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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM	3000 MILLS CHASE LOOP APEX, NC 27523

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 02/01/23 - 02/03/23.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 3 of 12 water fixtures at the sinks in two public bathrooms that were accessible for resident use across the hall from the residents dining room and at the sink in a resident's bathroom on the Assisted Living (AL) hall. The findings are: Observation of water temperatures on 02/01/23 at 9:45am of the sink in the women's bathroom across the hall from the resident's dining room, revealed the hot water temperature was 138.8°F. Observation of water temperatures on 02/01/23 at 9:48am of the sink in the men's bathroom across the hall from the resident's dining room, revealed the hot water temperature was 140.7°F.	D 113		

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D 113	Continued From page 1 Observation of water temperatures on 02/01/23 at 9:48am of the sink in Resident Room 1001 was 119.8°F. Review of the monthly water temperature logs dated 08/2022 to 01/2023 ranged from 101°F - 115°F. Interview with the resident residing in room 1001 on 02/01/23 at 9:50am revealed he had no problems with the water being too hot or too cold as he was able to adjust it. Interview with a personal care aide (PCA) on 02/01/23 at 10:00am revealed: -There were no complaints of the water being too hot or too cold when using the bathrooms across the hall from the dining room. -She had not noticed the water being too hot or too cold, but she did not usually use that bathroom. Interview the Maintenance Director on 02/01/23 at 9:50am revealed: -He checked the water temperature and completed the logs monthly. -He had not thought to check these two bathrooms since residents rarely use them. -He knew the correct temperature range was 100°F - 116°F. -He would adjust the mixer valve to get the temperatures between 100°F and 116°F. -He would go back and check the water temperatures to make sure what he had done had fixed the problem. -He had not had anyone (residents or staff) report problems with the water being too hot or too cold. -The water temperature logs were kept in his office.	D 113		

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D 113	Continued From page 2 -If the water temperatures were not within the 100°F and 116°F range, he would report it and then fix it. -He reported any water temperatures that were out of the range to the Director of Clinical Services (DCS) and the Administrator. -He would contact the corporate maintenance director for assistance if there was something that needed to be fixed that he could not do himself. Interview the Administrator on 02/01/23 at 10:05am revealed: -She expected the water temperatures to be checked by the Maintenance Director or designee if he was not available. -The Maintenance Director reported to her and the Administrator whenever any water temperatures were out of the 100°F and 116°F range. -She was not aware of the temperatures in the two bathrooms across from the resident's dining room were over 116°F. -None of the resident's had complained that the water was too hot	D 113		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 270		

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Based on observations, interviews, and record reviews the facility failed to provide 2 of 4 sampled residents (#2, #4) with increased supervision who had multiple recurrent falls.

The findings are:

Review of the facility's Fall Management Policy dated 07/15/20 revealed:
-The policy was in place to promote safety and preserve mobility by reducing the risk of falls and fall related injuries.
-Each fall should be investigated to determine causative factors and the effectiveness of safety measures implemented to minimize falls based on situation, contributing factors, safety measures/devices, and medications.
-Interventions were to be documented on the resident's care plan and communicated to the facility staff.

1. Review of Resident #2's current FL-2 dated 07/19/22 revealed:
-Diagnoses included altered mental status and acute urinary tract infection (UTI).
-The resident was constantly disoriented and semi-ambulatory with a walker/rollator.

Review of Resident #2's current care plan dated 10/03/22 revealed:
-The resident sometimes had bouts of hallucinations and needed reassurance.
-The resident required extensive assistance with toileting, bathing, and dressing, limited assistance with eating and grooming, supervision with ambulation, and was independent with transfers.

Review of Resident #2's Assessment Tool dated 01/10/23 revealed:

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D 270	Continued From page 4 -The resident required minimal assistance with ambulation and occasional needed verbal cues or reminders. -The resident had 2 or more falls in the last 3 months and unstable gait. -The resident required hands on physical assistance with toileting to include transfers. -The resident had moderate confusion and required occasional redirection. Review of Resident #2's physician orders dated 12/12/22 revealed: -There was an order for Seroquel 12.5mg (used to treat mood disorders) every morning. -There was an order for Seroquel 25mg every night at bedtime. -There was an order for Seroquel 25mg every 12 hours as needed for hallucinations or paranoia. Observation of Resident #2 on 02/01/23 at 10:46am revealed: -The resident was pointing at the wall talking to the medication aide (MA) about something on the wall that was not there. -The resident was seated on the couch with her walker next to her and required significant assistance in being repositioned with more support behind her back by the MA. Interview with the MA on 02/01/23 at 10:53am revealed: -Resident #2 had Lewy Body dementia and had been experiencing significant hallucinations and delusions that morning. -She was going to administer the resident's medications and see if they were effective in treating the hallucinations before administered the as needed (PRN) medication prescribed to the resident to treat the hallucinations and delusions.	D 270		

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D 270	Continued From page 5 Interview with Resident #2's family member on 02/03/23 at 9:46am revealed: -Resident #2 had resided at the facility for about one year because she needed 24/7 care with diagnoses such as Parkinson's disease, dementia, and falls. -The staff turnover was frequent and follow-up to Resident #2's care and needs was inconsistent. -He brought numerous concerns to the Administrator and Director of Clinical Services (DCS) while visiting at the facility or via email and he often never received any response or follow-up. -He wanted to implement a sitter, which he was willing to pay for with out-of-pocket funds, for Resident #2 because she had been having delusions, hallucinations, falls, and changes in mental status when she had a UTI, but that still had not happened due to lack of response from the facility. -He felt like there was a delay in noticing Resident #2's change in mental status in the early stages of her development of a UTI which he felt delayed her treatment and subsequently contributed to her falls leading to visits to the emergency that he felt could be prevented. -He emailed the DCS twice within the last two months about implementing a sitter for Resident #2 because he was told there was a list of approved sitters he could pay for privately and has still not received a response. -When he saw the DCS in person at the facility he also inquired about a sitter for Resident #2 she said she "would get to it" and he still had not heard back. -He had lost count of the resident's falls, but the resident had been to the emergency department (ED) 4-5 times since July 2022 when she fell for the first time in which she had sustained injuries	D 270		

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such as a hematoma and brain bleed.
-The facility was supposed to have the resident on increased supervision with 30-minute checks but were often understaffed and he was not sure that was always happening.
-When he visited, he would sometime press the resident's call bell and it always took 20-30 minutes for someone to respond to the resident's room.

Review of Resident #2's hospital admission note dated 07/14/22 at 11:17pm revealed:
-The resident had a history of Alzheimer's disease, dementia, Parkinson's disease, a pacemaker who presented that day with increased confusion and a fall.
-She was experiencing pain in left shoulder, the back of her head, and her middle back into her left hip.
-The resident was assessed as a chronically ill appearing female who was acutely who was acutely delirious and she was admitted to the hospital.
-Acute trauma was ruled out but the resident was hypertensive (high blood pressure), unable to follow commands, confused, and admitted to the hospital for further evaluation with a diagnosis of altered mental status and acute UTI.
-The resident was discharged back to the facility on 07/22/22 after treatment for altered mental status and assessed to have poor insight and judgement making skills, and changes in her medications to treat hallucinations and UTI.

Review of Resident #2's Incident/Accident (I/A) report dated 09/14/22 at 10:10am revealed:
-The medication aide (MA) found the resident on the floor in her room without obvious injury.
-The resident stated she hit the back of her head "lightly" when her legs got caught in her blanket

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and she slipped out of bed.
-Emergency medical services (EMS) were called, and the resident was transported to the emergency department (ED) for further evaluation.
-There was a predisposing situational factor documented that ambulating without assistance may have contributed to the resident's fall.

Review of Resident #2's ED provider note dated 09/14/22 at 8:22am revealed:
-The resident had an unwitnessed fall hitting her head and denied pain.
-Imaging was performed and significant trauma or injury were ruled out.
-The resident was discharged back to the facility with a diagnosis of closed head injury and fall with instructions to return to the ED for any increased confusion, headache, changes in vision, dizziness, lightheadedness, weakness, numbness, trouble swallowing, slurred speak, balance and coordination difficulties when walking, vomiting, fever, or any other worsening of condition.

Review of Resident #2's I/A report dated 10/01/22 at 10:40am revealed:
-Staff heard a big boom and when they entered the residents room found her on the floor by her bed in which she had a tender spot on the back of her head but had no other obvious injuries.
-The resident stated she fell and hit her head.
-EMS was called and the resident was transported to the ED for further evaluation.
-There were predisposing factors documented that may have contributed to the resident's fall such as confusion, impaired memory, and use of a walker.

Review of Resident #2's ED provider note dated

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D 270	Continued From page 8 10/01/22 at 10:12am revealed: -The resident had an unwitnessed fall with evidence of head trauma, bruising, and right shoulder pain along with increased confusion. -The resident had an abrasion with tenderness to the back of her scalp, pain with range of motion in her right shoulder, and tenderness over the bone on the upper arm. -She reported that she had been on the floor at the facility for hours but had a diagnosis of Parkinson's disease and dementia and her ability to recount details as a historian was unreliable. -Imaging was performed and there was no sign of significant trauma and UTI was ruled out. -The resident was discharged back to the facility with instructions to take Tylenol to treat the pain from her "bumps and bruises". Review of email correspondence dated 11/21/22 revealed: -Resident #2's family member emailed the resident's primary care provider (PCP) and copied the Administrator stating the had recently visited the resident and observed her to be weak and wobbly on her feet; they requested thoughts and interventions to a care plan to avoid any additional falls. -There was no reply to Resident #2's family member from the facility. Review of Resident #2's progress notes dated 12/10/22 at 1:20pm revealed: -The resident had an unwitnessed fall on 12/10/22, was diagnosed with a UTI, and had been assessed with increased unsteadiness and weakness that shift. -The resident almost fell 3 times while walking to the bathroom with assistance and was very lethargic.	D 270		

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Review of Resident #2's progress reports dated 12/10/22 revealed:
-The resident was hallucinating and talking about leaving the facility.
-At 6:13pm, the resident had an unwitnessed fall without injury in her room and stated she did not hurt anywhere.

Review of Resident #2's progress reports dated 12/15/22 at 9:01pm revealed the resident had not slept all night, had hallucinations of children in her room she attempted to chase and almost fell, and was very confused and disoriented but not able to be redirected.

Review of Resident #2's progress reports 12/15/22 at 4:51pm revealed:
-The resident was screaming in her room for police and staff heard the resident fall and hit her head.
-EMS was called the resident was sent to the ED for further evaluation.

Review of Resident #2's ED provider note dated 12/15/22 at 5:21pm revealed:
-The resident had an unwitnessed fall with a small scalp hematoma (bruise) and coccyx (tailbone) pain upon EMS arrival.
-There was no evidence of substantial injuries, and the resident was discharged back to the facility with Tylenol for pain control.

Review of Resident #2's progress reports dated 12/16/22 at 6:14am revealed the resident had a fall in her room while ambulating without her walker, was complaining of back and head pain, and was sent out via EMS to the ED for further evaluation.

Review of Resident #2's ED provider note dated

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12/16/22 at 6:28am revealed:
-The resident had an unwitnessed fall with increased confusion per the facility, was last seen for a fall in the ED yesterday, and this was her third fall that week.
-The resident had dementia, Parkinson's disease, and hypothyroidism and was complaining of significant pain in her left rib cage, right shoulder, thoracic and lumbar pain, and pain with range of motion.
-The resident was to have Tylenol for pain because there was a concern with the side effects of a stronger pain medication due to how unsteady on her feet she already was.
-The resident's trauma work-up was negative and she was discharged back to the facility with instructions to come back as needed.

Review of Resident #2's progress reports dated 12/16/22 at 9:41pm revealed the resident was seated at the nurse's station because she was not ready to go to bed and she could not be left alone due to trying to get up with a very unsteady gait.

Review of Resident #2's progress reports dated 12/17/22 at 2:55pm revealed the resident had been to the ED for 2 unwitnessed falls and had been lethargic and sleeping all day refusing breakfast and lunch.

Review of Resident #2's progress reports dated 12/20/22 at 11:15am revealed:
-The note was documented by a MA.
-The resident had not slept, had severe hallucinations that a man was there to kill her, and was combative and resistive to care unable to be redirected.
-The resident was at an increased risk of falling due to the hallucinations and delusions and the

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family had requested a mental health provider (MHP) intervention.
-A Telehealth request was sent to the resident's MH provider per the family's request.

Review of email correspondence dated 12/21/22 to 02/06/23 revealed:
-On 12/21/22, Resident #2's family member emailed the DCS and the Resident Care Coordinator (RCC) to inquire about obtaining a sitter and asking for a list of people that could provide that service; there was no response.
-On 12/27/22, Resident #2's family member sent a second email to the DCS and RCC requesting recommendations for a sitter.
-On 12/27/22, the DCS responded back to the email stating she provided the family member with an updated medication list but she did not respond to the request for a sitter.
-On 12/28/22, Resident #2's family member asked the DCS and RCC about a list of care givers to provide a sitter and there was no response.

Review Resident #2's PCP visit note dated 01/04/23 revealed:
-The resident had dementia with medication management with appropriate mood.
-The resident had visual and audible hallucinations per facility staff but did not have any increase or changes in behavior, appetite, or sleep pattern since her last assessment.

