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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 12/13/22 to 12/16/22 and 12/19/22 with an exit conference via telephone on 12/19/22.	D 000		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's	D 255		

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disease or diabetes;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 1 of 5 sampled residents (#2) who declined in her ambulatory status and became dependent on staff for personal care and safety.

The findings are:

Review of Resident #2's current FL2 dated 04/06/22 revealed:
-Diagnoses included advanced dementia, stage 3 coronary artery disease.
-The Special Care Unit (SCU) was documented as the recommended level of care.
-Resident #2 was constantly disoriented and was documented as ambulatory, with no assistive device checked.

Review of the Resident Register for Resident #2 revealed an admission date of 03/21/22.

Review of Resident #2's Profile and Care plan dated 03/21/22 revealed:
-She was a new admit to the SCU.

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-She was always disoriented with a significant loss of memory.
-She was independent with eating, transfers, and ambulated without the use of assistive devices.
-She was incontinent of bowel and bladder and required assistance from staff with personal hygiene, grooming, and dressing.

Review of Resident #2's SCU Resident Profile and Care Plan dated 11/08/22 revealed:
-The document was a quarterly assessment.
-She required prompting to complete meals or snacks.
-She was a two-person assist with transfers and toileting.
-She was a one-person assist with ambulation, dressing, grooming, hygiene, and using a wheelchair.
-Special Management needs for Resident #2 were to offer snacks and hand her baby dolls to her.
-Resident #2's cognitive impairment consisted of a severe loss of memory.

There was no documentation of a subsequent assessment or care plan after 03/21/22 reflecting Resident #2's increased dependency on staff for transfers, ambulation and personal care needs, multiple falls nor interventions related to sexual assault or use of pommel cushion, lab belt or personal alarm.

Interview with a medication aide (MA) on 12/14/22 at 9:53am revealed:
-Resident #2 was able to ambulate independently when she was admitted to the SCU.
-She was able to assist with her bathing, dressing and grooming.
-Presently, Resident #2 required staff assistance with transfers, dressing, and toileting, and

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ambulated independently and with the assistance of staff in her wheelchair.
-Resident #2 was not able to assist with her activities of daily living (ADLs) anymore, staff had to do them for her.
-Resident #2 had really declined since July 2022.

Interview with a personal care aide (PCA) on 12/14/22 at 9:30pm revealed:
-Resident #2 was confused and wandered throughout the facility daily, had episodes of crying and would now cried out when staff attempt to provide incontinence care which she had not done prior to July.
-She required staff assistance with toileting, and ambulation with her wheelchair because her feet didn't touch the floor with the pommel cushion, then hospice lowered the wheelchair and now she can use her feet to move.
-The pommel kept her from falling out of her chair, she used a seat belt but it didn't work because she broke two of them by leaning forward in her wheelchair when the seatbelt was fastened and fell out of the wheelchair.
-She thought Resident #2 had declined since July 2022.

Telephone interview with Resident #2's family member on 12/13/22 at 3:20pm revealed:
-Resident #2 was not prescribed any medications and ambulated independently when she was admitted to the SCU in March of 2022.
-Over the course of Resident #2's stay she had been prescribed several different medications, had numerous falls requiring her being sent to the local emergency department (ED) with head injuries and was sexually assaulted by another resident.
-Currently she used a lowered wheelchair with a pommel cushion (a cushion with a large inner

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foam between the residents legs to prevent a wheelchair resident from sliding down and possibly falling out of a wheelchair) and a personal alarm.
-She significantly declined after so many falls out of the wheelchair/bed, the sexual assault, numerous medications changes and was admitted to Hospice on 08/17/22.

Observation of Resident #2 on 12/13/22 at 9:16am revealed:
-Resident #2 was alert.
-Resident #2 sitting in her room in her wheelchair on a pommel cushion with a personal alarm.
-There was a fall mat under Resident #2's bed in her room.
-She attempted to propel herself using the furniture in her room, the doorframe and the handrail in the hallway.

Interview with the Special Care Coordinator (SCC) on 12/15/22 at 10:00am revealed:
-It was her responsibility to complete a new care plan when a new resident was admitted and yearly thereafter and send the new care plan to the physician to be reviewed.
-She did not know an assessment for a significant change for Resident #2 should have been completed.

Interview with the Executive Director on 12/16/22 at 4:30pm revealed:
-Resident #2 had declined since she was admitted to the facility.
-The SCC was responsible for the care plans, significant changes and getting the physician to sign the care plans.
-She was not aware the SCC had not completed a significant change for Resident #2.

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D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 3 of 7 sampled residents (Resident #3, #7, and #9) related to delayed evaluation of a dislocated shoulder injury and right leg contusion (#7), not reporting increased occurrences of low blood sugar values to the primary care provider (PCP) (#3), and notification of the PCP concerning abnormal behaviors (#9). The findings are: 1. Review of Resident #7's current FL2 dated 11/09/22 revealed diagnoses included Alzheimer's Dementia and head injury. Review of Resident #7's Care Plan dated 04/17/22 revealed: -The resident was totally dependent with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transfers. -The resident required limited assistance with eating. -The resident required a high-backed wheelchair for ambulation. -The resident had limited range of motion, strength, and eye-hand coordination in the upper extremities. -The resident had significant memory loss and	D 273		

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weak, slurred speech.

a. Review of Resident #7's FL2 dated 11/09/22 revealed:
-There was an order for tramadol (used to treat pain) 50mg 2 tablets three times a day.
-There was an order for hydrocodone (used to treat pain) 5-325mg 1 tablet every 6 hours as needed or pain.

Review of Resident #7's Incident Report dated 11/02/22 at 1:03am revealed:
-Resident #7's right shoulder "popped" while staff performed care.
-The resident was not sent to the emergency room (ER) for evaluation.
-Resident #7 complained of right shoulder pain and was given Tylenol for pain.
-Resident #7's Nurse Practitioner (NP) was notified of the incident on 11/02/22 at 1:30am.

Review of Resident #7's NP order dated 11/02/22 revealed mobile x-ray right shoulder status post popping noise with pain on movement.

Review of Resident #7's right shoulder mobile x-ray report dated 11/03/22 revealed:
-The x-ray was requested on 11/03/22.
-Two x-ray frontal views of the right shoulder were obtained on 11/03/22.
-The clinical indication for the x-rays was pain with and without movement.
-The x-ray showed there was an anterior (forward) dislocation at glenohumeral joint (shoulder joint).
-The x-ray was electronically signed by a physician on 11/04/22.

Telephone interview with Resident #7's NP on 12/16/22 at 11:10am revealed:

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-Facility staff notified her by text message on 11/02/22 at 1:30am Resident #7's right shoulder "popped" during care and the resident complained of pain afterward.
-She did not see the text message until she woke up on the morning of 11/02/22.
-She "assumed" facility staff had sent Resident #7 to the hospital for evaluation of the right shoulder when the injury occurred.
-Facility staff were able to send a resident to the emergency room (ER) for evaluation without an order from her to do so.
-When she arrived at the facility on 11/02/22 at 9:00am, she discovered Resident #7 had not been sent to the ER for evaluation of the shoulder.
-She then wrote an order for a mobile x-ray of the right shoulder.
-When she ordered the mobile x-ray, she did not realize it would take 24-hours to get the results of the x-ray.

Review of Resident #7's NP order dated 11/03/22 revealed assisted living facility (ALF) staff can assist with passive range of motion (ROM) exercises as part of home exercise program.

Review of Resident #7's NP order dated 11/04/22 revealed ALF staff to perform passive ROM exercises all extremities twice a day for duration of 10 minutes daily.

Review of Resident #7's NP visit note dated 11/09/22 revealed:
-Resident #7 was seen today to follow-up on right shoulder x-ray (11/03/22) with dislocation of right shoulder.
-Resident #7 received Home Health Physical Therapy (PT) for passive range of motion exercises as part of a home exercise program.

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-Resident #7 did not appear to have any pain or discomfort at this time and continued to be prescribed scheduled tramadol (used to treat pain) and as needed Norco (used to treat pain) which were effective.

Review of Resident #7's Orthopedic note dated 11/10/22 revealed:
-The visit was a new patient visit.
-The chief complaint was further evaluation of right shoulder pain.
-Caregiver stated about a week ago, Resident #7 was being lifted and somebody pulled on his right shoulder, and they felt a pop.
-Resident #7 had previous x-rays obtained and was told of possible dislocation.
-There was an obvious clinical deformity noted in the right shoulder consistent with shoulder dislocation.
-The physician sent Resident #7 to the ER for a closed reduction right anterior shoulder dislocation with sedation (a procedure to restore the normal anatomical position of the humeral head joint surface with the joint surface of glenoid without surgery).

Review of Resident #7's hospital history and physical dated 11/10/22 revealed:
-Resident #7 present for a right shoulder dislocation.
-Resident #7 was being dressed about one week ago and the assistant noted a pop from his shoulder with immediate deformity.
-X-ray obtained confirmed dislocation.
-For unclear reasons, presentation to orthopedics was delayed.

Review of Resident #7's operative report dated 11/10/22 revealed:
-The preoperative diagnosis was chronic right

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shoulder dislocation locked.
-An attempted closed reduction of right shoulder (a way to set a dislocated shoulder without surgery) under anesthesia was unsuccessful.
-The shoulder clearly had been dislocated for a long period of time and had adhered to the undersurface of the glenoid.
-All reduction maneuvers were attempted with no success.
-The resident would need an open reduction (bone realigned during surgery) versus arthroplasty (surgical reconstruction or replacement of a joint) for his problem as there was probably glenoid (a hollow in a bone where it formed a joint with the ball-shaped end of another bone) bone loss from his humeral head being perched on the glenoid for a long period of time.

Review of Resident #7's orthopedic physician note dated 11/30/22 revealed:
-Resident #7 did not wish to have surgery on his right shoulder.
-Resident #7 indicated he would be okay with having the shoulder dislocated for the rest of his life.
-Resident #7 did not have pain at rest only pain with transfers.
-Resident #7 was at a high risk to undergo surgery and at a high risk for postsurgical complications.
-The plan was discussed with a family member and the family member agreed it would be best if surgery was avoided.

Interview with the Area Clinical Director on 12/14/22 at 10:31am revealed:
-Staff A was providing incontinent care to Resident #7 on 11/02/22.
-Staff A stated Resident #7 had his hands across his lap to prevent Staff A from getting the

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incontinent brief between his legs.
-Staff A took Resident #7's right arm and placed it behind his back and pulled the brief up.
-Staff A then pushed Resident #7's legs down, with Resident #7's right arm still behind his back.
-Staff A reported hearing a pop in the right shoulder when he pushed Resident #7's legs down.
-Resident #7 did not report any pain at the time, but later in the shift complained of pain in the right shoulder.
-Staff B was in the room and heard Resident #7's shoulder pop and agreed with the events as Staff A had described them.

Interview with the Special Care Coordinator (SCC) on 12/15/22 at 11:50am revealed:
-She did not know why Resident #7 was not sent to the ER on 11/02/22 for evaluation of his right shoulder after it popped, and the resident complained of pain.
-She found out about Resident #7's right shoulder incident and pain when she closed the incident report on 11/03/22 at 12:05pm.
-Resident #7's NP was notified by a medication aide (MA) about the incident on 11/02/22 at 1:30am.
-Resident #7's NP was onsite and saw the resident on 11/02/22 for the shoulder injury.

