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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow up-survey on September 14, 2022 to September 16, 2022.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (Residents #1, and #4) related to a resident who had eight falls in four months (#4), a resident who had two falls one which resulted in an injury (#1). The findings are: Review of the facility's policy on falls/incidents and accidents dated February 2022 revealed: -Residents who had a fall should have a post fall evaluation completed to consider possible interventions to reduce the potential for a future fall. -A fall referred to unintentionally coming to rest on the ground, floor or other lower level either witnessed or unwitnessed, with or without an injury. -A post fall evaluation was completed after a resident fall; individualized interventions were considered, and the evaluation would be a part of	D 270		

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the resident record.
-When a fall occurs notify the health and Wellness Director (HWD), Administrator, the primary care provider (PCP) and family/responsible party and document in the resident's record.
-When a fall occurs document in the resident's record the resident's fall/injuries, response and interventions taken.
-When a fall occurs the [resident's] service plan is reviewed for fall interventions and updated, the fall is reviewed at the next stand up meeting, and discussed at the next collaborative care review meeting.

1. Review of Resident #4's current FL-2 dated 08/30/22 revealed:
-Diagnosis included dementia, hearing loss, hypertension, hyperlipidemia, anemia, major depression , insomnia and gastroesophageal reflux disease (GERD).
-Resident #4 was ambulatory without assisted devices.

Review of Resident #4's personal care plan dated 05/18/22 revealed:
-Resident #4 was ambulatory with the use of a walker.
-Resident #4 had fallen in the last 12 months and was on alert to heightened risk for falling.
-There was a note to prevent falls educate resident on reducing environmental clutter and arrange furniture for adequate walkways.
-Consider Resident #4 for physical therapy (PT) or occupational therapy (OT) to consult to increase strength, gait training, cognition and adaptive equipment.

Review of Resident #4's most current Licensed Health Professional Support (LHPS) assessment

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dated 03/10/22 revealed:
-Ambulation with assisted devices was not checked off.
-Other prescribed physical and occupational therapy was checked off and PT was handwritten in.
-There was documentation Resident #4 was doing PT to help with balance, weakness and stability and was going well per the therapist.

Review of Resident #4's progress notes from June 2022 to September 2022 revealed:
-On 06/26/22, Resident #4 was found on the floor in her room beside her bed on her left side with injury to her forehead above her left eye.
-Resident #4's vitals were taken and the primary care provider (PCP) and power of attorney (POA) were notified.
-There was nothing else noted on 06/26/22.
-On 07/01/22, Resident #4 had a fall on first shift; there was no complaint of pain and the vitals were checked.
-There were no other notes on 07/01/22.
-On 07/06/22, Resident #4 was found on the floor next to her bed wrapped up in a blanket.
-Resident #4 said she was going to the bathroom, but her legs did not want to work; there were no injuries at that time.
-The PCP, the facility nurse and the POA were notified.
-There was nothing else noted on 07/06/22.
-On 08/12/22, Resident #4 slid off the edge of her bed and sat on the floor; she denied any pain.
-The Executive Director (ED), the PCP and the POA were notified.
-There was nothing else noted on 08/12/22.
-On 08/20/22, Resident #4 was found sitting on the floor in her room; the resident stated she spilled water on the floor and slipped in it.
-There was no apparent injury, but the resident

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had bruising on her right buttocks from a previous fall.
-The ED, and POA were notified.
-There was nothing else noted on 08/20/22.
-On 08/23/22, Resident #4 had a fall in her room; she had no injuries and no complaints of pain.
-The POA was notified and there were no other notes on 08/23/22.
-On 09/01/22, Resident #4 had a fall at 10:00pm; she stated she was getting up to get pajamas and fell on her knees.
-Her knees were red, but she did not complain of pain; her vitals were taken and the POA was notified.
-There was nothing else noted on 09/01/22.
-On 09/02/22, Resident #4 had a fall at 8:27pm and could not remember if she hit her head; she did have a complaint of a headache.
-The local emergency medical services (EMS) were called; Resident #4 refused to be transported to the local emergency department.
-There was nothing else noted on 09/02/22.
-There were no interventions noted on the progress notes for Resident #4.

Review of an incident report dated 07/06/22 revealed:
-Resident #4 had a fall at 8:00am.
-She did not appear to have any injuries.
-Resident #4 was found on the floor beside her bed wrapped in the bedsheet, stating her legs were weak and did not want to work.
-She did not have any apparent injuries and no interventions were noted.
-No other incident reports were provided.

Observation of Resident #4 on 09/14/22 at 3:10pm revealed she was ambulating in the main hallway with the use of a walker.

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Observation of Resident #4 on 09/15/22 at 2:26pm revealed:
-She was ambulating in the main hallway with the use of her walker.
-She was walking towards her room.
-She had on slipper socks without a non-skid surface on the bottom.
-She had a disposable cup full of water without a lid on the seat of her walker.

Observation of Resident #4's room on 09/15/22 at 4:31pm revealed:
-Her room was the first room located on the corner of the first hall off the main hallway.
-She resided in a room by herself.
-The flooring was a waxed vinyl tiled floor; there were no area rugs or carpeting in the room.
-There was a dresser, a bed, a nightstand, and a small dining table with two chairs.
-There were items on the floor around her nightstand and under the dining table with the two chairs.
-There were unopened packages of adult briefs, various bags and items on the floor.
-There were various items on the nightstand including a cup of water without the lid.

Interview with Resident #4 on 09/15/22 at 4:31pm revealed:
-She had fallen in the last few months, but she did not remember how many times.
-She would get dizzy or slip and fall.
-She had not had PT lately; she could not remember when her PT was finished.
-The PT did not help her; her falls were more related to being dizzy.
-She had slipped getting out of her bed once.
-She could not recall if she went to the hospital for any of her falls.

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Telephone interview with Resident #4's PCP on 09/15/22 at 5:02pm revealed:
-Resident #4 had a lot of falls; she would fall "off and on".
-Resident #4 had a messy room that contributed to her falls; she was not sure if the resident would trip or slide trying to navigate around the clutter in her room.
-She had a balance issue and had done PT in an effort to reduce the number of falls she was having.
-Resident #4 had done the best she could do with PT; she could be difficult and non-compliant at times.
-Resident #4 had seen a neurologist for her balance and vertigo; she had an as needed (PRN) medication ordered to help with complaints of vertigo.
-Resident #4 needed to clean her room to prevent most of her falls.

Interview with a personal care aide (PCA) on 09/16/22 at 10:37am revealed:
-Resident #4 had fallen but she had not witnessed her falls.
-Resident #4 was usually found on the floor in her room after a fall.
-Resident #4 complained about her legs getting weak.
-She had noticed Resident #4 was getting weaker and weaker in the last few weeks.
-Sometimes Resident #4 ate breakfast in her room because she was too weak in the morning to walk to the dining room.

Interview with a second PCA/medication aide (MA) on 09/16/22 at 10:43am revealed:
-Resident #4 had been found on the floor a few times on various shifts; she had never found the resident.

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D 270	Continued From page 6 -The PCAs had found Resident #4 and reported to her before. -When Resident #4 was found on the floor she would take her vitals and check her for injuries as well as document the fall in the progress notes. -After a resident had a fall, they would be placed on a three-day watch; the resident's vitals would be taken on each shift during those three days. -All residents were checked every two hours; the checks were not documented. -Frequency of checks would not increase during the three days after a fall. -Incident reports were always completed after a fall. -Resident #4 had not been on any preventions or interventions for falls. -Resident #4 needed to clean the clutter in her room. -The clutter in Resident #4's room contributed to her falls because she did not have a clear area to walk. -She knew Resident #4 slid off her bed trying to get to the bathroom. -One of Resident #4's falls was due to her pants falling down around her ankles. -Resident #4 complained of muscle pain in her legs and she had increased confusion over the last three months. -She had noticed a slight decrease in Resident #4 cognition and physical abilities in the past three months. -She had reported her concerns to the previous HWC but had not reported it to the new HWC. -Resident #4 could benefit from increased checks as well as decluttering her room. Interview with a second MA on 09/16/22 at 2:08pm revealed: -Resident #4 had increased falls in the past two months.	D 270		

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-After a fall she monitored the resident for 72 hours; she monitored for change in vitals, behaviors or general conditions.
-There were no increased checks for Resident #4, but she did walk by her room more often and check on her.
-Resident #4's falls were documented in the progress notes.
-She filled out incident reports after a fall and turned them into the HWC, she did not know where the report went after that.
-She did not know of any interventions for Resident #4.
-Resident #4 fell because she would trip or slid getting out of the bed.
-Resident #4 fell because her room was so messy and cluttered.
-Resident #4 walked the hallways all day and never fell; Resident #4 only fell when she was in her room.
-She had not noticed a decline in Resident #4, but she had not really worked with her enough to know how much.

