCU), one walked toward surveyor and another had risen from a chair wrapped in a blanket in the common area.
-There was a resident in the common area sitting in a chair without a walker or cane close by her.
-The resident remained sitting in the common area as a staff left the area entering resident's room leaving her unsupervised.
-The resident in the common area got up from the chair without her walker, she went to the courtyard door unlocked the lock (no alarm sounded) and walked out onto the courtyard patio.
-The courtyard door leading to the outside patio area had a "hook latch lock" that could be easily be reached and opened.
-Between 5:01am-5:45am the courtyard door in the SCU was unlocked.

Interview with a personal care aide (PCA) on 11/08/18 at 5:22am revealed:
-She was assigned to the front desk on 11/08/18 third shift.
-She had left the front desk to go upstairs and get her purse and coat because her shift ended at 6:00am.
-She had left the front desk un-attended for 15 or 20 minutes, she had not told the supervisor she had left the desk.
-All the residents had a call bell pendant that are

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D980	Continued From page 176 activated by the resident pushing the pendant when they need assistance. -The computer alarmed when a resident pushed the call bell pendant. -She did not have access to the computer system to answer resident's call bells. -"I've never been trained on the computer, I can't even log on." -"I do not have the password for the computer." -There was a computer on second floor that monitored the call bell system also, and staff could tell which resident's rooms were needing assistance. -There was to be someone at the front desk at all times to answer the telephone, monitor who enters the facility, and the answer the resident call bells. Interview with the supervisor on third shift on 11/08/18 at 5:55am revealed: -The staff person who was assigned to work the front desk on third shift had called out on 11/08/18. -The PCA who worked the front desk had worked second shift and had volunteered to work the front desk on third shift on 11/08/18. -She did not know the PCA assigned to the front desk on 11/08/18 did not have access to the computer system to answer call bell pendants if a resident had required assistance. -She did not know the PCA had left the front desk un-attended on 11/08/18. -There was a computer on the second floor that resident's call bell pendants could be answered. -She was unsure if a staff person was on the second floor at that computer. -She did not know a staff person was in a resident room on the first floor in a recliner laid back, with her feet propped up watching the television.	D980		

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D980	Continued From page 177 -She did not know a staff person had been on a resident's couch in the resident's room on third floor sleeping / snoring. -She did not know residents in the facility were attempting to provide personal care to themselves because the staff were not available. Interview with Marketing Director on 11/08/18 at 1:40pm revealed: -She was in charge of the facility on 11/08/18 due to the Administrator was out of town. -All residents in the facility on the assisted living side had call bell pendants. -She did not know the PCA who had monitored the front desk had not been trained on the computer, and did not have access to answering the pendant call bell system. -She did not know the staff were sleeping, outside smoking, or that staff was in a resident's room sitting in a recliner watching television. -The third shift supervisor had not reported any of these findings to her. Confidential interview with two staff revealed: -The Administrator was out of town the week of 11/05/18 to 11/12/18. -The Administrator was in charge of day to day operations. -There was no management in the facility, "that is why the facility is like it is." -Staff would do "whatever they wanted." -Staff worked double shifts to provide care to residents due to "lack of staff." -She felt that the care provided "could be better" for the residents. -She expressed her concerns with the Administrator and nothing had been done. Interview with the Marketing Director on 11/08/18 at 1:40pm revealed:	D980		

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-She was responsible for the day to day operations of the facility while the Administrator was out of the building.
-She was in the facility Monday through Friday.
-The Administrator's Assistant (AA) was the next person in charge if the Marketing Director was not in the facility.
-The RCC was the next person in charge in the facility if the AA was unavailable.
-The Assisted Living Nurse Supervisor and the SCU Nurse Supervisor would be the next in charge person if the above management team were not in the facility.
-On third shift the supervisor was in charge, with all the management team being available by telephone 24/7 if they were needed.
-She did not know the PCA who had monitored the front desk had not been trained on the computer and did not have access to answering the pendant call bell system.
-She did not know the staff were sleeping, outside smoking, or that staff was in a resident's room sitting in a recliner watching television.
-The third shift supervisor had not reported any of the findings to her.

