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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	**1107 CARTHAGE STREET SANFORD, NC 27350**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on May 3 - 5, 2022 with an exit conference via telephone on May 5, 2022.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 4 exit doors, accessible to a disoriented resident, were equipped with a sounding device. The findings are: Observation of the facility during initial tour on 05/03/22 at 8:30am revealed: -The exit door at the end of the West hall was not locked and no alarm was visible or sounded when the door was opened. -The front door to the facility was not locked and	D 067		

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no alarm was visible or sounded when the door was opened.
-The exit door in the dining room to the smokers' patio was not locked and no alarm was visible or sounded when the door was opened.
-There was no gate on the fencing on the smokers' patio, allowing residents to leave the patio without staff knowledge.

Review of Resident #6's current FL-2 dated 03/31/22 revealed:
-Diagnoses included heart attack, high blood pressure, and insomnia.
-There was no information about her cognitive status.

Review of Resident #6's Resident Register dated 03/31/22 revealed:
-She was admitted to the facility 04/05/22.
-She had significant memory loss and had to be redirected.

Review of Resident #6's Licensed Health Professional Support assessment dated 04/26/22 revealed:
-She ambulated independently without an assistive device.
-She required redirection due to her memory impairment.

Observation of Resident #6 on 05/03/22 at 9:29am revealed:
-She opened the exit door on the West hall and stood in the doorway.
-The door was not locked and no alarm sounded.
-No staff went to Resident #6 to redirect her from the door.

Interview with Resident #6 on 05/03/22 at 9:20am revealed:

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-She did not remember how long she had lived in the facility.
-She wanted to go to her home because she believed people had gone to her home and stolen her things.

Interview with a medication aide (MA) on 05/03/22 at 9:43am revealed:
-Resident #6 was newly admitted to the facility.
-Resident #6 could be confused at times.
-There were not any alarms on the doors and the doors were not locked.

Telephone interview with Resident #6's family member on 05/03/22 at 3:17pm revealed:
-Resident #6 went to the facility due to her impaired cognition.
-Her friends had reported to him that Resident #6's dementia had worsened and she could no longer take care of herself.

Interview with the Administrator on 05/03/22 at 1:27pm revealed:
-The doors were locked in the evening.
-She was not aware doors in the assisted living needed to be locked or alarmed even with disoriented residents, just that the memory care facility needed to have locks or alarms.

D 176 | 10A NCAC 13F .0601 (a) Management Of Facilities | D 176

10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents

(a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the

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Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations, as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to personal care and supervision, and health care.

The findings are:

Telephone interview with Resident #6's family member on 05/03/22 at 3:17pm revealed since the previous RCC and business office manager/assistant administrator left the facility, he had trouble getting answers to questions.

Telephone interview with the facility's community podiatry provider office manager on 05/04/22 at 3:32pm revealed:
-The podiatrist used to go to the facility to provide nail care.

D 176 Continued From page 4 D 176

-The podiatrist no longer visited the facility because the turnover in administration made coordinating visits difficult.

Telephone interview with a primary care provider (PCP) on 05/05/22 at 10:17am revealed:
-The facility had multiple turnovers with the RCC position since the end of 2021.
-She had concerns about newly written orders not being implemented in a timely manner for multiple residents over the past 6 months.
-She had concerns about referral appointments not being scheduled for multiple resident over the past 6 months.
-The Administrator from the sister facility also managed the senior living facility.
-She was concerned the senior living facility was being ignored by management and all their focus was placed on the sister memory care facility.
-She had concerns about the residents' personal care and supervision needs were not being meet because management was divided between the two facilities.
-She had voiced her concerns about the senior care facility to her supervisors within the facility's contracted healthcare company per the appropriate chain of command.

Telephone interview with a medication aide (MA) on 05/05/22 at 1:26pm revealed:
-In the year she had worked at the facility, there had been two RCCs.
-There was no RCC after the last one left (March 2022).
-The RCC from a nearby sister facility came to the facility some of the time.

Interview with the RCC of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-She covered the responsibilities of the RCC in

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this facility the best she could.
-There were 50 residents in the nearby sister facility and 18 residents in this facility.
-She was not sure of the date in April 2022 when she started covering the RCC responsibilities.
-There had been 4 RCCs at this facility since September 2020.
-She tried to spend a few hours each day, Monday through Friday at this facility.
-She also worked some weekends as a MA at both facilities.
-There was a "supervisor" (assistant Executive Director) in the facility before she took over the responsibilities of the RCC.
-The supervisor also worked as a personal care aide (PCA) and office manager (OM).
-The MAs were also supervisors.

Telephone interview with the Administrator on 05/05/22 at 1:53pm revealed:
-She was the Administrator for this facility and the nearby sister facility.
-She started at the nearby sister facility on 10/20/21.
-The RCC at the nearby sister facility was the fourth RCC to cover this facility since she started on 10/20/21.
-The first RCC's employment ended 10/26/21.
-She could not remember the start date of the second RCC, but her employment ended 12/27/21.
-The third RCC started on 01/05/22 and her employment ended on 03/15/22.
-There was an assistant Executive Director (ED) who was the OM who covered this facility between 10/20/21 and Thanksgiving 2021.
-That position was terminated, and one Administrator was responsible for both facilities after Thanksgiving 2021.
-The RCC from the nearby sister facility covered

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D 176	Continued From page 6 the responsibilities of the RCC for this facility when there was no RCC. -The RCC was responsible for everything related to resident care such as making sure medications were in the building, documents (FL2, care plans, orders) were in the resident record and appointments. -The MAs also worked as supervisors when she and the RCC were not in the facility. -She flexed her time between the two facilities. -There was an issue with staff leaving prior to the end of their shift on third shift. -She had developed a plan to correct the problem of staff leaving the facility unstaffed through working with the County Department of Social Services (DSS). -The plan developed with DSS was for her and the RCC to call and verify staff were present in the building daily for each shift. -The absence of staff at various times on third shift impacted resident personal care, medication administration and supervision. -Trainings had been done with PCAs and MAs on personal care expectations but there was no process to monitor staff compliance with providing personal care and supervision. -There was a corporate nurse available to her as a resource. -The corporate nurse and a second corporate staff were at the facility in March 2022 assisting with resident chart audits to ensure compliance with FL2s, orders and resident assessments and care plans. -She did not receive an update, documentation or summary of the audit. -She was not aware of a lot of what was going on in this facility because she took the previous RCCs' word that things were done such as annual FL2s, care plans, physician orders, appointments and resident care.	D 176		

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-She was not aware of any concerns related to follow up on orders/referrals from PCPs.
-She was available to residents' family members "24/7" if they had concerns.

Interview with the Administrator on 05/04/22 at 2:40pm revealed:
-There was no process of monitoring the facility staff performing personal care and supervision tasks.
-She worked out of her office at a nearby sister facility.
-She went to the facility at random times and completed walk throughs observing the residents, environment and staff.

Noncompliance identified at violation level included:

1. Based on observations, interviews, and record reviews, the facility failed to provide personal care for 2 of 3 sampled residents (#1, #3) related to catheter care (#1), and feeding assistance being completed, hair being neatly groomed, facial hair being neatly groomed, bathing, incontinence care, and repositioning being completed (#3), and nails being neatly trimmed and clean, being neatly dressed (#1, #3) [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care & Supervision (Type A2 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#3) with a history of a falls resulting in rib contusions and 4 subsequent falls within a 7 week time-frame in which she sustained injuries including a pelvis fracture and an arm laceration [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A1 Violation)].

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D 176	Continued From page 8 3. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the healthcare needs for 3 of 3 sampled residents (#1, #2, #3) related to failure to follow-up with physical therapy, occupational therapy and an orthopedic specialist as ordered for a resident who had multiple falls and bilateral pelvic fractures (#3); failure to refer three diabetic residents who had long, thick and curved toenails to podiatry (#1, #2, #3); failure to follow-up with a urology specialist for a resident with an indwelling urinary catheter and a hematology specialist for treatment of anemia (#1); failure to follow-up with an ophthalmologist for a resident's glass eye replacement (#2); and for not notifying the provider of a resident's refusal of multiple doses of vitamin supplements and medications to treat nerve pain, depression, high blood pressure, and urinary tract infections (#3) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. ________________________________ The Administrator failed to ensure the management and total operations of the facility, as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to personal care, supervision and health care. The Administrator's failure resulted in a catheter associated urinary tract infection after a lack of care and cleaning of the catheter, delay in reporting on the appearance and function of the catheter and a six week delay in follow up with the urologist (#1); and two unwitnessed falls in the restroom resulting in bilateral pelvic fractures and a laceration of the elbow, an eleven week delay in physical and occupational therapy evaluations related to falls and a 3 week delay in follow up with an orthopedic specialist for the pelvic fractures (#3)	D 176		

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which demonstrates serious harm and neglect, and constitutes a Type A1 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/22 for this violation.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 4, 2022.

D 259 10A NCAC 13F .0802(a) Resident Care Plan D 259

10A NCAC 13F .0802 Resident Care Plan
(a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure an assessment and individualized written care plan for 2 of 3 sampled residents (#1 and #3) was completed annually (#1) and was completed within 10 days following a significant change in condition related to ambulation and transfer (#3).

The findings are:

1. Review of Resident #1's current FL-2 dated 03/17/22 revealed diagnoses included urinary tract infection, altered mental status, dementia, benign prostate hypertrophy, hyperlipidemia, hypertension, type II diabetes mellitus and acute

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kidney injury.

Review of Resident #1's care plan dated 01/11/21 revealed:
-He was ambulatory with a wheelchair, had limited upper extremity strength, was sometimes incontinent of bowel and bladder and sometimes disoriented.
-He required supervision with eating, limited assistance with transfers and ambulation and extensive assistance with toileting, bathing and dressing.
-There was no documentation of assistance requirements with cleaning, emptying and positioning of a urinary catheter.

Observation of Resident #1 outside in the smoking area on 05/03/22 at 10:37am revealed:
-He had a urinary catheter bag hanging from the armrest of his wheelchair.
-He had limited range of motion, strength and ability to use his left arm and hand.
-He used his right hand to move his left arm and secured a cup in his left hand by using his right hand to put his fingers around the cup.
-He was able to maneuver his wheelchair using his feet and left arm.
-He was not able to open the door to re-enter the facility; another resident assisted with the door.