Interview with a third MA on 09/16/22 at 3:59pm revealed:
-She worked second shift.
-Resident #4 had a history of falls but they were always in her room.
-Resident #4 collected water in cups without lids and would insist on transporting them and storing them on the seat of her walker.
-One of Resident #4's falls was because she slipped on water that was on the floor in her room from a cup of water.
-Resident #4 had too much "stuff" in her room and was always tripping over it.
-Resident #4 also would fall getting up from her bed; she would slide to the floor.
-Resident #4 did not have any interventions to

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prevent falls that she was aware of.

Interview with the HWC on 09/16/22 at 4:20pm revealed:
-She had only worked at the facility for a week; she was a Licensed Practical Nurse (LPN).
-Any time a resident was found on the floor it was considered a fall even when it was a slide to the knees or to the bottom.
-She was concerned Resident #4 was going to fall while in her room from the amount of clutter on the floor.
-She had seen an old incident report for Resident #4 where she was found on the floor in her room.
-After a fall the MAs were required to take a resident's vitals and check them for injury and if no injuries, they could help the resident off the floor.
-The MAs were required to fill out an incident report for all falls.
-After a resident had a fall, they were monitored for 72 hours; vitals were taken on each shift and the were monitored for pain.
-Interventions should have been put into place after each fall in an attempt to prevent more falls.
-The interventions could include increase in frequency of checks.
-There was a list of questions to determine what interventions needed to be put into place after each fall.
-The things to consider in the questions were change in health care, changes in cognition, decline in health, evaluation of the environment like trip or slip hazards, evaluation of equipment for ambulation, evaluation for PT and urinary analysis are considered.
-The review of interventions would be conducted by the HWC and the Health and Wellness Director (HWD) who was a Registered Nurse (RN).

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-The new HWD had not started to work at the facility yet; she was due to begin the following week.
-She did not think Resident #4 had interventions put into place prior to her beginning at the facility.
-She would begin by decluttering Resident #4's room and checking her walker.
-She was concerned Resident #4 may have experienced some kind of decline that had been missed.
-She knew Resident #4's room was cluttered; she was concerned she may have issues moving around the room due to the number of personal items that were in the room.

Interview with the Assistant Executive Director (AED) on 09/16/22 at 5:21pm revealed:
-The MAs did assessments for vitals and injuries after a fall; falls with a head injury were automatically sent out to the hospital.
-The clinical team consisted of the HWC and the HWD.
-The clinical team were responsible for evaluation of the fall for a decision about interventions.
-The clinical team would look at the reason for the fall and go through the list of interventions based on the cause of the fall; examples would be PT, or increased assistance with task like going to the bathroom.
-She knew Resident #4 had a history of falls, but she thought it was due to the clutter in her room and not being able to move around safely.
-She would discuss cleaning the room with the resident, the family and the PCP or mental health provider if needed.
-She would be concerned if interventions were not put into place for a resident because something could be done to prevent falls and prevent injuries.

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Attempted interview with Resident #4's power of attorney (POA) on 09/16/22 at 11:32am was unsuccessful.
2. Review of Resident #1's current FL2 dated 04/05/22 revealed:
-Diagnosis included moderate protein calorie malnutrition, anemia, type 2 diabetes, hyperlipidemia, hyponatremia, myocardial infarction, and generalized anxiety.
-Resident #1 was ambulatory.

Review of Resident #1's care plan dated 08/28/22 revealed Resident #1 was independent with ambulation and transfer.

Review of the 24-hour shift reports for Resident #1 revealed:
-There were no shift reports dated 08/15/22 or 08/16/22.
-There was no documentation Resident #1 had a fall in August 2022.

Review of the facility's Incident/Accident reports revealed there were no Incident/Accident reports available for review for Resident #1.

Review of Resident #1's progress noted dated 08/16/22 at 12:59pm revealed:
-Resident #1's family members notified staff that he was not at his baseline.
-Resident #1 stated he had a headache for 2 days, was confused when he fell and hit his head, had heart palpitations, and had trouble walking.
-Resident #1's PCP wrote an order for a urinalysis (U/A) on 08/16/22, but his family insisted he be sent out to the local hospital for evaluation.

Observation of Resident #1 on 09/14/22 at 8:55am revealed:

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-Resident #1 was seated his recliner in his room with his feet on the floor.
-Resident #1 had a large bandage on his left knee and brusing on his right knee.

Interview with the medication aide (MA) who documented the progress note on 08/16/22 at 12:59pm on 09/16/22 at 9:05am revealed:
-She came to work on 08/16/22 towards lunch time.
-Staff on the previous shift told her Resident #1 fell twice over the previous weekend.
-Staff told her Resident #1 hit his head, but he was not sent out to the emergency room after either fall.
-Resident #1's family was in the facility and told her Resident #1 was not himself.
-The previous Health and Wellness Coordinator (HWC) requested an order for a U/A from Resident #1's PCP, but Resident #1's family wanted him sent out to the hospital.
-If a resident fell and hit his head, staff would assess the resident, check vitals, call the facility nurse, call the family, and call the ambulance.

Review of Resident #1's progress notes for August 2022 revealed there was no documentation regarding details of a fall.

Interview with Resident #1 on 09/15/22 at 11:21am revealed:
-He fell a couple of weeks ago and hit his head.
-Staff found him in his room and helped him up off the floor, but he did not remember any details.
-Staff did not send him out to the hospital after his fall.
-Staff put a bandage on his knee because he scraped it when he fell, but they did not do anything else differently for him.
-He did not remember who was working on the

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day he fell.
-He went to the hospital on the next day after his family visited him and requested that he be sent out.

Interview with a medication aide (MA) on 09/15/22 at 1:33pm revealed:
-She thought Resident #1 had 2 falls, but she was not working when he fell; she did not know if Resident #1 sustained injuries from his falls.
-If a resident fell, staff was to assess the resident.
-If the resident hit his head or was bleeding, then she would call 911 and send the resident out to the hospital.
-The family was notified, the residents was assess for pain and changes once on each shift for 3 days, staff documented, the residents primary care provider (PCP) and family were notified.
-Personal care aides (PCA) checked on Residents every 2 hours and MAs checked on residents when they went to their rooms to administer medication.
-Staff checked on residents after a fall, but there were no increased scheduled checks.
-She had not been told to do anything differently for Resident #1 after he fell.
-Resident #1 had not been on any scheduled checks and she did not know of any interventions put in place for Resident #1 they she knew about.
-There had been residents in the past who were on 1 hour checks according to their needs, but Resident #1 had not been on any increased checks.
-She would have thought Resident #1 would have been appropriate for increased checks after he came back from the hospital.
-Increased checks for residents were determined by the HWC.

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Interview with the HWC on 09/15/22 at 2:57pm revealed:
-If a resident had a fall, staff should have made extra rounds to check on the resident a few extra times a shift.
-She was new to the facility and had not come across documentation of scheduled safety checks for increased supervision.
-She could not find an Incident/Accident report for Resident #1 after his fall on 08/16/22.
-The MA on duty when a resident had a fall, should have completed an Incident/Accident report.

Interview with Resident #1's primary care provider (PCP) on 09/15/22 at 4:40pm revealed:
-She had not been notified prior to 08/16/22 that Resident #1 had fallen.
-Staff notified her on 08/16/22 that Resident #1 fell twice over the weekend prior to 08/16/22, hit his head, and experienced dizziness.
-Resident #1's family member declined a visit and wanted him to be sent out to the local hospital for evaluation.

Interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am revealed:
-She did not know of Resident #1 fell twice in the month of August 2022.
-Resident #1 should have been sent out to the hospital if he hit his head.
-She expected staff to document the details of the falls and increase supervision of Resident #1.

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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

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of residents.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, record reviews, and interviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled resident (#1) related to a physician's order for a urinalysis (U/A) and a physician's order for a physical therapy (PT)/occupational therapy (OT) evaluation and treatment.

The findings are:

Review of Resident #1's current FL2 dated 04/05/22 revealed diagnoses included moderate protein calorie malnutrition, anemia, type 2 diabetes, hyperlipidemia, hyponatremia, myocardial infarction, and generalized anxiety.

a. Review of Resident #1's physician's order sheet revealed:
-The previous Health and Wellness Director (HWD) completed the physician's order sheet on 07/10/22.
-There was documentation Resident #1 complained of frequent urination, but there was no laboratory work.
-Urinalysis was documented in the new order section of the form.
-The form was not signed or dated by the physician.

Review of Resident #1's Primary Care Provider's (PCP) encounter note dated 07/26/22 revealed:
-The visit on 07/26/22 was a new patient visit and to establish care as his PCP.
-Resident #1 reported some increased urination.
-There was an order to collect a urine sample for

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a urinalysis (U/A)

Review of the 24-hour shift reports revealed there was no documentation a urinalysis was ordered, or urine was collected on or after 07/26/22 for Resident #1.

Review of Resident #1's record revealed there were no U/A results from the facility contracted laboratory.