Interview with Resident #4's Power of Attorney (POA) on 11/06/18 at 2:12pm revealed:
-He was in the facility on 11/06/18 to move Resident #4 out of the facility "for her safety."
-Resident #4 had an injury and was sent to the emergency room on 10/16/18 with a diagnosis of right a shoulder dislocation and possible clavicle fracture.
-The Administrator had not yet provided an explanation how Resident #4's right shoulder had been dislocated.
-For Resident #4's safety the POA decided to move her to another facility.
-"This facility does not care what happened to

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D980	Continued From page 179 [Resident #4] and did not communicate with me exactly what caused the dislocated shoulder." Attempted telephone interview with the owner/licensee on 11/06/18 at 9:50am was unsuccessful. Telephone interview with the Administrator on 11/09/18 at 2:00pm revealed: -He started as the Administrator in October 2017. -He had conducted training for the staff and conducted in-services for staff. -He was responsible for the day to day operation of the facility. -When the he was not available or not in the facility the Marketing Director was in charge of the day to day operations of the facility. -The facility Nurse Supervisors were responsible for the care giver staff. Non-compliance was identified in the following rule areas: 1. Based on observations, interviews and record reviews, the facility failed to notify the physician for 5 of 6 sampled residents (Residents #1, #2, #3, #6, and #15) regarding blood pressure and edema medications not being available and not referring a resident for treatment for an illness in a timely manner (#3), high blood sugars and diabetic medications not administered (#1), a perineal wound with bleeding and discomfort (#2), fentanyl patch not being available then administered without an order after discontinued (#15) and refusals for three medications and with an order for a psychological evaluation and treatment for a resident who displayed aggressive behaviors (#6). [Refer to Tag 273,10A NCAC 13F .0902(b) Health Care (Type A1 Violation).]	D980		

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D980	Continued From page 180 2. Based on observations, interviews, and record reviews, the facility failed to assure 4 of 6 sampled residents (#3, #4, #5, and #8) were free of neglect and physical abuse related to not providing Foley catheter care and supplies to 2 residents with Foley catheters, resulting in one resident being hospitalized for urosepsis (Resident #3) and one resident having to carry his uncovered, urine-filled Foley catheter bag in one hand while walking with his cane in the other hand (Resident #8); not providing personal care assist with toileting, showers, transfers, and positioning while in bed, resulting in 2 residents receiving injuries of unknown origin related to multiple skin tears and bruising to his right forearm and left hand (Resident #5) had a dislocated right shoulder (Resident #4). [Refer to Tag 338,10A NCAC 13F .0909 Resident Rights (Type A1 Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 6 sampled residents (#2, #3, #6, #15, and #19) related to unavailable medications for blood pressure that led to a hospitalization (Resident #3), not completing a dose titration for a medication for agitation for a resident in the Special Care Unit (Resident #19), applying narcotic pain patches to a resident after the order had been discontinued (Resident #15), an order for anxiety medication not being available to administer (Resident #6) and incorrect administration of an insulin preparation (Resident #2). [Refer to Tag 358,10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).] 4. Based on observations, interviews, and record reviews, the facility failed to assure staff provided personal care assistance for 6 of 6 sampled	D980		

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	HAL060158	A. BUILDING: _____ B. WING _____	R-C 11/09/2018