Observation of Resident #1 on 05/04/22 at 8:45am revealed he needed two emergency medical technicians (EMTs) to transfer from his wheelchair to the stretcher.

Review of Resident #1's current Licensed Health Professional Support (LHPS) evaluation dated 04/04/22 revealed:
-He used a wheelchair for mobility and sometimes needed assistance with ambulation

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and transfers.
-He had a urinary catheter managed by home health (HH).

Telephone interview with the Home Health (HH) Nurse on 05/03/22 at 4:04pm revealed:
-Resident #1 was admitted for HH services on 03/18/22 and was visited weekly by a nurse.
-HH managed the resident's urinary catheter by changing the catheter every month and checking the catheter at weekly visits.
-Staff were responsible for emptying the bag and cleaning around the insertion site with showers.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-The RCC was responsible for completing assessments and care plans for residents annually and with significant changes.
-The previous RCC was working with the Veteran's Administration (VA) to get a new care plan signed.
-She did not know what the former RCC did with the unsigned copy of the assessment and care plan.
-Staff knew what care to provide for Resident #1 because she and the staff talked to each other.
-The assistance Resident #1 required for activities of daily living (ADLs) had not changed since his last care plan dated 01/11/21.
-He had been in a wheelchair and was able to transfer himself to and from his bed or toilet and the wheelchair.
-He needed staff assistance to shower.
-The urinary catheter was new since the last assessment and care plan.

Telephone interview with the Administrator on 05/05/22 at 1:53pm revealed:

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-The RCC from the nearby sister facility told her the former RCC sent forms including a new care plan for signing to Resident #1's primary care provider (PCP) at the VA.
-Signed forms were not returned from the PCP.
-The RCC was responsible for completing resident assessments and care plans and would know when the last one was done.

2. Review of Resident #3's current FL-2 dated 04/13/22 revealed:
-Diagnoses included type II diabetes mellitus, polyneuropathy, arthritis, glaucoma, repeated falls, essential hypertension and anemia.
-She was intermittently disoriented.
-She required assistance with bathing, dressing and feeding as needed.
-She was semi-ambulatory with a walker for assistance.
-There was a recommendation to change her level of care to a skilled nursing facility.

Review of Resident #3's current care plan dated 08/18/21 revealed:
-Resident #3 required total assistance with toileting, bathing, dressing, grooming and with transferring.
-Resident #3 required limited assistance with eating and ambulation.
-Resident #3 was compliant with taking her medications.
-Resident #3 required a rollator walker to assist with ambulation.
-Resident #3 was sometimes disoriented and forgetful.

Interview with a medication aide (MA) on 05/03/22 at 1:12pm revealed:
-Resident #3 required total care for her activities of daily living (ADL).

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-Resident #3 had a rollator walker in her room because she was able to walk at one time.
-Resident #3 was now using the high back wheelchair for mobility.
-She could not recall when Resident #3 completely stopped using her rollator walker.

Observation of Resident #3 on 05/03/22 at 4:30pm revealed:
-The resident required assistance from 2-3 staff members when transferred from her bed to her wheelchair.
-She was unable to walk and complained of right hip pain when she attempted to take a few steps.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/03/22 at 4:47pm revealed:
-Resident #3's care plan dated 08/18/21 was the most recent care plan on file.
-Resident #3's care plan was not updated with the resident's dependence on the wheelchair for mobility.
-Resident #3's was now in need of total assistance with ambulation.
-An updated care plan had not been completed because there were orders for Resident #3 to discharge to a skilled nursing facility.

D 269 | 10A NCAC 13F .0901(a) Personal Care and Supervision | D 269

10A NCAC 13F .0901 Personal Care and Supervision
(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

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

Based on observations, interviews, and record reviews, the facility failed to provide personal care for 2 of 3 sampled residents (#1, #3) related to catheter care (#1), and feeding assistance being completed, hair being neatly groomed, facial hair being neatly groomed, bathing, incontinence care, and repositioning being completed (#3), and nails being neatly trimmed and clean, being neatly dressed (#1, #3).

The findings are:

Review of the facility's undated policies and procedures for resident care revealed:
-Residents' status were communicated using shift report and verbal exchange; walking rounds were encouraged between caregivers at shift change.
-Residents were checked every two hours unless indicated otherwise on the resident's service plan.
-Incontinence care was given as necessary to residents requiring assistance every two hours.
-Residents were to have a full shower/bath according to their needs and preferences, and at least twice per week.
-Refusal of necessary hygiene and grooming was reported to the Resident Care Coordinator (RCC) by the caregivers.
-Continued refusals of hygiene and grooming was noted in charting notes and the Administrator was notified.
-Caregivers monitored the length and condition of the toe and fingernails of residents receiving bathing, dressing, or grooming services.
-The Administrator and/or designee scheduled

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podiatry appointments for foot and/or nail care other than cleaning or moisturizing.

Interview with a resident on 05/03/22 at 9:21am revealed:
-The staff that worked at the facility did not help residents.
-There were three residents who when they yelled out "help" no one went to help them; this happened on all shifts whenever the residents needed help.
-Staff were not always at the desk or on the hall on 3rd shift.
-The 3rd shift staff would sit out in their car or sit in a vacant room.
-There was a 1st shift personal care aide (PCA) that spent the entire shift in the TV room watching TV.

1. Review of Resident #1's current FL-2 dated 03/17/22 revealed diagnoses included urinary tract infection, altered mental status, dementia, benign prostate hypertrophy, hyperlipidemia, hypertension, type II diabetes mellitus and acute kidney injury.

Review of Resident #1's care plan dated 01/11/21 revealed:
-He was ambulatory with a wheelchair, had limited upper extremity strength, was sometimes incontinent of bowel and bladder and sometimes disoriented.
-He required supervision with eating, limited assistance with transfers and ambulation and extensive assistance with toileting, bathing and dressing.
-There was no documentation of staff assistance requirements with cleaning, emptying and positioning of a urinary catheter.

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Telephone interview with Resident #1's family member on 05/03/22 at 3:29pm revealed:
-The resident was wet and smelled like urine and "something else" when he visited on 05/01/22.
-He did not know what the something else was and this happened each time he visited.
-He was not contacted about the resident refusing nail care and shower assistance.
-The resident could be difficult and verbally aggressive like cursing at staff, but he did not mean anything by it and would cooperate while being verbally aggressive.

Interview with a personal care aide (PCA) on 05/03/22 at 9:50am revealed:
-Resident #1 was one of 4 residents who needed the most assistance with activities of daily living (ADLs).
-The resident was able to use the bathroom, but needed assistance with bathing, dressing and mobility.

a. Observation of Resident #1 outside in the smoking area on 05/03/22 at 10:37am revealed:
-He had a catheter coming out of the left pant leg that had yellow liquid with a thick white substance in the dependent part of the tubing.
-The catheter bag was enclosed inside a clear garbage bag and hung from the armrest of his wheelchair at the level of his waist.
-The valve of the catheter bag was not enclosed inside the clear protective cover on the catheter bag.

Interview with a personal care aide (PCA) on 05/03/22 at 1:14pm revealed:
-All floor staff kept an eye on Resident #1's urinary catheter because it leaked.
-Staff placed the clear garbage bag over the catheter bag because it leaked.

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Interview with a medication aide (MA) on 05/03/22 at 3:01pm revealed:
-She only emptied the urinary catheter bag.
-She did not receive any training on caring for the catheter.
-She did not think staff at assisted living facilities (ALFs) cared for urinary catheters.
-Staff put the clear plastic bag over the catheter bag because it was leaking.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/03/22 at 3:01pm revealed:
-Resident #1 received home health services for care of his urinary catheter.
-Staff at ALFs did not care for catheters; they only emptied the bag.

Telephone interview with the Home Health (HH) Nurse on 05/03/22 at 4:04pm revealed:
-Resident #1 was admitted for HH services on 03/18/22 and was visited weekly by a nurse.
-HH managed the resident's urinary catheter by changing the catheter every month and checking the catheter at weekly visits.
-Staff were responsible for emptying the bag and cleaning around the insertion site with showers.
-She had done a little teaching about catheter care with the RCC of the nearby sister facility.
-She was not able to teach staff because they were not present at HH visits.

Review of Resident #1's current Licensed Health Professional Support (LHPS) evaluation dated 04/04/22 revealed:
-There was documentation the resident had a foley catheter that was managed by HH.
-There were no markings or documentation on staff competency validation.

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Telephone interview with the facility's LHPS Nurse on 05/03/22 at 4:51pm revealed:
-She completed catheter care training with newly hired staff as part of the skills check off.
-She completed additional training if it was requested by the facility for a new catheter.
-No one at the facility had requested training to care for Resident #1's urinary catheter.
-Catheter care skills for staff included keeping the bag below the level of the bladder, wiping off the spout/valve with an alcohol wipe before and after emptying and measuring output.
-She was at the facility two to three times each month and encouraged staff to ask for her assistance every time she was there.

Observation of Resident #1 in the dining room on 05/04/22 at 8:00am revealed:
-His catheter was hung from the armrest of his wheelchair.
-There was no clear plastic garbage bag covering the catheter bag.
-The catheter valve was hanging down over the small front wheel of the wheelchair.
-The RCC from the nearby sister facility went over to the resident and put the catheter valve back under the protective cover on the catheter bag without wiping it off with an alcohol pad.

Observation of Resident #1 in the dining room on 05/04/22 at 3:05pm revealed:
-His catheter was hung from the frame at the seat of his wheelchair.
-The catheter valve was hanging down touching the small front wheel of the wheelchair.

Second telephone interview with the LHPS Nurse on 05/04/22 at 3:34pm revealed:
-When she completed new hire skills check off

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she covered where to position urinary catheter bags and cleaning the catheter tubing from insertion site down to the bag.
-Not cleaning the catheter, not bathing and cleaning the urinary meatis, and the presence of the catheter could all cause a catheter associated urinary tract infection.