Telephone interview with the Executive Director (ED) on 12/19/22 at 10:00am revealed:
-Staff did not inform her about the dislocation of Resident #7's shoulder when it occurred.
-Staff notified Resident #7's NP as soon as the injury occurred.
-The NP "usually" responded to staff when they texted information to her.
-She found out about Resident #7's shoulder dislocation when she found out he was at an

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orthopedic appointment on 11/10/22.

Review of the facility's policy on accidents or emergencies dated September 2021 revealed:
-Send for or call for help.
-Evaluation the situation.
-Call 911 or have someone call 911, if necessary.
-Assess the resident.
-If injury is apparent or possible, do not move resident.
-Continue emergency intervention until emergency medical services (EMS) arrives.
-Staff member must remain with resident until EMS arrives.
-Send appropriate information with resident.
-Call/notify the resident's physician and responsible party.
-If injury, complete the Report of Accident and Incident Form.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

b. Review of Resident #7's incident report dated 11/11/22 at 6:34pm revealed:
-The resident was found in his room on the floor in front of his wheelchair.
-The resident had no documented injuries.
-The resident was not sent to the emergency room (ER) for evaluation.

Review of Resident #7's progress note dated 11/13/22 at 12:53pm revealed documentation of new bruising found on resident was reported to the Nurse Practitioner (NP) via text message.

Review of Resident #7's NP visit note dated 11/16/22 revealed:
-On 11/11/22 staff reported they found Resident

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#7 on the floor of his room in front of his wheelchair.
-Today noted to be with a contusion of the left side of his tongue and left jaw edema.

Review of Resident #7's incident report dated 11/17/22 at 1:53pm revealed:
-Staff noticed bruising and swelling in resident's leg.
-Resident #7's NP requested resident be sent to the ER for evaluation.

Review of Resident #7's NP order dated 11/17/22 revealed arterial doppler to right leg for swelling and bruising.

Review of Resident #7's ER discharge summary dated 11/17/22 revealed:
-The chief complaint was lower leg pain/injury.
-The resident presented with bruising of the right femur and leg.
-He had no known injury and was sent for evaluation.
-X-rays of the right femur, right hip and pelvis, and right tibia and fibula were all negative for fracture.
-The clinical impression was contusion (a bruise) of the right leg and thigh.

Interview with a medication aide (MA) on 12/15/22 at 10:00am revealed:
-She was told by other staff the bruise on Resident #7's leg was caused when he rolled out of bed.
-She had never known Resident #7 to fall before.

Interview with a second MA on 12/15/22 at 10:10am revealed:
-On 11/13/22, she discovered the bruise on Resident #7's leg when she provided incontinent

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care.
-The bruise was on the back of his right leg from his knee to the bottom of his bottom.
-The center of the bruise was deep purple and the edges of the bruise were yellow.
-No one knew anything about the bruise prior to that shift.

Interview with the SCC on 12/15/22 at 11:50am revealed:
-She did not remember the exact day when the bruising was discovered on Resident #7's posterior right leg.
-On 11/17/22, Resident #7's right leg started swelling.
-She reported the swelling to Resident #7's NP.
-The NP ordered a doppler ultrasound to make sure there was not a blood clot.

Telephone interview with Resident #7's NP on 12/16/22 at 11:15am revealed:
-Resident #7 was not one to fall out of his wheelchair.
-She never got an response from staff as to how the resident fell out of his high-backed wheelchair.
-The SCC had notified her about the swelling in Resident #7's leg.
-Resident #7 had a contusion from the groin to the knee.
-She could not associate "the" fall with the contusion.
-Resident #7 would have had to fall "extremely hard."
-She saw the tongue and leg bruising on her 11/16/22 visit.
-On 11/17/22, the leg bruising had increased.
-Her impression of the bruising was staff had moved Resident #7 with too much force and hit the leg.

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-No matter how she looked at it, she could not relate the fall out of the wheelchair with the severity of the contusion on the resident's leg.
-Resident #7 was transported by EMS, the orthopedic office, and had experienced transfers with the hospital on 11/10/22 when they were attempting to treat his dislocated shoulder.
-Resident #7 should have been sent out to the hospital on 11/13/22 when staff first became aware of the bruising on Resident #7's leg.

Telephone interview with the Executive Director (ED) on 12/19/22 at 10:00am revealed:
-The SCC did not notify her about Resident #7's right leg contusion.
-It was the SCC's responsibility to notify her of incident's she reviewed.
-She was not aware of the contusion on Resident #7's leg until the state survey team notified her.
-An MA did an incident report about the contusion.
-The SCC closed out the incident report about the contusion.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

2. Review of Resident #3's FL2 dated 10/12/22 revealed:
-Diagnoses included dementia with behavioral disturbances, type 2 diabetes insulin dependent, and hypertension.
-There was an order for Lantus (used to lower blood sugar) 100u/ml inject 10 units subcutaneously every morning hold for fingerstick blood sugar (FSBS) less than 100.
-There was an order to call MD with FSBS less than 70 or greater than 551.

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Review of Resident #3's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lantus 100u/ml inject 10 units every morning scheduled at 6:30am hold if FSBS less than 100.
-From 10/01/22 to 10/31/22, there were 13 occurrences out of 30 opportunities when the FSBS was less than 100 and there was no documentation the MD was notified.
-From 10/01/22 to 10/31/22, the FSBS range was 75-132.

Review of Resident #3's November 2022 eMAR revealed:
-There was an entry for Lantus 100u/ml inject 10 units every morning scheduled at 6:30am hold if FSBS less than 100.
-From 11/01/22 to 11/30/22, there were 14 occurrences out of 30 opportunities when the FSBS was less than 100 and there was no documentation the MD was notified.
-From 11/01/22 to 11/30/22, the FSBS range was 74-133.

Review of Resident #3's December 2022 eMAR from 12/01/22 to 11/13/22 revealed:
-There was an entry for Lantus 100u/ml inject 10 units every morning scheduled at 6:30am hold if FSBS less than 100.
-From 12/01/22 to 12/13/22, there were 8 occurrences out of 13 opportunities when the FSBS was less than 100 and there was no documentation the MD was notified.
-From 12/01/22 to 12/13/22, the FSBS range was 87-137.

Telephone interview with Resident #3's Nurse Practitioner (NP) on 12/16/22 at 11:14am revealed:

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-She was not notified of all the occurrences of Resident #3's FSBS's less than 100 from 10/01/22 to 12/13/22.
-If Resident #3's FSBS were that low in the mornings, he was receiving too much sliding scale insulin at night.
-She would have expected staff to notify her so she could adjust Resident #3's 9:00pm sliding scale insulin.

Telephone interview with the Special Care Coordinator (SCC) on 12/29/22 at 10:45am revealed there was an order to notify Resident #3's NP if FSBS's were less than 70 or greater than 551.

Telephone interview with the Executive Director (ED) on 12/19/22 at 10:00am revealed:
-There was an order to call MD with FSBS's less than 70 or greater than 551.
-The MA's were responsible for contacting the NP to report low FSBS values.
-After the first reported low FSBS, the MA's should also notify the SCC and the ED concerning low BS values.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.
3. Review of the current FL2 for Resident #9 dated 01/05/22 revealed:
-Diagnoses of dementia, atrial fibrillation, chronic obstructive pulmonary disease, anxiety, hypertension, heart failure with mid-range ejection fraction.
-There was documentation Resident #9 was intermittently confused and had wandering behaviors.
-The level of care was documented as domiciliary, Special Care Unit (SCU).

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D 273	Continued From page 17 Review of the Care Plan for Resident #9 dated 04/29/22 revealed: -Behavior was documented as wandering with no other behaviors noted. -Resident #9 required stand by assist with showers and was independent with other activities of daily living (ADL's). Review of the incident reports for Resident #9 revealed: -There was an incident report dated 07/11/22 that involved Resident #9 who had sexually assualted a female resident. -Staff heard a female resident yelling, entered Resident #9's room where staff observed Resident #9 sexually assualting a female resident. -There were no other incident reports involving Resident #9. Review of the Progress notes for Resident #9 revealed there was no documentation of inappropriate sexual behaviors. Telephone interview with a Medication Aide (MA) on 12/14/22 at 3:20pm revealed: -About a week prior to his sexual assault on another resident, she walked into Resident #9's room and observed Resident #9 rubbing his penis on a baby doll. -She did not say anything to him. -She backed out of the room and closed the door back. -She never told anyone. -She saw a lot of residents do strange things, she thought it was a strange occurrence and did not report it to anyone. -The baby doll belonged to another female resident.	D 273		

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D 273	Continued From page 18 Interview with personal care aide (PCA) on 12 14/22 at 3:45pm revealed: -About a month before the sexual assault Resident #9 was stealing a female residents baby dolls and hiding them in his room. -Resident #9 would hide them from staff. -She saw him with one of the baby dolls but could not recall the date, the doll was sitting in his lap and he was brushing the dolls hair and changing its clothes. -When he realized she was watching him he hid the doll behind his back. - She did not tell anyone about the doll because he wasn't doing anything inappropriate with it. -She knew it was a female residents doll as it had her name on it. Interview with a certified nursing assistant (CNA) on 12/14/22 at 3:55pm revealed: -Resident #9 had baby dolls in his room. -He tried to keep the baby dolls hidden from staff. -He did not like anyone in his room and didn't care for staff coming in as it would make him mad. -He didn't want assistance from staff with any personal care/shower. Interview with a second PCA on 12/15/22 at 9:40am revealed: -Resident #9 did not appear to be confused as he could carry on a good conversation. -He had a female residents baby dolls hid in his room. -A female residents name was on the baby dolls. -He would play with them. -She had observed him wrap the baby doll up in a sheet and act like he was feeding it, if he left his room he would wrap the baby doll up and hide it under the bed or he would put it at the foot of his	D 273		

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bed where it was not easily seen.
-She had not observed this behavior previously.
-She never said anything to anyone about the new behavior.

Interview with the Special Care Coordinator (SCC) on 12/15/22 at 10:00am revealed:
-She had been in his room but did not recall any baby dolls in his room.
-She was made aware of the baby dolls after the 7/11/22 sexual assault on a female resident.
-She was not the SCC on 07/11/22.
-She was the medication aide (MA) supervisor for day shift on 07/11/22 and was not in the facility when the incident occurred as she already left for the day.
-Upon returning to work the next day staff began telling her Resident #9 had sexually assaulted a female resident and had been touching himself with the baby dolls that belonged to the female resident.
-Resident #9's roommate also told her Resident #9 had been touching himself with the baby dolls.
-Staff nor Resident #9's roommate had not told her anything about the baby dolls prior to the incident on 07/11/22.