Review of Resident #2's facility record revealed:
-The resident had documentation of falls on 07/14/22, 09/14/22, 10/01/22, 12/10/22, 12/15/22, and 12/16/22.
-There was documentation in the resident's progress notes that she was on every 30-minute checks on 12/13/22, 12/15/22 and 12/19/22 but

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there was no other documentation of increased supervision for the resident.

Interview with a medication aide (MA) on 02/03/23 at 3:16pm revealed:
-It was important to communicate falls and report them to the resident's provider to guide resident care and obtain orders as needed.
-Resident #2 needed to be watched closely and she would check on the resident every 30-minutes when she worked because the resident had hallucinations and delusions.
-She had never been instructed to check on the resident more often than the facility's expectation of every 2-hours but the resident had wandering behaviors and falls and she felt the resident should be monitored more closely.
-She did not document her 30-minute checks on Resident #2 and there were no orders or instructions for increased supervision or a sitter for the resident otherwise.

Interview with a second MA on 02/03/23 at 6:34pm revealed:
-Resident #2 had wandering behaviors with hallucinations and delusions and was unsteady on her feet.
-Resident #2 was checked on every 2-hours and there were no other orders or interventions in place to check on the resident more often.
-Resident #2's family member had requested increased supervision and a sitter and reached out to the RCC, DCS, and Administrator about their request but had not received any follow-up yet.
-She had never been instructed to check on Resident #2 more often than every 2-hours but would try to park her computer outside of the resident's door to try and keep a closer eye of her due to her fall risk and because she was worried

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about the resident's safety and knew the family was worried too.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility.
-Resident #2's family member visited her almost every day and they had never asked her for information regarding hiring a private sitter but did request a facility staff member to sit with her.
-The staff tried to keep Resident #2's door open to keep a better eye on her and staff were to check on her every hour instead of every two hours per instructions at staff meeting the previous week.
-There was no documentation of resident supervision checks and there were no specific orders for increased supervision or a sitter for the resident.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-Resident #2 had experienced some falls around having UTIs when she had a change in mental status and had some hallucinations and wandering behaviors.
-Any interventions for falls to include increased supervision would have been documented in the resident's progress notes.
-Resident #2 was supposed to receive increased rounding each hour instead of the normal every two hours any time she was on an antibiotic for treatment of a UTI for about one week and then the increased rounding would end.
-When a resident fell and had injuries that required more than basic first aid, they were sent

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to the ED for further evaluation and a post-fall evaluation with any implemented interventions would be documented in their progress notes with increased monitoring for 72 hours after the fall.
-It was important for Resident #2's PCP to be aware of all her falls for continuity of care.
-She was not aware Resident #2's family wanted a sitter for the resident but thought it was an excellent intervention for the resident's safety.

Interview with Resident #2's primary care provider (PCP) on 02/02/23 at 3:30pm revealed:
-She was aware the resident had experienced falls around a UTI diagnosis but had not been made aware that the resident fell on 09/14/22, 10/01/22, 12/10/22, or 12/16/22 despite facility documentation.
-She expected the facility to provide the resident with supervision according to her needs to prevent falls.
-She expected to be notified of all resident falls to ensure the resident's safety and to have the option to assess the resident for injuries and ensure their behavior was appropriate after the fall.
-If she had been made aware of the resident's additional falls, she would have ensured the resident's safety to prevent injury due to the resident's orientation status and placed an order for the resident to have sitter.

2. Review of Resident #4's current FL-2 dated 09/16/22 revealed:
-Diagnoses include dementia, mood disturbance, anxiety, abnormalities of gait and mobility, and muscle weakness.
-The resident was constantly disoriented, non-ambulatory, and unable to communicate needs.

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D 270	Continued From page 15 Review of Resident #4's current care plan dated 11/03/22 revealed: -The resident received services from hospice and had little interaction with anyone other than her spouse. -The resident was constantly disoriented and did not speak. -The resident required extensive assistance with eating and was totally dependent on staff assistance for all other activities of daily living. Review of Resident #4's Resident Assessment dated 08/15/22 revealed: -The resident required hands on physical assistance with ambulation and transfers on a regular basis. -The resident exhibited severe confusion and required frequent redirection and monitoring. Review of Resident #4's facility progress note dated 09/29/22 reveled: -The resident was found on the floor after unwitnessed fall by the hospice provider. -The resident had gash to her lower left leg and bruising that extended up to the knee with pain that was assessed and cleaned by the hospice provider. Review of Resident #4's Incident/Accident (I/A) report dated 09/29/22 revealed the resident was found on the floor by her hospice provider and had impaired memory. Review of Resident #4's physician communication form dated 10/11/22 revealed the resident was found on the floor beside her bed with a skin tear on her left forearm. Review of Resident #4's I/A report dated 10/11/22 revealed:	D 270		

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-The resident had an unwitnessed fall with a skin tear to her left forearm.
-The resident had impaired memory, gait imbalance, and weakness.

Review of Resident #4's physician communication form dated 10/29/22 revealed the resident had an unwitnessed fall next to her bed with no injuries.

Review of Resident #4's I/A report dated 10/29/22 revealed:
-The resident had an unwitnessed fall with no pain.
-The resident was confused with impaired memory and incontinent.

Review of Resident #4's facility progress note dated 01/01/23 revealed the resident was found on the floor in her room with no sign of obvious injury.

Review of Resident #4's physician triage note dated 01/01/23 revealed the resident was to be on supervision checks per facility protocol due to a fall and to follow up for acute changes.

Review of Resident #4's facility progress note dated 01/03/23 revealed the resident was on 30-minute checks for a recent unwitnessed fall.

Review of Resident #4's facility progress note dated 01/04/23 revealed the resident had an unwitnessed fall without injury or pain and was on 30-minute checks.

Review of Resident #4's facility progress note dated 01/05/23 revealed:
-The resident was on 30-minute checks due to a recent fall.

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D 270	Continued From page 17 -The resident had been up most of the night and would continue to be monitored. Review of Resident #4's facility progress note dated 01/13/23 revealed the resident was on 30-minute checks to prevent falls. Review of Resident #4's facility progress note dated 01/14/23 revealed: -The resident was found on her bedroom floor around 4:00pm without obvious injury. -Her fall mat was not in place next to her, and her providers were notified. Review of Resident #4's facility progress note dated 01/15/23 revealed: -The resident had an unwitnessed fall and was awake most of the night. -The resident was on 30-minute checks. Review of Resident #4's hospice provider note dated 01/20/23 revealed: -On 01/04/23 the resident was lethargic, weak, and in need of total assistance for activities of daily living. -On 01/13/23, the resident was weak, lethargic, and unable to support her own weight. -On 01/16/23 the resident was asleep, unresponsive, and kept her eyes closed the entire visit. -The facility was to monitor the resident and reinforce fall precautions. Review of Resident #4's facility record revealed: -The resident had 7 documented falls on 09/29/22, 10/11/22, 10/29/22, 01/01/23, 01/04/23, 01/14/23, and 01/15/23. -The resident received 30-minutes checks on 01/03/23, 01/04/23, 01/05/23, 01/13/23, and 01/15/23 but had no other documentation of	D 270		

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D 270	Continued From page 18 increased supervision from 08/15/22 to 02/03/23. Interview with a medication aide (MA) on 02/03/23 at 3:16pm revealed: -It was important to communicate falls and report them to the resident's provider to guide resident care and obtain orders as needed. -Resident #4 had frequent falls but was very cooperative and there were no interventions in place for the resident to have increased supervision; she did not know why. -She had never been instructed to check on Resident #4 more frequently than every 2-hours but tried to check on the resident more often because of her risk of falling when she worked. Interview with a second MA on 02/03/23 at 6:34pm revealed: -Resident #4 was on every 2-hour supervision checks and there were no other orders or interventions in place to provide the resident with increased supervision that she was aware of. -She had never been instructed to check on the resident more frequently and the resident did not have a sitter in place. Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed: -She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility. -It was important to notify the PCP of falls or change in behaviors so they could provide care as indicated and the facility could implement those orders as needed such as imaging(x-rays), medication reviews, transfer to a higher level of care, or other interventions. -The staff tried to keep Resident #4's door open	D 270		

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to keep a better eye on her and staff were to check on her every hour instead of every two hours per instructions at staff meeting the previous week.
-There was no documentation of resident supervision checks and there were no specific orders for increased supervision or a sitter for the resident.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-Any interventions for falls to include increased supervision would have been documented in the resident's progress notes.
-When a resident fell and had injuries that required more than basic first aid, they were sent to the ED for further evaluation and a post-fall evaluation with any implemented interventions would be documented in their progress notes with increased monitoring, in which the resident was checked on more often that every two hours as normal, for 72 hours after the fall.
-Staff would know to provide a resident with increased monitoring because there would be communication and a task in the computer to do so.
-Resident #4 had experienced multiple falls with skin tears, her hospice provider and PCP should be aware, and she never needed more than basic first aid from her falls.
-The facility had implemented a fall mat and concave mattress for Resident #4 per her hospice provider's orders, but there was no increased supervision for resident in place because the family could not afford a private sitter for her.

Interview with Resident #4's primary care provider (PCP) on 02/02/23 at 3:30pm revealed she expected the facility to provide the resident with

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supervision according to her needs to prevent falls.

Interview with Resident #4's hospice nurse on 02/03/23 at 5:28pm revealed:
-He was aware of the residents falls and when he assessed her the injuries observed were consistent with what the facility had reported to him.
-He visited the resident 3-times per week since October 2022 and last saw her that day, 02/03/23.
-Falls were a concerning issue for Resident #4 and he had provided orders to the facility for fall mat and had performed a medication review to try and decrease her risk of falls.
-To his knowledge, the resident was on supervision checks every 2-hours just like all the other residents and had not received any increased supervision.
-The facility did not need an order to check on the resident more frequently or provide the resident with a sitter and he expected the facility to provide increased supervision as indicated per resident needs as needed to prevent falls and injury as much as possible.
-Providing increased supervision to residents who were a high fall risk was always helpful in reducing falls and improving outcomes.

Attempted interview with Resident #4's family member on 02/03/23 at 2:50pm was unsuccessful.

The facility failed to ensure increased supervision for 2 of 4 sampled resident (#2, #4) who were high falls risks and each sustained multiple falls. Resident #2 sustained 6 falls resulting in 5 emergency room (ED) visits, 1 hospitalization, and injuries that included right ribs, hip, shoulder,

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D 270	Continued From page 21 and arm pain, lacerations to the head, bruising to the head and right arm, and back and coccyx (tailbone) pain. Resident #4 sustained 7 falls that resulted in a gash to her left leg and multiple skin tears. The failure of the facility put the residents at risk of severe injury and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/03/23. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED March 5, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to notify 1 of 3 sampled residents (#2) primary care provider (PCP) of recurrent falls and worsening behaviors in which medication was not effective in treating. The findings are: Review of Resident #2's current FL-2 dated 07/19/22 revealed: -Diagnoses included altered mental status and acute urinary tract infection (UTI). -The resident was constantly disoriented and semi-ambulatory with a walker/rollator.	D 273		

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D 273	Continued From page 22 Review of Resident #2's current care plan dated 10/03/22 revealed: -The resident sometimes had bouts of hallucinations and needed reassurance. -The resident required extensive assistance with toileting, bathing, and dressing, limited assistance with eating and grooming, supervision with ambulation, and was independent with transfers. Review of Resident #2's physician orders dated 12/12/22 revealed additional diagnoses included Alzheimer's disease, hypertension, hypothyroidism, and Parkinson's disease. Interview with Resident #2's family member on 02/03/23 at 9:46am revealed: -Resident #2 had resided at the facility for about one year because she needed 24/7 care with diagnoses of Parkinson's disease, dementia, and falls. -He brought numerous concerns to the Administrator and Director of Clinical Services (DCS) while visiting at the facility or via email and he often never received any response or follow-up. -When Resident #3 was suffering from a UTI he emailed the DCS to request a referral to a specialist 3 times and did not get a response to that request until 5-6 weeks later. -He felt like there was a delay in noticing Resident #2's change in mental status and behaviors in the early stages of her development of a UTI which he felt delayed her treatment and subsequently contributed to her falls leading to visits to the emergency that he felt could be prevented. -He had lost count of the resident's falls, but the resident had been to the emergency department (ED) 4-5 times since July 2022 when she fell for the first time in which she had sustained injuries	D 273		

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D 273	Continued From page 23 such as a hematoma and brain bleed. a. Review of the facility's Fall Management Policy dated 07/15/20 revealed: -The policy was in place to promote safety and preserve mobility by reducing the risk of falls and fall related injuries. -All resident falls should be reported to the resident's primary care provider (PCP) for review as well as any recommended they must include an incident report which was required to be completed with each fall. Review of Resident #2's Assessment Tool dated 01/10/23 revealed: -The resident required minimal assistance with ambulation and occasionally needed verbal cues or reminders. -The resident had 2 or more falls in the last 3 months and an unstable gait. -The resident required hands on physical assistance with toileting to include transfers. -The resident had moderate confusion and required occasional redirection. Review of Resident #2's hospital admission note dated 07/14/22 at 11:17pm revealed: -The resident had a history of Alzheimer's disease, dementia, Parkinson's disease, a pacemaker who presented that day with increased confusion and a fall. -She was experiencing pain in left shoulder, the back of her head, and her middle back into her left hip. -The resident was hypertensive (high blood pressure), acutely delirious, unable to follow commands, confused, and admitted to the hospital for further evaluation with a diagnosis of altered mental status and acute UTI. -The resident was discharged back to the facility	D 273		

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on 07/22/22 after treatment for altered mental status with changes in her medications to treat hallucinations and UTI.