Interview with the RCC of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-Resident #1's urinary catheter was placed in March 2022; he did not have a catheter prior to that.
-HH services were initiated for catheter care.
-She did not request any training for staff relating to caring for the catheter.
-HH showed staff how to empty the catheter.
-Staff tried to keep the bag lower than the bladder but the resident would move the bag.

Interview with the Administrator on 05/04/22 at 11:10am revealed:
-Staff were trained to empty Resident #1's catheter by HH.
-Staff contacted HH if there were any issues with the catheter.

Review of Resident #1's emergency room discharge instructions dated 05/04/22 revealed the resident was seen and treated for a catheter associated urinary tract infection and prescribed an antibiotic.

b. Review of Resident #1's activities of daily living (ADL) logs for March, April and May 2022 revealed:
-There was documentation nail care was provided on 03/07/22, 03/21/22 and 03/28/22, 04/04/22, 04/11/22, 04/25/22 and 05/02/22.
-There was one refusal documented on 04/18/22.

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Review of Resident #1's electronic charting notes for March, April and May 2022 revealed there was no documentation the resident refused assistance with nail care.

Observation of Resident #1 on 05/03/22 at 10:37am revealed:
-The nails on his right hand were greater than ¼ inch in length, had jagged edges on the thumb, first and third fingernails and a thick black substance underneath the pinky fingernail.
-The nails on his left hand were greater than ¼ inch in length, had jagged edges on the thumb, first and second fingernails and a thick black substance under all nails.
-Both his hands had a layer of dirt on the palms and dry peeling skin.

Interview with Resident #1 on 05/03/22 at 10:37am revealed he could not remember when his fingernails were last cut.

Interview with a personal care aide (PCA) on 05/03/22 at 1:14pm revealed:
-He did not let staff trim his fingernails.
-She had never tried to trim his fingernails because he could get kind of ugly by cursing at staff.

Interview with a medication aide (MA) on 05/03/22 at 3:01pm revealed:
-Nail care documented on the activities of daily living (ADL) record meant staff cleaned under the resident's nails.
-She tried to clean and trim Resident #1's fingernails that morning (05/03/22), but he refused.
-Staff were supposed to provide nail care daily.
-When a resident refused, she documented the

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refusal in the resident's charting notes.
-She did not report the refusal to anyone.
-She would try multiple times to get the resident to allow staff to provide nail care.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 3:01pm revealed:
-Resident #1 would not let staff clean under his nails; he would curse at staff.
-She let the resident's family member know that he refused a lot of things like having his nails cleaned.
-It was difficult to get Resident #1's primary care provider (PCP) on the phone because he was with the Veteran's Administration (VA).

Observation of Resident #1 in the dining room on 05/04/22 at 8:00am revealed:
-His nails were trimmed on both hands.
-Both hands had dirt on the palms and dry, peeling skin.

Interview with the Administrator on 05/04/22 at 11:10am revealed:
-Staff were not able to trim fingernails for residents with diabetes; they were able to clean and file nails.
-Nail care was done weekly and as needed.
-The RCC checked residents with diabetes for nail care needs and was responsible for contacting the PCP for a podiatry referral.

c. Review of Resident #1's activities of daily living (ADL) logs for March, April and May 2022 revealed:
-There was documentation the resident was assisted with a tub bath /shower on 12 days in March 2022, 13 days in April 2022 and one day in May 2022 (05/03/22).

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-There were no documented refusals.

Review of Resident #1's electronic charting notes for March, April and May 2022 revealed there was no documentation the resident refused assistance with bathing, dressing and grooming.

Observation of Resident #1 on 05/03/22 at 10:37am revealed:
-He had on a pair of khaki colored pants that had various colored stains on both thigh areas and below the zipper area.
-He had on red collared shirt with a white T-shirt on that had a dark stain around the collar and brown stains on the upper chest area.

Interview with a personal care aide (PCA) on 05/03/22 at 1:14pm revealed Resident #1 needed help with bathing; he was able to use the toilet and put his clothes on.

Observation of Resident #1 in the dining room on 05/04/22 at 8:00am revealed he was wearing the same stained khaki colored pants, red shirt with the stained white T-shirt underneath.

Interview with Resident #1 on 05/04/22 at 8:38am revealed he needed help changing his clothes and needed clean clothes to put on.

Second interview with a PCA on 05/04/22 at 4:03pm revealed:
-She did not know which days of the week Resident #1 was scheduled for showers.
-The shower assignment was kept in a binder at the front desk.
-She and two additional staff assisted the resident with a shower today (05/04/22) without incident.
-Three staff were needed to assist with transferring and washing him.

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-She did not know the resident's baseline assistance requirements for bathing and dressing because 3rd shift staff normally got him up and dressed in the morning.
-There was no assignment for PCAs, staff worked as a team to provide care.
-Staff left the oncoming shift a note of what was done each shift.
-PCAs completed a shower sheet each time they assisted a resident with bathing/showers.
-She did not know if a shower sheet was completed today (05/04/22).
-Refusals were documented on the shower sheet and kept under each resident's name in the binder at the front desk.

Review of the shower book revealed:
-There was a shower list with Resident #1's name listed under second shift on Tuesdays, Thursdays and Saturdays.
-Shower days included shave and finger and toenails cut unless the resident was diabetic.
-There were no completed shower sheets for Resident #1.

Telephone interview with a medication aide (MA) on 05/05/22 at 1:26pm revealed:
-She sometimes assisted with showering residents, but the PCAs did most of the showers.
-Staff did not keep up with documenting showers on the shower sheets and just communicated verbally showers that were done or refused.
-Shower sheets were typically done if a skin concern was found or the resident refused.
-If a resident refused a shower the PCA should document the refusal on a shower sheet and let her know and the resident would at least get wiped down.
-She had noticed the physical condition of Resident #1.

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-She did not know if the PCP was contacted for Resident #1 refusing bathing assistance.
-She was told by emergency medical technicians (EMTs) who brought the resident back from the hospital on 03/17/22 that they could not get the urinary catheter bag wet.
-They were only trained to empty the catheter bag, so they just wiped Resident #1 down instead of giving him a shower.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-Residents were showered three times a week and as needed if they were soiled.
-PCAs were supposed to let the MA know if a resident refused assistance with bathing/showers.
-The MA was supposed to attempt or ask staff another shift to try showering the resident.
-If the resident continued to refuse the MA reported to the RCC who attempted to encourage/assist the resident.
-If the resident continued to refuse the RCC contacted the family member and the primary care provider (PCP).
-A resident's refusal of personal care assistance was supposed to be documented in charting notes by PCAs and/or MAs.
-The MA should be contacting the PCP directly about repeated refusals of personal care assistance.
-She now knew this was not happening and staff needed more training.
-She was just stepping in covering the RCC responsibilities in this facility and did not yet contact the Resident #1's PCP about his refusals for personal care assistance.

Interview with the Administrator on 05/04/22 at 11:10am revealed:

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-Staff were expected to provide incontinence care every two hours and as needed.
-Residents were assisted with showers three times a week.
-PCAs reported any resident refusals for assistance with incontinence care and showering to the MA.
-The MA was expected to attempt providing the assistance and if the resident continued to refuse the MA reported to the RCC.
-Both PCAs and MAs were expected to document refusals on the ADL record and charting notes.
-There was one PCA who was unable to document on the electronic resident record.

Second interview with the Administrator on 05/04/22 at 2:40pm revealed there was no system or process in place for her or the RCC from the nearby sister facility to check physical condition of heavy care residents like Resident #1.

Attempted telephone interview with Resident #1's Primary Care Provider on 05/03/22 at 3:45pm and was unsuccessful.

2. Review of Resident #3's current FL-2 dated 04/13/22 revealed:
-Diagnoses included type II diabetes mellitus, polyneuropathy, arthritis, glaucoma, repeated falls, essential hypertension and anemia.
-She was intermittently disoriented.
-She required assistance with bathing, dressing and feeding as needed.
-She was semi-ambulatory with a walker for assistance.
-There was a recommendation to change her level of care to a skilled nursing facility.

Review of Resident #3's Resident Register

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revealed the date of admission was 07/15/2018.

Review of Resident #3's care plan dated 08/18/21 revealed:
-She required limited assistance with eating and ambulation.
-She required total assistance with toileting, bathing, dressing, grooming and transferring.

Observation of Resident #3 on 05/03/22 at 9:32am revealed:
-She was asleep in her bed and was positioned on her right side with a pillow under her right knee on top of her comforter.
-There were two overlapping large disposables under pads between the resident and her comforter.
-She was wearing a blue and white hospital gown and white incontinent briefs.
-She was not covered with a sheet or blanket, and her briefs, legs and feet were exposed.
-Her hair was uncombed and slightly matted, and her facial hair was unshaven.
-There was a high-back wheelchair positioned next to her bed and facing her bed.
-There was a strong urine odor in her room and in her individual restroom.
-The bottom of her left foot was soiled with a brown colored stain and brown staining between the third, fourth and fifth toes.
-Her skin was dry and flaky, and there were multiple skin tears on each arm at various stages of healing.

Observation of Resident #3 on 05/03/22 at 10:36am revealed she was asleep in her bed, positioned in the same manner, and wearing the same hospital gown and incontinence briefs as at 9:32am on 05/03/22.

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Observation of Resident #3 on 05/03/22 at approximately 11:40am revealed she was asleep in her bed, positioned in the same manner, and wearing the same hospital gown and incontinence briefs as at 9:32am on 05/03/22.

Interview with a medication aide (MA) on 05/03/22 at 9:30am revealed Resident #3 required total assistance with her personal care which included bathing, dressing, grooming, incontinence care and eating.

Interview with a MA on 05/03/22 at 1:12pm revealed:
-Resident #3 required total assistance from 2-3 staff members with her personal care and transferring from her bed to her wheelchair.
-Resident #3 did not use her walker because she could no longer walk.
-Resident #3 had been incontinent of urine for about a month and did not call for toileting assistance until it was too late to get her to the restroom.
-Resident #3 received a bath on Mondays, Wednesdays and Fridays, and a wipe down with a wet washcloth or personal care wipes when needed.
-Resident #3 wore hospital gowns because it made it easier for the staff and resident in changing her brief.
-Staff was responsible to offer and provide incontinence care every 2 hours to Resident #3.
-She changed Resident #3's gown and provided incontinence care this morning at approximately 7:00 am.
-Personal care was documented in the resident's activities of daily living (ADL) logs once per shift.