Interview with second MA on 12/15/22 at 10:40am revealed:
-She had noticed the baby dolls in his room prior to the 07/11/22 incident.
-She had not told anyone Resident #9 had the baby dolls in his room.
-She did not think anything about the baby dolls being in his room.
-She was present on the night the sexual assault occurred between Resident #9 and a female resident.
-The baby dolls were in his room when the incident occurred and they did not have any

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clothes on.
-The night of the incident Resident #9's roommate told the MA and other staff Resident #9 was having sex with the baby dolls.

Based on observations and interviews, it was determined Resident #9's roommate was not interviewable.

Interview with the Executive Director (ED) on 12/15/22 at 3:30pm revealed:
-She found out about Resident #9 and the baby dolls on 07/11/22 immediately after the incident with a female resident.
-As she and the Administrator and the police officer were in the room talking to Resident #9 about the assault, she noticed a female residents baby dolls in his room.
-She asked Resident #9 how he got them and he stated he had found them in the hall.
-She was aware the baby dolls were a female residents baby dolls as the name was on them and she had seen the family bring them into the female resident.
-Resident #9's roommate arrived at the room and the roommate told the ED and the Administrator, Resident #9 had been having sex with the baby dolls.

Telephone interview with the Nurse Practioner (NP) on 12/16/22 at 3:00pm revealed:
-Resident #9 had a diagnosis of dementia.
-Resident #9 exhibited some aggression with other residents entering his room but no sexual behaviors that she was aware of.
-She was not aware a staff member had observed him being inappropriate with the baby doll and staff was aware of Resident #9 hiding the baby dolls in his room.
-It would have been appropriate for the MA to

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D 273	Continued From page 21 report what she had observed to "keep a closer eye on his behaviors". -That type of behavior certainly warranted a closer look at his behaviors. -She commented it was "strange behavior for a man at any age." -She felt it was certainly a "red flag" if he was masturbating with a female residents baby doll. _____ The facility's failure to evaluate Resident #7's right shoulder dislocation for 8 days due to the humeral head becoming locked on the glenoid which reduced Resident #7's options to surgical repair of the injury which was not recommended by the physician resulted in Resident #7 having a chronically dislocated right shoulder. This failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 18, 2023.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record	D 338		

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reviews, the facility failed to protect 3 of 3 sampled residents (Residents #1, #4, and #7) from abuse and neglect related to a dislocated right shoulder, a laceration with bruising of the left ear, a contusion of the right leg, and a cut beneath the 4th and 5th toe (#7), rough incontinent care (#4), and twisting of arms and elbow, pushing resident into a wall, and keeping the resident locked in his room (#1).

The findings are:

1. Review of Resident #7's current FL2 dated 11/09/22 revealed diagnoses included Alzheimer's Dementia and head injury.

Review of Resident #7's Care Plan dated 04/17/22 revealed:
-The resident was totally dependent with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transfers.
-The resident required limited assistance with eating.
-The resident required a high-backed wheelchair for ambulation.
-The resident had limited range of motion, strength, and eye-hand coordination in the upper extremities.
-The resident had significant memory loss and weak, slurred speech.

Interview with a personal care aide (PCA) on 12/13/22 at 2:45pm revealed:
-Staff A was a PCA who worked the 7:00pm to 7:00am shift.
-Resident #7 kept getting "hurt" when Staff A worked.
-There were three accidents that occurred within about 3 weeks of each other that involved Staff A providing care to Resident #7 with subsequent

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injuries to Resident #7.
-There was an incident during which Staff A removed Resident #7's sock and a cut occurred on the foot somehow at the bottom of the middle toe.
-There was a second incident during which Staff A was getting Resident #7 up in the morning Resident #7's ear "got caught" on Staff A's hoodie somehow and resulted in a laceration to the back of the resident's ear.
-There was a third incident during which Resident #7's shoulder was dislocated while receiving care from Staff A.
-The incidents all happened within 3 weeks of each other.
-She thought the circumstances around the injuries sustained by Resident #7 were "strange."
-Staff A had "anger issues."

a. Review of Resident #7's Incident Report dated 11/02/22 at 1:03am revealed Resident #7's right shoulder "popped" while staff performed care.

Review of Resident #7's right shoulder mobile x-ray report dated 11/03/22 revealed there was an anterior (forward) dislocation at glenohumeral joint (shoulder joint).

Telephone interview with a medication aide (MA) who worked 7:00pm to 7:00am on 12/13/22 at 9:55pm revealed:
-She was the Supervisor on duty when Resident #7's shoulder was injured.
-Staff A, PCA, reported he and Staff B, PCA, were rolling Resident #7 to provide incontinent care when they heard the resident's shoulder "pop."
-Staff A and Staff B "immediately" reported the incident to her.
-She contacted Resident #7's Nurse Practitioner

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(NP) and an x-ray was obtained of the affected shoulder.

Interview with a second PCA on 12/14/22 at 9:15am revealed:
-One morning when she came to work, Staff A told her Resident #7's arm "popped."
-Staff A did not tell her how the shoulder injury occurred.

Interview with a third PCA on 12/14/22 at 9:32am revealed Staff A told her that he and Staff B were getting Resident #7 up for breakfast and providing incontinent care and heard a "big pop" and it was Resident #7's shoulder.

Interview with a fourth PCA on 12/13/22 at 3:29pm revealed Staff A had admitted the dislocation of Resident #7's shoulder was an "accident" which occurred when he was trying to move the resident.

Interview with the Area Clinical Director on 12/14/22 at 10:31am revealed:
-She interviewed Staff A on 12/13/22 concerning Resident #7's right shoulder dislocation.
-Staff A was providing incontinent care to Resident #7 on 11/02/22 when Resident #7's shoulder popped.
-Staff A stated Resident #7 had his hands across his lap to prevent Staff A from getting the incontinent brief between his legs.
-Staff A took Resident #7's right arm and placed it behind his back and pulled the brief up.
-Staff A then pushed Resident #7's legs down, with Resident #7's right arm still behind his back.
-Staff A reported hearing a pop in the right shoulder when he pushed Resident #7's legs down.
-Resident #7 did not report any pain at the time,

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but later in the shift complained of pain in the right shoulder.
-Staff B was in the room at the time of the incident, but was assisting Resident #7's roommate with care at the time of the incident.

Interview with the Special Care Coordinator (SCC) on 12/14/22 at 11:10am revealed:
-She could not remember when she found out about Resident #7's shoulder dislocation.
-She did close the incident report about the dislocation on 11/03/22.
-Staff A self-reported to her while he was performing care the shoulder "popped."

Second telephone interview with the SCC on 12/19/22 at 10:45am revealed:
-She had received training on identifying abuse and neglect prior to the incident with Resident #7's shoulder dislocation on 11/02/22.
-She was trained to report incidents of abuse and neglect to upper management.
-She was supposed to report incidents to her immediate supervisor which would be the Executive Director (ED).
-She had not "thought anything about" the shoulder injury which occurred to Resident #7 under Staff A's care.
-She did not report the dislocated shoulder during care incident to the ED.

Interview with the Executive Director (ED) on 12/13/22 at 4:30pm and on 12/19/22 at 10:00am revealed:
-She knew Resident #7 sustained a shoulder dislocation during care provided by Staff A.
-She did not find out about Resident #7's dislocated shoulder until the resident went for an appointment with orthopedics on 11/10/22.
-The SCC knew about Resident #7's shoulder

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injury and Staff A's involvement when she reviewed the incident report and closed it on 11/03/22.
-Staff A self-reported to the night shift MA he was providing care when the injury of Resident #7's shoulder occurred.
-Staff A had self-reported to her another incident where an injury occurred to Resident #7's ear (11/11/22) when his hoodie cut the resident's ear.
-She felt Staff A self-reporting incidents made it less probable these were incidents of abuse.
-She did not investigate the incident involving Resident #7's dislocated shoulder.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

Refer to the facility's policy on resident abuse, neglect, and exploitation dated September 2021.

b. Review of Resident #7's Incident Report dated 11/11/22 at 6:43am revealed:
-The incident was described as an injury of unknown origin cut on back of ear.
-Resident #7's ear was bleeding as a result of the injury.
-Staff noticed a laceration on the back of Resident #7's left ear while getting the resident ready for breakfast.
-Resident #7 was not sent to the emergency room (ER) for evaluation.
-The wound was cleaned with normal saline and a bandage was applied.
-The primary care provider (PCP) was notified via text message.
-The Power of Attorney (POA) was notified.
-Resident would followup with PCP on next scheduled visit.

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Observation of Resident #7's left ear on 12/15/22 at 10:57am revealed there was vertical reddened scabbed area approximately 1 inch long located on the back of the resident's left ear.

Interview with a medication aide (MA) on 12/14/22 at 2:25pm revealed:
-She worked when the injury occurred to Resident #7's ear.
-She completed the incident report.
-Staff A told her he was providing incontinent care to Resident #7 and the resident's ear was bleeding.
-Then later when Staff A got Resident #7 up, he noticed the resident's ear had a "big gash" on it.
-Staff A stopped the bleeding.
-After Resident #7 got up, the MA looked at the ear injury more closely.
-The back of the ear was red and bruised and it started bleeding again.
-The injury was like a "cut."
-Staff A said his hoodie must have caught Resident #7's ear during transfer.
-Staff A could be "rough" when he provided care to residents.

Interview with the Executive Director (ED) on 12/13/22 at 4:30pm revealed:
-She was made aware of the incident involving Staff A's hoodie string getting caught on Resident #7's ear during transfer and causing an abrasion on the back of the resident's ear.
-Staff A had self-reported the resident's ear injury.
-The other care staff expressed they were "upset" over Resident #7's ear.
-She did not know why the other care staff had been upset about the ear.
-She felt Staff A self-reporting incidents made it less probable these were incidents of abuse.
-She did not investigate the incident involving

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Resident #7's ear injury.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

Refer to the facility's policy on resident abuse, neglect, and exploitation dated September 2021.

c. Review of Resident #7's incident report dated 11/11/22 at 6:34pm revealed:
-The resident was found in his room in the floor in front of his wheelchair.
-The resident had no documented injuries.
-The resident did not require emergency room (ER) evaluation.

Review of facility staff schedule for 11/11/22 revealed:
-Staff A, personal care aide (PCA), was scheduled to work 7:00pm to 7:00am on 11/11/22.
-Staff A was assigned to provide care for Resident #7.

Review of facility time records for 11/11/22 revealed Staff A worked from 7:03pm until 1:30am.

Review of Resident #7's progress note dated 11/13/22 at 12:53pm revealed:
-Staff reported new bruising found on the resident to the Nurse Practitioner (NP) via text message.
-Documented bruising was "probably from fall on 11/11/22."

Review of Resident #7's NP visit note dated 11/16/22 revealed:
-On 11/11/22 staff reported they found Resident #7 on the floor of his room in front of his

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wheelchair.
-Today noted to be with a contusion of the left side of his tongue and left jaw edema.

Review of Resident #7's incident report dated 11/17/22 at 1:53pm revealed:
-Staff noticed bruising and swelling in resident's leg.
-Resident #7's NP requested resident be sent to the ER for evaluation.

Review of Resident #7's NP order dated 11/17/22 revealed arterial doppler to right leg for swelling and bruising.