Review of Resident #2's incident/accident (I/A) report dated 09/14/22 at 10:10am revealed:
-The medication aide (MA) found the resident on the floor in her room without obvious injury.
-The resident stated she hit the back of her head "lightly" when her legs got caught in her blanket and she slipped out of bed.
-Emergency medical services (EMS) were called, and the resident was transported to the emergency department (ED) for further evaluation.
-There was a predisposing situational factor documented that ambulating without assistance may have contributed to the resident's fall.
-The resident's PCP was documented as notified.

Review of Resident #2's ED provider note dated 09/14/22 at 8:22am revealed:
-The resident had an unwitnessed fall hitting her head and denied pain.
-Imaging was performed and significant trauma or injury were ruled out.
-The resident was discharged back to the facility with a diagnosis of closed head injury and fall with instructions to return to the ED for any increased confusion, headache, changes in vision, dizziness, lightheadedness, weakness, numbness, trouble swallowing, slurred speak, balance and coordination difficulties when walking, vomiting, fever, or any other worsening of condition.

Review of Resident #2's I/A report dated 10/01/22 at 10:40am revealed:
-Staff heard a big boom and when they entered the residents room found her on the floor by her

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bed in which she had a tender spot on the back of her head but had no other obvious injuries.
-The resident stated she fell and hit her head.
-EMS was called and the resident was transported to the ED for further evaluation.
-There were predisposing factors documented that may have contributed to the resident's fall such as confusion, impaired memory, and use of a walker.
-The resident's PCP was documented as notified notified.

Review of Resident #2's ED provider note dated 10/01/22 at 10:12am revealed:
-The resident had an unwitnessed fall with evidence of head trauma, bruising, and right shoulder pain along with increased confusion.
-She reported that she had been on the floor at the facility for hours but had a diagnosis of Parkinson's disease and dementia and her ability to recount details as a historian was unreliable.
-Imaging was performed and there was no sign of significant trauma and UTI was ruled out.
-The resident was discharged back to the facility.

Review of Resident #2's progress note dated 12/10/22 at 1:20pm revealed:
-The resident had an unwitnessed fall on 12/10/22, was diagnoses with a UTI, and had been assessed with increased unsteadiness and weakness that shift.
-The resident almost fell 3 times while walking to the bathroom with assistance and was very lethargic.
-There was no documentation that the resident's PCP was notified.

Review of Resident #2's progress note dated 12/10/22 at 4:20pm with a follow up at 7:55pm revealed Seroquel 25mg had been administered

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and was not effective as the resident was still hallucinating, had a fall, and was talking about leaving the facility.

Review of Resident #2's progress note dated 12/10/22 at 6:13pm revealed:
-The resident had an unwitnessed fall without injury in her room and stated she did not hurt anywhere.
-It was documented that "all" parties were notified.

Review of Resident #2's progress note dated 12/15/22 at 4:51pm revealed:
-The resident was screaming in her room for police and staff heard the resident fall and hit her head.
-EMS was called the resident was sent to the ED for further evaluation.

Review of Resident #2's ED provider note dated 12/15/22 at 5:21pm revealed:
-The resident had an unwitnessed fall with a small scalp hematoma and coccyx pain upon EMS arrival.
-There was no evidence of substantial injuries, and the resident was discharged back to the facility with Tylenol for pain control.

Review of Resident #2's progress note dated 12/15/22 at 9:01pm revealed the resident had not slept all night, had hallucinations of children in her room she attempted to chase and almost fell, and was very confused and disoriented but not able to be redirected.

Review of Resident #2's ED provider note dated 12/16/22 at 6:28am revealed:
-The resident had an unwitnessed fall with increased confusion per the facility, was last seen

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for a fall in the ED yesterday, and this was her third fall that week.
-The resident had dementia, Parkinson's disease, and hypothyroidism and was complaining of significant pain in her left rib cage, right shoulder, and thoracic and lumbar pain.
-The resident was to have Tylenol for pain because there was a concern with the side effects of a stronger pain medication due to how unsteady on her feet she already was.
-The resident's trauma work-up was negative and she was discharged back to the facility with instructions to come back as needed.

Review of Resident #2's progress note dated 12/16/22 at 6:14am revealed:
-The resident had a fall in her room while ambulating without her walker and was complaining of back and head pain.
-The resident was sent out via EMS to the ED for further evaluation.

Review of Resident #2's progress note dated 12/17/22 at 2:55pm and 10:19pm revealed:
-The resident had been to the ED for 2 unwitnessed falls and had been lethargic and sleeping all day refusing breakfast and lunch.
-The resident had two recent falls and had napped all day.

Review of Resident #2's facility record revealed:
-The resident had documentation of falls on 07/14/22, 08/17/22, 09/14/22, 10/01/22, 12/10/22, 12/15/22, and 12/16/22.
-It was documented that "all parties were notified" of the incident on 12/10/22 at 6:13pm in the resident's progress notes, but there was no other documentation that the resident's PCP had been notified of falls on 07/14/22, 12/15/22, or 12/16/22.

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D 273	Continued From page 28 Interview with Resident #2's primary care provider (PCP) on 02/02/23 at 3:30pm revealed: -She was aware the resident had experienced falls around a UTI diagnosis but she had not been made aware that the resident fell on 09/14/22, 10/01/22, 12/10/22, or 12/16/22 despite the facility's documentation. -She expected to be notified of all resident falls to ensure the resident's safety and to have the option to assess the resident for injuries and ensure their behavior was appropriate after the fall. -It was important to assess residents after falls because it could signify unknown head trauma and result in a possible need for further evaluation at the hospital if the resident had not been assessed at the hospital already. -If she had been made aware of the resident's additional falls, she would have ensured the resident's safety to prevent injury due to the resident's orientation status and placed an order for the resident to have sitter. Interview with a medication aide (MA) on 02/03/23 at 3:16pm revealed: -It was important to communicate falls and report them to the resident's provider to guide resident care and obtain orders as needed. -She had not reported Resident #2's falls to the PCP because she had not been present when the resident had fallen. Interview with a second MA on 02/03/23 at 6:34pm revealed: -All falls were supposed to be reported to the resident's PCP because there could be unknown injury and the PCP could provide guidance and follow-up. -She was not sure why Resident #2's PCP was	D 273		

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not aware of her falls.
-The MAs were responsible to fill out the post-fall evaluation, obtain vital signs, and report the fall to the PCP via fax, telehealth, or phone and to the RCC, RCD, or the Administrator.
-She thought she notified Resident #2's PCP of her falls when she had been present but did not know for sure.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility.
-It was important to notify the PCP of falls so they could provide care as indicated and the facility could implement those orders as needed such as imaging(x-rays), medication reviews, transfer to a higher level of care, or other interventions.
-The MAs were responsible to have reported falls and change in behavior to her, the RCC, and the resident's PCP which should have been done for Resident #2 then documented in the progress notes.
-She was not aware or sure why Resident #2's PCP was not aware of all the resident's falls.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-Resident #2 had experienced some falls around having UTIs when she had a change in mental status.
-When a resident fell and had injuries that required more than basic first aid, they were sent to the ED for further evaluation and a post-fall evaluation with any implemented interventions would be documented in their progress notes.
-The DCS was responsible to notify her, the

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resident's family member, PCP, and local DSS of falls and she was not aware that the PCP had not been notified of all of Resident #2's falls as expected.
-It was important for Resident #3's PCP to be aware of all her falls for continuity of care.
-The facility did not report Resident #2's falls to her mental health provider (MHP) but it may have been important to the titration and treatment around changing medications.

b. Review of Resident #2's Assessment Tool dated 01/10/23 revealed the resident had moderate confusion and required occasional redirection.

Review of Resident #2's physician orders dated 12/12/22 revealed:
-There was an order for Seroquel 12.5mg (used to treat mood disorders) every morning.
-There was an order for Seroquel 25mg every night at bedtime.
-There was an order for Seroquel 25mg every 12 hours as needed for hallucinations or paranoia.

Review Resident #2's PCP visit note dated 01/04/23 revealed:
-The resident had dementia with medication management with appropriate mood.
-The resident had visual and audible hallucinations per facility staff but did not have any increase or changes in behavior, appetite, or sleep pattern since her last assessment.

Review of Resident #2's progress reports revealed:
-On 12/06/22 at 10:27pm, the resident walked down the hall with her walker saying someone was coming to get her at 8:24am, that someone had been at her door, that people were coming to

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get a newspaper in room, and pointing to things that were not there.
-On 12/06/22 at 10:28pm and 12/07/22 at 12:01am, Seroquel 25mg was administered and was ineffective as the resident was still up and down in her room with hallucinations.
-On 12/10/22 at 4:20pm and 7:55pm, Seroquel 25mg had been administered and was not effective as the resident was still hallucinating and was talking about leaving the facility.
-On 12/10/22 at 10:51, the resident was observed at dinner talking to someone at her table that was not there stating she was leaving the facility.
On 12/12/22 at 7:33am the resident had been up and down all night walking around in her room, was unable to relax, and staff were going to continue to monitor her to ensure she did not bring herself harm.
-On 12/12/22 at 10:35pm, the resident was more confused that usual.
-On 12/13/22 at 10:37am, the resident was very lethargic.
-On 12/15/22 at 5:47am, the resident was up talking to a little boy who was not there while pointing at him when she was asked who she was talking to.
-On 12/15/22 at 6:02am, the resident had still had slight confusion but in good spirits.
-On 12/15/22 at 4:51pm, the resident was screaming in her room for police.
-On 12/15/22 at 9:01pm, the resident had not slept all night, had hallucinations of children in her room she attempted to chase and almost fell, and was very confused and disoriented but not able to be redirected.
-On 12/16/22 at 9:41pm, the resident was seated at the nurse's station because she was not ready to go to bed and she could not be left alone due to trying to get up with a very unsteady gait.
-On 12/17/22 at 2:55pm, the resident had been to

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the ED for 2 unwitnessed falls and had been lethargic and sleeping all day refusing breakfast and lunch.
-On 12/17/22 at 10:19pm, the resident had two recent falls and had napped all day.
-On 12/18/22 at 10:03pm, the resident had a recent fall and continued to see things and people who were not there.
-On 12/19/22 at 6:13am, the resident had returned from the ED after a fall, had slept most of the night with a few occasions in which she had been found sitting up on the side of her bed and kept saying she was going to be kicked out of the facility at 8:00am.
-On 12/19/22 at 10:20pm, Seroquel 25mg was documented as having been administered because the resident was in her room saying she was going to "be put out" in the morning and was talking to another person in the room that was not there.
-On 12/20/22 at 11:15am, the resident had not slept, had severe hallucinations that a man was there to kill her, and was combative and resistive to care unable to be redirected. The resident was at an increased risk of falling due to the hallucinations and delusions and the family had requested a mental health (MH) intervention. A telehealth request was sent to the resident's MH provider per the family's request.
-On 12/20/22 at 11:40am, the MH provider was going to review the resident's current medications and fax new order recommendations.
-On 12/20/22 at 4:53am and 5:13am, Seroquel 25mg was documented as having been administered because the resident had been awake all night hallucinating thinking someone was trying to kill her and that someone was trying to "come and get the babies". The resident tried to get up twice throughout the night and was directed to try and get some sleep, but the

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medication was ineffective.
-On 12/28/22 at 7:15am and 7:48am, Seroquel 25mg was documented as having been administered the resident's hallucinations and delusions.
-On 12/28/22 at 9:39am, the resident was hallucinating a lot that morning and became very sleepy after a PRN medication was administered but hallucinations persisted until the resident fell asleep.
-On 12/29/22 at 8:28am and 8:49am, Seroquel 25mg was documented as having been administered but ineffective in treating the resident's hallucinations and delusions and the resident was still hallucinating and unable to be redirected.
-On 12/30/22 at 7:43am and 8:14am, Seroquel 25mg was documented as having been administered but ineffective in treating the resident's hallucinations and delusions.
-On 01/04/23 at 7:51am and 8:38am, Seroquel 25mg was documented as having been administered but ineffective in treating the resident's hallucinations and delusions.
-On 01/05/23 at 8:01am and 10:11am, Seroquel 25mg was documented as having been administered but ineffective in treating the resident's hallucinations of dead children.
-On 01/21/23 at 6:03am, the resident had been up all night with hallucinations and delusions and a PRN medication was administered but not effective.
-On 01/21/23 at 6:55am, Seroquel 25mg was documented as having been administered but ineffective in treating the resident's hallucinations and vivid delusions.
-On 01/21/23 at 8:12am, the resident had increased delusions and hallucinations, was unable to be redirected, and a PRN medication was given the previous shift but was not effective.