Observation of Resident #3 on 05/03/22 at 1:30pm revealed:

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D 269	Continued From page 28 -She had been changed into a different hospital gown. -She was asleep and laying in her bed on her right side, knees slightly bent with a pillow under her right knee. -She was laying on 2 overlapping large disposable under pads atop of her comforter and 1 large disposable under pad pulled between her legs. -She was not wearing an incontinence brief. Review of Resident #3's May 2022 ADL log revealed: -Personal hygiene care, shaving, skin care including face, hands and feet were documented as completed by a MA between 7:00am to 3:00pm on 05/03/22. -Eating assistance and supervision, and ambulation from room to room were documented as completed by a MA between 7:00am to 3:00pm on 05/03/22. -Nail care and shampooing were documented as completed by a MA at 8:00am on 05/03/22. Observation of Resident #3 on 05/03/22 at 4:30pm revealed: -She was awake, laying in her bed on her right side. -She was wearing the same hospital gown from the 1:30pm observation. -The 2 overlapping large disposable under pads appeared to be saturated with a yellow colored liquid. -Her hair was uncombed and matted, and her facial hair was unshaven. -Her fingernails were long or broken off and visibly dirty. -Her feet were visibly dirty as they were at the 9:32am observation. -There was a Styrofoam covered meal container	D 269		

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labeled with the resident's name, 1 small Styrofoam cup of brown colored liquid covered with a clear plastic wrap and a large Styrofoam cup of water setting on the resident's nightstand.
-The meal appeared to be untouched by the resident.

Interview with Resident #3 on 05/03/22 at 4:30pm revealed:
-She had not been up and out of bed at all on 05/03/22.
-She needed staff to help her turn in the bed, to go to the bathroom and help her clean when she was incontinent.
-She yelled for the staff when she needed help because she could not reach the call button or the bell on her nightstand.
-She had hip and leg pain and could not use her left arm because of the neuropathy.
-She did not know when she last ate a meal, but she was very hungry and wanted to eat now.
-She was not aware there was a meal on her nightstand.
-She needed the staff to help her eat because of her neuropathy in her left arm and weakness in her right arm.

Observation of staff assisting Resident #3 with incontinence care and dressing on 05/03/22 at 4:38pm revealed:
-A personal care aide (PCA) asked the resident why she had not touched her meal; to which the resident replied she did not know it was on her nightstand.
-The same PCA looked in the resident's closet for briefs, large disposable under pads and wipes, but did not locate them.
-A second PCA looked in the resident's chest of drawers for briefs, large disposable under pads, and wipes, but did not locate them, and left the

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room.
-A third PCA pulled a pair of white socks from the resident's chest of drawers and applied them to the resident's dirty feet.
-The second PCA returned to Resident #3's room with large disposable under pads and wipes.
-Two PCAs turned the resident to her left side, exposing the resident's back and buttocks area.
-They removed the urine saturated large disposable under pads from the resident's lower back and buttocks area.
-The resident's right lower back area was reddened, and she complained of discomfort in her perineal area when wiped by a PCA.
-PCAs placed 2 overlapping large disposable under pads under the resident's lower back and buttocks, repositioned her to her back, and changed her into a clean hospital gown.
-The resident requested to be sat up to eat her meal in her bed.
-The Administrator came into Resident #3's room and requested the resident be placed in her wheelchair and brought to the dining room to eat.
-Two PCAs assisted the resident in putting on her shoes and transitioning to a high back wheelchair.
-The resident and her meal were taken to the dining room at approximately 5:15pm by staff.

Observation of Resident #3's personal care on 05/04/22 at 7:45am revealed:
-She was laying in her bed on her left side facing the wall.
-She was laying on top of her left arm, and her hand was red and swollen.
-Her fitted sheet was soiled with a partially dried dark orange stain.
-There were 2 overlapping large disposable under pads between her and the fitted sheet.
-Her gown was saturated with urine on the lower

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front and back areas.
-She was wearing a disposable incontinence brief that was saturated with urine.
-She complained of right hip pain and pain when she was moved from her left to right side during incontinence care provided by 2 PCAs and a MA.
-The MA administered the resident's scheduled pain medication at approximately 8:05am.
-The PCAs and MA continued to provide incontinence care.
-She cried and yelled at the staff and asked them to stop when rolling her from side to side during incontinence care.
-The Administrator entered the room at 8:26am and announced she wanted to send the resident out to the hospital because she was in so much pain.
-Resident #3 refused to go to the hospital and asked a PCA to help get her up.

Observation of Resident #3 on 05/04/22 at 10:30am revealed:
-She was wearing a clean black top and black pants, a shoe on her left foot and a sock on her right foot.
-Her hair was brushed and secured with an elastic hair band, and her facial hair was groomed.

Telephone interview with Resident #3's family member on 05/04/22 at 4:15pm revealed:
-The resident had diabetic neuropathy and limited use of both of her arms.
-She had not visited the resident since November 2021.
-Two other family members visited more often because they lived closer to the facility.
-One family member reported the resident's room frequently had a strong urine odor and grooming was not done.

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-She was not impressed with the care the resident had received at the facility but was afraid to complain because she feared they would discharge Resident #3.
-She was not aware the resident required 2-3 staff members to assist with her personal care.
-She received a letter from the facility stating the resident needed to be transferred to a skilled nursing facility dated 04/04/2022.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-With every supervision check staff should be checking for toileting needs and changing incontinence briefs as needed.
-Resident #3 could be fussy about nail care and washing her hair, she might not want staff to assist her.
-When the PCA reported resident refusals of personal care to the MA, then the MA should offer personal care assistance to the resident.
-If the resident continued to refuse personal care by the MA, then the MA documented it in the resident's activities of daily living (ADL) log.

Telephone interview with Resident #3's listed contact person on 05/05/22 at 9:22am revealed:
-She visited the resident every other week when she brought another family member to visit the resident.
-She purchased the high back wheelchair because the resident refused to use her rollator walker correctly by sitting and propelling herself backwards.
-She had brought in clothing for the resident but rarely saw her wearing them.
-She had not come into the facility in about 2 months.
-The staff dressed the resident and took her

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outside to meet them on the front porch area.
-The resident had a strong urine odor and ungroomed facial hair at some of the visits, but she could not remember the dates.

Telephone interview with Resident #3's primary care provider (PCP) on 05/05/22 at 10:17am revealed:
-The facility did not have adequate skilled staff to care for Resident #3 and she required a higher level of care.
-Resident #3's plan of care since March 2022 had been to discharge her from the assisted living facility to a skilled nursing facility but the facility Administrator and the RCC requested to have her remain in the facility and refer to physical therapy in April 2022.

Interview with the Administrator on 05/04/22 at 2:40pm revealed there was no system or process in place for her or the RCC from the nearby sister facility to check physical condition of heavy care residents like Resident #3.

Telephone interview with a MA on 05/05/22 at 1:26pm revealed:
-She sometimes assisted with showering residents, but the PCAs did most of the showers.
-Staff did not keep up with documenting showers on the shower sheets and just communicated verbally showers that were done or refused.
-Shower sheets were typically done if a skin concern was found or the resident refused.
-If a resident refused a shower the PCA documented the refusal on a shower sheet and let her know and the resident would at least get wiped down.
-She had noticed the physical condition of Resident #3.
-She was concerned that Resident #3 was

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refusing to shower and mentioned it to the RCC from the nearby sister facility.
-Resident #3's family member was concerned about the resident not being clean.
-She did not know if the PCP was contacted for Resident #3.
-Resident #3 required 3 staff to assist her with showers so staff would just wipe her down at night.

____

The facility failed to provide personal care assistance with eating, bathing, shaving, grooming, nail care, toileting and incontinence care and care of a urinary catheter. The facility's failure resulted in a catheter associated urinary tract infection (#1) and in two unwitnessed falls in the restroom with one resulting in a pelvic fracture injury (#3) which demonstrates substantial risk for physical harm and risk for serious neglect and constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/04/22 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 4, 2022.

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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.

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#3) with a history of a falls resulting in rib contusions and 4 subsequent falls within a 7 week time-frame in which she sustained injuries including a pelvis fracture and an arm laceration.

The findings are:

Review of the facility's undated fall assessment policy revealed:
-A resident's risk of falls was to be identified during the assessment process, when a resident experienced a change in condition, and when a fall risk was identified post-fall.
-Interventions to decrease a resident's fall risk should be identified and put into place.
-It was the responsibility of the Administrator to ensure compliance with the fall assessment policy.

Review of Resident #3's current FL-2 dated 04/13/22 revealed:
-Diagnoses included type II diabetes mellitus, polyneuropathy, arthritis, glaucoma, repeated falls, essential hypertension and anemia.
-She was intermittently disoriented, required assistance with bathing, dressing and feeding as needed, and was semi-ambulatory with a walker for assistance.
-There was a recommendation to change her level of care to a skilled nursing facility (SNF).

Review of Resident #3's previous FL-2 dated 03/08/22 revealed:

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-Diagnoses included type II diabetes mellitus, polyneuropathy, arthritis, glaucoma, repeated falls, essential hypertension and anemia.
-She was intermittently disoriented, required assistance with bathing and dressing, and was semi-ambulatory with a device for assistance.
-Her recommended level of care was an assisted living facility.

Review of Resident #3's care plan dated 08/18/21 revealed:
-She required limited assistance with eating and ambulation.
-She required total assistance with toileting, bathing, dressing, grooming and transferring.

Review of Resident #3's licensed healthcare professional support (LHPS) quarterly review dated 12/20/21 revealed the resident required assistance with transfers and ambulation.

Observation of Resident #3's room on 05/03/22 at 9:32am revealed:
-Her room was the first resident room on the right side of the east hall nearest to the nursing station.
-There was a common television room between the resident's room and the nursing station.
-Her room was the only room occupied by a resident on the east hall.
-A high back wheelchair was positioned facing her bed, flush with the edge of her bed and the wheels were locked.
-The resident was asleep on her bed.