Interview with a representative from the facility's contracted laboratory on 09/15/22 at 10:02am revealed they did not receive an order for a urinalysis dated 07/26/22.

Review of Resident #1's progress notes dated 08/16/22 at 12:18pm revealed:
-The progress note was written by the facility's previous nurse.
-Resident #1's family requested that he be seen in the emergency room for change in cognition and heart palpitations.
-Resident #1 was seen by his PCP the morning of 08/16/22 and she ordered a U/A to rule out a urinary tract infection (UTI), but Resident #1's family did not want to wait for the results of the U/A as Resident #1 was not feeling well.
-Resident #1 complained of heart palpitations, headache, and dizziness.
-Resident #1's PCP was notified of his transport to the emergency room.

Review of Resident #1's progress noted dated 08/16/22 at 12:59pm revealed:
-Resident #1's family members notified staff that he was not at his baseline.
-Resident #1 stated he had a headache for 2 days, was confused when he hit his head, had heart palpitations, and had trouble walking.

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-Resident #1's PCP wrote an order for a U/A on 08/16/22, but his family insisted he be sent out to the local hospital for evaluation.

Review of Resident #1's local hospital report dated 08/26/22 revealed:
-Resident #1 was admitted to the hospital on 08/16/22 with the chief complaint of altered mental status, fall, and head injury.
-Resident #1 presented to the emergency room with complaints of altered mental status, palpitations, and lower extremity swelling that started on 08/12/22 after a fall.
-Resident #1's family member reported he was using the bathroom and he stated he "fell asleep" and woke up on the floor.
-Resident #1 fell again on Sunday, 08/14/22 and was found on the floor by a facility staff.
-Resident #1's family member noticed some confusion and slurred speech while on the phone with him.
-Resident #1 complained of lightheadedness, dizziness, and tremors.
-Resident #1 had a U/A completed and he tested positive for urine nitrite and a urine white blood cell (WBC) count of 12.
-Resident #1's urine showed some abnormalities possibly related to infection.
-One of Resident #1's discharge diagnosis was a UTI with klebsiella pneumonia (bacteria).

Interview with the medication aide (MA) who documented the progress note on 08/16/22 at 12:59pm on 09/16/22 at 9:05am revealed:
-She came into work on 08/16/22 towards lunch time.
-Resident #1's family was in the facility when she got there, and they were telling her he was not himself.
-The Health and Wellness Coordinator (HWC) at

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D 273	Continued From page 17 the time requested a order for a U/A from Resident #1's PCP and she told the family. -Resident #1's family wanted him to be sent to the hospital because the U/A could be completed quicker there. -She had not seen any difference in Resident #1's level of functioning prior to him being sent out to the hospital on 08/16/22. Interview with Resident #1 on 09/15/22 at 11:21am revealed: -He fell a couple of weeks ago and hit his head. -Staff found him in his room and helped him up off the floor. -He did not remember what happened, but staff did not send him out to the hospital after his fall. -Staff put a bandage on his knee because he scraped it when he fell, but they did not do anything else differently for him. -He did not remember who was working on the day he fell or who helped him off the floor. -He went to the hospital on the next day after his family visited him and requested that he be sent out. -He was diagnosed with coronary issues and he thought he had a UTI and was treated with antibiotics. -He had urine collected at the hospital, but staff at the facility had never collected urine from him. Interview with a medication aide (MA) on 09/15/22 at 1:33pm revealed: -MAs were responsible for following through with orders for a urinalysis. -She did not know about any orders to collect a sample for a urinalysis for Resident #1. -If she had known about the order, she would have collected a urine sample and called the laboratory for a pick. -Laboratory results were faxed back to the facility,	D 273		

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and she placed the results in residents' records; laboratory results were also sent to the PCP.
-If the results were not received from the laboratory, she would have called to see why the results were not faxed.
-She had not noticed any changes in Resident #1's cognitive or physical functioning prior to him going to the hospital on 08/16/22.

Interview with a MA on 09/15/22 at 2:37pm revealed:
-MAs were responsible for following up on medication and treatment orders.
-The HWC was responsible for following up with any orders for outside providers.
-She did not know about the order dated 07/26/22 for a urinalysis and she did not know if a urinalysis had been completed for Resident #1 prior to his hospitalization on 08/26/22.
-She had not noticed any changes in Resident #1's cognitive or physical functioning prior to him being admitted to the hospital on 08/16/22.

Interview with Resident #1's family member on 09/16/22 at 10:09am revealed:
-She saw Resident #1 on 08/13/22, and he appeared to be fine.
-On 08/14/22, Resident #1 told a family member that he fell in the bathroom; she thought he fell off the commode.
-She did not know if staff knew he fell..
-She and another family member visited Resident #1 on 08/16/22 and staff told her Resident #1 had a fall on 08/14/22; staff found him on the floor between his bed and the window and he was disoriented and very weak.
-Resident #1 had not been able to go to the dining room for meals since the fall on 08/14/22.
-She did not remember who the staff were, but the staff were very concerned on 08/16/22.

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-When she saw him on 08/16/22, he was extremely different than when she saw him on 08/13/22; he had edema in his legs, he did not have any strength, he kept saying he needed to lay down, and he fell back into his bed.
-On 08/16/22, Resident #1 was talking, but he was somewhat confused.
-The family made the decision that Resident #1 needed to go to the hospital to be evaluated.
-Resident #1 had ongoing issues with frequent urination and was diagnosed with a UTI in the hospital.
-She did not know there was an order for a urinalysis on 07/26/22.

Interview with the HWC on 09/16/22 at 2:56pm revealed:
-She and the MAs were responsible for reviewing physician's orders and processing them.
-She had worked at the facility for less than 2 weeks and was not aware of the physician's order dated 07/26/22 for Resident #1 to collect a urine sample to have a U/A completed.
-She knew, through reading progress notes, there had been an order to collect a urine sample on 08/16/22, but Resident #1's family opted to have him sent to the hospital instead of collecting the sample.
-A new order tracking sheet should have been completed for Resident #1.
-She had not found a tracking sheet for the order to collect a urine sample for a U/A dated 07/26/22.

Interview with Resident #1's primary care provider (PCP) on 09/15/22 at 4:40pm revealed:
-She saw Resident #1 for a new patient evaluation on 07/26/22.
-Resident #1 had a history of urinary retention and reported to her during the visit that he was

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having increased urination.
-She ordered a urinalysis to rule out a UTI.
-She would have expected the facility to follow through with the order to collect a urine sample and to send it to the laboratory for testing.
-An untreated UTI could have caused infection or sepsis.

Interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am revealed:
-MAs and HWC were responsible for reviewing orders and following the order through to completion.
-The HWC was responsible for ensuring physician's orders were in place.
-She did not know about the order dated 07/26/22 for Resident #1 to collect a urine sample.

b. Review of Resident #1's Primary Care Provider's (PCP) encounter note dated 07/26/22 revealed:
-The visit on 07/26/22 was a new patient visit and to establish care as his PCP.
-To restore function, physical therapy (PT)/occupational therapy (OT) services were ordered to evaluate and treat Resident #1's decline in function and mobility secondary to primary osteoarthritis of multiple joints.
-It was the PCP's judgment that there was a reasonable expectation that Resident #1 would demonstrate improved function as a result of PT/OT services over the next few months.

Interview with Resident #1 on 09/15/22 at 11:21am revealed he did not remember if he received PT or OT prior to going to the hospital in August 2022.

Interview with a representative from Resident #1's home health agency on 09/15/22 at 10:33am

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D 273	Continued From page 21 revealed: -There was not an order for PT dated 07/26/22. -There was not an order for OT dated 07/26/22. -The home health agency received an order dated 08/26/22 for PT from the hospital. -A physical therapist made a referral for OT on 09/08/22 due to Resident #1's decline in the ability to perform activities of daily living. -Resident #1 received a one-time OT visit on 09/08/22 for evaluation and no other OT services were needed. Interview with a medication aide (MA) on 09/15/22 at 1:33pm revealed: -MAs were responsible for reviewing new orders and the primary care provider's progress notes for orders and for following up with orders. -New orders were placed in the computer for tracking and on the white board in health and wellness room as a reminder. -The Health and Wellness Coordinator (HWC) was responsible for following up to ensure the orders had been completed. -She was not aware of the order for PT and OT dated 07/26/22. -Resident #1 did not have PT or OT prior to going to the hospital on 08/26/22. Interview with a MA on 09/15/22 at 2:37pm revealed: -MAs were responsible for following up on medication and treatment orders. -The HWC was responsible for following up with any orders for outside providers. -She did not remember seeing an order for PT/OT for Resident #1 dated 07/26/22. -Resident #1 did not have PT/OT prior to his hospitalization on 08/26/22. Interview with the HWC on 09/16/22 at 2:56pm	D 273		

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revealed:
-She and the MAs were responsible for reviewing physician's orders and processing them.
-She had was not aware of the physician's order dated 07/26/22 for Resident #1 to have a PT/OT evaluation and treatment.
-A new order tracking sheet should have been completed for Resident #1.
-She had not found any for the order for PT/OT dated 07/216/22.