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-On 01/24/23 at 8:44am, the resident had increased confusion and hallucinations and as needed (PRN) medication was not effective.
-On 01/25/23 at 2:13pm, the resident had vivid hallucinations and delusions and was intermittently able to be redirected.
-It was documented that the resident's MHP was notified of behaviors per the family's request on 12/20/22 at 11:40am, but there was no other documentation that the resident's PCP or MHP was notified of any behaviors otherwise from 12/06/22 to 02/01/23.

Observation of Resident #2 on 02/01/23 at 10:46am revealed:
-The resident was pointing at the wall talking to the medication aide (MA) about something on the wall that was not there.
-The resident was seated on the couch with her walker next to her and required significant assistance in being repositioned with more support behind her back by the MA.

Interview with the MA on 02/01/23 at 10:53am revealed:
-Resident #2 had Lewy Body dementia and had been experiencing significant hallucinations and delusions that morning.
-She was going to administer the resident's medications and see if they were effective in treating the hallucinations before administered the as needed (PRN) medication prescribed to the resident to treat the hallucinations and delusions.

Interview with a medication aide (MA) on 02/03/23 at 3:16pm revealed:
-MAs were responsible to report changes in behaviors to resident's PCP or MHP, document the fall in the progress notes, and communicate

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the fall to the next shift after assessing the resident and checking their vital signs.
-It was important to communicate changes in behavior and report them to the resident's provider to guide resident care and obtain orders as needed.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility.
-It was important to notify the PCP of changes in behaviors so they could provide care as indicated and the facility could implement those orders as needed such as imaging(x-rays), medication reviews, transfer to a higher level of care, or other interventions.
-The MAs were responsible to have reported changes in behavior to her, the RCC, and the resident's PCP which should have been done for Resident #2 and then documented in the progress notes.
-She was not aware or sure why Resident #2's PCP was not aware of her changes in behavior.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-Resident #2 had experienced some falls around having UTIs when she had a change in mental status and had some hallucinations and wandering behaviors.
-About one month ago Resident #2 kept getting lost in the facility while ambulating with her walker and was having delusions.
-The DCS was responsible to notify her, the resident's family member, PCP, and local DSS of behavior concerns and she was not aware that

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D 273	Continued From page 36 the PCP was not notified of Resident #2's behaviors as expected. -It was important for Resident #3's PCP to be aware of all changes in behavior for continuity of care. Interview with Resident #2's primary care provider (PCP) on 02/02/23 at 3:30pm revealed: -It was important to assess for changes in behavior after falls because it could signify unknown head trauma and result in a possible need for further evaluation at the hospital if the resident had not been assessed at the hospital already. -She had not been notified that the resident had been experiencing increased behaviors, resistance to care, wandering and increased hallucinations. -She expected the facility to report any behaviors to her for resident safety. -If she had been made aware of the resident's behaviors, she would have ensured the resident's safety to prevent injury due to the resident's orientation status and placed an order for the resident to have sitter and followed up with her MHP. _____ The facility failed to notify residents' primary care provider (PCP) for 1 of 3 sampled residents (#2) of recurrent falls resulting in multiple visits to the emergency department (ED) and to report her prescribed medication was ineffective in treating her increasing hallucinations (behaviors) which contributed to falls. The failure of the facility put the residents at risk of severe injury and neglect and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/01/23.	D 273		

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D 273	Continued From page 37 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 20, 2023.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 3 sampled	D 280		

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residents (#2) had a licensed health professional support (LHPS) assessment.

The findings are:

Review of Resident #2's current FL-2 dated 07/19/22 revealed:
-Diagnoses included altered mental status and acute urinary tract infection (UTI).
-The resident was constantly disoriented and semi-ambulatory with a walker/rollator.
-The resident was to have physical therapy (PT) and occupational therapy (OT).

Review of Resident #2's current care plan dated 10/03/22 revealed:
-The resident sometimes had bouts of hallucinations and needed reassurance.
-The resident required extensive assistance with toileting, bathing, and dressing, limited assistance with eating and grooming, supervision with ambulation, and was independent with transfers.

Review of Resident #3's PT/OT facility visit notes revealed the resident had been seen for PT/OT services from 08/24/22 to 02/01/23 approximately three times per week to work on self-feeding, transferring, bed mobility, balance, strength, coordination, gait, walking, toileting, cognitive communication skills, visual perception, orientation, and other functional tasks.

Review of Resident #2's record revealed there were no LHPS assessments documented which would have included tasks for PT/OT therapy and transferring.

Observation of Resident #2 on 02/01/23 at 10:50am revealed:
-The PT staff were leaving the resident's room

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upon entrance to her room.
-The resident was seated on the couch with her walker/rollator next to her.
-The resident was repositioned with extensive assistance and cueing by the medication aide (MA).

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility.
-She was responsible to ensure residents had an LHPS assessment as needed for tasks necessary.
-She was not sure why Resident #2 did not have an LHPS assessment and must have somehow overlooked the fact that the resident needed one.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-She was not aware Resident #2 did not have an LHPS assessment as needed, expected, and required.
-It was the DCS's responsibility to identify tasks and ensure residents received an LHPS assessment as needed.
-Resident #2 should have received an LHPS assessment and it was important to have done to ensure the facility can perform the tasks needed to care for the resident.

Interview with the Regional Director on 02/02/23 at 2:56pm revealed:
-Resident #2 should have had an LHPS evaluation due to having tasks that required it.
-It was important to have LHPS evaluations completed on residents who had associated

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D 280	Continued From page 40 tasks to ensure staff were competent and knew how to effectively care for the resident's needs that required additional oversight. -LHPS assessments had been completed by a Registered Nurse (RN) at a sister facility for the last 2-3 quarters and she was not sure why the resident had not received an LHPS assessment from her. -It was the DCS's responsibility to identify when a resident had a task that required an LHPS assessment and add the resident to the RN's list to be completed when she came. -She assumed the DCS did not identify or overlooked the resident's need for an LHPS and therefore did not receive an assessment as expected.	D 280		
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 B VIOLATION Based on observations, interview, and record reviews the facility failed to ensure residents had reasonable response times when pushing their call bells and that 2 of 5 sampled residents (#2, #5) were treated with respect, dignity, and were free from misappropriation of resident property, consideration related to the violation of privacy and theft of Resident #5's money, reasonable response to grievances, and the lack of consideration and dignity in which Resident #2 had to wait over one hour to receive feeding	D 338		

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assistance while watching other residents eat in the dining room.

The findings are:

Review of the facility's Resident Rights Acknowledgement (not dated) revealed:
-Every resident was to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.
-To receive care and services which were adequate, appropriate, and in compliance with relevant federal and state laws, rules, and regulations.
-To be free of mental and physical abuse, neglect, and exploitation.
-To receive a reasonable response to his or her request from the facility administrator or staff.

1. Interview with a resident on 02/01/23 at 9:49am revealed:
-Staff turned over quickly at the facility but he was unsure if the facility struggled with staffing the facility for resident care.
-He used his call bell when he needed assistance with things such as transferring.
-Staff usually responded to his call bell quickly, but sometimes he had to wait up to 30 minutes.

Interview with a second resident on 02/01/23 at 10:09am revealed:
-She was independent but sometimes used her call for assistance.
-Staff usually responded to her call bell within 15-20 minutes.

Interview with a resident's family member on 02/03/23 at 9:46am revealed:
-The staff turnover was frequent and follow-up to resident care and needs was inconsistent.

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-When he visited the facility would sometime press the resident's call bell and it always took 20-30 minutes for someone to respond to the resident's room.

Interview with a personal care aide (PCA) on 02/03/23 at 8:35am revealed:
-She was responsible to answer call bells and to provide residents with assistance to meet their needs.
-The call bell system could be "glitchy" but she tried to respond to each request for assistance from the call bell system within 10-15 minutes and sometimes sooner if she was able based on staffing.
-She was often unable to assist other staff members with answering their call bells due to needing to attend to her own assigned residents.
-Medication Aides (MAs) did not answer call bells while passing medications which meant residents sometimes had to wait more than 15-30 minutes for assistance due to staffing and staff assignments.
-It was often hard to tell what room to go to next and who needed assistance because there were no lights outside of resident rooms indicating who had pressed their call bell when she was in another resident's room.
-Staff members were often late or called out and they were short staffed 1-2 times per week.

Interview with a second PCA on 02/03/23 at 9:16am revealed:
-She was responsible to assist residents as needed when they rang their call bells for the residents she was assigned to care for each shift.
-She tried not to make residents wait more than 5-20 minutes when answering their call bells.
-Some staff had the call bell system downloaded to their personal phone so they would know what

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room to go to next and it also showed when they rang the bell and how long they had been waiting.
-Sometimes they were understaffed, and she felt overwhelmed and rushed trying to meet resident needs.
-Some residents needed total care or a higher level of care such a feeding assistance which occupied a lot of her time.

Review of the call bell system log on the second PCA's phone on 02/03/23 at 9:29am revealed a resident in room 3134 had called for assistance using their call bell at 9:03am and was still waiting for assistance 26 minutes later.

Interview with a medication aide (MA) on 02/01/23 at 11:54am revealed:
-Staff frequently called out and she often worked over or extra shifts to cover the facility's short staffing.
-Today, there were 2 MAs, 1 personal care aide (PCA) came in late about 20 minutes prior, and the other PCA called out leaving the staffing for that shift short.
-Residents often had to wait a long time for a staff response to call bells when staffing was short because the MAs were having to take care of all the residents needs that would be done by PCAs, housekeeping, or dining staff and management would not help answer or respond to call bells during short staffing.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility.
-She was not sure how long the call bell response

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time had been an issue and she just got access and started getting notifications from the call bell system in December 2022.
-She had been working with the contracted company to service the call bell system to order more pagers and fix a 5-minute delay in the system because it was taking too long for staff to respond but they had not been able to fix it yet.
-It was important for staff to respond to call bells timely to assist residents as needed and she would like to see that response time at about 6-7 minutes.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-Delayed response to call bells had been an issue at the facility prior to her working at the facility in April 2022 and they had been trying to work on it.
-The issues they had addressed involved problems with the internet, the phones the call bell system went to weren't clearing the calls when they were answered, and faulty pendants for residents and staff along with other mechanical failures.
-Since those issues had been corrected, she expected staff to respond to call bells within 5-7 minutes; sometimes sooner and sometimes longer depending on the situation or day.
-The reports were showing that residents were waiting longer than the expectation but she did not think they were accurate due to mechanical failure and internet issues.
-She had some family members and residents complain and staff were to round on residents every two hours in between call bells to ensure resident needs were met.

Interview with the Regional Director on 02/02/23 at 9:48am and 11:13am revealed:
-She knew the facility had an on-going issue with

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the response time to call bells and it was an initiative the facility was working on to try and improve.
-She expected the response time to call bells to attend to resident needs to be 10 minutes or less.
-She was not sure what the current response time was but was not aware residents had reported having to wait from 15-60 minutes when they used their call bell which was too long.
-The Business Office Manager (BOM) was responsible for scheduling and staffing and reports to the Administrator who was responsible to ensure staffing was adequate to meet resident's needs.

2. Review of Resident #2's current FL-2 dated 07/19/22 revealed:
-Diagnoses included altered mental status and acute urinary tract infection (UTI).
-The resident was constantly disoriented and semi-ambulatory with a walker/rollator.

Review of Resident #2's current care plan dated 10/03/22 revealed:
-The resident sometimes had bouts of hallucinations and needed reassurance.
-The resident required extensive assistance with toileting, bathing, and dressing, limited assistance with eating and grooming, supervision with ambulation, and was independent with transfers.

Review of Resident #2's physician communication form dated 10/28/22 revealed:
-Per the resident's physical and occupational therapy evaluations the resident required 1:1 feeding assistance due to sensory-perceptive deficits associated with Alzheimer's disease.
-There was an order to assist the resident with all meals and to discuss the possible need of a higher level of care with the resident's family.

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D 338	Continued From page 46 Review of Resident #2's diet order dated 12/12/22 revealed the resident was on a regular diet with finger foods that could be eaten easily with her hands instead of cutlery to offer independence as able. Review of Resident #2's Assessment Tool dated 01/10/23 revealed -The resident required hands on physical assistance with meals and may wander during meals requiring assistance and redirection. -The resident had moderate confusion and required occasional redirection. Observation on 02/02/23 at 7:50am revealed: -Resident #2 was seated at a table in the dining room with a cup with a drinking straw. -There were 4 other residents seated in the dining room with no staff present. Observation on 02/03/23 at 8:10am in the residents dining room revealed: -A PCA entered the residents" dining room pushing a resident in a wheelchair. -The PCA began feeding the resident whom she had assisted into the dining room. Observation on 02/03/23 at 9:05am in the residents dining room revealed: -Another PCA had entered the residents' dining room and seated herself at Resident #2's table. -She was seated to the right of Resident #2 and had begun to feed Resident #2. Interview with a personal care aide (PCA) on 02/03/23 at 8:35am revealed: -The PCAs were responsible to assist residents with feeding assistance as needed. -She was expected to not make any resident's	D 338		

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wait to eat.
-Residents were to be served upon entrance into the dining room and she was not sure how long residents who needed feeding assistance normally had to wait, but it would also depend on staffing.
-There were usually only 2 PCAs scheduled per shift and there were two residents who required feeding assistance at each meal.
-If one PCA was busy, it might make one of the residents have to wait to eat until the second PCA was available to assist because one PCA would not feed more than one resident at a time.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-It was unacceptable for Resident #2 to have waiting 65 minutes to eat her breakfast.
-She expected residents to be acknowledged immediately and to be assisted with eating at the same time that all the residents ate and should not have to wait to eat.
-All care staff were capable to assist residents with eating and if there was not enough staff to feed a resident staff should have reported the issue to management to obtain assistance.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-Residents should not have to wait to eat and should be served right away while food is hot.
-PCAs were responsible to assist residents with eating and dietary staff were aware of which residents required feeding assistance.
-She was not aware Resident #2 had to wait to eat for over an hour on 02/02/23 and there was no reason she should have waited because there were plenty of staff who could have assisted her.
-If staff were unable to assist Resident #2 with feeding assistance, they should have reported the

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issue to management for assistance to ensure proper supervision of all residents who needed assistance and that they were served in a timely manner.