Review of Resident #3's Incident/Accident report dated 12/25/21 revealed:
-The resident had an unwitnessed fall in her room at 8:30am.
-There was no apparent injury.
-The resident was sent out to the hospital for

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observation.
-The resident was to follow up with her primary care provider (PCP) and be monitored for 72 hours.

Review of Resident #3's staff charting notes documented by a medication aide (MA) revealed the resident had an unwitnessed fall, complained of pain in her right side and right arm, and was sent to the hospital on 12/26/22.

Review of Resident #3's emergency room (ER) note dated 12/26/21 revealed the diagnosis was rib contusion and a follow up appointment was scheduled with her PCP on 01/05/22.

Review of Resident #3's PCP telehealth note dated 01/05/22 revealed an order to continue with current care plan.

Review of Resident #3's PCP visit notes dated 02/16/22 revealed:
-The resident's problem list included repeated falls.
-The resident was seen on 02/16/22 for right eye redness.
-The resident had a suspicious lesion on her right lower eyelid since a fall 2021.
-The facility requested physical therapy (PT) and occupational therapy (OT) consults as the resident was having issues with activities of daily living (ADL).
-The resident complained of pelvic pain on movement of her hips.
-The resident required "24/7 supervision".
-There was an order for PT and OT evaluations.

Review of Resident #3's staff charting notes documented by a MA revealed:
-The resident was having a hard time transferring

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to the toilet from her wheelchair on 03/01/22.
-There was not a charting note related to the resident's fall on 03/02/22.

Review of Resident #3's emergency room (ER) note dated 03/02/22 revealed:
-Diagnoses included a fall and right knee pain.
-The resident was to follow up with her primary care provider (PCP) within 3-5 days.

Review of Resident #3's staff charting notes documented by a MA revealed the resident required 2-3 staff members to assist with transferring and standing on 03/04/22.

Review of Resident #3's licensed healthcare professional support (LHPS) quarterly review dated 03/07/22 revealed:
-The resident was not ambulatory at the time of the nurse's review.
-The resident required assistance with wheelchair.
-The resident required maximum assistance with transfers and ambulation.
-The Registered Nurse's notes included a recommendation for fall precautions be continued.

Review of Resident #3's Incident/Accident report dated 03/09/22 revealed:
-The resident was in her room and complaining of hip pain at 11:12pm.
-There was no documented fall or documented injury.
-The resident was sent out to the hospital for observation.
-The resident was to follow up with her PCP.

Review of Resident #3's ER discharge summary dated 03/10/22 revealed diagnoses included a

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urinary retention and degenerative arthritis of both hips.

Review of Resident #3's Incident/Accident report dated 04/02/22 revealed:
-The resident had an unwitnessed fall at approximately 5:00pm.
-The resident was transferring from the chair to the commode and fell in her restroom.
-There were no apparent injuries documented.
-The resident was sent to the hospital.
-The resident was to follow up with her PCP.

Review of Resident #3's staff charting notes documented by a MA revealed the resident had a fall attempting to transfer herself from her wheelchair to the toilet on 04/02/22.

Review of Resident #3's ER discharge summary dated 04/02/22 revealed:
-Diagnoses included a fall, tachycardia, dehydration and a urinary tract infection (UTI).
-The resident was to follow up with her PCP within 2-4 days.
-There was an addendum note dated and signed on 04/07/22 at 8:21am with diagnoses of fall, risk of falls, fracture of the left superior pubic ramus, and fracture of the right inferior pubic ramus.

Review of Resident #3's Incident/Accident report dated 04/07/22 revealed:
-The resident had an unwitnessed fall at 6:00am.
-The resident fell in her restroom while trying to use the toilet alone.
-There were no apparent injuries documented.
-The resident was sent to the hospital.

Review of Resident #3's ER discharge summary dated 04/07/22 revealed:
-Diagnoses included a fall, at risk for falls and

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bilateral pelvic fractures.
-The resident was to follow up with an orthopedic specialist within 2-4 days.

Review of Resident #3's PCP visit notes dated 04/13/22 revealed:
-The resident was seen on 04/13/22 for an ER follow up.
-The resident was sent to the ER on 04/02/22 for a fall and was treated for a UTI.
-The resident was sent to the ER on 04/07/22 for a fall and diagnosed with bilateral pelvic fractures.
-The resident's problem list included repeated falls and pelvis fractures.
-The resident complained of pelvic pain on movement of her hips.
-The resident stated she slipped out of bed and that was how she fractured her pelvis.
-The resident required "24/7 supervision".
-She previously recommended the resident be transferred to a skilled nursing facility, but the facility requested a trial of physical therapy.

Review of Resident #3's Incident/Accident report dated 04/16/22 revealed:
-The resident had an unwitnessed fall at 2:46am.
-The resident fell out of her bed and was found on the floor in her room.
-There was a laceration on her left forearm and the resident was sent to the hospital.
-The resident was to follow up with her PCP.

Review of Resident #3's staff charting notes documented by a MA revealed there was not a charting note related to the resident's fall on 04/16/22.

Review of Resident #3's ER note dated 04/16/22 revealed:
-The resident reported she rolled out of bed and

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had left elbow pain.
-The resident admitted bilateral groin pain which she related to frequent falls.
-The emergency department provider repaired a 10cm Y-shaped laceration on her left elbow.

Interview with a MA on 05/03/22 at 1:12pm revealed:
-Resident #3 was considered a total care resident.
-Resident #3 required assistance with transferring, changing briefs and toileting, and feeding.
-All residents were usually checked on every 2 hours by a PCA or MA.
-Staff increased resident checks to every 30 minutes for 24-72 hours after having a fall but it was not documented anywhere in the facility.
-There was no place to document the 2 hour or 30-minute checks in the resident's chart or electronic record, but it was communicated to staff during the change of shift reports.
-She knew Resident #3 had multiple falls and went to the hospital, but she was not sure if she had injuries with the falls.
-She checked on Resident #3 every 30 minutes or at least every hour.

Interview with the Administrator on 05/04/22 at approximately 3:00pm revealed:
-Residents with falls were expected to be sent to the hospital for evaluation.
-The staff should increase supervision from every 2 hours to every hour for 72 hours after the resident returns to the facility.
-She was unsure if the staff documented when they completed each hourly check of the residents.

Telephone interview with Resident #3's family

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member on 05/04/22 at 4:15pm revealed:
-She was only aware of the resident falling 2 times in the past few months but did not know of the other 2 falls.
-She was informed by the facility the resident was to be transferred to a SNF last month because they could no longer provided the level of care the resident needs.
-She expected the facility to have put something in place to keep the resident from repeated falls.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-MAs were responsible for initiating monitoring sheets after a fall.
-Increased checks after a fall were every hour for 72 hours.
-Hourly supervision checks included staff checking to make sure the resident was clean and dry, sleep or wake, and if they had any needs such as something to drink.
-There was nowhere for staff to document each incontinence change completed for a resident.

Interview with Resident #3 on 05/03/22 at 4:30pm revealed:
-She had fallen multiples times in the past.
-She could not reach the call button located in the middle of the wall near her bed.
-She usually just yelled for the staff when she needed their help.
-She had a bell on her night stand she could ring when she needed help, but she could not reach it because of neuropathy and weakness in both of her hands and arms.
-She did not know how long it took the staff to respond to her yelling.
-She did not know how often the staff came to check on her.

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D 270	Continued From page 43 Observation of Resident #3's room on 05/03/22 at 4:30pm revealed: -There was a small metal bell located on the resident's nightstand behind a Styrofoam food container. -It was not within reaching distance for the resident to easily access. Telephone interview with Resident #3's PCP on 05/05/22 at 10:17am revealed: -The resident required more frequent checks than every 2 hours because she was non-compliant with calling for assistance and has had multiple falls in the past 6 months. -The resident had a fall with an injury in March 2022. -Resident #3's falls and related injuries most likely resulted from the resident's non-compliance or inability to call for assistance and the lack of appropriate supervision provided by the facility staff. Telephone interview with a medication aide (MA) on 05/05/22 at 1:26pm revealed: -Staff knew residents were a high fall risk because they talked to one another. -Most residents were kept in the areas around the front desk near staff. -Staff should check all residents every two hours and every 30 minutes to one hour for increased supervision. ___________________ The facility failed to provide supervision for one resident with a history of a falls which resulted in rib contusions and 4 subsequent falls, one of which resulted in bilateral pelvic fractures and one which resulted in a laceration of the elbow (#3). This failure resulted in serious physical harm and constitutes a Type A1Violation.	D 270		

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/04/22.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 5, 2022.

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 A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the healthcare needs for 3 of 3 sampled residents (#1, #2, #3) related to failure to follow-up with physical therapy, occupational therapy and an orthopedic specialist as ordered for a resident who had multiple falls and bilateral pelvic fractures (#3); failure to refer three diabetic residents who had long, thick and curved toenails to podiatry (#1, #2, #3); failure to follow-up with a urology specialist for a resident with an indwelling urinary catheter and a hematology specialist for treatment of anemia (#1); failure to follow-up with an ophthalmologist for a resident's glass eye replacement (#2); and for not notifying the provider of a resident's refusal of multiple doses of vitamin supplements and medications to treat nerve pain, depression, high blood pressure, and urinary tract infections (#3).

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The findings are:

1. Review of Resident #3's current FL-2 dated 04/13/22 revealed:
-Diagnoses included type II diabetes mellitus, polyneuropathy, arthritis, glaucoma, repeated falls, essential hypertension and anemia.
-She was intermittently disoriented and was semi-ambulatory with a walker for assistance.
-She required assistance with bathing, dressing and grooming.

a. Review of Resident #3's emergency room (ER) ER discharge summary dated 04/02/22 revealed:
-Diagnoses included a fall, tachycardia, dehydration and a urinary tract infection (UTI).
-The resident was to follow up with her PCP within 2-4 days.
-There was an addendum note dated and signed on 04/07/22 at 8:21am with diagnoses of fall, risk of falls, fracture of the left superior pubic ramus, and fracture of the right inferior pubic ramus.

Review of Resident #3's ER discharge summary dated 04/07/22 revealed:
-Diagnoses included a fall, at risk for falls and bilateral pelvic fractures.
-The resident was to follow up with an orthopedic specialist within 2-4 days.