Interview with Resident #1's PCP on 09/15/22 at 4:40pm revealed:
-She saw Resident #1 for a new patient evaluation on 07/26/22.
-She wrote an order on 07/26/22 for a PT/OT to evaluate and treat due to a diagnosis of osteoarthritis and a decline in mobility.
-She sent the order for PT/OT to the facility's contracted home health provider, but she expected the facility to follow up with the home health provider if no one showed up to evaluate Resident #1.

Interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am revealed:
-MAs and the HWC were responsible for reviewing orders and following the order through to completion.
-The HWC was responsible for ensuring physician's orders were in place.
-She did not know about the order dated 07/26/22 for Resident #1 to have a PT/OT evaluation and treatment.

____

The facility failed to follow up on acute health care needs and coordinated referrals for 1 of 5 sampled residents (#1) who had a history of urinary frequency with a physician's orders for a U/A which was not completed and had a

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hospitalization with diagnoses that included a UTI which could have resulted in infection and sepsis; and the resident had physician's orders for PT/OT due to osteoarthritis and a decline in mobility which were not followed up on. This failure resulted in substantial risk of serious physical harm and neglect to the residents and constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15//22.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.

D 276 10A NCAC 13F .0902(c)(3-4) Health Care D 276

10A NCAC 13F .0902 Health Care
(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure physicians' orders were implemented for 4 of 5 (#1, #3, #4, and #5) sampled residents, including an order for Thromboembolism-deterrent (TED) hose (#1 and #3), an order to check weekly blood pressures (#5), and assiting with turning on and putting hearing aids on in the morning and removing and charging in the evening (#4).

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The findings are:

1. Review of Resident #3's current FL2 dated 08/30/22 revealed diagnoses included diabetes, hypertension, polyneuropathy and osteoporosis.

Review of a signed physician's order dated 09/06/22 revealed an order for TED hose, apply in the morning and remove in the evening.

Interview with Resident #3 on 09/15/22 at 1:50pm revealed:
-She thought it had been about one week since her primary care provider (PCP) ordered TED hose for her.
-She did not have any TED hose.
-Her legs were not measured for TED hose sizing by staff.
-Her feet were swollen and had been that way for one or two weeks.
-Her PCP was aware her feet were swollen and that was the reason the PCP had ordered TED hose.

Observation of Resident #3 in her room on 09/15/22 at 1:55pm revealed she was not wearing TED hose.

Review of Resident #3's September 2022 electronic medication administration record (eMAR) revealed there was documentation in the eMAR notes on 09/14/22 at 6:11am that "Resident said she doesn't have any TED hose."

Interview with a first shift medication aide (MA) on 09/15/22 at 2:40pm revealed:
-She was not aware Resident #3 had an order for TED hose.
-She was not sure if Resident #3 had TED hose on.

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-The third shift MAs normally helped residents put TED hose on.
-She was not sure if anyone had contacted the pharmacy regarding Resident #3's TED hose because the facility was having issues with their fax machine.
-MAs were supposed to contact the pharmacy if a resident had an order for TED hose and the resident did not have any TED hose.

Interview with a second shift MA on 09/15/22 at 4:40pm revealed:
-She was aware Resident #3 had an order for TED hose.
-She was not sure if anyone had ordered TED hose from the pharmacy for Resident #3.
-She was not sure if TED hose were available in the facility for Resident #3.

Interview with the facility's contracted pharmacy on 09/15/22 at 3:20pm revealed that there was no order on file with the pharmacy for Resident #3's TED hose.

Telephone interview with Resident #3's primary care provider (PCP) on 09/15/22 at 5:04pm revealed:
-She wrote an order for TED hose for Resident #3 on 09/06/22.
-She was aware Resident #3's feet were swollen.
-She was not aware that Resident #3 did not have TED hose.
-She expected the facility to have implemented the TED hose order within one week of when the order was written.

Interview with the Health and Wellness Coordinator (HWC) on 09/16/22 at 8:30am revealed:
-She was not aware Resident #3 had an order for

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TED hose until 09/15/22.
-MAs and the HWC were responsible for measuring for TED hose sizing and contacting the pharmacy to order TED hose.
-Both MAs and the HWC were responsible for implementing the TED hose order for Resident #3.

Interview with the Associate Executive Director on 09/16/22 at 11:36am revealed:
-She was not aware Resident #3 had an order for TED hose.
-She was not aware Resident #3 was not wearing the TED hose on 09/15/22 during the day.
-Both MAs and the HWC were responsible for implementing orders.
-Both MAs and the HWC were responsible for measuring for appropriate TED hose size for Resident #3.
-She expected MAs to implement the TED hose order and for the HWC to follow up to ensure the order was implemented.

2) Review of Resident #5's current FL2 dated 08/19/22 revealed:
-Diagnoses included hypertension, chronic diastolic congestive heart failure, and end stage renal disease.
-There was an order to check blood pressure (BP) weekly.

Review of the facility's electronic documentation system on 09/16/22 at 3:32pm revealed:
-There was documentation Resident #5's BP was checked on 08/26/22, 08/27/22 and twice on 08/28/22.
-Resident #5's BP values were 130/64 on 08/26/22, 136/72 on 08/27/22, and 130/68 as well as 128/70 on 08/28/22.
-There was no documentation of BP values

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D 276	Continued From page 27 available for Resident #5 after 08/28/22. Review of Resident #5's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for move-in and monthly vital signs for evening shift on the 3rd of every month. -There was documentation Resident #5 was on a leave of absence on 09/03/22. -There was no documentation Resident #5's BP was checked in September 2022. Interview with Resident #5 on 09/16/22 at 10:38am revealed she thought her BP had not been checked since she was admitted to the facility a few weeks ago. Interview with a second shift medication aide (MA) on 09/16/22 at 3:14pm revealed: -BP documentation was normally kept inside the residents' records and documented on the eMAR. -She was not aware Resident #5 had an order to check BP weekly. -MAs were responsible to check BPs on the residents. -She had not checked BP weekly for Resident #5. -She thought it was standard procedure to check all the residents' BPs monthly. Interview with the Health and Wellness Coordinator (HWC) on 09/16/22 at 3:30pm revealed: -If a resident had an order for a weekly BP check, it should be documented on the eMAR. -She was not aware Resident #5 had an order to check BP weekly. -MAs normally checked BPs on residents. -Resident #5's BP was checked for three days after she was admitted on 08/26/22, 08/27/22 and 08/28/22.	D 276		

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Interview with the Associate Executive Director on 09/16/22 at 4:00pm revealed:
-She was not aware Resident #5 had an order to check BP weekly.
-MAs normally checked the residents' BPs.
-MAs were responsible for implementing a new order to check BP weekly.
-The HWC was responsible to follow up with the MAs to ensure that the order to check BP weekly was implemented.
-She expected the order to check Resident #5's BP weekly to have been implemented.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 09/16/22 at 9:48am unsuccessful.

3. Review of Resident #1's current FL2 dated 04/05/22 revealed:
-Diagnosis included moderate protein calorie malnutrition, anemia, type 2 diabetes, hyperlipidemia, hyponatremia, myocardial infarction, and generalized anxiety.
-Resident #1 was ambulatory.

Review of Resident #1's physician's order dated 08/30/22 revealed an order for thromboembolism-deterrent (TED) hose on in the morning and remove at bedtime.

Review of Resident #1's electronic Medication Administration Record (eMAR) for 08/30/22 through 08/31/22 revealed:
-There was an entry for TED hose apply in the morning scheduled for 8:00am.
-There was documentation TED hose were not applied for 2 of 2 opportunities between 08/30/22 and 08/31/22 due to new order, waiting for TED hose to come from pharmacy.

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-There was an entry for TED hose remove at bedtime scheduled for 8:00pm.
-There was documentation TED hose were removed for 2 of 2 opportunities between 08/30/22 and 08/31/22.

Review of Resident #1's eMAR for 09/01/22 through 09/16/22 revealed:
-There was an entry for TED hose apply in the morning scheduled for 8:00am.
-There was documentation TED hose were not applied for 5 of 16 opportunities between 09/01/22 and 09/16/22 due to waiting on the pharmacy on 09/01/22, 09/02/22, and 09/03/22, out of facility on 09/12/22, and reordered from pharmacy on 09/15/22.
-There was an entry for TED hose remove at bedtime scheduled for 8:00pm.
-There was documentation TED hose were removed for 14 of 15 opportunities between 09/01/22 and 09/15/22.

Interview with a representative from the facility's contracted pharmacy on 09/15/22 at 3:30pm revealed:
-The facility sent an order to the pharmacy for TED hose dated 08/30/22.
-The pharmacy sent a request form for measurements on 08/30/22, but the measurement form was not received back from the facility.
-A MA from the facility called the pharmacy on 09/03/22 with measurements for TED hose and the TED hose were sent out to the facility on the night of 09/03/22.
-Someone from the facility called the pharmacy today on 09/15/22 to reorder the TED hose and they would be delivered the evening of 09/15/22.