Review of Resident #7's ER discharge summary dated 11/17/22 revealed:
-The chief complaint was lower leg pain/injury.
-Patient presented with bruising of the right femur and leg.
-Patient has no known injury and sent for evaluation.
-The clinical impression was contusion (a bruise) of the right leg and thigh.

Interview with a medication aide (MA) on 12/15/22 at 10:00am revealed:
-She was told by staff the bruise on Resident #7's leg was caused when he rolled out of bed.
-She had never known Resident #7 to fall before.

Interview with a second MA on 12/15/22 at 10:10am revealed:
-On 11/13/22, she discovered the bruise on Resident #7's leg when she provided incontinent care.
-The bruise was on the back of his right leg from his knee to the bottom of his bottom.
-The center of the bruise was deep purple and the edges of the bruise were yellow.

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D 338	Continued From page 30 -No one knew anything about the bruise prior to that shift. Telephone interview with Resident #7's NP on 12/16/22 at 11:15am revealed: -Resident #7 was not one to fall out of his wheelchair. -She never got an response from staff as to how the resident fell out of his high-backed wheelchair. -Resident #7 had a contusion from the groin to the knee. -She could not associate the fall with the contusion. -Resident #7 would have had to fall "extremely hard." -She saw the tongue and leg bruising on her 11/16/22 visit. -Her impression of the bruising was staff had moved Resident #7 with too much force and hit the leg. -No matter how she looked at it, she could not put the fall out of the chair with the severity of the contusion on the resident's leg. -She felt Resident #7 should have been sent out to the hospital on 11/13/22 when staff first became aware of the bruising on Resident #7's leg. Telephone interview with the Executive Director (ED) on 12/19/22 at 10:00am revealed she did not become aware of the contusion on Resident #7's leg until the state survey team notified her. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. Refer to the facility's policy on resident abuse, neglect, and exploitation dated September 2021.	D 338		

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d. Review of Resident #7's incident report dated 10/27/22 at 8:21am revealed:
-The incident was documented as a wound under the right 4th and 5th toe.
-Staff pulled the resident's sock off and he had an open wound under his right 4th and 5th toe.
-First aide was administered.
-Palliative care and the primary care provider (PCP) were notified.
-Orders were obtained for wound care.

Interview with the Special Care Coordinator (SCC) on 12/14/22 at 11:10am revealed:
-Staff A, personal care aide (PCA), self-reported Resident #7's toe injury to her.
-She completed the incident report.

Review of Resident #7's NP visit note dated 11/02/22 revealed:
-The resident was seen for a follow-up to a toe wound.
-Staff reported they pulled Resident #7's sock off and he had a wound under his right 4th and 5th toe.
-The wound appeared to be a trauma wound.
-Resident will receive skilled nursing visits for wound care.

Interview with a PCA on 12/14/22 at 9:37am revealed:
-Staff A told the PCA he was pulling Resident #7's sock off and Resident #7's "toe got cut."
-She thought the explanation was "weird."
-She could not understand how the resident's foot was cut just by removing a sock.

Telephone interview with Resident #7's NP on 12/16/22 at 11:15am revealed she had no idea how the wound occurred under Resident #7's toe

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just by staff putting a sock on.

Telephone interview with the Executive Director (ED) on 12/13/22 at 4:30pm and 12/19/22 at 10:00am revealed:
-She was not made aware of Resident #7's toe injury and Staff A's involvement until 12/13/22.
-She did not do an investigation around the incident until 12/14/22.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

Refer to the facility's policy on resident abuse, neglect, and exploitation dated September 2021.

2. Review of Resident #4's current FL2 dated 06/22/22 revealed diagnoses included dementia with behavioral disturbance, diabetes mellitus type 2, hypertension, and history of stroke.

Review of Resident #4's Care Plan dated 09/01/21 revealed:
-The resident was totally dependent with toileting, bathing, and grooming/personal hygiene.
-The resident required extensive assistance with ambulation/locomotion and transfers.

Telephone interview with a medication aide (MA) on 12/16/22 at 6:37am revealed:
-On 11/25/22 at the 3:00am round, she observed Staff A, personal care aide (PCA) providing incontinent care to Resident #4.
-Staff A had both of Resident #4's feet in his hands and had Resident #4's legs up so that his knees touched Resident #4's forehead.
-Staff B, PCA, was also in the room providing incontinent care to the another resident who resided in the room.

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D 338	Continued From page 33 Telephone interview with Resident #4's Nurse Practitioner on 12/16/22 at 11:15am revealed: -Pulling a resident's legs up to where their knees were at their forehead to perform incontinent care was not appropriate. -Performing incontinent care in that way was not acceptable. Interview with the Special Care Coordinator (SCC) on 12/14/22 at 11:10am revealed: -A MA reported to her an incident involving Resident #4. -The MA told her she walked in Resident #4's room and saw Staff A and Staff B providing incontinent care for Resident #4. -The MA said Staff A had picked Resident #4's legs up and it looked "rough." -She asked the MA what she said to Staff A. -The MA told her she was in shock and didn't know what to say. -She told the MA she "probably" needed to say something because Staff A was maybe rougher than he intended to be. -She told the MA she did not think Staff A was being intentional with those actions. -She told the MA she should call the Executive Director (ED) to report the incident so she could better explain what she saw. -She did not report the incident to the ED. Interview with the ED on 12/15/22 at 9:05am revealed: -A MA had reported the incident with Resident #4 and Staff A to her on 11/25/22. -The conversation with the MA did not take place at work, but in a location where there were a lot of distractions. -She had forgot about the incident. -She did not do an investigation of the incident.	D 338		

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D 338	Continued From page 34 Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Refer to the facility's policy on resident abuse, neglect, and exploitation dated September 2021. 3. Review of Resident #1's current FL2 dated 04/13/22 revealed diagnoses included dementia with behaviors, Parkinson's Disease, and hypertension. Review of Resident #1's Care Plan dated 04/15/22 revealed the resident required extensive assistance with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transfers. Review of Resident #1's Incident Report dated 12/03/22 revealed: -Resident #1 approached staff at 5:00pm appearing agitated. -Resident #1 stated a staff member threw him into a mirror, twisted his hands and elbows, and locked him in his room for two weeks. -Staff noted bruising on Resident #1's hand. -The primary care provider (PCP), power of attorney (POA), and Executive Director (ED) were notified. -Hospice was notified to evaluate the resident. -PCP will follow-up with resident on next scheduled visit. Interview with a personal care aide (PCA) on 12/13/22 at 2:05pm revealed: -Resident #1 told her on 12/03/22 that Staff A, PCA, pushed him into a mirror and twisted his wrist and tried to lock him in his room. -Resident #1 said Staff B, the PCA who was	D 338		

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working with Staff A, watched.

Interview with a second PCA on 12/13/22 at 3:29pm revealed:
-On 12/03/22, Resident #1 came up and said he wanted to file a complaint with the office about physical abuse.
-He said Staff A grabbed his arm and elbow and twisted it and pushed him into the bathroom walls and mirror.
-She and a second PCA were asked by the MA to check Resident #1 for bruises and to take pictures.
-They found Resident #1's elbow was bruised and he had other small bruises on his chest and legs.
-There was also some bruising above the elbow.
-The Executive Director (ED) and the Special Care Coordinator (SCC) came in on the evening of 12/03/22 and spoke with Staff A.

Telephone interview with Resident #1's Nurse Practitioner (NP) on 12/16/22 at 11:15am revealed:
-Resident #1 had recently been able to quote information back to her with accuracy that she had relayed to him.
-Resident #1 had recently shown her he was still able to critically think.
-She believed he was "lucid."

Interview with the ED on 12/13/22 at 4:30pm revealed:
-She completed an investigation of the allegations Resident #1 made against Staff A.
-She unsubstantiated the allegations against Staff A.
-She interviewed Resident #1, Staff A, Staff B, and the MA who had been on duty the evening the incident occurred.
-She also obtained written statements from all the

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staff on the 7:00am to 7:00pm shift concerning the incident.
-During her investigation, nothing was communicated to her about staff having previous concerns about Staff A's treatment of other residents.
-The bruising on Resident #1's arms was consistent with recent falls that had occurred.
-The bruises identified by staff on 12/03/22 on the resident's hand, forearm, and leg were not fresh bruises.

Interview with the MA who worked 7:00pm to 7:00am on 12/02/22 to 12/03/22 revealed:
-Staff A called her sometime during the shift to Resident #1's room.
-She went down to the room and Resident #1 was seated on the toilet.
-She gave the resident an as needed medication for a behavior issue and left.

Interview with the ED on 12/14/22 at 11:00am revealed:
-She did not suspend Staff B regarding the allegations made by Resident #1.
-She did not suspend her because when she interviewed Resident #1, he told her Staff B was a "good girl."
-She then asked Resident #1 if Staff B had been in the room with Staff A at any point that night and Resident #1 said "yeah, I think, maybe."
-Staff B reported she held Resident #1's elbow to keep him from hitting Staff A.
-She saw no reason to suspend Staff B, because the allegations were not made against her.

Interview with the Special Care Coordinator (SCC) on 12/14/22 at 11:10am revealed:
-She came in with the ED on the evening of 12/03/22 to talk to Resident #1 and all of third

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D 338	Continued From page 37 shift (7:00pm to 7:00am). -After they spoke with Resident #1 and all the staff, they had a meeting in the dining room and talked to staff about handling residents and when to step away and let another staff member step in. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to the facility's policy on resident abuse, neglect, and exploitation dated September 2021. Review of the facility's policy on resident abuse, neglect and exploitation dated September 2021 revealed: -In the event of any accusation of abuse of a resident by staff, community management will direct staff to assure the immediate safety of the resident. -The physician will be notified for any additional orders which may include referral to outside resources for further medical evaluation. -The family, responsible party, and guardian will be notified and advised of their right to request notification of local authorities. -If there is any physical harm or injury present the resident will be sent out to the hospital for further evaluation unless resident or responsible party declines further evaluation. -The Division Vice President of Operations and Division Director of Clinical Services will be notified immediately, and all required reporting will be completed as required not limited to local law enforcement and the Department of Social Services. -The community will complete the Health Care Personnel Registry (HCPR) 24-hour report and begin an immediate investigation.	D 338		

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D 338	Continued From page 38 -Immediate suspension of the accused individual (staff) pending investigation. -Community Management begins the investigation to substantiate or unsubstantiate the allegations for reporting to the HCPR 5-day report. -Interview all staff present or individuals present during the allegation. -Interview any providers or ancillary support services that may have details regarding the alleged abuse. -Substantiated allegation, the employee will receive disciplinary action up to and including termination. _____ The failure of the facility to investigate an incident which occurred on 10/27/22 to Resident #7 during care provided by Staff A resulted in Resident #7 sustaining subsequent injuries, including a right shoulder dislocation on 11/02/22. This failure placed all residents in the facility at substantial risk of serious physical harm and abuse and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 18, 2023.	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	D 358		

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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 A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (Resident #3, #4, and #5) related to a medication used to treat a urinary tract infection (#4), medications to increase the appetite and assist with eliminating urinary retention (#5), a long-acting insulin to treat high blood sugar levels (#3), and 1 of 5 sampled residents (Resident #8) observed on the medication pass almost being administered a medication used to treat schizophrenia when the medication was discontinued.