Interview with the Administrator on 05/04/22 at 10:40am revealed Resident #3 was not referred to the orthopedic specialist because the resident was expected to transfer out of the facility to a skilled nursing facility by 05/03/22.

Telephone interview with Resident #3's primary care provider (PCP) on 05/05/22 at 10:17am revealed:
-Resident #3's plan of care since March 2022 had

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been to discharge her from the assisted living facility to a skilled nursing facility (SNF).
-The facility Administrator and Resident Care Coordinator (RCC) requested to have her remain in the facility in April 2022.
-The orthopedic appointment could have arranged by the facility and followed up by the SNF when the resident's transfer was completed.

b. Review of Resident #3's primary care provider (PCP) visit notes dated 02/16/22 revealed:
-The resident's problem list included repeated falls.
-The facility requested physical therapy (PT) and occupational therapy (OT) consults as the resident was having issues with activities of daily living (ADL).
-The resident complained of pelvic pain on movement of her hips.
-The resident required "24/7 supervision".
-There were orders for PT and OT evaluations.

Review of Resident #3's licensed healthcare professional support (LHPS) quarterly review dated 03/17/22 revealed the nurse recommended to refer the resident to physical therapy and occupational therapy due to recent falls.

Review of Resident #3's record revealed there were no documented visits with physical therapy or occupational therapy from 02/16/22 to 05/04/22.

Interview with the Administrator on 05/04/22 at 10:40am revealed Resident #3 was not referred to physical and occupational therapy because plans were initiated in March 2022 to transfer the resident out of the facility to a skilled nursing facility by 05/03/22.

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Telephone interview with Resident #3's PCP on 05/05/22 at 10:17am revealed:
-Resident #3's plan of care since March 2022 had been to discharge her from the assisted living facility to a skilled nursing facility.
-The facility Administrator and Resident Care Coordinator (RCC) requested to have her remain in the facility and refer to physical therapy in April 2022.
-She did not know why the resident was not referred to physical and occupational therapy from her 02/16/22 orders.
-It was possible the physical and occupational therapy referrals may have decreased the resident's risk of falling in the subsequent months.

c. Observation of Resident #3 on 05/03/22 at 4:37pm revealed:
-Her toenails were thick and long.
-The second toenail on her right foot and third toenail on her left foot were jagged and sharp.
-The fourth toenail on her right foot was curved upward and the fifth toenail on her right foot was curved towards the fourth digit.
-The great toenail and second toenail on her left foot were curved towards each other.
-The fourth toenail on her left was curved toward the third digit and the fifth toenail was curved towards the fourth digit.

Interview with Resident #3 on 05/03/22 at 4:30pm revealed:
-It had been a long time since someone had trimmed her toenails, but she could not remember exactly how long ago.
-She complained to the staff it hurt to put on her shoes because the toenails were long and would get snagged on the inside of the shoe.

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Telephone interview with the facility's podiatry provider office manager on 05/04/22 at 3:32pm revealed:
-The podiatrist had last seen Resident #3 in April 2021.
-The podiatrist no longer visited the facility because turnover in administration made coordinating visits difficult.
-The facility was responsible for arranging appointments for residents to see the podiatrist in the office.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-The previous RCC was supposed to have planned for a new podiatrist but she could not find the paperwork which was supposed to be in the office.
-The former podiatrist was still seeing residents in the office but was not coming to the facility.
-The last time the podiatrist was at the facility was in August/September 2021.
-She did not know if any of the residents in the facility had been seen in the podiatrist's office.

Interview with the Administrator on 05/04/22 at 11:37 revealed:
-Staff in the facility did not cut the toenails of residents with diabetes.
-The RCC was responsible for arranging podiatry care in the facility.
-There was no other podiatry provider used by the facility.

d. Review of Resident #3's physician orders dated 03/11/22 revealed:
-There was an order for Gabapentin 300mg 1 capsule at bedtime. (Gabapentin is used to relieve nerve pain.)

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-There was an order for Toprol XL 50mg 1 tablet once a day. (Toprol is used to treat high blood pressure, chest pain, and heart failure.)
-There was an order for Lisinopril 40mg 1 tablet once a day. (Lisinopril is used to treat high pressure and heart failure.)
-There was an order for Escitalopram 5mg 1 tablet once a day. (Escitalopram is used to treat depression and anxiety.)
-There was an order for Meloxicam 7.5mg 1 tablet once a day. (Meloxicam is an anti-inflammatory drug used to treat osteoarthritis and rheumatoid arthritis.)
-There was an order for Vitamin D3 50mcg 1 tablet once a day. (Vitamin D3 is an essential vitamin the helps regulate calcium and phosphorus in the body.)
-There was an order for Vitamin B-12 1000mcg 1 tablet once a day. (Vitamin B-12 is an essential vitamin that helps with cell metabolism and nerve function.)
-There was an order for Bactrim DS 1 tablet twice a day for 7 days started on 03/10/22. (Bactrim DS is used to treat urinary tract infections.)

Review of Resident #3's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Gabapentin 300mg 1 capsule at bedtime, scheduled to be administered at 6:00pm,
-Gabapentin was documented as refused by the resident on 03/03/22, 03/08/22-03/10/22, 03/14/22-03/15/22, 03/25/22 and 03/31/22.
-There was a total of 8 doses of Gabapentin refused by the resident from 03/01/22 - 03/31/22.
-There was an entry for Toprol XL 50mg 1 tablet once a day, scheduled to be administered at 8:00am.
-Toprol XL was documented as refused by the

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D 273	Continued From page 50 resident on 03/12/22-03/15/22, and 03/25/22-03/27/22. -There was a total of 7 doses of Toprol XL refused by the resident from 03/01/22 - 03/31/22. -There was an entry for Lisinopril 40mg 1 tablet once a day, scheduled at 8:00am. -Lisinopril was documented as refused by the resident on 03/12/22-03/15/22 and 03/25/22-03/27/22. -There was a total of 7 doses of Lisinopril refused by the resident from 03/01/22 - 03/31/22. -There was an entry for Escitalopram 5mg 1tablet once a day, scheduled for 8:00am. - Escitalopram was documented as refused by the resident on 03/12/22-03/15/22 and 03/25/22-03/27/22. -There was a total of 7 doses of Escitalopram refused by the resident from 03/01/22 - 03/31/22. -There was an entry for Meloxicam 7.5mg 1 tablet once a day, scheduled at 8:00am. -Meloxicam was documented as refused by the resident on 03/12/22-03/15/22 and 03/25/22-03/27/22. -There was a total of 7 doses of Meloxicam refused by the resident from 03/01/22 - 03/31/22. -There was an entry for Vitamin D3 50mcg 1 tablet once a day, scheduled at 8:00am. -Vitamin D3 was documented as refused by the resident on 03/12/22-03/15/22 and 03/25/22-03/27/22. -There was a total of 7 doses of Vitamin D3 refused by the resident from 03/01/22 - 03/31/22. -There was an entry for Vitamin B-12 1000mcg 1 tablet once a day, scheduled at 8:00am. -Vitamin B-12 was documented as refused by the resident on 03/12/22-03/15/22 and 03/25/22-03/27/22. -There was a total of 7 doses of Vitamin B-12 refused by the resident from 03/01/22 - 03/31/22. -There was an entry for Bactrim DS 1 tablet twice	D 273		

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a day for 7 days, scheduled at 8:00am and 6:00pm.
-Bactrim DS was documented as refused by the resident for the 8:00am dose on 03/12/22-03/15/22 and for the 6:00pm dose on 03/14/22-03/15/22.
-There was a total of 6 doses of Bactrim DS refused by the resident from 03/10/22 - 03/17/22.

Review of Resident #3's physician orders dated 04/13/22 revealed:
-There was an order for Gabapentin 300mg 1 capsule three times a day.
-There was an order for Toprol XL 50mg 1 tablet once a day.
-There was an order for Escitalopram 5mg 1 tablet once a day.
-There was an order for Meloxicam 7.5mg 1 tablet once a day.
-There was an order for Vitamin D3 50mcg 1 tablet once a day.
-There was an order for Vitamin B-12 1000mcg 1 tablet once a day.

Review of Resident #3's April 2022 eMAR revealed:
-There was an entry for Gabapentin 300mg 1 capsule three times a day, scheduled to be administered at 8:00am, 4:00pm and 6:00pm,
-Gabapentin scheduled at 8:00am was documented as refused by the resident on 04/03/22, 04/13/22-04/14/22, 04/17/22 and 04/30/22.
-Gabapentin scheduled at 2:00pm was documented as refused by the resident on 04/03/22-04/03/22, and 04/13/22.
-Gabapentin scheduled at 6:00pm was documented as refused by the resident on 04/05/22.
-There was a total of 9 doses of Gabapentin

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D 273	Continued From page 52 refused by the resident from 04/01/22 - 04/30/22. -There was an entry for Toprol XL 50mg 1 tablet once a day, scheduled to be administered at 8:00am. -Toprol XL was documented as refused by the resident on 04/03/22, 04/13/22-04/14/22, 04/17/22, and 04/30/22. -There was a total of 5 doses of Toprol XL refused by the resident from 04/01/22-04/30/22. -There was an entry for Escitalopram 5mg 1tablet once a day, scheduled for 8:00am. -Escitalopram was documented as refused by the resident on 04/03/22, 04/13/22-04/14/22, 04/17/22, and 04/30/22. -There was a total of 5 doses of Escitalopram refused by the resident from 04/01/22-04/30/22. -There was an entry for Meloxicam 7.5mg 1 tablet once a day, scheduled at 8:00am. -Meloxicam was documented as refused by the resident on 04/03/22, 04/13/22-04/14/22, 04/17/22, and 04/30/22. -There was a total of 5 doses of Meloxicam refused by the resident from 04/01/22-04/30/22. -There was an entry for Vitamin D3 50mcg 1 tablet once a day, scheduled at 8:00am. -Vitamin D3 was documented as refused by the resident on 04/03/22, 04/13/22-04/14/22, 04/17/22, and 04/30/22. -There was a total of 5 doses of Vitamin D3 refused by the resident from 04/01/22-04/30/22. -There was an entry for Vitamin B-12 1000mcg 1 tablet once a day, scheduled at 8:00am. -Vitamin B-12 was documented as refused by the resident on 04/03/22, 04/13/22-04/14/22, 04/17/22, and 04/30/22. -There was a total of 5 doses of Vitamin B-12 refused by the resident from 04/01/22-04/30/22. Review of Resident #3's Incident/Accident (I/A) report dated 03/18/22 revealed the resident was	D 273		

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sent to the hospital for a low blood pressure of 80/69 and her primary care provider (PCP) was notified.