Observation of Resident #1 on 09/14/22 at

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8:55am revealed:
-Resident #1 was seated his recliner in his room with his feet on the floor.
-Resident #1 was barefooted and there was swelling in his right and left feet with more significant swelling in his right foot.
-The resident was not wearing TED hose.

Observation of Resident #1 on 09/14/22 at 1:02pm revealed Resident #1 did not have TED hose on.

Observation of Resident #1's room on 09/15/22 at 11:20am revealed:
-Resident #1 was seated in his recliner and did not have TED hose on.
-Resident #1's TED hose were laying on his bed; one of the TED hose had a rip from the top to about midway on the hose.
-There were no defects with the other TED hose.

Interview with Resident #1 on 09/15/22 at 11:21am revealed:
-Staff came to his room after he ate his breakfast on 09/15/22 to apply his TED hose, but one of the TED hose had a rip in it.
-His TED hose had not been applied in several days, but he was not sure how many days.

Interview with a medication aide (MA) on 09/15/22 at 1:33pm revealed:
-She had sent the original order for Resident #1's TED hose and called the pharmacy to give them measurements on 09/01/22 and they were delivered to the facility on 09/03/22.
-She attempted to put Resident #1's TED hose on after he ate breakfast on 09/15/22, but she was not able to put them on because one of the Ted hose had a tear in it.
-She contacted the pharmacy to reorder a new

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pair of TED hose.
-She did not put the one good TED hose on Resident #1 because the resident did not want the TED hose on just one leg.

Interview with a MA on 09/15/22 at 2:37pm revealed:
-Third shift usually put on Resident #1's TED hose and first shift documented they were on because the TED hose popped up in the eMAR system at 8:00am during first shift.; second shift removed them.
-She thought she last saw Resident #1 with TED hose on when she last worked on 09/13/22.

Interview with a MA on 09/16/22 at 9:05am revealed:
-Resident #1 had TED hose which were to be applied in the in the morning and removed at bedtime.
-Third shift put Resident #1's TED hose on and first shift documented the TED hose were on.
-She documented Resident #1's TED hose were on the last time she worked on 09/09/22, but she did not remember if they had been applied by third shift.
-She usually checked to see Resident #1's TED hose were applied, but she did not check every time before documenting.

Interview with a MA on 09/16/22 at 9:30am revealed:
-Third shift usually applied Resident #1's TED hose and first shift documented they were applied.
-The third shift MA told her the TED hose were applied before she documented, but she did not check to see if the TED hose had actually been applied.

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Interview with the Health and Wellness Coordinator (HWC) on 09/16/22 at 2:56pm revealed:
-She did not know Resident #1's TED hose had not been applied and removed daily as ordered.
-Staff told her on 09/15/22 that Resident #1's TED hose were ripped and that new TED hose had to be ordered.
-Third shift had been applying Resident #1's TED hose when he got ready in the morning and first shift documented, but the times could be changed so that third shift documented.
-She expected the first shift MA to check to make sure Resident #1's TED hose had been applied before documenting they had been applied.

Interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am revealed:
-She did not know Resident #1's TED hose had not been applied and removed daily as ordered.
-She did not know third shift staff were applying the TED hose and first shift was documenting.
-If the third shift MAs were applying Resident #1's TED hose, they should have been documenting they were applied.
-She would have expected first shift staff to make sure Resident #1's TED hose had been applied.

Attempted telephone interview with Resident #1's primary care physician on 09/16/22 at 9:48am was unsuccessful.

4. Review of Resident #4's current FL-2 dated 08/30/22 revealed:
-Diagnosis included dementia, hearing loss, hypertension, hyperlipidemia, anemia, major depression , insomnia and gastroesophageal reflux disease (GERD).
-Functional limitations included hearing.

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D 276	Continued From page 33 Review of Resident #4's physicians orders dated 05/10/22 revealed: -There was an order to assist resident with turning on hearing aids and putting hearing aids on in the morning. -There was an order to assist resident with removing hearing aids and placing them on the charging station in the evenings. Review of Resident #4's personal care plan dated 05/18/22 revealed under dressing and grooming resident was listed as using a hearing device for both ears. Review of Resident #4's most current Licensed Health Professional Support (LHPS) assessment dated 03/10/22 revealed: -Under LHPS personnel care task provided hearing aids was listed -Staff competency validated was checked off as yes for compliance. Review of Resident #4's LHPS assessment dated 04/26/21 revealed: -Under LHPS personnel care task provided insert and removal of hearing aids was listed -Staff competency validated was checked off as yes for compliance. Review of Resident #4's electronic medication administration record (eMAR) for July 2022 revealed: -There was an order to assist resident with putting hearing aids in and turning on in the morning scheduled at 10:00am. -There was documentation Resident #4 refused to wear her hearing aids 17 of 31 opportunities from 07/01/22 to 07/31/22. -There was an order to place Resident #4's hearing aids in the charger and verify charging at	D 276		

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bedtime scheduled at 8:00pm.
-There was documentation Resident #4 did not have her hearing aids in on 14 of 31 opportunities from 07/01/22 to 07/31/22.

Review of Resident #4's progress notes for July 2022 revealed:
-There was documentation Resident #4 refused to wear her hearing aids on 17 dates in July 2022.
-There was documentation Resident #4's hearing aids were turned on and she was assisted with putting them in on 07/02/22 to 07/04/22, 07/08/22, 07/22/22 and 07/26/22; there was documentation Resident #4 was not wearing her hearing aids in the evening on these dates.

Review of Resident #4's eMAR for August 2022 revealed:
-There was an order to assist resident with putting hearing aids in and turning on in the morning scheduled at 10:00am.
-There was documentation Resident #4 refused to wear her hearing aids 17 of 31 opportunities from 08/01/22 to 08/31/22.
-There was an order to place Resident #4's hearing aids in the charger and verify charging at bedtime scheduled at 8:00pm.
-There was documentation Resident #4 did not have her hearing aids in on 5 of 31 opportunities in the evening to place in the charger from 08/01/22 to 08/31/22.

Review of Resident #4's progress notes for August 2022 revealed:
-There was documentation Resident #4 refused to wear her hearing aids on 17 dates in August 2022.
-On 08/23/22, there was documentation at 8:00pm, Resident #4 stated the charger for her hearing aids was lost.

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-On 08/24/22, there was documentation at 8:00pm, Resident #4 stated she lost them [hearing aids] a week ago and reported it to the staff.
-On 08/25/22, there was documentation at 8:00pm Resident #4 stated the charger for the hearing aids was lost.
-On 08/31/22, there was documentation at 9:00pm Resident #4 stated the charger [for her hearing aids] was missing.

Review of Resident #4's eMAR for September 2022 revealed:
-There was an order to assist resident with putting hearing aids in and turning on in the morning scheduled at 10:00am.
-There was documentation Resident #4 refused to wear her hearing aids 8 of 16 opportunities from 09/01/22 to 09/16/22.
-On 09/13/22, and 09/16/22 there was documentation to see progress notes for the morning application.
-There was an order to place Resident #4's hearing aids in the charger and verify charging at bedtime scheduled at 8:00pm.
-There was documentation in the evening at removal time to see Resident #4's progress notes five times.

Review of Resident #4's progress notes for September 2022 revealed:
-On 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, 9/12/22, and 09/15/22 there was documentation Resident #4 refused to wear her hearing aids.
-On 09/13/22, there was documentation at 9:10am, Resident #4's hearing aids could not be found.
-On 09/13/22, there was documentation at 8:00pm Resident #4 was not wearing her hearing

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D 276	Continued From page 36 aids. -On 09/02/22, 09/09/22, 09/12/22, and 09/14/22, there was documentation from 8:00pm to 10:00pm, Resident #4 stated the charger for her hearing aids was lost. Observation of Resident #4 on 09/15/22 at 4:29pm revealed: -She did not have her hearing aids in her ears. -She leaned forward and asked for the person speaking to speak into her right ear. Observation of Resident #4's room on 09/15/22 at 4:31pm revealed her room was very cluttered including the nightstand; the charger and her hearing aids were not on the nightstand. Interview with Resident #4 on 09/15/22 at 4:31pm revealed: -She had hearing loss in her right ear; she heard better in her left ear. -She did not know how long her hearing aids had been lost; the charger and the hearing aids were missing. -The charger for her hearing aids was always kept on her nightstand; the hearing aids should be in the charger in the morning when she was ready to put them on. -Other residents came into her room and took her belongings and she thought someone took the charger with the hearing aids. -She did have difficulty hearing, but she would just ask people to repeat what they said if she could not understand them. -If people spoke in different tones, she could understand them better. -She did not complain about the missing hearing aids and she did not know if the staff knew about them.	D 276		

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Telephone interview with Resident #4's primary care provider (PCP) on 09/15/22 at 5:02pm revealed:
-She had not been told about Resident #4 not having or wearing her hearing aids.
-Resident #4 had not complained about not having her hearing aids in or about losing them.
-She would be concerned the resident would not be able to hear and it would contribute to some of her confusion.
-Resident #4 had an order to have her hearing aids placed in her ears and removed each day.
-She expected the facility to follow her orders for Resident #4 as they were written; including her hearing aids.