The findings are:

Review of the facility's medication administration policy dated September 2021 revealed:
-The facility utilized a preferred pharmacy that provides medications in a multi-dose packaging system except when antibiotics or psychotropics were ordered.
-All medications administered, handled, and stored were documented on the electronic medication administration record (eMAR).
-The facility ensured contact with the resident's prescribing practitioner for verification or clarification of orders for medications and treatments, dated and signed within 24 hours, if orders were not clear or complete, and staff ensured the verification or clarification was

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documented in the resident's record.
-A new medication order for an antibiotic shall be started no later than 9:00am the following day and all efforts should be made to start antibiotics at the next scheduled dose.
-All routine medication orders shall be started with the next regularly scheduled dose following the regular pharmacy delivery.
-All new orders were reviewed by the Special Care Coordinator (SCC) and faxed to the contracted pharmacy and scanned into the computer system.
-The SCC will wait for pharmacy to enter the medication into the electronic medication system, review the order, and approve the order for administration.
-The SCC will follow up timely to receive any necessary clarifications for physician's orders.
-Staff completed medication cart audits weekly and check to make sure all medications were available using a copy of the physician orders and sign and date the orders once the cart audit is complete and leave for the SCC.
-Medication errors included wrong doses, missed doses, missed documentation, or not initiating orders.
-Medication errors are immediately reported to the SCC or Executive Director (ED), the prescribing practitioner, document and follow instructions given, and complete an Incident Report.
-Discontinued medication orders are faxed to the pharmacy and a fax confirmation is attached, and a discontinue order is documented in the progress note.
-The SCC will review the discontinue order, compare it to the eMAR to ensure it has been correctly discontinued, scan the order into the computer system, and file the order in the resident's record.

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-When a medication in a multi-dose pack is discontinued, staff will place a change of direction or discontinue sticker on the package beside the medication name, and the medication aide will identify and remove the medication with a witness and document using the destruction form.
-Telephone orders for medications shall be countersigned by the prescribing practitioner within 15 days from the date the order is given.
-Hold orders would be placed on hold in the eMAR by the SCC and the medication is flagged with a bright colored sticker showing "hold" with the date, time, and initials.
-Missed or refused medication doses are documented on the eMAR and the MA or SCC notifies the prescribing practitioner while documenting the notification.
-The resident's vital signs are taken to determine the need for administration of medication, parameters for giving the medication are indicated on the eMAR, and a written record is made on the eMAR.
-Diabetic medications including insulin will be added to a diabetic flowsheet.
-The MA will notify the SCC of abnormal results of blood sugar readings and the SCC will review the readings and notify the provider.

1. Review of Resident #4's current FL2 dated 06/22/22 revealed:
-Diagnoses included dementia with behavioral disturbance.
-Orientation was documented as intermittently confused.
-He was incontinent of bowel and bladder.

Review of Resident #4's Care Plan dated 12/11/22 revealed:
-He was always disoriented with a significant loss of memory.

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-Weak speech with limited word usage.
-He was totally dependent on staff with personal hygiene and incontinent of urine and stool.

Review of Resident #4's urinalysis lab results dated 11/16/22 revealed:
-Resident #4 was diagnosed with male cystitis (a bladder infection).
-A note from a pharmacist indicated the bacteria identified in Resident #4's urine was resistant to some types of antibiotic treatment and treatment should be aggressive and monitored closely for treatment effectiveness.

Review of a physician's order dated 11/16/22 revealed amoxicillin-potassium clavulanate (an antibiotic medication used to treat bacterial urinary tract infections) 875mg take 1 tablet twice daily for 10 days.

Review of Resident #4's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry dated 11/17/22 through 11/26/22 for amoxicillin-potassium clavulanate 875-125mg take 1 tablet twice daily for 10 days.
- Amoxicillin-potassium clavulanate was documented as administered twice daily at 8:00am and 8:00pm on 11/17/22 through 11/19/22.
- Amoxicillin-potassium clavulanate was documented as not administered from 11/20/22 through 11/26/22 with reason as discontinued.

Observation of Resident #4's medications on hand on 12/13/22 at 3:48pm revealed there was a bottle of amoxicillin-potassium clavulanate 875-125mg with a dispense date of 11/23/22 in the quantity of 14 tablets (a 7 day supply dispensed out of a 10 day supply ordered) that

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D 358	Continued From page 43 had 7 tablets remaining in the bottle. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/13/22 at 4:39pm revealed: -Resident #4's order for amoxicillin-potassium clavulanate 875-125mg take one tablet twice daily for 10 days was received by fax on 11/16/22. -Amoxicillin-potassium clavulanate for Resident #4 was partially dispensed in the quantity of 6 tablets on 11/16/22 due to a low pharmacy supply. -A second dispense of Resident #4's amoxicillin-potassium clavulanate in the quantity of 14 tablets was completed on 11/23/22. -The facility was responsible to call the pharmacy and have Resident #4's eMAR updated to show when the amoxicillin-potassium clavulanate was to be administered and extend the "cut off" date. -The facility did not call the pharmacy to have the date extended on the eMAR for Resident #4's amoxicillin-potassium clavulanate. -The pharmacy did not receive any discontinue orders for Resident #4's amoxicillin-potassium clavulanate. Review of Resident #4's Progress Notes revealed: -On 11/17/22 at 9:10am, adverse effects for antibiotic therapy was documented as "none seen" with not applicable (N/A) documented for provider notifications. -On 11/17/22 at 11:36pm, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/18/22 at 8:56am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications.	D 358		

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D 358	Continued From page 44 -On 11/18/22 at 5:14pm, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/19/22 at 3:52am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/19/22 at 9:05am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/20/22 at 2:22am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/20/22 at 10:17am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/20/22 at 4:58pm, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/23/22 at 3:14am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/25/22 at 1:47am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/25/22 at 10:07pm, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/26/22 at 9:35am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications.	D 358		

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D 358	Continued From page 45 -On 11/26/22 at 3:41pm, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/27/22 at 12:34am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/27/22 at 11:47pm, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 11/28/22 at 9:00am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 12/01/22 at 1:16am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 12/02/22 at 12:45am, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 12/02/22 at 11:50pm, adverse effects for antibiotic therapy was documented as "none seen" with N/A documented for provider notifications. -On 12/13/22, Resident #4 was transported to the local hospital emergency room (ER) by emergency medical services (EMS) for blood in the urine and being lethargic. Interview with a medication aide (MA) on 12/13/22 at 5:10pm revealed: -She did not know why Resident #4's amoxicillin-potassium clavulanate was discontinued on the eMAR on 11/20/22. -She "threw away" Resident #4's remaining amoxicillin-potassium clavulanate that was	D 358		

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dispensed on 11/23/22 and the facility received the new antibiotic ordered on 12/13/22 for Resident #4 from the pharmacy.

Interview with a second MA on 12/14/22 at 7:56am revealed:
-Resident #4 was ordered amoxicillin in November for 10 days and was only administered the antibiotic for a "short amount of time" and then the antibiotic was "taken" off the eMAR.
-She did not know why the amoxicillin for Resident #4 was removed from the eMAR before the full dose of antibiotics was administered.
-She did not administer amoxicillin to Resident #4 on 11/21/22, 11/22/22, or 11/25/22 because the amoxicillin was discontinued on the eMAR even though there was still amoxicillin available for administration.
-She documented in Resident #4's progress notes "no adverse effects" from antibiotic therapy on 11/17/22 at 9:10am and 11/26/22 at 9:35am and 3:41pm because it was a scheduled task triggered in the computer system when a resident started an antibiotic and "no adverse effects" was a choice that generated from a drop down menu on the assigned task.

Interview with the Special Care Coordinator (SCC) on 12/14/22 at 8:45am revealed:
-The discontinue order for Resident #4's amoxicillin-potassium clavulanate was not in Resident #4's record because it was not signed by Resident #4's Nurse Practitioner (NP).
-She called the NP on 11/20/22 to get the discontinue order for Resident #4's amoxicillin due to the antibiotic was causing Resident #4 to itch.
-Resident #4's NP did not sign the order to discontinue the amoxicillin when she last visited the facility.

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-The NP did not give her an order for a new or different antibiotic for Resident #4.
-She did not know why the NP had not signed the discontinue order for Resident #4's amoxicillin.
-She was responsible for getting telephone orders signed by the prescribing practitioner and faxed the order to the pharmacy.
-She did not fax a discontinue order for Resident #4's amoxicillin to the pharmacy.
-She did not know why the MA's charted "none seen" for adverse reactions to the antibiotics in the progress notes.

Review of Resident #4's physician's orders revealed there was no order to discontinue amoxicillin-potassium clavulanate.

Telephone interview with Resident #4's healthcare power of attorney (HCPOA) on 12/14/22 at 9:58am revealed:
-The facility called her in November 2022 to report Resident #4 had a UTI and he was prescribed antibiotics.
-Resident #4 previously had trouble emptying his bladder and had to have an indwelling catheter until he pulled the catheter out.

Telephone interview with Resident #4's NP on 12/14/22 at 3:28pm revealed:
-Resident #4 was diagnosed with a urinary tract infection and ordered an antibiotic medication on 11/16/22 to take twice daily for 10 days.
-She received a message from the facility staff on 12/13/22 that Resident #4 was being transported to the local emergency room because Resident #4 was unresponsive, lethargic, and urinating blood.
-Resident #4 was ordered a new antibiotic at the local hospital on 12/13/22 for a UTI and could be related to a continuing infection from not receiving

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the full dose of amoxicillin ordered on 11/16/22.
-Resident #4 could become septic (a life-threatening medical emergency caused by infection) if he did not receive the full ordered dose of antibiotics causing rehospitalization or "worse".

Telephone interview with the Executive Director (ED) on 12/19/22 at 10:00am revealed:
-She did not know why there was a remaining partial supply of Resident #4's antibiotic ordered on 11/16/22.
-Any medications discontinued were supposed to be removed from the medication cart.
-She did not know if there was a signed physician's order to discontinue Resident #4's amoxicillin in November 2022.
-The SCC was responsible for contacting the prescribing provider to obtain discontinue orders, making sure the orders were signed by the provider, scanning the order to the pharmacy, and placing the order in the resident's record.
-She expected the MA's to administer antibiotics as ordered or contact the NP for any doses held.

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

2. Review of Resident #5's current FL2 dated 08/17/22 revealed:
-Diagnoses included Alzheimer's disease with moderate dementia.
-There was an order for monthly weights.
-She was constantly disoriented.
-A regular chopped meats diet was ordered.
-She was incontinent of urine.

Review of Resident #5's Care Plan dated 07/18/22 revealed:

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-She was always disoriented with a significant loss of memory.
-She required limited assistance from staff with eating.
-She required extensive assistance from staff with toileting, bathing, and personal hygiene.

a. Review of Resident #5's Incident/Accident report dated 11/21/22 revealed:
-Resident #5 was found in the floor with complaints of pain in her left hip and was transported by emergency medical services (EMS) to the local hospital emergency room (ER).
-Resident #5 was diagnosed with a hip fracture.