Interview with the Administrator on 05/04/22 at 11:10am revealed:
-Medications aides (MAs) were expected to notify the Resident Care Coordinator (RCC) of medication refusals each time a resident refused medications.
-She was not sure if the electronic medication administration record system had daily reports or dashboards showing missed and refused medications for all residents in the facility.

Telephone interview with Resident #3's PCP on 05/05/22 at 10:17am revealed:
-She was not notified by the facility of missed or refused medications for Resident #3 in March 2022 or April 2022.
-She expected the facility to notify her when a resident refused 3 or more consecutive doses of any medication.
-She reviewed Resident #3's March 2022 eMAR for missed or refused doses of Toprol XL after she had a concern about the resident experiencing hypotensive episode on 03/18/22.

2. Review of Resident #1's current FL-2 dated 03/17/22 revealed diagnoses included urinary tract infection, altered mental status, dementia, benign prostate hypertrophy, hyperlipidemia, hypertension, type II diabetes mellitus and acute kidney injury.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 3:01pm revealed:
-It was difficult to get Resident #1's primary care provider (PCP) on the phone because he was

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with the Veteran's Administration (VA).
-Resident #1 had refused to go to multiple medical appointments.

Telephone interview with Resident #1's family member on 05/03/22 at 3:29pm revealed:
-He normally took him to appointments at the VA.
-The resident was supposed to follow up with a physician one half mile from the facility after he was discharged from the hospital.
-The staff were supposed to take the resident to that appointment because he lived in another county from the facility.
-He did not know the resident had a urinary catheter until he was at the facility on 05/01/22.
-He was not contacted about the resident refusing medical appointments.
-The resident would become verbally aggressive like cursing at staff, but he did not mean anything by it and would cooperate while being verbally aggressive.

a. Observation of Resident #1 outside in the smoking area on 05/03/22 at 10:37am revealed:
-He had a catheter coming out of the left pant leg that had yellow liquid with a thick white substance in the dependent part of the tubing.
-The catheter bag was enclosed inside a clear garbage bag and hung from the armrest of his wheelchair.
-The valve of the catheter bag was not enclosed inside the clear protective cover on the catheter bag.

Review of Resident #1's occupational therapist (OT) visit note dated 04/22/22 revealed the caregiver was educated on keeping the resident hydrated and being aware of sediment in the urinary catheter tubing.

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Review of Resident #1's electronic charting notes dated 04/23/22 through 05/03/22 revealed:
-There was no documentation of the appearance of the urine in the catheter tubing.
-There was no documentation of contact with HH about the resident's urinary catheter.

Interview with a medication aide (MA) on 05/03/22 at 3:01pm revealed:
-Staff put the clear plastic bag over the catheter bag on 05/02/22 because it was leaking.
-The catheter bag would leak on and off since he got urinary catheter in March 2022.
-She did not receive any training on the urinary catheter and only knew to empty the catheter bag.
-She did not think staff at assisted living facilities cared for or monitored urinary catheters.
-If there was a problem with the catheter like not draining urine or if there was a leakage, she contacted home health (HH).
-She did not call the HH nurse.
-She told a HH physical therapist who was in the facility working with Resident #1 on 05/02/22 that the catheter bag was leaking.

Observation of Resident #1 in the dining room on 05/04/22 at 8:00am revealed:
-He was repeatedly saying to staff, "Help me, I hurt all over."
-She offered the resident to contact the primary care provider (PCP) or send him to the local hospital.
-He declined saying he just wanted to smoke a cigarette.

Interview with Resident #1 on 05/04/22 at 8:38am revealed:
-He hurt all over but especially at his lower abdomen and groin area.

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-He was not able to say how long he had been hurting.

Observation of Resident #1 on 05/04/22 at 8:39am revealed:
-The personal care aide (PCA) went up to the resident in the dining room and told him he was being sent to the local hospital because the Resident Care Coordinator (RCC) of a nearby sister facility was concerned about his catheter bag.
-The PCA first took the resident to his room and then to the front entrance area of the facility.
-Emergency Medical Technicians (EMTs) entered through the front door with a stretcher.
-The resident began cursing and refusing to go at the same time he followed staff prompts to stand with assistance of the two EMTs and pivot to the stretcher from his wheelchair.
-The RCC told the EMTs the resident's baseline was to curse you at you and laugh at the same time.

Review of Resident #1's emergency room (ER) discharge instructions dated 05/04/22 revealed the resident was seen for a catheter associated urinary tract infection and treated with an antibiotic.

Interview with the RCC of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-Staff contacted HH if there were any problems with the catheter.
-Resident #1's catheter bag did not leak, the clip on the valve would come loose and leak urine.
-No one reported any issues with the bag from 05/02/22 to her.
-She saw the clear plastic bag over the catheter bag on 05/03/22; the 3rd shift MA had put the clear plastic bag over the bag because the

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clip/valve was hanging out.
-The valve would not stay in the protective plastic cover attached to catheter bag
-She contacted HH about the catheter bag today (05/04/22) but had not documented the contact in the resident's charting notes.
-She did not specify what the concern for the catheter bag was.

Telephone interview with the HH Nurse on 05/03/22 at 4:04pm revealed:
-Resident #1 was admitted for HH services on 03/18/22 and was visited weekly by a nurse.
-The last as needed visit in response to a call from the staff about Resident #1's urinary catheter was on 04/18/22.
-Staff reported the urinary catheter was leaking but there was no leak, the valve was not closed properly.
-There were no calls from staff since 04/18/22, she had not received a message concerning the resident's catheter on 05/02/22.

Second telephone interview with the HH Nurse on 05/04/22 at 3:16pm revealed not properly cleaning the catheter and sediment in the tubing were two possible causes of a catheter associated urinary tract infection.

Telephone interview with the Licensed Health Professional Support (LHPS) Nurse on 05/04/22 at 3:34pm revealed:
-When she completed new hire skills check off she covered where to position urinary catheter bags and cleaning the catheter tubing from insertion site down to the bag.
-Not cleaning the catheter, not bathing and the presence of the catheter could all cause a catheter associated urinary tract infection.

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Interview with the Administrator on 05/04/22 at 11:10am revealed staff contacted HH if there were any issues with the catheter.

Attempted telephone interviews with the local emergency department physician on 05/04/22 at 2:52pm and 3:47pm were unsuccessful.

b. Review of Resident #1's hospital discharge documentation dated 03/17/22 revealed orders to follow up with the urologist on 03/22/22 at 9:30am.

Review of Resident #1's discharge summary dated 03/17/22 revealed:
-Urology saw the resident in the hospital and recommended a catheter for 5-7 days with a void trial at the urology clinic.
-He needed a cystoscopy (a procedure to visually examine the lining of the bladder) and cytology (examination of cells to screen for cancer) and further imaging for two right renal lesions concerning for malignancy.
-Urology would follow up with the resident at the upcoming appointment.

Telephone interview with a receptionist at the urologist's office on 05/03/22 at 4:46pm revealed:
-Resident #1 was a "no call, no show" for his appointments on 03/22/22 and 05/02/22.
-He did not show up for the appointments and the appointments were not canceled.
-The resident had an appointment scheduled for 05/11/22 which was scheduled on 05/03/22 at 8:44am.

Review of Resident #1's charting notes dated 03/17/22 through 05/02/22 revealed:
-On 05/02/22 at 2:22pm, the resident refused to go his urologist appointment.

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-There were no previous entries regarding contact with the urologist office or appointment refusals.
-There was no documentation of contacting the family member.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-Resident #1's urinary catheter was initially placed in March 2022; he did not have a catheter prior to that.
-She was checking the records of residents when she took over the RCC responsibilities in late March/early April 2022 and saw that Resident #1 needed an appointment with the urologist.
-She knew he had not seen the urologist and scheduled an appointment for 05/02/22.
-The resident just would not go to the appointment on 05/02/22.
-She called to reschedule the appointment which was scheduled for 05/11/22.
-Staff were responsible for taking the resident to the urologist.

c. Review of Resident #1's hospital discharge documentation dated 03/17/22 revealed orders to follow up with the primary care provider (PCP) within 1-2 weeks.

Review of Resident #1's electronic charting notes dated 03/17/22 through 05/02/22 revealed:
-On 05/02/22 at 2:22pm, an appointment was scheduled with the resident's PCP at the Veteran's Administration (VA).
-There were no previous entries regarding contact with the PCP or appointment refusals.
-There was no documentation of contacting the family member.

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Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-She did not send the hospital discharge paperwork from 03/17/22 related to the new urinary catheter placement to Resident #1's PCP.
-He had not seen his PCP at VA since discharge from the hospital on 03/17/22.
-She did not know if the family member had been contacted to arrange a follow up visit at the VA following the hospital discharge on 03/17/22.
-There should have been a charting note documenting the family member had been contacted.
-She thought the hospital talked to the family member about what happened during the resident's admission from 03/13/22 to 03/17/22.

d. Review of Resident #1's Veteran's Administration (VA) letter dated 05/26/21 revealed the VA's attempt to contact the resident to schedule a hematology appointment had failed.

Telephone interview with the receptionist at the hematologist's office on 05/04/22 at 3:29pm revealed:
-Resident #1 was last seen on 11/24/21 for anemia.
-The resident had appointments on 12/02/21 and 12/06/21 which were canceled.
-He had an appointment on 03/28/22 but was not seen.
-There was no cancellation for the 03/28/22 appointment and the appointment was not rescheduled.

Interview with the RCC of a nearby sister facility on 05/04/22 at 4:50pm revealed she did not know anything about a hematology follow up appointment on 03/28/22.

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e. Interview with Resident #1 on 05/03/22 at 10:37am revealed he could not remember when his fingernails and toenails were last cut.

Interview with a personal care aide (PCA) on 05/03/22 at 1:14pm revealed:
-She thought there was a provider that came to the facility and cut Resident #1's toenails.
-He would not let staff assist him with fingernail care.