Interview with a personal care aide (PCA) on 09/16/22 at 10:37am revealed:
-Resident #4 had hearing aids but she had not wanted them on in a while.
-Resident #4 complained about her hearing aids and did not want to wear them.
-Resident #4 said they were too loud and made too much noise when she wore them.
-She knew Resident #4's hearing aides were also lost.
-She did not know the last time Resident #4 had her hearing aids available to wear.
-Resident #4 had not complained about not wearing her hearing aids.
-She had not told anyone about Resident #4 not wearing her hearing aids because she did not want to wear them.

Interview with a second PCA/medication aide (MA) on 09/16/22 at 10:43am revealed:
-Resident #4's hearing aids were supposed to be placed in her ears each morning by 10:00am.
-The last time she saw them was Tuesday, 09/13/22, but today, 09/16/22 she could not find

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them.
-Resident #4 could not tell her were her hearing aids were.
-She documented on the eMAR that she could not find Resident #4's hearing aids.
-She reported to the new Health and Wellness Coordinator (HWC) that she could not find the hearing aids.
-She reported the lost hearing aids to the HWC on Tuesday and today.
-She verbally told the HWC; the HWC did not respond.
-Resident #4 did not know where the hearing aids were either.

Interview with a second MA on 09/16/22 at 3:59pm revealed:
-She worked second shift.
-She would remove Resident #4's hearing aids but the resident had not had them in a while.
-She would document on the eMAR when Resident #4 was not wearing the hearing aids.
-The HWC was new so she had not reported the missing hearing aids to her.
-Resident #4 said someone took the hearing aids out of her room.
-Resident #4's hearing aids were most likely in her room somewhere if she looked for them.
-If Resident #4 would clean her room she would probably find them.
-Resident #4 had not complained to her about not being able to hear or understand anyone.

Interview with the HWC on 09/16/22 at 4:20pm revealed:
-She had only worked at the facility for one week.
-She was a Licensed Practical Nurse (LPN).
-She was not aware Resident #4 had hearing aids or an order to wear them every day.
-The MAs were responsible for placing the

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hearing aids in Resident #4's ears each morning and removing them in the evening and placing them in the charger to charge once removed.
-Resident #4 should be checked throughout the day to ensure they were still in her ears.
-If Resident #4 was having issues with locating her hearing aids after they were removed then they should have been placed in the medication room each evening to charge them.
-If Resident #4 refused to wear the hearing aids then it should have been documented and brought to her attention.
-She was concerned Resident #4 did not have her hearing aids to wear because she had hearing loss.
-The PCP ordered them for a reason and would not discontinue an order for hearing aids.
-She was concerned staff had not let her know Resident #4 did not have her hearing aids to wear.

Interview with the Assistant Executive Director (AED) on 09/16/22 at 5:21pm revealed:
-She had only been at the facility for a couple of weeks.
-She did not know much about Resident #4.
-Resident #4 should have her hearing aids placed in her ears first thing in the morning if she had an order for them.
-Resident #4 should be checked during the day to ensure she still had them in her ears.
-If Resident #4 did not have her hearing aids then the staff should have notified the PCP after looking for them.
-If there was a problem with losing them over night then they should be charged in the medication room.
-Resident #4 had not complained to her about noise or frequency; she could have them adjusted.

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D 276	Continued From page 40 -Staff should report refusals and or lost hearing aids to the HWC. -She was concerned Resident #4 could not hear well without the hearing aids. Attempted interview with Resident #4's power of attorney (POA) on 09/16/22 at 11:32am was unsuccessful.	D 276		
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. 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 food service guidance for 4 of 4 sampled residents (#1, #2, #6 and #7) with physician's orders for a no added salt (NAS) diet (#1), a carbohydrate controlled diet (#2), a 2-gram sodium diet (#6), and a texture modified diet (#7). The findings are 1. Review of Resident #1's current FL2 dated 04/05/22 revealed: -Diagnosis included moderate protein calorie malnutrition, anemia, type 2 diabetes, hyperlipidemia, hyponatremia, myocardial infarction, and generalized anxiety.	D 296		

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-There was an order for a no added salt (NAS) diet.

Review of Resident #1's physician's diet order dated 07/25/22 revealed an order for a NAS diet.

Observation of the kitchen on 09/14/22 at 10:30am revealed:
-There was not a therapeutic diet list posted in the kitchen.
-There was a notebook on a table in the back corner of the kitchen that had a diet order report dated 08/29/22.
-Resident #1 was listed on the diet type report to receive a NAS diet.
-There were no therapeutic menus available for review.

Observation of the dining hall on 09/14/22 at 10:36am revealed there was a menu for regular diets posted on the wall for 07/13/22 through 07/16/22.

Observation of the lunch meal service on 09/14/22 at 1:05pm revealed:
-Resident #1 was served chicken tenders, 1 slice of bread, diced potatoes, mixed vegetables, tea, and water.
-It could not be determined if Resident #1 was served the appropriate diet due to a NAS menu was not available for food service staff guidance.

Observation of the breakfast meal service on 09/15/22 at 9:19pm revealed:
-Resident #1 was served sausage, eggs, grits, with butter, eggs, a biscuit and jelly, and water.
-It could not be determined if Resident #1 was served the appropriate diet due to a NAS menu was not available for food service staff guidance.

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D 296	Continued From page 42 Interview with Resident #1 on 09/15/22 at 11:21am revealed: -He was not on a special diet. -He received the same foods as the other residents. -He was told by his former primary care physician (PCP) prior to being admitted to the facility that he should not have salt. -He had not been told, since he was admitted to the facility on 04/08/22, that he should have been on a no added salt diet. Interview with Resident #1's primary care provider (PCP) on 09/15/22 at 4:40pm revealed: -She did not know Resident #1 was not being served according to a menu for a NAS diet as ordered. -She expected the facility should have a NAS menu for guidance. -If Resident #1 was not served a NAS diet as ordered, it could increase his risk of congestive heart failure (CHF), high blood pressure, and increased fluid. Attempted interview with the Dietary Manager on 09/14/22 at 10:40 was unsuccessful. Refer to Interview with the cook on 09/14/22 at 10:41am. Refer to interview with a personal care aide (PCA) on 09/14/22 at 1:12pm. Refer to second interview with the cook on 09/14/22 at 4:40pm. Refer to interview with a second cook on 09/15/22 at 8:02am. Refer to second interview with the second cook	D 296		

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D 296	Continued From page 43 on 09/15/22 at 2:10pm. Refer to interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am. 2. Review of Resident #2's current FL2 dated 08/03/22 revealed: -Diagnoses included essential hypertension, chronic kidney disease, heart failure, type 2 diabetes mellitus, and hyperlipidemia. -There was an order for a carbohydrate-controlled diet. Observation of the kitchen on 09/14/22 at 10:30am revealed: -There was not a therapeutic diet list posted in the kitchen. -There was a notebook on a table in the back corner of the kitchen that had a diet order report dated 08/29/22. -Resident #2 was listed on the diet type report to receive a carbohydrate-controlled diet. -There were no therapeutic menus available for review. Observation of the dining hall on 09/14/22 at 10:36am revealed there was a menu for regular diets posted on the wall for 07/13/22 through 07/16/22. Observation of the lunch meal service on 09/14/22 at 1:05pm revealed: -Resident #2 was served chicken tenders, 1 slice of bread, diced potatoes, mixed vegetables, tea, and water. -It could not be determined if Resident #2 was served the appropriate diet due to carbohydrate-controlled diet menu was not available for food service staff guidance.	D 296		

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Observation of the breakfast meal service on 09/15/22 at 9:19pm revealed:
-Resident #2 was served sausage, eggs, grits, with butter, eggs, a biscuit, sugar free jelly, and water.
-It could not be determined if Resident #2 was served the appropriate diet due to a carbohydrate-controlled diet menu was not available for food service staff guidance.

Interview with Resident #2 on 09/16/22 at 9:30am revealed he was not on a special diet and was served regular foods.

Attempted interview with the Dietary Manager on 09/14/22 at 10:40 was unsuccessful.

Attempted interview with Resident #2's primary care provider (PCP) on 09/15/22 at 4:24pm was unsuccessful.

Refer to Interview with the cook on 09/14/22 at 10:41am.

Refer to interview with a personal care aide (PCA) on 09/14/22 at 1:12pm.

Refer to second interview with the cook on 09/14/22 at 4:40pm.

Refer to interview with a second cook on 09/15/22 at 8:02am.

Refer to second interview with the second cook on 09/15/22 at 2:10pm.