Review of Resident #5's physician's order dated 11/28/22 revealed an order for mirtazapine (a medication used to stimulate the appetite) 7.5mg take 1 tablet at bedtime.

Review of Resident #5's November 2022 electronic medication administration record (eMAR) revealed:
-There was no entry for mirtazapine 7.5mg take 1 tablet at bedtime.
-There was an entry for monthly weights with a documented weight of 100.5 pounds on 11/11/22.

Review of Resident #5's December 2022 eMAR revealed:
-There was no entry for mirtazapine 7.5mg take 1 tablet at bedtime.
-There was an entry for monthly weights with a documented weight of 90.5 pounds on 12/11/22.

Observation of medications on hand on 12/15/22 at 12:55pm revealed there was no mirtazapine available for administration.

Interview with a medication aide (MA) on

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12/15/22 at 3:56pm revealed:
-The Special Care Coordinator (SCC) was responsible for faxing Resident #5's medication orders dated 11/28/22 to the pharmacy.
-The pharmacy did not dispense Resident #5's mirtazapine after it was ordered.
-The pharmacy did not add the mirtazapine to the eMAR because she or the SCC would approve the medications added to the profile by the pharmacy and the mirtazapine was not approved or in the eMAR system.
-She or the SCC were responsible to follow up with the pharmacy to see why the mirtazapine was not added to the eMAR.

Interview with the SCC on 12/15/22 at 4:01pm revealed:
-The fax machine stopped printing confirmations of orders being faxed to the pharmacy.
-She did not document if she faxed Resident #5's order for mirtazapine to the pharmacy.
-She was responsible to make sure all medication orders were faxed to the pharmacy.
-She did not follow-up with the pharmacy to see why Resident #5's mirtazapine was not added to the eMAR and why the medication was not sent because she "just forgot about it".

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/16/22 at 10:07am revealed:
-Resident #5's order dated 11/28/22 for mirtazapine 7.5mg was faxed by the facility to the pharmacy on 12/15/22.
-There were no previous faxes received by the pharmacy for Resident #5's mirtazapine order.

Telephone interview with Resident #5's HCPOA on 12/16/22 at 10:29am revealed Resident #5 recently had a decreased appetite and poor

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D 358	Continued From page 51 nutrition. Telephone interview with Resident #5's nurse practitioner (NP) on 12/16/22 at 10:57am revealed: -Resident #5 was ordered mirtazapine upon hospital discharge when she fell and broke her hip. -She reordered mirtazapine for Resident #5 on 11/28/22 because it was an appetite stimulant. -The facility called to notify her on 12/15/22 the order for Resident #5's mirtazapine dated 11/28/22 was never faxed to the pharmacy. -Resident #5 had orders for monthly weights and she did not know if Resident #5 experienced a weight loss decline recently. Telephone interview with Resident #5's hospice registered nurse (RN) on 12/16/22 at 11:34am revealed: -She saw Resident #5 as a new patient on 12/02/22 after Resident #5 returned from the hospital when she fell and broke her hip and had required surgery. -A 10 percent weight loss in one month would be a significant decline in Resident #5's health related to poor nutrition and intake. -Another hospice RN saw Resident #2 on 12/07/22 and documented a "fair" appetite for breakfast. -Mirtazapine was used for an appetite stimulant and would help to prevent weight loss which would be important in maintaining Resident #5's health. Second telephone interview with the NP on 12/16/22 at 1:05pm revealed: -Resident #5's 10 percent weight loss from November 2022 through December 2022 was a significant change in weight loss.	D 358		

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-The facility did not notify her until "last night" on 12/15/22 that Resident #5 had not been receiving the ordered mirtazapine.
-Mirtazapine was an appetite stimulant and would prevent weight loss.
-Resident #5's poor nutrition from not receiving mirtazapine could cause increased weight loss, decreased healing of the hip fracture, increase the risk of infection, and increased confusion.

Telephone interview with the Executive Director (ED) on 12/19/22 at 10:00am revealed:
-New medication orders were given to the SCC to copy and fax to the facility's contracted pharmacy.
-The pharmacy would add the medications to the resident's eMAR and dispense the medication for the resident.
-The SCC would look at each new order to make sure the pharmacy entered the medication into the eMAR system correctly and approve the entry made by the pharmacy if the order was correct.
-She did not know why Resident #5's mirtazapine was not on the eMAR or why the medication was unavailable for administration.
-She thought the order for Resident #5's mirtazapine was faxed on 11/28/22 and did not know how the order was "missed" being faxed or added to the profile by the pharmacy.
-She expected staff to follow the facility's policies and procedures regarding new medication orders for residents.

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

b. Review of Resident #5's physician's order dated 11/28/22 revealed an order for tamsulosin (a medication used in women with a bladder outlet obstruction) 0.4mg take 1 capsule daily.

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D 358	Continued From page 53 Review of Resident #5's November 2022 electronic medication administration record (eMAR) revealed there was no entry for tamsulosin 0.4mg take 1 capsule daily. Review of Resident #5's December 2022 eMAR revealed there was no entry for tamsulosin 0.4mg take 1 capsule daily. Observation of medications on hand on 12/15/22 at 12:55pm revealed there was no tamsulosin available for administration. Interview with a medication aide (MA) on 12/15/22 at 3:56pm revealed: -The Special Care Coordinator (SCC) was responsible for faxing Resident #5's medication orders dated 11/28/22 to the pharmacy. -The pharmacy did not dispense Resident #5's tamsulosin after it was ordered. -The pharmacy did not add the tamsulosin to the eMAR because she or the SCC would approve the medications added to the profile by the pharmacy and the tamsulosin was not approved or in the eMAR system. -She or the SCC were responsible to follow up with the pharmacy to see why the tamsulosin was not added to the eMAR. Interview with the SCC on 12/15/22 at 4:01pm revealed: -The fax machine stopped printing confirmations of orders being faxed to the pharmacy. -She did not document if she faxed Resident #5's order for tamsulosin to the pharmacy. -She was responsible to make sure all medication orders were faxed to the pharmacy. -She did not follow-up with the pharmacy to see why Resident #5's tamsulosin was not added to	D 358		

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the eMAR and why the medication was not sent because she "just forgot about it".

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/16/22 at 10:07am revealed:
-Resident #5's order dated 11/28/22 for tamsulosin 0.4mg was faxed by the facility to the pharmacy on 12/15/22.
-There were no previous faxes received by the pharmacy for Resident #5's tamsulosin order.
-The pharmacy would not dispense tamsulosin because Resident #5 had an adverse reaction notation for the medication and a telephone call was made and voicemail left for Resident #5's nurse practitioner (NP).

Telephone interview with Resident #5's NP on 12/16/22 at 10:57am revealed:
-She ordered tamsulosin on 11/28/22 for Resident #5 because Resident #5 was experiencing urinary retention.
-Tamsulosin would help relax the bladder so that it could empty.
-The facility called to notify her on 12/15/22 the order for Resident #5's tamsulosin dated 11/28/22 was never faxed to the pharmacy.
-She discontinued the order for Resident #5's tamsulosin on 12/15/22 because she was notified by the facility's contracted pharmacy that Resident #5 had an allergy to an ingredient in the tamsulosin.

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

Telephone interview with the Executive Director (ED) on 12/19/22 at 10:00am revealed:
-New medication orders were given to the SCC to

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copy and fax to the facility's contracted pharmacy.
-The pharmacy would add the medications to the resident's eMAR and dispense the medication for the resident.
-The SCC would look at each new order to make sure the pharmacy entered the medication into the eMAR system correctly and approve the entry made by the pharmacy if the order was correct.
-She did not know why Resident #5's tamsulosin was not on the eMAR or why the medication was unavailable for administration.
-She thought the order for Resident #5's tamsulosin was faxed on 11/28/22 and did not know how the order was "missed" being faxed or added to the profile by the pharmacy.
-She expected staff to follow the facility's policies and procedures regarding new medication orders for residents.

3. The medication error rate was 4% as evidenced by the observation of 1 error out of 25 opportunities during the 8:00am medication pass on 12/14/22.

Review of Resident #8's current FL2 dated 10/12/22 revealed:
-Diagnoses included dementia and schizophrenia.
-There was an order for haloperidol (a medication used to treat mental conditions such as schizophrenia) 2mg take 1 tablet three times a day.

Review of Resident #8's physician's order dated 12/07/22 revealed an order to discontinue haloperidol.

Observation of the medication pass on 12/14/22 at 8:01am revealed:
-Resident #8 walked up to the medication cart

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and informed the medication aide (MA) she wanted to be administered her morning medications.
-The MA pulled a multi-dose package of medications for Resident #8 out of the drawer and scanned the package.
-The multi-dose package of morning medications for Resident #8 included one haloperidol 2mg tablet.
-The MA emptied the medications into the medicine cup and picked up the cup and started handing the cup to Resident #8.
-Resident #8 told the MA she wanted her pain medication and did not want to take the haloperidol or another medication.
-The MA donned gloves and referred to the multi-dose package and removed a round white pill and a round pink pill (she identified as the haloperidol and the other medication Resident #8 refused) and discarded the 2 pills into the sharp's container.
-The MA added the pain medication to the medicine cup and administered the medications to Resident #8.

Review of Resident #8's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for haloperidol 2mg take 1 tablet three times daily at 9:00am, 3:00pm, and 9:00pm.
-Haloperidol was documented as administered three times daily from 12/01/22 through 12/10/22 except on 12/01/22 at 3:00pm and 9:00pm, 12/02/22 at 3:00pm, and 12/10/22 at 9:00pm with reason documented as "refused".
-There was an "X" on the eMAR for haloperidol 2mg at 9:00am, 3:00pm, and 9:00pm from 12/11/22 through 12/15/22.

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D 358	Continued From page 57 Interview with the MA on 12/14/22 at 10:34am revealed: -When a resident received discontinue medication orders or dose changes, the third shift MA completing the medication cart audit would place a sticker on the multi-dose medication package indicating there was a change and highlight the medication name. -The haloperidol for Resident #8 was not highlighted and there was not a sticker on the multi-dose medication package indicating the haloperidol was discontinued. -It was the responsibility of the MA administering Resident #8's medications to remove the haloperidol from the package. -She was responsible to check the medications listed on the package with the eMAR before administering the medications to Resident #8. -She did not know if the pharmacy received the order dated 12/07/22 to discontinue the haloperidol for Resident #8 since the new multi-dose package was dispensed on 12/09/22 and contained the haloperidol. -The Special Care Coordinator (SCC) was responsible for faxing new medication orders to the pharmacy. Interview with Resident #8 on 12/14/22 at 10:50am revealed: -She told the nurse practitioner (NP) "last week" she did not want to take the haloperidol any longer. -She asked the MA to remove the haloperidol from the medication cup because "she would have given it to me if I didn't tell her to take it out". -She asked staff daily to remove the haloperidol from her medication cup. -She started taking a new medication and was not supposed to take the haloperidol with the new medication.	D 358		

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-She thought the MA on 12/13/22 had administered both the new medication ordered and the haloperidol because it made her feel "mad and upset".

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 12/14/22 at 12:03pm revealed Resident #8's haloperidol was last dispensed on 12/09/22 in the quantity of 21 tablets in the multi-dose medication package.