3. Review of Resident #5's current FL-2 dated 05/04/22 revealed:
-Diagnoses included dementia with Lewy Bodies, hypothyroidism, and Type 2 diabetes.
-The resident was ambulatory and did not have an orientation status documented.

Review of Resident #5's current care plan dated 05/04/22 revealed the resident did not need any assistance with her activities of daily living (ADL) except for bathing.

Review of Resident #5's Resident Assessment Tool dated 12/07/22 revealed the resident was alert, oriented, pleasant, and cooperative.

Review of an email correspondence dated 01/25/23 revealed:
-The email was from the Director of Clinical Services (DCS) to the Administration and the Campus Executive Director (CED).
-The DCS notified the Administrator and the CED that Resident #5 reported money stolen from her wallet in her room and she was advised to lock her door going forward when leaving her room.
-The CED responded to the email that they could get together about the incident on the next day and the resident should be asked if she wanted to file a police report and do an investigation and send an alleged theft report.

Review of Resident #5's facility record revealed:
-There was no documentation of the incident in the resident's progress notes.
-There was no documentation available that an

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investigation had been completed.
-There was no documentation the resident received any follow-up to the incident.

Interview with Resident #5 on 02/01/23 at 10:09am revealed:
-She had $30.00 in a small wallet in her drawer than went missing about two weeks ago.
-She last saw the money on the morning it went missing.
-She came back from dinner and noticed her drawers were messed up and things in her room were out of place.
-Her room was not locked because she was told by facility management not to lock her room, but she could tell someone had been in her room.
-Whoever took the money, left the wallet the money was in, as well as the coins in a coin purse nearby.
-She reported her missing money to an MA, but could not recall who, and the Medication Aide (MA) told the nurse.
-She was told when the nurse returned to the facility, staff would review security camera footage to see if they could tell who had been in her room.
-She had not received any follow-up from facility management since she reported the missing money and was unsure if they were able to review security camera footage or if they had investigated the incident.

Interview with Resident #5's family member on 02/03/23 at 2:43pm revealed:
-Resident #5 told her she was missing money about 1-2 weeks ago and the facility called her about the issue yesterday (02/02/23).
-There was $30.00 missing out of a wallet in the resident's drawer and she knew the money was there previously because she was the one who

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gave the money to the resident and put it in the resident's wallet for her.
-If the resident had lost the money on her own, she would have lost the whole wallet, not just the money and the wallet was still in the resident's drawer.
-This was not the first incident that the resident had a personal item missing and there was no resolution or follow-up from the facility.
-Last year, in March 2022 when the resident was in rehabilitation after a stroke, the resident had requested her to go to the facility and get her favorite jacket out of her room.
-When she went to the resident's room, it was obvious that someone had been in there because she left items in specific places and in order but there were items out of place, pillows strewn, and the resident's jacket was missing among other small items that she could not recall at the time.
-She never received any follow-up from the facility on the issue and was unsure if that issue had been investigated.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-An MA reported Resident #5 was missing money out of her room to her on 01/25/22.
-She asked Resident #5 about the incident who showed her the drawer where the money and wallet had been; all the drawers were pulled all the way out.
-The wallet the money was in was empty of money but the resident's identification and insurance card were left in the wallet and there was a coin purse with some change near the wallet as well.
-Resident #5 stated she left her room at 11:00am to go to lunch and when she came back realized it was missing.
-Resident #5 stated she last saw her money

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about a week prior.
-She notified the Administrator and the Campus Executive Director (CED) of Resident #5's missing money via email and the CED replied stating to investigate the incident and ask the resident if she wanted to file a police report.
-Resident #5 declined a police report and she advised the resident to start locking her door when she left her room.
-She was not sure who was responsible to complete the full investigation and was not sure what her role in the situation was supposed to be.
-It was important for Resident #5 because she had a right to have receive follow up and a full investigation to help the resident feel safe after she expressed to her that her privacy had been violated.

Interview with the Administrator on 02/02/23 at 8:10am and 10:35am revealed:
-She was aware of Resident #5's missing money and stated she came back from a meal, and someone had gone through her drawers and her money was missing.
-The Director of Clinical Services (DCS) reported the issue to her via email on 01/25/23 and asked her what to do.
-She did not complete a full investigation as she was not aware that she was supposed to complete it.
-Resident #5 declined to file a police report and they did not proceed in doing an investigation.
-When she discussed looking at security camera footage with Campus Executive Director (CED) she was told that the cameras were not in hallways or resident care areas, and it would not be helpful information.
-She discussed the incident with Resident #5 about two days ago (01/31/23) to update her that she did not know anything further.

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D 338	Continued From page 52 Second interview with the Administrator on 02/03/23 at 11:55am revealed: -It was important to investigate incidents such as Resident #5's missing money to identify if someone was exploiting residents, stealing resident's belongings, or invading resident's privacy to remove the risk and ensure residents were care for. -She did not complete a full investigation to include reporting to the Health Care Personnel Registry (HCPR) and investigating who may have taken the missing money. Interview with the Regional Director on 02/02/23 at 11:13am revealed: -She was not aware of Resident #5's missing money until it had been brought to her attention that morning on 02/02/23. -The Administrator was responsible to follow up with the resident and should have known to complete a full investigation. _____ The facility failed to ensure all residents were treated with respect and dignity while waiting for assistance and during resident feeding assistance and residents being free of misappropriation of resident property. This failure was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/16/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 20, 2023. 2. Review of Resident #2's current FL-2 dated 07/19/22 revealed:	D 338		

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-Diagnoses included altered mental status and acute urinary tract infection (UTI).
-The resident was constantly disoriented and semi-ambulatory with a walker/rollator.

Review of Resident #2's current care plan dated 10/03/22 revealed:
-The resident sometimes had bouts of hallucinations and needed reassurance.
-The resident required extensive assistance with toileting, bathing, and dressing, limited assistance with eating and grooming, supervision with ambulation, and was independent with transfers.

Review of Resident #2's physician communication form dated 10/28/22 revealed:
-Per the resident's physical and occupational therapy evaluations the resident required 1:1 feeding assistance due to sensory-perceptive deficits associated with Alzheimer's disease.
-There was an order to assist the resident with all meals and to discuss the possible need of a higher level of care with the resident's family.

Review of Resident #2's diet order dated 12/12/22 revealed the resident was on a regular diet with finger foods that could be eaten easily with her hands instead of cutlery to offer independence as able.

Review of Resident #2's Assessment Tool dated 01/10/23 revealed
-The resident required hands on physical assistance with meals and may wander during meals requiring assistance and redirection.
-The resident had moderate confusion and required occasional redirection.

Observation on 02/02/23 at 7:50am revealed:
-Resident #2 was seated at a table in the dining

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room with a cup with a drinking straw.
-There were 4 other residents seated in the dining room with no staff present.

Observation on 02/03/23 at 8:10am in the residents dining room revealed:
-A PCA entered the residents" dining room pushing a resident in a wheelchair.
-The PCA began feeding the resident whom she had assisted into the dining room.

Observation on 02/03/23 at 9:05am in the residents dining room revealed:
-Another PCA had entered the residents' dining room and seated herself at Resident #2's table.
-She was seated to the right of Resident #2 and had begun to feed Resident #2.

Interview with a personal care aide (PCA) on 02/03/23 at 8:35am revealed:
-PCAs responsible to assist residents with feeding assistance as needed.
-She was expected to not make any resident's wait to eat.
-Residents were to be served upon entrance into the dining room and she was not sure how long residents who needed feeding assistance normally had to wait, but it would also depend on staffing.
-There were usually only 2 PCAs scheduled per shift and there were two residents who required feeding assistance at each meal.
-If one PCA was busy, it might make one of the residents have to wait to eat until the second PCA was available to assist because one PCA would not feed more than one resident at a time.

Interview with a second PCA on 02/03/23 at 9:16am revealed:
-She was responsible to assist residents with

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feeding as needed.
-She was expected to sanitize her hands in between each resident interaction and have clean gloves as needed.
-She was not provided feeding assistance training upon hire and did not know that she should was not supposed to touch resident's food with her bare hands or other surfaces while feeding residents.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility.
-It was unacceptable for Resident #2 to have waiting 65 minutes to eat her breakfast.
-She expected residents to be acknowledged immediately and to be assisted with eating at the same time that all the residents ate and should not have to wait to eat.
-All care staff were capable to assist residents with eating and if there was not enough staff to feed a resident staff should have reported the issue to management to obtain assistance.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-Residents should not have to wait to eat and should be served right away while food is hot.
-PCAs were responsible to assist residents with eating and dietary staff were aware of which residents required feeding assistance.
-She was not aware Resident #2 had to wait to eat for over an hour on 02/02/23 and there was no reason she should have waiting because there were plenty of staff who could have assisted her.
-If staff were unable to assist Resident #2 with

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feeding assistance, they should have reported the issue to management for assistance to ensure proper supervision of all residents who needed assistance and that they were served in a timely manner.

3. Call Bells

Interview with a resident on 02/01/23 at 9:49am revealed:
-Staff turned over quickly at the facility but he was unsure if the facility struggled with staffing the facility for resident care.
-He used his call bell when he needed assistance with things such as transferring.
-Staff usually responded to his call bell quickly, but sometimes he had to wait up to 30 minutes.

Interview with a second resident on 02/01/23 at 10:09am revealed:
-She was independent but sometimes used her call for assistance after having a stroke.
-Staff usually responded to her call bell within 15-20 minutes.

Interview with a resident's family member on 02/03/23 at 9:46am revealed:
-The staff turnover was frequent and follow-up to resident care and needs was inconsistent.
-When he visited the facility would sometime press the resident's call bell and it always took 20-30 minutes for someone to respond to the resident's room.

Interview with a personal care aide (PCA) on 02/03/23 at 8:35am revealed:
-She was responsible to answer call bells and provide residents with assistance to meet their needs.
-The call bell system could be "glitchy" but she

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tried to respond to each request for assistance from the call bell system within 10-15 minutes and sometimes sooner if she was able based on staffing.
-She was often unable to assist other staff members with answering their call bells due to needing to attend to her own assigned residents.
-MAs did not answer call bells while passing medications which meant residents sometimes had to wait more than 15-30 minutes for assistance due to staffing and staff assignments.
-It was often hard to tell when room to go to next and who needed assistance because there were no lights outside of resident rooms indicating who had pressed their call bell when she was in another resident's room.
-Staff members were often late or called out and they had decreased short staffing 1-2 times per week.

Interview with a second PCA on 02/03/23 at 9:16am revealed:
-She was responsible to assist residents as needed when they rang their call bells for the residents she was assigned to care for each shift.
-She tried not to make residents wait more than 5-20 minutes when answering their call bells.
-Some staff had the call bell system downloaded to their personal phone so they would know what room to go to next and which showed when they rang the bell and how long they had been waiting.
-Sometimes they were understaffed and she fell overwhelmed and rushed trying to meet resident needs.
-Some residents needed total care or a higher level of care such a feeding assistance which occupied a lot of her time.

Review of the call bell system log on the second PCA's phone on 02/03/23 at 9:29am revealed a

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resident in room 3134 had called for assistance using their call bell at 9:03am and was still waiting for assistance 26 minutes later.

Interview with a medication aide (MA) on 02/01/23 at 11:54am revealed:
-Staff frequently called out and she often worked over or extra shifts to cover the facility's short staffing.
-That day, there were 2 MAs, 1 personal care aide (PCA) came in late about 20 minutes prior, and the other PCA called out leaving the staffing for that shift short.
-Residents often had to wait a long time for a staff response to call bells when staffing was short because the MAs were having to take care of all the residents needs that would be done by PCAs, housekeeping, or dining staff and management would not help answer or respond to call bells during short staffing.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed:
-She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility.
-She was not sure how long the call bell response time had been an issue and she just got access and started getting notifications from the call bell system in December 2022.
-She had been working with the contracted company to service the call bell system to order more pagers and fix a 5-minute delay in the system because it was taking too long for staff to respond but they had not been able to fix it yet.
-It was important for staff to respond to call bells timely to assist residents as needed and she would like to see that response time at about 6-7

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minutes.

Interview with the Administrator on 02/03/23 at 11:55am revealed:
-Delayed response to call bells had been an issue at the facility prior to her working at the facility in April 2022 and they had been trying to work on it.
-The issues they had addressed involved problems with the internet, the phones the call bell system went to weren't clearing the calls when they were answered, and faulty pendants for residents and staff along with other mechanical failures.
-Since those issues had been corrected, she expected staff to respond to call bells within 5-7 minutes; sometimes sooner and sometimes longer depending on the situation or day.
-The reports were showing that residents were waiting longer than the expectation but she did not think they were accurate due to mechanical failure and internet issues.
-She had some family members and residents complain and staff were to round on residents every two hours in between call bells to ensure resident needs were met.