Refer to interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am.

3. Review of Resident #6's current FL2 dated

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D 296	Continued From page 45 07/22/22 revealed: -Diagnoses included Alzheimer disease, coronary artery disease, hyperlipidemia, hypertension, fatty liver, and iron deficiency anemia. -There was an order for a regular diet. Review of Resident #6's diet order dated 08/02/22 revealed an order for a 2-gram sodium diet. Observation of the kitchen on 09/14/22 at 10:30am revealed: -There was not a therapeutic diet list posted in the kitchen. -There was a notebook on a table in the back corner of the kitchen that had a diet order report dated 08/29/22. -Resident #6 was listed on the diet type report to receive a 2-gram sodium diet. -There were no therapeutic menus available for review. Observation of the dining hall on 09/14/22 at 10:36am revealed there was a menu for regular diets posted on the wall for 07/13/22 through 07/16/22. Observation of the lunch meal service on 09/14/22 at 1:05pm revealed: -Resident #6 was served chicken tenders, 1 slice of bread, diced potatoes, mixed vegetables, tea, and water. -It could not be determined if Resident #6 was served the appropriate diet due to a 2-gram sodium diet menu was not available for food service staff guidance. Observation of the breakfast meal service on 09/15/22 at 9:19pm revealed: -Resident #6 was served sausage, eggs, grits,	D 296		

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with butter, eggs, a biscuit, sugar free jelly, and water.
-It could not be determined if Resident #6 was served the appropriate diet due to a 2-gram sodium diet menu was not available for food service staff guidance.

Interview with Resident #6 on 09/16/22 at 9:55am revealed:
-He had cardiac issues, but he was not on a special diet.
-No one told him he was supposed to be on a 2-gram sodium diet, but the facility served him food with no salt.
-His blood pressure was okay because he was taking medication and watching his salt intake.
-He was served the same meals as everyone else was served.

Interview with a nurse from Resident #6's primary care provider's (PCP) office on 09/16/22 at 10:55am revealed:
-Resident #6 should have been served a 2-gram sodium diet.
-The PCP did not know Resident #6 had not been served a 2-gram sodium diet according to a 2-gram sodium diet menu.
-If Resident #6 had not been served a 2-gram sodium diet, he should start now.

Attempted interview with the dietary manager on 09/14/22 at 10:40 was unsuccessful.

Refer to Interview with the cook on 09/14/22 at 10:41am.

Refer to interview with a personal care aide (PCA) on 09/14/22 at 1:12pm.

Refer to second interview with the cook on

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09/14/22 at 4:40pm.

Refer to interview with a second cook on 09/15/22 at 8:02am.

Refer to second interview with the second cook on 09/15/22 at 2:10pm.

Refer to interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am.

4. Review of Resident #7's current FL2 dated 12/13/21 revealed:
-Diagnoses included dementia, Alzheimer disease, hyperlipidemia, cardiomegaly, hypertension, and osteoarthritis.
-There was an order for a mechanical soft diet.

Review of Resident #7's physician's diet order dated 07/26/22 revealed an order for a texture modified diet.

Observation of the kitchen on 09/14/22 at 10:30am revealed:
-There was not a therapeutic diet list posted in the kitchen.
-There was a notebook on a table in the back corner of the kitchen that had a diet order report dated 08/29/22.
-Resident #7 was listed on the diet type report to receive a texture modified diet.
-There were no therapeutic menus available for review.

Observation of the dining hall on 09/14/22 at 10:36am revealed there was a menu for regular diets posted on the wall for 07/13/22 through 07/16/22.

Observation of the lunch meal service on

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09/14/22 at 1:05pm revealed:
-Resident #7 was served chicken tenders, 1 slice of bread, diced potatoes, mixed vegetables, tea, and water.
-It could not be determined if Resident #7 was served the appropriate diet due to a texture modified diet menu was not available for food service staff guidance.

Observation of the breakfast meal service on 09/15/22 at 9:19pm revealed:
-Resident #7 was served sausage, eggs, grits, with butter, eggs, a biscuit, sugar free jelly, and water.
-It could not be determined if Resident #7 was served the appropriate diet due to a texture modified diet menu was not available for food service staff guidance.

Interview with Resident #7 on 09/15/22 at 9:42am revealed:
-She was not on a special diet.
-She did not have any top teeth, but she had a few bottom teeth that probably needed to be removed.
-The dietary staff did not always cut up her meats.
-She usually cut them up herself.

Interview with Resident #1's primary care provider (PCP) on 09/15/22 at 4:40pm revealed:
-She did not know Resident #7 was not being served according to a menu for a texture modified diet as ordered.
-She expected the facility to have a menu for a texture modified diet for guidance.
-If Resident #1 was not served a texture modified diet as ordered, it could increase her risk of choking or aspirating.

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Attempted interview with the dietary manager on 09/14/22 at 10:40 was unsuccessful.

Refer to Interview with the cook on 09/14/22 at 10:41am.

Refer to interview with a personal care aide (PCA) on 09/14/22 at 1:12pm.

Refer to second interview with the cook on 09/14/22 at 4:40pm.

Refer to interview with a second cook on 09/15/22 at 8:02am.

Refer to second interview with the second cook on 09/15/22 at 2:10pm.

Refer to interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am.

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Interview with the cook on 09/14/22 at 10:41am revealed:
-She did not have therapeutic diet menus for guidance in preparation of meals.
-There were therapeutic diet menus in the kitchen prior to the new dietary manager starting work at the facility about a week ago.
-She did not know what happened to the menus.
-She used her memory to prepare meals for residents; she prepared meals that she had previously prepared.
-She was not sure of the different therapeutic diets offered at the facility, but there was a document that listed diet orders for each resident.
-She knew what meal items to serve each resident because she had worked at the facility for over a year.
-She was preparing chicken tenders, cubed roasted potatoes, and mixed vegetables for the

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lunch meal on 09/14/22.
-All residents were going to be served the same food items unless they requested an alternate meal.

Interview with a personal care aide (PCA) on 09/14/22 at 1:12pm revealed:
-She assisted in the dining hall during meals by serving beverages and meals.
-The cook told her which plate to give to each resident.
-All the meals were usually the same unless the resident wanted an alternative meal.

Second interview with the cook on 09/14/22 at 4:40pm revealed:
-She prepared baked flounder with poultry seasoning (no salt), beef and vegetable soup with no added seasonings, broccoli with butter, mashed potatoes with butter, and ice cream for dessert for the dinner meal on 09/14/22.
-The food items were being served to all residents although some requested sandwiches.
-She did not use a menu to prepare meals for the residents on therapeutic diets.
-She did not know what specific food items to serve to residents on therapeutic diets without looking at a therapeutic menu.

Interview with a second cook on 09/15/22 at 8:02am revealed:
-She was preparing scrambled eggs, biscuits, sausage, grits, and oatmeal for the breakfast meal on 09/15/22.
-She prepared the same meal every morning except she alternated between sausage and bacon, and between biscuits and toast.
-She did not have a therapeutic diet menu available for guidance in preparing the breakfast meal on 09/15/22 or for any other meals.

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-She always prepared each meal with a meat, vegetable, a starch, and a dessert.
-She gave diabetic residents a different dessert than she gave to residents who were not diabetic.
-She knew who was diabetic because she had worked at the facility for almost 3 years.

Second interview with the second cook on 09/15/22 at 2:10pm revealed:
-She prepared fried shrimp, steamed squash, and coleslaw seasoned with garlic and onion powder for lunch on 09/15/22.
-She did not use a menu to prepare the lunch meal on 09/15/22.
-She last used a menu to prepare meals in August 2022 and the menu did not have food items for therapeutic diets listed.
-She looked at the residents and knew what they could and could not eat.
-She did not know all the residents' diets orders or the residents who should have been served a therapeutic diet.
-The Dietary Manager was responsible for ensuring therapeutic menus were in place, but she was new to the facility and had been out of work for a few days.

Interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am revealed:
-She did not realize there were no therapeutic diet menus available until the morning of 09/15/22.
-She had just hired a new Dietary Manager and she was getting trained on how to use the menu manager.
-She was currently working on getting therapeutic diet menus in place now for the dietary staff to use as guidance in preparing meals for all residents.

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D 358	Continued From page 52	D 358		
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#8, #9) observed during the medication pass including errors with administering a medication that should be administered on an empty stomach (#8) and a multivitamin (#9). The findings are: 1. The medication error rate was 6.4% as evidenced by the observation of 2 errors out of 31 opportunities during the 8:00am medication pass on 09/15/22. a. Review of Resident #8's current FL2 dated 04/12/22 revealed: -Diagnoses included a history of cerebrovascular accident (CVA), essential hypertension and hyperlipidemia. -There was an order for nifedipine ER 60mg tablet daily (used to treat high blood pressure). Observation of the 8:00am medication pass for Resident #8 on 09/15/22 at 7:58am revealed: -The medication aide (MA) prepared Resident	D 358		

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#8's medications.
-All of Resident #8's morning medications were administered, including nifedipine ER.