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D980	Continued From page 181 residents (Residents #3, #2, #8, #18, #22 and #23) regarding a resident not receiving Foley catheter care or showers and presented to physician appointments covered in urine and feces (#3), residents not receiving assistance with incontinence care and an open perineal wound that was not assessed (#2, #8, #18 and #22), and a resident not receiving bed linen changes (#23). [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation).] 5. Based on observations, interviews, and record reviews, the facility failed to assure staff provided supervision for 1 of 6 sampled residents (Resident #19) related to Resident #19 unlocking the special care unit (SCU) door, and exiting the facility unsupervised in the dark. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).] 6. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 6 sampled residents with physician ordered therapeutic diets were served as ordered for a mechanical soft ground diet (Resident #2), mechanical soft no added salt (MS-NAS) diet (Resident #12), and pureed meats, controlled carbohydrate diet (Resident #14). [Refer to Tag 210, 10A NCAC 13F .0904(e)(4) Nutrition and Food Services (Type B Violation).] 7. Based on observations and interviews, the facility failed to assure 3 storage rooms (janitor's closet, a storage closet, and kitchen supply room) containing hazardous chemicals were locked and not accessible to residents. [Refer to Tag 056, 10A NCAC 13F .0305(f)(4) Physical Environment.]	D980		

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D980	Continued From page 182 8. Based on observations and interviews, the facility failed to assure the facility was maintained without chronic odors of urine. [Refer to Tag 075, 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings.] 9. Based on observations and interviews, the facility failed to assure the chairs in the resident hallways on the 2nd and 3rd floors were kept clean and in good repair.[Refer to Tag 076, 10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings.] 10. Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menus for 2 of 6 sampled residents with a mechanical soft, no added salt (MS-NAS) diet for Resident #12 and no menu for a pureed carbohydrate controlled diet for Resident #14. [Refer to Tag 296,10A NCAC 13F .0904 (c)(7) Nutrition And Food Service.] 11. Based on observations, record reviews, and interviews, the facility failed to assure a therapeutic diet list was maintained for the guidance of dietary staff for 3 of 6 residents sampled (#1, #2, #14) who had physician's orders for a therapeutic diets.[Refer to Tag 309, 10A NCAC 13F .0904 (e)(3) Nutrition and Food Service.] 12. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 medication aides (MAs) observed during the medication passes implemented infection control measures related to failing to properly clean nebulizer equipment between use and administration of medications for 1 of 6 residents (Resident #20), and 2 of 2 MAs accessing insulin	D980		

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D980	Continued From page 183 pens using insulin syringes in place of pen needles for 2 of 6 residents (Resident #1 & #9). [Refer to Tag 371, 10A NCAC 13F .1004(n) Medication Administration.] 13. Based on observation, record review, and interview, the facility failed to ensure that the residents' medications were stored in a safe and secure manner for 3 of 6 sampled residents (Resident #10, #11 and #12) who self-administer medications.[Refer to Tag 377, 10A NCAC 13F .1006(a) Medication Storage.] _____ The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing a non-secured storage room on the first floor of the facility with containers of hazardous chemicals, strong odors of urine in resident rooms and hallways throughout the facility, furniture in good repair throughout the facility, resident rights to be treated with dignity related to Foley catheter care and not providing personal care resulting in a wound, resident rights related to injury of residents, call bells not being answered placing residents at high risk for injury, one resident who was totally dependent on staff wheelchair bound with an emergency room visit with a diagnosed shoulder dislocation, one resident who had a laceration of unknown origin to his hand, staff not responding to residents' needs for several hours presenting with signs of sickness, fever and weakness and sent to the hospital with a life threatening illness, infection control measures related to medications administration, therapeutic diets, diet list not available for use to prepare meals, medications in multiple residents rooms unsecured, medications not administered as ordered for multiple residents, failure to notify	D980		

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D980	Continued From page 184 physicians of medication refusal, wound and elevated blood sugars, neglected to supervise multiple residents one who resided in the SCU who unlocked the door leading to the outside patio, ambulated outside unsupervised with staff not knowing her whereabouts; all of which are the responsibility of the Administrator. The Administrator's failure resulted in neglect and serious physical harm which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 8, 2018.	D980		