Interview with the SCC on 12/15/22 at 11:07am revealed:
-She was responsible for faxing medication orders to the facility's contracted pharmacy.
-The pharmacy dispenses resident's medications in multi-dose medication packages every Friday.
-Medication cart audits were completed on Saturdays with the last being completed on 12/10/22.
-Resident #8's haloperidol should have been discontinued on 12/10/22 when the new medication ordered for Resident #8 was started.
-She, the MAs, or the MA supervisor were responsible for highlighting the medication on a multi-dose medication package if the medication was discontinued or dose changed.
-She did not know why Resident #8's haloperidol was not highlighted and discontinued written next to the medication on the multi-dose package.
-There should have been an alert "pop up" on the screen of the eMAR indicating the haloperidol for Resident #8 was discontinued when the MA scanned the multi-dose package.
-The MA should have removed and discarded the haloperidol for Resident #8 before Resident #8 had a chance to refuse the haloperidol.

Telephone interview with the NP on 12/16/22 at

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10:57am revealed:
-She ordered Resident #8 a new medication to treat schizophrenia on 12/07/22 and included a discontinue order for Resident #8's haloperidol when the new medication started.
-Resident #8 requested a medication change and was refusing the haloperidol.
-Both the new medication and haloperidol should not be given together because they can cause an irregular heart rhythm.

Interview with the Executive Director (ED) on 12/14/22 at 9:50am revealed:
-Resident #8's haloperidol was still in the multi-dose medication package provided by the facility's contracted pharmacy.
-Resident #8's medications were dispensed by the pharmacy for one week at a time.
-The MAs knew to pull the haloperidol from the medication package when administering Resident #8's medications.
-She did not know why the MA did not remove the haloperidol from Resident #8's medication cup before Resident #8 refused the medication.
-Resident #8's eMAR did not have an entry for Resident #8's haloperidol.
-The haloperidol in the multi-dose medication package should have been highlighted and discontinued should have been written next to the haloperidol when the new medication started.
-She expected the MAs to follow the facility's policies and procedures regarding medication administration.

4. Review of Resident #3's FL2 dated 10/12/22 revealed:
-Diagnoses included dementia with behavioral disturbances, type 2 diabetes insulin dependent, and hypertension.
-There was an order for Lantus (used to lower

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blood sugar) 100u/ml inject 10 units subcutaneously every morning hold for fingerstick blood sugar (FSBS) less than 100.

Review of Resident #3's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Lantus 100u/ml inject 10 units every morning scheduled at 6:30am hold if FSBS less than 100.
-From 10/01/22 to 10/31/22, there were 6 occurrences where Lantus was documented as administered when the FSBS was less than 100.
-Resident #3's FSBS results ranged from 75-97.

Review of Resident #3's November 2022 eMAR revealed:
-There was an entry for Lantus 100u/ml inject 10 units every morning scheduled at 6:30am hold if FSBS less than 100.
-From 11/01/22 to 11/30/22, there were 3 occurrences where Lantus was documented as administered when the BS was less than 100.
-Resident #3's FSBS results ranged from 74-96.

Review of Resident #3's December 2022 eMAR from 12/01/22 to 11/13/22 revealed:
-There was an entry for Lantus 100u/ml inject 10 units every morning scheduled at 6:30am hold if FSBS less than 100.
-From 12/01/22 to 12/13/22, there was 1 occurrence where Lantus was documented as administered when the FSBS was less than 100.
-On 12/13/22, Resident #3's FSBS was 89.

Telephone interview with a medication aide (MA) on 12/13/22 at 9:55pm revealed:
-She knew not to give Resident #3's 6:30am Lantus if the FSBS was less than 100.
-The Lantus she documented as having

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administered to Resident #3 on 10/04/22, 10/08/22, 10/09/22, 10/14/22, 10/18/22, 11/01/22, 11/24/22, 11/29/22, and 12/13/22 were documentation errors due to the eMAR software.
-Sometimes she would document holding a medication, but the eMAR would show it as having been administered even though she did not administer it.

Telephone interview with Resident #3's Nurse Practitioner (NP) on 12/16/22 at 11:14am revealed:
-She wrote the order to hold the 6:30am Lantus if the FSBS was less than 100, because if Resident #3 did not eat breakfast his chances were higher of having a hypoglycemic (low blood sugar) event later in the day.
-Low FSBS at 6:30am meant Resident #3 was getting too much insulin the evening before and his evening dosages might need to be adjusted.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

_____

The facility failed to administer medications as ordered for one resident who was administered an antibiotic to treat a urinary tract infection 3 out of the 10 days which could cause worsening infection or sepsis requiring hospitalization (Resident #4) and another resident's ordered appetite stimulant was not administered which resulted in poor nutrition and significant weight loss in a one month period (Resident #5). This failure placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/22 for

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D 358	Continued From page 62 this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 18, 2023	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure electronic medication administration records (eMARS) were accurate for 1 of 5 sampled residents (Resident #5) related to a medication used to treat high blood pressure.	D 367		

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D 367	Continued From page 63 The findings are: Review of the facility's medication administration policy dated September 2021 revealed: -The resident's vital signs are taken to determine the need for administration of medication, parameters for giving the medication are indicated on the eMAR, and a written record is made on the eMAR. -Medication errors included wrong doses, missed doses, missed documentation, or not initiating orders. -Medication errors are immediately reported to the SCC or Executive Director (ED), the prescribing practitioner, document and follow instructions given, and complete an Incident Report. -The facility utilized a preferred pharmacy that provides medications in a multi-dose packaging system. Review of Resident #5's current FL2 dated 08/17/22 revealed: -Diagnoses included Alzheimer's disease with moderate dementia. -She was constantly disoriented. Review of Resident #5's Care Plan dated 07/18/22 revealed she was always disoriented with a significant loss of memory. Review of Resident #5's physician's order dated 09/14/22 revealed an order for amlodipine (a medication used to treat high blood pressure) 2.5mg take 1 tablet daily if the blood pressure reading was greater than 150/90. Review of Resident #5's physician's order dated 11/28/22 revealed to discontinue amlodipine.	D 367		

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D 367	Continued From page 64 Review of Resident #5's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine 2.5mg take 1 tablet daily if the blood pressure reading is greater than 150/90. -There was documentation amlodipine was administered 13 instances out of 31 opportunities when the blood pressure reading was less than 150/90. Review of Resident #5's November 2022 eMAR revealed: -There was an entry for amlodipine 2.5mg take 1 tablet daily if the blood pressure reading is greater than 150/90. -There was documentation amlodipine was not administered due to Resident #5 was hospitalized from 11/22/22 through 11/28/22. -There was documentation amlodipine was administered 13 instances out of 23 opportunities when the blood pressure reading was less than 150/90. Interview with a medication aide (MA) on 12/14/22 at 4:50pm revealed: -She thought she had signed Resident #5's amlodipine as administered on 10/02/22 and 11/03/22 by accident. -She knew to hold Resident #5's amlodipine when the blood pressure reading was less than 150/90. -Resident #5's amlodipine was in a multi-dose medication package and when she scanned the package the computer checked all the boxes of medications in the package. -She should have unchecked the box with amlodipine on the eMAR before she signed the medications as administered but she "forgot". -She discarded the amlodipine in the sharp's	D 367		

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container when it was not administered to Resident #5.

Interview with the Special Care Coordinator (SCC) on 12/15/22 at 11:07am revealed:
-Resident's medications were dispensed by the facility's contracted pharmacy in multi-dose packs.
-The MA would scan the multi-dose pack and all the medications in the bubble pack would come up on the eMAR with a check mark.
-When a medication in a multi-dose pack was not administered, the MA would have to uncheck the medication on the eMAR.
-Resident #5's amlodipine should have been removed from the multi-dose pack by the MA if the blood pressure reading was less than 150/90, the amlodipine discarded, and the MA should have documented on the eMAR the amlodipine was not administered with the reason why it was not administered.
-The MA administering Resident #5's amlodipine was responsible to notify the primary care provider (PCP) of a medication error when the amlodipine was administered outside the ordered parameters.
-She did not know who was responsible for eMAR audits to monitor for documentation accuracy or when an eMAR audit was last completed.

Interview with a second MA on 12/15/22 at 11:35am revealed she thought she held Resident #5's amlodipine when the blood pressure reading was less than 150/90 and she accidentally signed the amlodipine as administered.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/16/22 at 10:07am revealed:
-Resident #5's amlodipine 2.5mg was last

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dispensed on 12/09/22 in the quantity of 7 tablets.
-Resident #5's amlodipine 2.5mg was dispensed in a multi-dose medication package weekly.
-The pharmacy never received a fax from the facility to discontinue Resident #5's amlodipine.

Telephone interview Resident #5's nurse practitioner (NP) on 12/16/22 at 10:57am revealed:
-She ordered a hospice consult for Resident #5 upon return from the hospital after Resident #5 sustained a hip fracture with a fall.
-The hospice registered nurse (RN) notified her that Resident #5's blood pressure reading was low.
-Resident #5's amlodipine was not being administered so she discontinued the amlodipine on 11/28/22.
-Resident #5's heart rate was either 51 or 57 on 12/15/22.
-Amlodipine could lower Resident #5's heart rate even more causing it to drop down in the 40's range or cause Resident #5 to become hypotensive (abnormally low blood pressure) which could contribute to falls or require additional medical interventions.

Interview with the Executive Director (ED) on 12/14/22 at 4:10pm revealed:
-She did not know Resident #5's amlodipine was documented as administered on the October 2022 and November 2022 eMAR when the medication should have been held per the physician's order.
-She thought Resident #5's amlodipine was not administered when the blood pressure was less than 150/90 and the MAs documented incorrectly.
-The MAs were responsible to notify the PCP when a medication error occurred to see if additional orders or treatments were needed

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D 367	Continued From page 67 because of the medication error. -She did not know if Resident #5's PCP was notified when the amlodipine was documented as administered and the blood pressure reading was not greater than 150/90. -The facility's policy and procedure for medication administration included administering or holding medications as ordered and document accurately on the eMARs. -The SCC was responsible to monitor eMARs to make sure staff were documenting correctly. -She did not know when the eMARs were last audited. Based on observations, interviews, and record review it was determined Resident #5 was not interviewable.	D 367		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to notify local law enforcement immediately of alleged abuse for 1 of 1 sampled resident (#1).	D 453		

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D 453	Continued From page 68 The findings are: Review of the facility's policy on resident abuse, neglect and exploitation dated September 2021 revealed: -In the event of any accusation of abuse of a resident by staff, community management will direct staff to assure the immediate safety of the resident. -If there is any physical harm or injury present the resident will be sent out to the hospital for further evaluation unless resident or responsible party declines further evaluation. -The Division Vice President of Operations and Division Director of Clinical Services will be notified immediately, and all required reporting will be completed as required not limited to local law enforcement and the Department of Social Services. -Immediate suspension of the accused individual (staff) pending investigation. -Interview all staff present or individuals present during the allegation. -Interview any providers or ancillary support services that may have details regarding the alleged abuse. -Substantiated allegation, the employee will receive disciplinary action up to and including termination. Review of Resident #1's Incident Report dated 12/03/22 revealed: -Resident #1 approached staff at 5:00pm appearing agitated. -Resident #1 stated staff threw him into a mirror, twisted his hands and elbows, and locked him in his room for two weeks. -Staff noted bruising on Resident #1's hand. -The primary care provider (PCP), power of	D 453		

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attorney (POA), and Executive Director (ED) were notified.