Observation on 09/15/22 at 7:53am of medications on hand for Resident #8 revealed there was one nifedipine ER 60mg bubble pack medication card dispensed on 08/26/22 and there were 9 of 28 tablets that remained.

Observation of Resident #8 in the dining room on 09/15/22 at 8:08am revealed Resident #8 was eating ten minutes after he was administered nifedipine ER.

Interview with the MA observed during the 8:00am medication pass on 09/15/22 revealed:
-She was not aware Resident #8 was supposed to take nifedipine ER on an empty stomach.
-She was aware Resident #8 started eating 10 minutes after he was administered nifedipine ER.
-Resident #8 was normally administered all his morning medications, including nifedipine ER, at the same time because they were scheduled at the same time.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/22 at 11:31am revealed:
-There was an order on file for nifedipine ER 60mg take one tablet daily on an empty stomach.
-The pharmacist recommended that a medication taken on an empty stomach be administered at least 30 minutes before eating or at least 1 hour after eating.
-If nifedipine ER 60mg was not taken on an

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empty stomach, it would be less effective.
-Nifedipine ER 60mg was last filled on 08/19/22 and dispensed on 08/26/22 for a quantity of 28 tablets.
-Twenty-eight tablets of nifedipine ER 60mg was a 4 week supply.

Telephone interview with Resident #8's primary care provider (PCP) on 09/15/22 at 5:04pm revealed:
-She was not aware Resident #8's nifedipine ER was not being administered on an empty stomach.
-She would have expected the facility staff to administer medications as ordered, including nifedipine ER.
-She thought that when nifedipine ER was not administered on an empty stomach, the medication lost some effectiveness.

Interview with the Health and Wellness Coordinator (HWC) on 09/16/22 at 8:30am revealed:
-She was not aware nifedipine ER was administered right before Resident #8 started eating breakfast on 09/15/22.
-MAs were responsible to administer medications as ordered.
-She planned to start electronic medication administration record (eMAR) and medication cart audits on 09/17/22.

Interview with the Associate Executive Director on 09/16/22 at 11:32am revealed:
-She was not aware staff administered nifedipine ER to Resident #8 shortly before he started eating.
-MAs were responsible to administer medications as ordered.
-She did not think that anyone had audited the

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medication carts recently because the HWC and herself had started working at the facility less than two weeks ago.
-She expected MAs to administer medications as ordered.

b. Review of Resident #9's current FL2 dated 11/24/21 revealed diagnoses included Parkinson's disease and hypertension.

Review of Resident #9's signed physician orders dated 05/10/22 revealed that there was an order for one multivitamin tablet daily (used as a dietary supplement).

Observation of the 8:00am medication pass for Resident #9 on 09/15/22 at 8:30am revealed:
-The medication aide (MA) prepared Resident #9's medications.
-There were no multivitamin tablets in stock for Resident #9 on the medication cart.

Observation of the medications on hand for Resident #9 on 09/15/22 at 8:31am revealed:
-There were no multivitamin tablets available for administration.
-The MA requested a refill of the multivitamin tablets from the pharmacy.

Interview with the MA observed during the medication pass on 09/15/22 at 8:58am revealed if the facility had to reorder a missing medication, the pharmacy normally dispensed the medication on the same day it was ordered.

Second interview with the medication aide (MA) observed during the medication pass on 09/15/22 at 2:38pm revealed:
-She was not sure when Resident #9 was last administered her multivitamin.

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-If there was a medication that was not available, the MAs normally faxed the pharmacy and then called the pharmacy to make sure the fax was received.
-MAs were responsible for requesting medication refill orders from the pharmacy.

Interview with Resident #9 on 09/15/22 at 1:40pm revealed:
-She thought staff always administered her multivitamin.
-Staff administered her medications on time.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/22 at 11:32am revealed:
-There was an order on file for a multivitamin tablet once daily.
-Multivitamin tablets were last dispensed on 08/27/22 for a quantity of 10 tablets for Resident #9.
-The multivitamins would have run out on 09/06/22 if the first tablet was administered the day after it was dispensed.
-He thought the multivitamin tablets should be on a cycle fill from the pharmacy and be dispensed as a one month supply.
-He was not sure why there were only 10 multivitamin tablets dispensed at a time.

Telephone interview with Resident #9's primary care provider on 09/15/22 at 5:05pm revealed:
-She was not aware Resident #9 was not administered a multivitamin on 09/15/22.
-She expected facility staff to contact the pharmacy prior to a resident being out of a medication, including the multivitamin.
-She did not expect Resident #9 to experience any adverse effects as a result of not being administered a multivitamin.

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D 358	Continued From page 57 Interview with the Health and Wellness Coordinator (HWC) on 09/16/22 at 8:30am revealed: -She was not aware Resident #9 was out of stock of her multivitamin during the 8:00am medication pass on 09/15/22. -MAs were responsible to administer medications as ordered. -MAs normally faxed a refill order to the pharmacy when a resident was low on a medication and the pharmacy would send a refill. -She planned to start electronic medication administration record (eMAR) and medication cart audits on 09/17/22. Interview with the Associate Executive Director on 09/16/22 at 11:35am revealed: -She was not aware Resident #9 did not have any multivitamin tablets available for administration during the 8:00am medication pass on 09/15/22. -MAs were responsible for administering medications as ordered. -She expected the MAs to reorder medications prior to medications running out, including Resident #9's multivitamin.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	D 451		

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D 451	Continued From page 58 This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to notify the County Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 1 of 5 residents (Resident #1) who hit his head as a result of an unwitnessed fall. The findings are: Review of Resident #1's current FL2 dated 04/05/22 revealed: -Diagnosis included moderate protein calorie malnutrition, anemia, type 2 diabetes, hyperlipidemia, hyponatremia, myocardial infarction, and generalized anxiety. -Resident #1 was ambulatory. Review of Resident #1's care plan dated 08/28/22 revealed Resident #1 was independent with ambulation and transfer. Review of Resident #1's Incident/Accident reports revealed, there were no Incident/Accident reports for July, August or September 2022. Review of Resident #1's progress note dated 08/16/22 revealed: -Resident #1's family members notified staff that he was not at his baseline. -Resident #1 stated he had a headache for 2 days, was confused when he fell and hit his head, had heart palpitations, and had trouble walking. -Resident #1's PCP wrote an order for a urinalysis on 08/16/22, but his family insisted he be sent out to the local hospital for evaluation. Review of Resident #1's progress notes for July,	D 451		

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August, and September 2022 revealed there was no documentation detailing any falls for Resident #1.

Observation of Resident #1 on 09/14/22 at 8:55am revealed:
-Resident #1 was seated his recliner in his room with his feet on the floor.
-Resident #1 had a large bandage on his left knee and bruising on his right knee.

Interview with Resident #1 on 09/15/22 at 11:21am revealed:
-He fell a couple of weeks ago and hit his head.
-Staff found him in his room and helped him up off the floor, but he did not remember any details.
-Staff did not send him out to the hospital after his fall.
-Staff put a bandage on his knee because he scraped it when he fell, but they did not do anything else differently for him.
-He did not remember who was working on the day he fell.
-He went to the hospital on the next day after his family visited him and requested that he be sent out.

Interview with the Health and Wellness Coordinator on 09/15/22 at 2:57pm revealed:
-Anytime a resident fell, an Incident/Accident report should have been completed.
-The MA working the shift of the fall should have completed the Incident/Accident report.
-If a fall was unwitnessed, staff were to check for bruises and lacerations.
-If the resident hit their head or if staff did not know if the resident hit their head, then the resident should have been assessed for pain and changes every shift for 72 hours.

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D 451	Continued From page 60 Interview with a MA on 09/16/22 at 9:05am revealed: -She did not know if an Incident/Accident report had been completed for Resident #1. -The MA who was working when the fall occurred should have completed the Incident/Accident report if the resident had injuries or if the resident was sent out to the hospital. Interview with a representative from the local department of social services on 09/16/22 at 1:41pm revealed: -There had not been any Incident/Accident reports submitted to the county from the facility for Resident #1. -She expected the facility to notify DSS when an incident or accident occurred resulting in an emergency room (ER) visit or hospitalization for any resident with an injury requiring medical treatment. Interview with the Assistant Executive Director (AED) on 09/16/22 at 11:34am revealed: -She was not aware Resident #1 had sustained falls and hit his head in August 2022. -If Resident #1 hit his head, he should have been sent out to the hospital and an Incident/Accident report should have been completed and sent to the local department of social services. -She did not know an Incident/Accident report had not been completed for Resident #1 after his falls and hospitalization.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	D912		

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D912	Continued From page 61 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on 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 health care. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled resident (#1) related to a physician's order for a urinalysis (U/A) and a physician's order for a physical therapy (PT)/occupational therapy (OT) evaluation and treatment. [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D912		