Interview with the Regional Director on 02/02/23 at 9:48am and 11:13am revealed:
-She knew the facility had an on-going issue with the response time to call bells and it was an initiative the facility was working on to try and improve.
-She expected the response time to call bells to attend to resident needs to be 10 minutes or less.
-She was not sure what the current response time was but was not aware residents had reported having to wait from 15-60 minutes when they used their call bell which was too long.
-The Business Office Manager (BOM) was responsible for scheduling and staffing and

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D 338	Continued From page 60 reports to the Administrator who was responsible to ensure staffing was adequate to meet resident's needs	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policy for 2 of 3 sampled residents (#2, #4) observed during the morning medication pass including medications scheduled multiple times per day that were administered late to treat mood disorders (#2, #4), to treat pain, (#2, #4), vitamin supplements (#2, #4), and a nutritional supplement (#4). The findings are: The medication error rate was 25% as evidenced by the observation of 7 errors out of 28 opportunities during the 8:00am/8:30am and 9:00am/9:30am medication passes on 02/01/23 Review of the facility's Medication/Treatment	D 358		

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Administration Policy dated 07/15/20 revealed:
-The document was in place to ensure residents received medications and treatments in accordance with physician orders.
-Appropriately trained/licensed associates will administer medications/treatments following the specific state regulations and guidelines of; right resident; right medication/treatment, right dose, right time, right route, right documentation, and right to refuse.
-Each medication would be compared to the eMAR verifying the medication is administered correctly to the right resident, dose, time and route.
-Documentation would be completed at the time of administration.
-Medications would be administered within the appropriate time window for administration; one hour before and one hour after the scheduled allotted time.
-When a medication error occurred an incident report should be completed including notifying the resident, the provider/primary care provider (PCP), responsible party, and facility management; appropriate follow-up as indicated to include emergency treatment is required.

Review of the facility's Medication Administration electronic medication administration record (eMAR) Review Verification Policy dated 07/15/20 revealed:
-The policy was in place to ensure the documentation of required review verification of medication by the on-coming and off-going associates to include appropriate documentation of errors/omission have been addressed.
-The review was to verify that proper administration of medications has occurred according to order per the PCP/provider.
-For any errors or omissions of administration

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indicated on the eMAR there would be documentation of follow-up actions taken.

Interview with the medication aide (MA) on 02/01/23 at 10:30am revealed:
-She was still working on the administration of the 8:00am/8:30am and 9:00am medications to all the residents assigned to her that day.
-The administration of many medications was late that day because it had been a chaotic morning.

1. Review of Resident #2's current FL-2 dated 07/19/22 revealed:
-Diagnoses included altered mental status and acute urinary tract infection (UTI).
-The resident was constantly disoriented and semi-ambulatory with a walker/rollator.

a. Review of Resident #2's physician orders dated 12/12/22 revealed there was an order for Tylenol 325mg three times daily for pain.

Observation of the 8:00am/8:30am and 9:00am medication pass on 02/01/23 revealed the MA prepared Tylenol 325mg and administered it to Resident #2 at 10:50am and documented administration at 10:53am.

Interview with the MA on 02/01/23 at from 10:30am to 10:53am revealed Resident #2 had not had any medications yet that morning.

Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol 325mg three times daily at 8:30am, 2:30pm, and 8:30pm.
-The Tylenol 325mg was documented as administered on 02/01/23 at 8:30am and 2:30pm.

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D 358	Continued From page 63 Interview with the facility's contracted pharmacist on 02/01/23 at 4:01pm revealed: -Tylenol was commonly prescribed to treat pain. -If the Tylenol was given late, the resident could experience discomfort. -If the Tylenol was scheduled more than once per day, and a dose was given late, the next dose should be delayed avoiding having too much at one time. -The facility should notify a resident's primary care provider (PCP) for guidance when Tylenol was given late, and multiple doses were scheduled. Interview with Resident #2's PCP on 02/02/23 at 3:30pm revealed: -She was not notified or aware that Resident #2 had received her 8:30am dose of Tylenol almost 2 ½ hours late on 02/01/23 at 10:50am. -Giving Resident #2's Tylenol late put the dose too close to the next scheduled dose. -Receiving doses of Tylenol too close together was too much medication in that time frame and could stress the resident's liver. -She expected the facility to notify her of late medication administration and if she had been notified that Resident #2 received her Tylenol late, she would have held the resident's next dose or rescheduled her subsequent doses for the day to spread them out. Refer to interview with the MA on 02/01/23 at 11:27am and 5:17pm. Refer to second interview with the MA on 02/03/23 at 6:34pm. Refer to second interview with a second MA on 02/03/23 at 3:16pm.	D 358		

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D 358	Continued From page 64 Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm. Refer to interview with the Administrator on 02/03/23 at 11:55am. Refer to interview with the Regional Director on 02/01/23 at 2:53pm. Refer to interview with the Regional Director on 02/02/23 at 9:48am and 11:13am. Refer to interview with the PCP on 02/02/23 at 3:30pm. b. Review of Resident #2's physician orders dated 12/12/22 revealed there was an order for a probiotic urinary tract capsule twice daily (a vitamin supplement used to help prevent urinary tract infections). Observation of the 8:00am/8:30am and 9:00am medication pass on 02/01/23 revealed the MA prepared a probiotic urinary tract capsule and administered it to Resident #2 at 10:50am and documented administration at 10:53am. Interview with the MA on 02/01/23 at 10:30am to 10:53am revealed Resident #2 had not had any medications yet that morning. Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for a probiotic urinary tract capsule twice daily at 9:30am and 8:30pm. -The probiotic urinary tract capsule was documented as administered on 02/01/23 at 9:30am and 8:30pm.	D 358		

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Interview with the facility's contracted pharmacist on 02/01/23 at 4:01pm revealed:
-Probiotics were important to give timely as ordered and scheduled around food to ensure absorption.
-Probiotics were best absorbed one hour before meals or one hour after meals on an empty stomach.

Interview with Resident #2's primary care provider (PCP) on 02/02/23 at 3:30pm revealed:
-Not administering Resident #2's probiotic as scheduled and around food could cause stomach upset.
-She expected the facility to administer the probiotic on time as scheduled to prevent the risk of the resident having stomach upset or diarrhea.
- She expected the facility to notify her of late medication administration and if she had been notified that Resident #2 had received her probiotic late, she would have provided an order to monitor the resident for gastrointestinal/stomach upset.

Refer to interview with the MA on 02/01/23 at 11:27am and 5:17pm.

Refer to second interview with the MA on 02/03/23 at 6:34pm.

Refer to second interview with a second MA on 02/03/23 at 3:16pm.

Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm.

Refer to interview with the Administrator on 02/03/23 at 11:55am.

Refer to interview with the Regional Director on

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THE RESERVE AT MILLS FARM	3000 MILLS CHASE LOOP APEX, NC 27523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 66 02/01/23 at 2:53pm. Refer to interview with the Regional Director on 02/02/23 at 9:48am and 11:13am. Refer to interview with the PCP on 02/02/23 at 3:30pm. c. Review of Resident #2's physician orders dated 12/12/22 revealed: -There was an order for Seroquel 12.5mg every morning (used to treat mood disorders). -There was an order for Seroquel 25mg every night at bedtime. -There was an order for Seroquel 25mg as needed (PRN) every 12 hours for hallucinations or paranoia. Observation of Resident #2 on 02/01/23 at 10:46am revealed: -The resident was pointing at the wall talking to the medication aide (MA) about something on the wall that was not there. -The resident was seated on the couch with her walker next to her and required significant assistance in being repositioned with more support behind her back by the MA. Observation of the 8:00am/8:30am and 9:00am medication pass on 02/01/23 revealed the MA prepared Seroquel 12.5mg and administered it to Resident #2 at 10:50am. Interview with the MA on 02/01/23 from 10:30am to 10:53am revealed: -Resident #2 had Lewy Body dementia and had been experiencing significant hallucinations and delusions that morning. -She gave Resident #2 her scheduled morning dose of Seroquel and was waiting to see if it was	D 358		

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effective in treating the resident's hallucinations and delusions before administering the PRN dose of Seroquel if needed.
-Resident #2 had not had any medications yet that morning or a PRN dose of Seroquel within the last 12 hours.

Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Seroquel 12.5mg every morning at 8:30am.
-The Seroquel 12.5mg was documented as administered on 02/01/23 at 8:30am.
-There was an entry for Seroquel 25mg every night at 8:30pm.
-The Seroquel 25mg was documented as administered on 02/01/23 at 8:30pm.
-There was an entry for Seroquel 25mg every 12 hours PRN for hallucinations or paranoia.
-There Seroquel 25mg PRN was not documented as administered on 02/01/23.

Interview with the facility's contracted pharmacist on 02/01/23 at 4:01pm revealed:
-Seroquel was commonly prescribed to treat mood disorders and should be administered as on time as ordered.
-If Seroquel was administered late, the symptoms for which it was prescribed for could be exacerbated.
-If Seroquel was administered late, the resident's primary care provider (PCP) should be notified and contacted for guidance due to it being a medication error.
-If the PCP was not made aware of the late dose for Seroquel, the resident could experience inaccurate dosing and discomfort related to mood disorders.
-Having doses of Seroquel given too close

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together could cause too high of a concentration in the resident's body and potential overdose.
-Signs of Seroquel overdose and inaccurate dosing could include mood swings, lethargy, and sleepiness.

Interview with Resident #2's mental health provider (MHP) on 02/02/23 at 11:13am revealed:
-The resident was prescribed Seroquel to treat mood disorders and Resident #2 experienced hallucinations.
-It was important to administer Seroquel on time as ordered because the residents' symptoms could be exacerbated when given late and pushes the late dose too close to the next scheduled dose.
-Administering Seroquel or any medications late should be reported to her as a medication error so she could provide orders.
-Giving doses of Seroquel too close together could cause Resident #2 to be overmedicated with signs and symptoms of oversedation, excessive sleeping, drowsiness, and increased risk of falls.
-The resident was already an increased risk of falls due her diagnosis of Parkinson's disease and not giving her Seroquel on time as ordered increased her risk further.
-She was not aware that Resident #2 had received her medications late that day, and if she had been notified, she would have provided an order to monitor the resident for signs and symptoms of overdose and to hold the next dose.
-If she had been made aware that Resident #2 was routinely receiving her medications late, she would have reiterated the importance of administering medications on time as ordered, contacted the Administrator to correct the issue, and provided orders to adjust medications as needed and accordingly.

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D 358	Continued From page 69 Refer to interview with the MA on 02/01/23 at 11:27am and 5:17pm. Refer to second interview with the MA on 02/03/23 at 6:34pm. Refer to second interview with a second MA on 02/03/23 at 3:16pm. Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm. Refer to interview with the Administrator on 02/03/23 at 11:55am. Refer to interview with the Regional Director on 02/01/23 at 2:53pm. Refer to interview with the Regional Director on 02/02/23 at 9:48am and 11:13am. Refer to interview with the PCP on 02/02/23 at 3:30pm. 2. Review of Resident #4's current FL-2 dated 09/16/22 revealed: -Diagnoses include dementia, mood disturbance, anxiety, abnormalities of gait and mobility, and muscle weakness. -The resident was constantly disoriented, non-ambulatory, and unable to communicate needs. a. Review of Resident #4's physician orders dated 12/12/22 revealed: -There was an order for Lorazepam 0.5mg every 12 hours (used to treat mood disorders). -There was an order for Lorazepam 0.5mg as needed (PRN) every 6 hours for agitation or	D 358		

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D 358	Continued From page 70 seizure activity. Observation of the 8:00am/8:30am and 9:00am medication pass on 02/01/23 revealed the MA prepared Lorazepam 0.5mg and administered it to Resident #4 at 11:17am. Interview with the MA on 02/01/23 from 11:03am to 11:17am revealed the resident had not yet had any medications that morning and had just been assisted with eating about 20 minutes prior to the administration of her morning medications that day (02/01/23) at 11:17am. Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg every 12 hours for anxiety at 8:00am and 8:00pm. -The Lorazepam 0.5mg was documented as administered on 02/01/23 and 02/02/23 at 8:00am and 8:00pm. -There was an entry for Lorazepam 0.5mg PRN every 6 hours as needed for agitation or seizure activity. -The Lorazepam PRN was documented as administered on 02/03/23 at 4:41am. Interview with the facility's contracted pharmacist on 02/01/23 at 4:01pm revealed: -Lorazepam was commonly prescribed for mood disorders and anxiety. -It was very important to administer Lorazepam on time as ordered because having doses too close together could cause concerning overdose symptoms such as intense sedation, dizziness, lethargy, and sleepiness among other adverse reactions. -Not giving Lorazepam on time as ordered could exacerbate symptoms when given late and have	D 358		

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decreased effectiveness in the resident's treatment.
-The resident's primary care provider (PCP) should be notified if a dose of Lorazepam was given late for guidance and orders because it would be considered a medication error that could adversely affect the resident.