Interview with a personal care aide (PCA) on 12/13/22 at 2:05pm revealed:
-Resident #1 told her on 12/03/22 Staff A pushed him into a mirror and twisted his wrist and tried to lock him in his room.
-Resident #1 said "a blonde headed girl" watched as Staff A did these things to him.
-The blonde headed girl was Staff B who routinely worked with Staff A.

Review of Staff A's personnel file revealed:
-Date of hire 05/20/22.
-Staff A's position title was PCA.
-Staff A worked 7:00pm to 7:00am.

Review of Staff B's personnel file revealed:
-Date of hire 06/10/22.
-Staff B's position title was PCA.
-Staff B worked 7:00pm to 7:00am.

Interview with a second PCA on 12/13/22 at 3:29pm revealed:
-On 12/03/22, Resident #1 came up and said he wanted to file a complaint with the office about physical abuse.
-He said Staff A grabbed his arm and elbow and twisted it and pushed him into the bathroom walls and mirror.
-He said the "blonde girl watches."
-The blonde girl was Staff B who routinely worked with Staff A.
-She and a second PCA were asked by the MA to check Resident #1 for bruises and to take pictures.
-They found Resident #1's elbow was bruised and he had other small bruises on his chest and legs.
-There was also some bruising above the elbow.

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D 453	Continued From page 70 Telephone interview with Resident #1's Nurse Practitioner (NP) on 12/16/22 at 11:15am revealed: -Resident #1 had recently been able to quote information back to her with accuracy that she had relayed to him. -Resident #1 had recently shown her he was still able to critically think. -She believed he was "lucid." Interview with the Executive Director (ED) on 12/14/22 at 11:00am revealed: -She did not notify local law enforcement of any of the allegations of abuse made against Staff A on 12/03/22. -The 12/03/22 abuse allegation was the first abuse allegation she had encountered in her role as ED. -As soon as her staff notified her of the abuse allegation on 12/03/22, she called the Regional Director of Operations (RDO). -The RDO directed her to do a 24-hour health care personnel registry (HCPR) report. -She did the initial HCPR report and sent it to the Area Clinical Director (ACD). -Then she faxed the completed HCPR report into Health Care Personnel Investigations. Interview with the ACD on 12/14/22 at 4:00pm revealed: -Staff were trained to report anything which looked like abuse or neglect of a resident to the Special Care Coordinator (SCC) and the ED. -It was the responsibility of the ED to complete an investigation into the allegation. -If they knew there had been abuse or the allegation was substantiated, they notified law enforcment. -If they saw evidence of abuse, they immediately	D 453		

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D 453	Continued From page 71 notified law enforcement. Interview with the ED on 12/15/22 at 9:05am revealed: -All of the allegations of abuse made against Staff A were reported to local law enforcement on 12/14/22 after it was brought to their attention by the state survey team. -Staff B's involvement in the same allegations were reported to local law enforcement on 12/15/22 after it was brought to their attention by the state survey team. The failure of the facility to immediately report abuse allegations placed all residents at serious risk of physical harm, abuse, and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 18, 2023.	D 453		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the	D 482		

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D 482	Continued From page 72 use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physical	D 482		

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restraints were used only after an assessment and care planning process had been completed through a team process; used only with a written physician's order with the required components and updated every 3 months; and restraints were checked at least every 30 minutes and released at least every 2 hours for 1 of 1 resident (#2) sampled who had a wheelchair with a pommel cushion and a personal alarm.

The findings are:

Review of the facility's policy and procedure for Physical Restraints and Care of Residents with Physical Restraints dated September 2021 revealed:
-The use of physical restraints refers to the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily, which restricts freedom of movement.
-The decision for a restraint will be a team decision and will include the representative of the resident.
-Alternatives must be tried and documented.
-The least restrictive restraint will be used.
-A restraint Assessment and Care Plan will be completed.

Review of Resident #2's current FL2 dated 04/06/22 revealed:
-Diagnoses included advanced dementia, stage 3 coronary artery disease.
-The Special Care Unit (SCU) was documented as the recommended level of care.
-Resident #2 was constantly disoriented and was documented as ambulatory, with no assistive device checked.

Review of the Resident Register for Resident #2

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D 482	Continued From page 74 revealed an admission date of 03/21/22. Review of physician orders for Resident #2 revealed: -There was an order dated 09/23/22 for a pommel cushion (prevents a wheelchair resident from sliding down and possibly falling out of wheelchair) for safety. -There was an order on 10/31/22 to discontinue the use of the pommel cushion and use a seatbelt while up in wheelchair at family request. Review of Resident #2's Profile and Care plan dated 03/21/22 revealed: -There was documentation Resident #2 independent without devices with ambulation, incontinent and required staff assistance for toileting needs and hygiene, limited assistance with bathing, dressing, grooming and hygiene and independent with transfers. -There were no interventions, special management needs noted. Review of Resident #2's SCU Resident Profile and Care Plan dated 11/08/22 revealed: -The document was a quarterly assessment for the Special Care Unit (SCU). -There was documentation Resident #2 needed a 2 person assist with toileting, a one person assist using the wheelchair requiring staff assistance with ambulation, extensive assistance with dressing grooming and hygiene, 2 person assist with transfers. -There were no special management needs for Resident #2 relevant to safety. -There was no mention of multiple falls with head injury, fall mat beside bed, concave mattress, use of a seat belt, or pommel cushion and a personal alarm.	D 482		

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Review of Resident #2's Licensed Health Professional Support (LHPS) review dated 9/12/22 revealed:
-The LHPS tasks included ambulation with assistive device and transferring.
-There was no documentation tasks for wheelchair with seatbelt or pommel cushion with personal alarm.
-The nurse's recommendation was to continue the current plan of care.

Review of Resident #2's record revealed there was no documentation of consents related to the use of restraints.

Review of the electronic medication administration (eMAR) record for October 2022 revealed:
-There was a computer-generated entry for a pommel cushion every shift while in wheelchair.
-There were documented entries from 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm- 7:00am from 10/1/22-10/31/22 the pommel cushion was in place.

Review of the eMAR record for November 2022 revealed:
-There was a computer-generated entry for a pommel cushion every shift while in wheelchair.
-There was a documented entry from 7:00am-3:00pm on 11/01/22 the pommel cushion was in place.
-There was a computer-generated entry for a seat belt every shift while in wheelchair.
-There were documented entries from 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm- 7:00am from 11/01/22-11/30/22 the seat belt was in place.

Review of the eMAR record for December 2022 revealed:

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D 482	Continued From page 76 -There was a computer-generated entry for a pommel cushion every shift while in wheelchair. -There were documented entries from 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm- 7:00am from 12/08/22- 12/13/22 the pommel cushion was in place. -There was a computer-generated entry for a seat belt every shift while in wheelchair. -There were documented entries from 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm- 7:00am from 12/01/22-12/13/22 the seat belt was in place. Observation of Resident #2 on 12/13/22 at 9:16am revealed Resident #2 was sitting in her wheelchair in the doorway of her room a with pommel cushion and personal alarm in place. Observation of Resident #2 on 12/14/22 at 9:20am revealed: -Resident #2 was sitting in her room in her wheelchair with the pommel cushion and personal alarm in place. -She was hitting her pommel cushion and saying, "its not mine, I gotta get this off." -She was leaning forward attempting to scoot over to her dresser. Observation of Resident #2 on 12/15/22 at 9:35am revealed: -She was sitting in her wheelchair in the front hallway near the nurse's station. -She had a pommel cushion and a personal alarm in place. Telephone interview with Resident #2's family member on 12/13/22 at 3:20pm revealed: -She was very concerned over the number of falls her mother had experienced during her stay at the facility.	D 482		

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-She had asked for a seat belt restraint to keep Resident #2 safe and from falling out of her wheelchair again.
-She had not signed an informed consent for the seat belt but she had spoken with the staff at the facility about the use of a restraint.
-She did not recall a care plan meeting to discuss the use of restraints for Resident #2.

Interview with personal care aide (PCA) on 12/14/22 at 9:30am revealed:
-She had a history of multiple falls from the bed and out of her wheelchair.
-The facility had tried her in a seat belt but she "broke" two of them because she constantly leaned forward and scooted.
-She did not think she could get up over the pommel cushion even if she wanted to.

Interview with medication aide (MA) on 12/14/22 at 9:53am revealed:
-Resident #2 had multiple falls and the facility had tried different things to keep her from falling.
-Resident #2 had used a seat belt and she broke it and then they put her back in the pommel cushion.
-The pommel cushion kept her from scooting to far in her chair and falling out of it.
-She could not stand up anymore and she doubted Resident #2 could stand up and over the pommel cushion to get out of her chair now.
- She did not recall staff releasing the seat belt as she was supposed to be in it while she was up in her wheelchair.

Interview with Special Care Coordinator (SCC) on 12/15/22 at 10:00am revealed:
-She did not know a restraint assessment needed to be completed for Resident #2 as the facility was a restraint free facility.

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D 482	Continued From page 78 - The facility currently had orders for the lap belt and pommel cushion and the personal alarm. -She was not sure who was responsible to complete the assessment or the signed consent, but she was responsible for completing the care plan for Resident #2. -She had no documentation to show where the seat belt had been checked or released other than the regular expectations of staff to lay eyes on each resident in the facility every 30 minutes. -She had not updated the care plan to include Resident #2's numerous falls or included the use of the lap belt, pommel cushion with personal alarm. -She did not know there needed to be an assessment and care plan along with and a signed consent by the Resident #2's family or legal representative. Interview with the Executive Director on 12/15/22 at 4:30pm revealed: -The facility was a restraint free facility and did not use restraints. -Resident #2 could no longer stand on her own but continued to try and move and lean forward in her chair. -The facility had placed her in a pommel cushion. -She had had a conversation with a family member for Resident #2 who voiced her concern and wanted Resident #2 restrained to prevent further falling. -The Nurse Practitioner (NP) had written an order on 12/07/22 for the pommel cushion. -It was the SCC's responsibility to keep the Resident records updated. Telephone interview with Resident #1's NP on 12/16/22 at 3:00pm revealed: -The original order was for a pommel cushion on 09/23/22.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 482	Continued From page 79 -Resident #2 had experienced multiple falls. -She wrote the order for a seat belt at the family's request on 10/31/22. -The seat belt did not work as Resident #2 would take it off or tear them up and continue to fall. -She had torn up 2 seat belts. -Around the 1st week of December, she had written an order to go back to the pommel cushion for safety. -She had noticed on 12/14/22 that the eMAR had her using the seat belt and the pommel. -She spoke with the SCC on 12/16/22 and told her it needed to be corrected for Resident #2 to be using the pommel cushion with the personal alarm and discontinue the seat belt.	D 482		