Interview with Resident #4's PCP on 02/02/23 at 3:30pm revealed:
-She was not notified or made aware that Resident #4 received her Lorazepam late on 02/01/23 at 11:17am instead of the scheduled time of 8:00am.
-Not administering Lorazepam on time as ordered could cause the doses to be too close together and increase the resident's risk dizziness and falls.
-She expected the facility to notify her of late medication administration and if she had been notified, she would have held or rescheduled the resident's next dose and provided an order to monitor the resident for anxiety, dizziness, and put interventions in place to prevent her from falls.

Interview with Resident #4's mental health provider (MHP) on 02/02/23 at 11:13am revealed:
-The resident was prescribed Lorazepam to treat mood disorders and specifically for anxiety for Resident #4.
-It was important to administer Lorazepam on time as ordered because the residents' symptoms could be exacerbated when given late and pushes the late dose too close to the next scheduled dose.
-Administering Lorazepam or any medications late should be reported to her as a medication error so she could provide orders.
-Giving doses of Lorazepam too close together

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could cause Resident #4 to be overmedicated with signs and symptoms of oversedation, excessive sleeping, drowsiness, and increased risk of falls.
-Not giving Resident #4's Lorazepam on time as ordered increased her risk of falling.
-She was not aware that Resident #4 had received her medications late that day, and if she had been notified, she would have provided an order to monitor the resident for signs and symptoms of overdose and to hold the next dose of Lorazepam if needed.
-If she had been made aware that Resident #4 was routinely receiving her medications late, she would have reiterated the importance of administering medications on time as ordered, contacted the Administrator to correct the issue, and provided orders to adjust medications as needed and accordingly.

Refer to interview with the MA on 02/01/23 at 11:27am and 5:17pm.

Refer to second interview with the MA on 02/03/23 at 6:34pm.

Refer to second interview with a second MA on 02/03/23 at 3:16pm.

Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm.

Refer to interview with the Administrator on 02/03/23 at 11:55am.

Refer to interview with the Regional Director on 02/01/23 at 2:53pm.

Refer to interview with the Regional Director on 02/02/23 at 9:48am and 11:13am.

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D 358	Continued From page 73 Refer to interview with the PCP on 02/02/23 at 3:30pm. b. Review of Resident #4's physician orders dated 12/12/22 revealed there was an order for Vitamin B-12 1000mcg (a vitamin supplement commonly used to treat decreased levels of Vitamin B-12, low energy, and memory) twice daily. Observation of the 8:00am/8:30am and 9:00am medication pass on 02/01/23 revealed the MA prepared Vitamin B-12 1000mcg and administered it to Resident #4 at 11:17am. Interview with the MA on 02/01/23 from 11:03am to 11:17am revealed the resident had not yet had any medications that morning and had just been assisted with eating about 20 minutes prior to the administration of her morning medications that day (02/01/23) at 11:17am. Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin B-12 1000mcg at 9:00am and 9:00pm. -The Vitamin B-12 1000mcg was documented as administered on 02/01/23 and 02/02/23 at 9:00am and 9:00pm. Review of Resident #4's progress noted dated 02/03/23 at 2:46am revealed the resident was still awake. Interview with the facility's contracted pharmacist on 02/01/23 at 4:01pm revealed: -Vitamin B-12 was a supplement commonly prescribed to provide energy to a patient.	D 358		

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-If Vitamin B-12 was administered late, it could cause a delayed effect and benefit to the resident or cause the resident to be restless and have difficulty sleeping toward the end of the day when it was time to rest.

Interview with Resident #4's primary care provider (PCP) on 02/02/23 at 3:30pm revealed:
-The resident was prescribed Vitamin B-12 to treat her memory and energy levels and she was not aware the medication was administered late on 02/01/23 at 11:17am instead of 9:00am as ordered.
-She expected the facility to notify her of late medication administration and if she had been notified, she would have held the next dose and had the facility notify the resident's hospice provider to consult her.
-She would want the hospice provider to be consulted before returning to normal administration as ordered after late dosing so lab values could be checked and reviewed as needed.

Refer to interview with the MA on 02/01/23 at 11:27am and 5:17pm.

Refer to second interview with the MA on 02/03/23 at 6:34pm.

Refer to second interview with a second MA on 02/03/23 at 3:16pm.

Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm.

Refer to interview with the Administrator on 02/03/23 at 11:55am.

Refer to interview with the Regional Director on

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D 358	Continued From page 75 02/01/23 at 2:53pm. Refer to interview with the Regional Director on 02/02/23 at 9:48am and 11:13am. Refer to interview with the PCP on 02/02/23 at 3:30pm. c. Review of Resident #4's physician orders dated 12/12/22 revealed there was an order for Tylenol 500mg every 12 hours for pain. Observation of the 8:00am/8:30am and 9:00am medication pass on 02/01/23 revealed the MA prepared Tylenol 500mg and administered it to Resident #4 at 11:17am. Interview with the MA on 02/01/23 from 11:03am to 11:17am revealed the resident had not yet had any medications that morning and had just been assisted with eating about 20 minutes prior to the administration of her morning medications that day (02/01/23) at 11:17am. Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Tylenol 500mg at 8:00am and 8:00pm. -The Tylenol 500mg was documented as administered on 02/01/23 at 8:00am and 8:00pm. Interview with the facility's contracted pharmacist on 02/01/23 at 4:01pm revealed: -Tylenol was commonly prescribed to treat pain. -If the Tylenol was given late, the resident could experience discomfort. -If the Tylenol was scheduled more than once per day, and a dose was given late, the next dose should be delayed avoiding having too much at	D 358		

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one time.
-The facility should notify a resident's primary care provider (PCP) for guidance when Tylenol was given late, and multiple doses were scheduled.

Interview with Resident #4's PCP on 02/02/23 at 3:30pm revealed:
-She was not notified or aware that Resident #4 had received her morning dose of Tylenol on 02/01/23.
-Giving Tylenol late put the dose too close to the next scheduled dose.
-Receiving doses of Tylenol too close together could stress the resident's liver.
-She expected the facility to notify her of late medication administration.

Refer to interview with the MA on 02/01/23 at 11:27am and 5:17pm.

Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm.

Refer to interview with the Administrator on 02/03/23 at 11:55am.

Refer to interview with the Regional Director on 02/01/23 at 2:53pm.

Refer to interview with the Regional Director on 02/02/23 at 9:48am and 11:13am.

Refer to interview with the PCP on 02/02/23 at 3:30pm.

d. Review of Resident #4's physician orders dated 12/12/22 revealed there was an order for Ensure (a dietary supplement to provide increased calories) to give one bottle twice daily

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D 358	Continued From page 77 between meals for weight loss. Interview with the MA on 02/01/23 from 11:03am to 11:17am revealed: -Resident #4 had not yet had any medications that morning and had just been assisted with eating about 20 minutes prior to the administration of her morning medications that day (02/01/23) at 11:17am. -She would pull Resident 4's Ensure from her refrigerator in her room when she went in to administer her other morning medications that morning and give it to her. Observation of the 8:00am/8:30am and 9:00am medication pass on 02/01/23 revealed the MA did not administer the Ensure and then documented it as administered it to Resident #4 at 11:25am. Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Ensure twice daily at 8:00am and 8:00pm. -The Ensure was documented as administered on 02/01/23 at 8:00am and 8:00pm. Interview with the MA on 02/01/23 at 11:27am and 5:17pm revealed: -She did not administer Resident #4's Ensure that morning even though she documented the medication as administered because she got distracted when in the resident's room and forgot to get it out of the resident's refrigerator and give it to her due to being late with medications and feeling rushed. -She would usually give Resident #4's Ensure to her on time in the mornings with breakfast in the dining room but was unable to that morning.	D 358		

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D 358	Continued From page 78 Interview with the facility's contracted pharmacist on 02/01/23 at 4:01pm revealed: -Ensure was a nutritional supplement commonly prescribed to replaced nutritional values for residents. -It was important to administer Ensure on time as prescribed around meals to ensure intake. -If the resident was routinely missing or refusing the Ensure due to late administration, the resident could have an adverse effect on their nutritional status and/or experience weight loss. Interview with Resident #4's primary care provider (PCP) on 02/02/23 at 3:30pm revealed: -She expected the resident's Ensure to be administered on time as ordered and was not aware it was not administered at all on 02/01/23 at 8:00am as expected. -It was important for the resident to receive her Ensure as ordered because it was needed as a nutritional supplement for weight loss, and she expected to be notified if it wasn't administered as ordered or the eMARs were inaccurate. -It was important for her to be notified of missed administration and for the eMAR to be accurate regarding administration because she reviews the eMAR for medication compliance to guide care in writing orders for residents. -If the resident was losing or gaining weight and she was relying unknowingly on inaccurate eMARs it could adversely affect the care she provided to residents. Refer to interview with the MA on 02/01/23 at 11:27am and 5:17pm. Refer to second interview with the MA on 02/03/23 at 6:34pm. Refer to second interview with a second MA on	D 358		

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D 358	Continued From page 79 02/03/23 at 3:16pm. Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm. Refer to interview with the Administrator on 02/03/23 at 11:55am. Refer to interview with the Regional Director on 02/01/23 at 2:53pm. Refer to interview with the Regional Director on 02/02/23 at 9:48am and 11:13am. Refer to interview with the PCP on 02/02/23 at 3:30pm. _____ Interview with the MA on 02/01/23 at 11:27am and 5:17pm revealed: -She was expected to pull medications by looking at the resident's eMAR to see what was ordered and then compare the label on the medication to the order for accuracy ensuring the 6 rights of medication (right resident, medication, time, route, dose, and documentation). -After preparing the medications per the order on the eMAR, she administered the medications to the resident, then documented the administration after observing the resident take the medication. -It was important to document administration after the medication was given to the resident and not before to ensure accurate documentation because the resident might refuse the medication. -Her medications were administered late to multiple residents that morning because the facility was short-staffed and two PCAs had called out. -She was not notified of the call outs until 8:30am so she had to perform the PCA's tasks and	D 358		

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ensure all the residents made it to the dining room for breakfast in addition to administration of medications.
-There was no one sent to help her and the other MA when they were short staffed which put her behind in medication administration.
-Medications were administered late approximately 5-6 times per week usually due to short staffing since she started in June of 2022.

Second interview with the MA on 02/03/23 at 6:34pm revealed:
-Late administration of medications had been an issue at the facility since she started in June 2022.
-She was not sure who was responsible to report medication errors to a resident's primary care provider (PCP).
-She had attended numerous staff meetings that discussed late medication administration and medications were usually administered late due to short staffing.
-Staff were told medications could not be late but she was not aware that the administration of late medications was considered a medication error until the previous day, 02/02/23, when management made her aware.
-Management was aware of the on-going issue of late medications and when she administered medications late, she would report it to the Resident Care Coordinator (RCC) or Administrator who never advised her it was a medication error or that she need to contact the resident's PCP.
-She had never reported late medications to residents' PCP because she did not know to do so.

Interview with a second MA on 02/03/23 at 3:16pm revealed:

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D 358	Continued From page 81 -MAs were responsible to report late medications as a medication error to resident's PCP or MHP, document it in the progress notes, and communicate it to the next shift. -It was important to communicate medication errors and report them to the resident's provider to guide resident care and obtain orders as needed. -Medications were expected to be administered one hour before or after the scheduled administration time on the resident's eMAR as ordered. Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed: -She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility. -Late medication administration had been an on-going issue about 2-3 days per week since she started in fall of 2022. -Late medication administration was considered a medication error and she though she verbally told the facility's contracted PCP but did not formally report the late administration of medications and did not have documentation that she notified the PCP of the issue. -It was important to notify the PCP of late medication administration so they could provide care as indicated and the facility could implement those orders as needed. -She did not formally notify the PCP of the late mediation administration because she did not think to do so. -If medications were administered late it could cause doses to be too close together and too high of a concentration of the medication in the resident's body.	D 358		

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D 358	Continued From page 82 -She along with the MA and RCC were responsible to have reported late medication administration to the residents' providers and should have been done because she tracked the late administration of medications daily. Interview with the Administrator on 02/03/23 at 11:55am revealed: -The facility did not report the on-going late administration or the late administration of mediations on 02/01/23 to Resident #2 or Resident #4's PCP or MHP and should have because it was considered a medication error and could contribute to falls. -It was important to report medication errors for resident safety because the mediation was not administered on time and was ordered to treat a specific diagnosis for a medical condition the resident needed treatment for. -Late medications were expected to be reviewed daily by the DCS and she had not seen the report lately but knew the issue of late medication administration had been an on-going issue since she started as the Administrator in November 2022. -Medications were late 4-5 times per week and had never been a bigger issue than now, especially when they had agency staff working. -Errors had not been reported to resident providers which was also an on-going issue and should have been. Interview with the Regional Director on 02/01/23 at 2:53pm revealed: -Medications were to be administered within one hour before or one hour after the time scheduled on the resident's eMAR. -It was important to administer medications on time accurately as ordered by the resident's provider to ensure resident safety and to ensure	D 358		

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that medications were not given too close together - especially if the resident had multiple doses of the same medication scheduled each day.

Interview with the Regional Director on 02/02/23 at 9:48am and 11:13am revealed:
-She knew the facility had an on-going issue with the administration of late medication and it was an initiative the facility was working on to try and improve.
-The Business Office Manager (BOM) was responsible for scheduling and staffing and reports to the Administrator who was responsible to ensure staffing was adequate to meet resident's needs.

Interview with the facility's contracted primary care provider (PCP) on 02/02/23 at 3:30pm revealed:
-She had not been made aware that medications had been administered late on 02/01/23 or any other day and expected to be notified because the administration of late medication was a medication error.
-She was aware the facility had staffing issues on 02/01/23 but had not been made aware that medications were late that day, or that there were issues on any other days prior to 02/01/23.
-If medications were routinely being given late due to staffing issues or any other reasons and she was not made aware it could adversely affect residents' outcomes.
-Depending on resident diagnosis, co-morbidities, and medications prescribed, the administration of late medications could adversely affect residents' health and safety potentially causing hospitalization.
-It was also important for medications to be documented accurately on the eMARs so that

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D 358	Continued From page 84 when she reviewed resident eMARs for compliance she could guide and provide orders for care based on accurate information and to ensure her orders were being followed as written and expected. _____ The facility failed to administer medications as ordered and on time on 02/01/23 and on an on-going daily basis since at least fall 2022 for 2 of 2 sampled residents (#2, #4) regarding medications prescribed to treat mood disorders that could result in exacerbation of symptoms and an increased risk for falls when administered late, and inaccurate assessment and dosing due to inaccuracy of documentation on eMARs in which Resident #2 experienced increased behaviors and falls and Resident #4 experienced lethargy, sleepiness, and falls. The failure of the facility put the residents at risk of severe injury and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/01/23. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED March 5, 2023.	D 358		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk.	D 400		

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D 400	Continued From page 85 Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly pharmacy reviews were completed for 2 of 3 sampled residents (#1 and #3). The findings are: 1. Review of Resident #3's current FL-2 dated	D 400		

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D 400	Continued From page 86 09/09/22 revealed: -Diagnoses included hypertension, hyperlipidemia, chronic kidney disease stage 3, atrial fibrillation, chronic obstructive pulmonary disease, aortic aneurysm, and edema. -There was an order for Torsemide (used to treat fluid overload) 20 mg to be administered on Monday, Wednesday, and Friday mornings. -There was an order for Torsemide (used to treat fluid overload) 20 mg to be administered every day as needed when weight is above 194 lbs. until weight returns to baseline (under 194 lbs.). Review of Resident #3's pharmacy reviews revealed: -The last pharmacy review was completed on 12/28/22 by a pharmacist with a consulting pharmacy provider. -The recommendation was to ensure the primary care provider (PCP) was aware the Torsemide order was not being followed. -There was no Torsemide given toward goal weight of 194 lbs. when Resident #3 was weighed in December and weighed 202.1 lbs. on 12/01/22. Interview with Resident #3's primary care provider (PCP) on 02/02/23 at 3:30pm revealed: -She had not been made aware of the resident's 4th quarter 2022 medication review recommendations that were available from the pharmacy. -If she had been made aware, she would have referred the resident to his cardiologist and requested they complete a medication review to ensure he was taking the Torsemide accurately as ordered per the parameters ordered by the cardiologist. Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm.	D 400		

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D 400	Continued From page 87 2. Review of Resident #1's current FL-2 dated 10/31/22 revealed: -Diagnoses included type 2 diabetes, thrombocytopenia, dysphasia, reported falls, dementia without behavioral disturbances, gastroesophageal reflux disorder, aspiration pneumonia, and hypertension. -There was an order for Silodosin 8 mg to give one capsule by mouth every day. -There was an order for Tamsulosin 0.4 mg to give one capsule by mouth every day. Review of Resident #1's pharmacy reviews revealed: -The last pharmacy review was completed on 12/28/22 by a pharmacist with a consulting pharmacy provider. -The recommendation was to ensure the primary care provider (PCP) was aware that Resident #1 s was receiving Silodosin and Tamsulosin and that these target the same receptor. -These medications were not usually given together and may increase risks of adverse effects. Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm. Interview with Resident #1's primary care provider (PCP) on 02/02/23 at 3:30pm revealed: -She had not been made aware of the resident's 4th quarter 2022 medication review recommendations that were available from the pharmacy. -If she had been aware she would have either discontinued the Silodosin or Tamsulosin because they were prescribed by other providers, and she was not aware he was on both mediations at the same time. -She also would have provided an order to	D 400		

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D 400	Continued From page 88 monitor the resident for increased blood pressure if they were not already doing so. -She would have referred the resident and the order recommendation for the Terbinafine to a podiatrist because she was not sure why it had been prescribed that way, but it could cause liver damage and the resident had hepatomegaly (enlargement of the liver). -She would have placed an order to separate the administration times of the creams to give them time to be absorbed into the skin as needed. _____ Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed: -She was responsible to submit quarterly medication review recommendations to the resident's PCP when she received them. -She did not know the 4th quarter medication reviews had been completed by the pharmacy and therefore did not submit them to the resident's PCP. -If she had known the report had been completed, she would have called and requested them, but did not think to call and find out when they would be completed because she usually saw when they came to the facility and knew when it had been done. -It was important to submit medication review recommendations to a resident's PCP to support resident care and safety ensuring medication changes were ordered as needed and there were no contraindications of resident medications and to ensure lab work was ordered as necessary and recommended, etc.	D 400		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and	D 451		

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D 451	Continued From page 89 Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to report falls to the local Department of Social Services (DSS) that required evaluation and treatment beyond first aid for 1 of 2 sampled residents (#2) in which the resident sustained multiple falls in which she hit her head and required evaluation via ambulance at the local hospital. The findings are: Review of Resident #2's current FL-2 dated 07/19/22 revealed: -Diagnoses included altered mental status and acute urinary tract infection (UTI). -The resident was constantly disoriented and semi-ambulatory with a walker/rollator. Review of Resident #2's record revealed documentation of falls on 07/14/22, 09/14/22, 10/01/22, 12/10/22, 12/16/22, and 12/19/22 in which the resident required care more than basic first aid and was sent to the hospital via ambulance for further evaluation. -There was no documentation that the local Department of Social Services (DSS) was notified of any of the falls. Telephone interview with the adult home specialist at the local DSS on 02/02/23 at	D 451		

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D 451	Continued From page 90 12:38pm revealed they did not have any documentation from the facility that Resident #2 fell on 07/14/22, 09/14/22, 10/01/22, 12/10/22, 12/16/22, and 12/19/22 in which she sustained suspected injury and required evaluation and treatment beyond first aid. Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed: -She was responsible to have reported Resident #2's falls that required care beyond basic first aid to the local DSS. -She was not sure if she reported all of Resident #2's falls to DSS as expected and did not know why. Interview with the Administrator on 02/02/23 at 11:55am revealed: -Resident #2 had experienced some falls around having UTIs when she had a change in mental status. -When a resident fell and had injuries that required more than basic first aid, they were sent to the emergency department (ED) for further evaluation. -The DCS was responsible to report the incident to the local Department of Social Services and she was not aware all of Resident #2's falls that required more than first aid had not been reported as expected. Refer to tag 273 10A NCAC 13F .0902(b) Health Care.	D 451		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND	D 611		

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D 611	Continued From page 91 PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak.	D 611		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure infection control practices of hand hygiene were observed per their policy and procedure during residents' medication administration and assistance in feeding.

The findings are:

Review of the facility's Hand Washing Policy dated 03/12/22 revealed:
-The policy was in place to ensure proper hand washing for the management of the spread of infection.
-Staff were to wash hands before and after each resident contact, and before applying and after the removal of gloves.

1. Review of the facility's Medication/Treatment Administration Policy dated 07/15/20 revealed appropriate infection control practices would be followed during the administration process by washing hands or using hand sanitizer in-between residents.

Observation of the 8:00am/8:30am and 9:00am medication pass on 02/01/23 revealed:
-The medication aide (MA) prepared and administered medications to a resident from 10:33am to 10:50am without performing hand hygiene prior to beginning or after the administration.
-The MA then prepared and administered

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	HAL-092221	A. BUILDING: _____ B. WING _____	02/03/2023

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medications to a second resident from 10:56am to 11:00am without performing hand hygiene prior to beginning or after the administration.
-The MA then prepared and administered medications to a third resident from 11:03 to 11:24 without performing hand hygiene prior to beginning and then used hand sanitizer after the administration at 11:25am.

Interview with the MA on 02/01/23 at 11:27am revealed:
-She was expected to use hand sanitizer or wash her hand with soap and water in between care for each resident and anytime her hands were visibly soiled.
-She did not realize she did not perform hand hygiene in between each resident during medication pass that morning, 02/01/23, but should have done it as expected.
-That morning, 02/01/23, had been a hectic morning for her and hand hygiene must have slipped her mind.
-It was important to practice hand hygiene to protect residents and herself from the transmission of germs to prevent infections.

Refer to interview with a personal care aide (PCA) on 02/03/23 at 8:35am.

Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm.

Refer to interview with the Administrator on 02/03/23 at 11:55am.

Refer to interview with the Regional Director on 02/01/23 at 2:53pm.

Refer to interview with the facility's contracted primary care provider (PCP) on 02/02/23 at

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D 611	Continued From page 94 3:30pm. 2. Review of the facility's Hand Washing Policy dated 03/12/22 revealed: -Staff were to wash hands before and after each resident contact, when handling food, before applying and after the removal of gloves. -Alcohol based hand rubs were to not be used in place of hand washing in a food service setting. Observation on 02/03/23 at 9:05am in the residents dining room revealed: -The personal car aide (PCA) was seated to the right of Resident #2 at a table in the residents dining room. -The PCA was not wearing gloves and the plate on the table in front of the resident had pancakes and bacon. -The bacon was in small bite size (approximately 1") pieces. -The PCA was feeding Resident #2 the pancakes. -The PCA picked up a piece of bacon with her bare hands and placed it up to Resident #2's mouth and the resident took the piece of bacon into her mouth and ate it. -The PCA would adjust her own face mask with her bare fingers periodically throughout the meal and go back to feeding Resident #2 without performing hand hygiene. -The PCA continued to feed Resident #2 her pancakes with the fork and fed Resident #2 the bacon with her bare fingers without performing hand hygiene. Interview with a personal care aide (PCA) on 02/03/23 at 8:35am revealed: -PCAs responsible to assist residents with feeding assistance as needed. -She was expected to not touch the resident's food with her bare hands, and not to touch other	D 611		

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surfaces while assisting or feeding a resident.
-She had not received any training from the facility regarding feeding assistance.

Interview with a second PCA on 02/03/23 at 9:16am revealed:
-She was responsible to assist residents with feeding as needed.
-She was expected to sanitize her hands in between each resident interaction and have clean gloves as needed.
-She was not provided feeding assistance training upon hire and did not know that she should was not supposed to touch resident's food with her bare hands or other surfaces while feeding residents.

Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed she expected staff to use silverware to pick up resident's food when assisting them with eating and to never touch resident's food with their bare hands.

Refer to interview with a personal care aide (PCA) on 02/03/23 at 8:35am.

Refer to interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm.

Refer to interview with the Administrator on 02/03/23 at 11:55am.

Refer to interview with the Regional Director on 02/01/23 at 2:53pm.

Refer to interview with the facility's contracted primary care provider (PCP) on 02/02/23 at 3:30pm.

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D 611	Continued From page 96 Interview with a personal care aide (PCA) on 02/03/23 at 8:35am revealed: -She was expected to wash her hands before, after, and in between each resident. -It was important to maintain infection control for hand hygiene to prevent the spread of germs and cross-contamination to protect herself and the residents she served. Interview with the Director of Clinical Services (DCS) on 02/03/23 at 3:52pm revealed: -She was responsible for staffing, processing orders, care plans, overseeing resident care and medication administration, and covering for the Resident Care Coordinator while she was out of the facility. -She expected staff to wash or sanitize their hands in between each resident interaction to prevent the spread of germs or bacteria to other residents or staff. Interview with the Administrator on 02/03/23 at 11:55am revealed: -She expected staff to sanitize or wash their hands before and in between assisting any resident with care for safety. -She expected staff to ensure they had sanitizer nearby where they were working, and the facility had plenty on hand to ensure they had access to it. -Staff were trained upon hire and on-going to the process and reasons behind handwashing and infection control which was important to prevent the spread of germs and infection. Interview with the Regional Director on 02/01/23 at 2:53pm revealed: -She expected staff to use hand sanitizer before and after interaction with each resident and to use soap and water to wash their hands after	D 611		

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D 611	Continued From page 97 every 3 resident interactions or when visibly soiled. -Proper hand hygiene was important to maintain sanitization and prevention of infections. Interview with the facility's contracted primary care provider (PCP) on 02/02/23 at 3:30pm revealed: -She expected staff to wash their hands with hand sanitizer or soap and water in between each resident encounter to prevent the transmission of germs which could save lives and prevent infections and outbreaks for resident safety. -She expected staff to don gloves especially when touching food or any other substance that came into direct contact with the residents and to change gloves if they touched other surfaces in between. _____ The facility failed to ensure infection control processes were performed per the facility's policy and procedure to include hand hygiene during medication administration and during resident feeding assistance. The failure of the facility put the residents' at risk for contamination and the spread of germs that could lead to infection and outbreaks and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/02/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 20, 2023.	D 611		