Observations of Resident #1 in his room on 05/04/22 at 8:40am revealed:
-His toenails were greater than ½ in length on both feet.
-The second toenail on the left foot was curled over the toe and bent toward the first toe.
-The second, third and fourth toenails were curved over the end of the toe.
-Both his feet had dry, scaly and flaking skin around the toes and on the heels and soles.

Interview with the RCC of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-The previous RCC was supposed to have planned for a new podiatrist but she could not find the paperwork which was supposed to be in the office.
-The former podiatrist was still seeing residents in the office but was not coming to the facility.
-The last time the podiatrist was at the facility was in August/September 2021.
-She did not know if any of the residents in the facility had been seen in the podiatrist's office.

Interview with the Administrator on 05/04/22 at 11:10am revealed:
-Staff were not able to trim fingernails for residents with diabetes; they were able to clean

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and file nails.
-Nail care was done weekly and as needed by PCAs and medication aides (MAs).
-The RCC was responsible for checking the residents with diabetes for foot care needs and following up with podiatry appointments.

Second interview with the Administrator on 05/04/22 at 2:40pm revealed there was no system or process in place for her to check physical condition of heavy care residents like Resident #1.

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Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-There was another RCC working at the facility in March 2022; she did not know what the other RCC did as far as managing residents' appointments.
-She kept an appointment book at the nearby sister facility.
-She did not have any appointments for Resident #1 in the appointment book at the nearby sister facility.
-She started an appointment book for residents at this facility on 05/04/22.
-The family member took the resident to his VA appointments.
-Staff were responsible for taking the resident to the urologist.

Interview with the Administrator on 05/04/22 at 11:10am revealed:
-The RCC was responsible for making follow up appointments and maintaining the appointment calendar.
-The facility was responsible for arranging and transporting the residents to their appointments if a family member or other transport was

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unavailable.
-Appointment refusals were reported to the family member and PCP by the RCC and were documented in the residents charting notes.
-She was responsible for overseeing the duties of the RCC.
-She monitored the RCC through communication during the daily stand up and chart audits done by the Regional Nurse and Director of Operations.

Second telephone interview with the Administrator on 05/05/22 at 1:53pm revealed:
-Hospital discharge orders were supposed to be faxed to the resident's PCP with a follow up confirmation call by the RCC.
-The RCC could delegate faxing paperwork to the PCP and the staff who contacted the PCP should document the task was done in the resident's charting notes.
-Staff were expected to document any contact with Resident #1's family member regarding refusals of care and appointments.

Attempted telephone interview with Resident #1's PCP on 05/03/22 at 3:45pm and was unsuccessful.

3. Review of Resident #2's current FL-2 dated 10/18/21 revealed:
- Diagnoses including history of a stroke and diabetes.
-He was intermittently disoriented and was semi-ambulatory in his wheelchair.

Observation of Resident #2 on 05/04/22 at 4:14pm revealed:
-Resident #2 did not have a right eye. His eyelid was covering his eye socket.
-Resident #2's toenails were long, grown beyond the tips of his toes on both feet.

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Interview with Resident #2 on 05/04/22 at 4:19pm revealed:
-He used to have a glass eye for his right eye.
-His toenails were long.
-He had not seen the podiatrist in a long time.
-His family had provided new shoes so his toenails did not hurt his feet.

a. Telephone interview with the facility's podiatry provider office manager on 05/04/22 at 3:32pm revealed:
-The podiatrist had last seen Resident #2 on 04/26/21.
-The podiatrist used to go to the facility to provide nail care.
-The podiatrist no longer visited the facility because the turnover in administration made coordinating visits difficult.
-The facility was responsible for arranging appointments for residents to see the podiatrist in the office.
-There were no recent or pending appointments for Resident #2.

Interview with the Resident Care Coordinator (RCC) at a sister facility on 05/04/22 at 5:35pm revealed:
-She acted as the RCC at the facility.
-She was aware the podiatrist was no longer visiting the facility and appointments must be made for residents to be seen.
-She had not made an appointment for Resident #2 to be seen by the podiatrist.
-She was not aware of any podiatry appointments made by the previous RCC.
-It was important for residents with diabetes to be seen by the podiatrist for nail care.

Interview with the Administrator on 05/04/22 at

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11:37am revealed:
-Staff in the facilities did not cut the toenails of residents with diabetes.
-The RCC was responsible for arranging podiatry care in the facility.
-There was no other podiatry provider used by the facility.

b. Review of Resident #2's Optometrist's Progress Note revealed:
-Resident #2 had seen the facility optometrist on 05/20/21.
-The optometrist recommended Resident #2 to see an ophthalmologist due to needing his glass eye repaired.
-The optometrist was not able to repair his glass eye.
-There was no documentation that Resident #2 had seen an ophthalmologist.

Telephone interview with the facility's optometry provider office manager on 05/04/22 at 3:35pm revealed:
-Resident #2 was seen by the optometrist for a follow up appointment in 11/2021.
-Resident #2 needed to be seen by the ophthalmologist for repair or replacement of his glass eye.
-She said a referral had been provided to another vision clinic.

Telephone interview with the vision clinic office manager on 05/04/22 at 3:43pm revealed Resident #2 was not seen by the clinic and was not a patient of theirs.

Interview with the RCC on 05/04/22 at 5:49pm revealed:
-She was told that Resident #2 had lost his glass eye.

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D 273	Continued From page 66 -There had not been any follow up since a previous RCC left in 12/2021. Interview with the Administrator on 5/04/22 at 11:37am revealed it was the responsibility of the RCC to ensure residents were seen by outside providers. ______________________________ The facility failed to implement referrals for orthopedics and physical and occupational therapies following a hip fracture (#3), ensure hospital follow up with a urologist for a urinary catheter removal, cystoscopy and imaging to follow up on renal lesions (#1) and contact the primary care provider for diabetic foot care for 3 residents (#1, #2 and #3) and multiple medication refusals (#3). The facility's failure resulted in a six week delay in follow up with the urologist (#1), an eleven week delay in physical and occupational therapy evaluations (#3), and a 3 week delay in follow up with an orthopedic specialist (#3) which demonstrates substantial risk of death and serious neglect and constitutes a Type A2 Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/04/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 4, 2022.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes:	D 282		

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D 282	Continued From page 67 (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the kitchen was clean and protected from contamination related to a live roach on the preparation table and a dead roach on top of the dishwasher. The findings are: Review of Food Establishment Inspection Report dated 11/08/21 revealed: -The facility scored 96.5 out of 100. -There were no demerits related to pests in the kitchen. Observation of the kitchen on 05/04/22 at 7:58am revealed: -A roach walked on top of the clean preparation table. -A dead roach and food particles were on top of the dishwashing machine. Interview with the dietary cook on 05/04/22 at 8:00am revealed: -She did not know there were roaches in the kitchen. -The top of the dishwasher needed to be cleaned. Interview with the dietary cook on 05/04/22 at 4:42pm revealed: -There was no cleaning schedule in the kitchen. -The preparation table was cleaned at least daily by dietary staff and as needed. -The top of the dishwasher would be cleaned	D 282		

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D 282	Continued From page 68 approximately twice a month. -She did not remember when pest control last came to treat the kitchen. Review of the facility's pest control company visit summaries revealed the kitchen was last treated for roaches on 11/10/21 and 01/12/22. Interview with the Maintenance Director on 05/04/22 at 8:27am revealed: -He was new to the facility. -He did not know when the kitchen was last treated for pest control. Interview with the Administrator on 05/04/22 at 9:32pm revealed: -The facility was having trouble getting the pest control company to come to the facility. -When the pest control company did not visit, the Maintenance Director would treat the kitchen for pests.	D 282		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain orders in 1 of 4 sampled resident records (Resident #7) reviewed for medications.	D 345		

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D 345	Continued From page 69 The findings are: Review of Resident #7's current FL-2 dated 06/25/21 revealed: -Diagnoses included paranoid schizophrenia and diabetes -Medication orders included olanzapine 15mg once a day, Duoneb 0.5-3(2.5)mg one vial via nebulizer twice a day as needed (olanzapine is an anti-psychotic and duoneb is used for shortness of breath). Review of March 2022, April 2022, and May 2022 electronic medication administration records (eMARs) revealed: -There were no entries for olanzapine or Duoneb. -There was an entry for Latuda 60mg every evening documented as administered daily (Latuda is an antipsychotic medication). Review of Resident #7's medical record revealed: -There were no physician orders in the record. -There were no orders discontinuing the olanzapine or the Duoneb. -There was no order for Latuda. Observation of Resident #7's medications on hand on 05/04/22 at 3:18pm revealed: -There was no supply of olanzapine or Duoneb for Resident #7. -There was a blister pack of Latuda 60 mg dispensed 04/21/22 with 15 of the 30 pills dispensed remaining. Interview with the Resident Care Coordinator (RCC) at a sister facility on 05/04/22 at 5:53pm revealed: -She acted as the RCC. -Resident #7 would go to his primary care provider (PCP) appointments alone and to his	D 345		

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psychiatric provider appointments with his family member and would not return with any orders or paperwork.
- The orders would go to the pharmacy electronically directly from the provider.
-The pharmacy would input the medication orders and have the medications delivered to the facility.
-The medication aides (MA) would acknowledge the change of medications in the computer system and place the medication on the cart to administer.
-The MAs did not have access to the medical record if there were questions about the medication changes.

Telephone interview with Resident #7's family member on 05/05/22 at 10:00am revealed there was no paperwork provided by the doctor to the resident or family after an appointment.

Telephone interview with Resident #7's psychiatrist's office manager on 05/05/22 at 10:08am revealed if there are any questions or concerns, the physician's office would send paperwork from the appointment if the assisted living facility requested it.

Telephone interview with Resident #7's PCP's office registered nurse on 05/05/22 at 10:40am revealed:
-Resident #7's current medication orders included Latuda 60 mg one tablet in the evening with food.
-There no current orders for olanzapine or Duoneb but she did not have the discontinued date available.
-The physician's office usually sent medication orders and changes directly to the pharmacy.
-Resident #7 would have usually received information about his next appointment but no other information about the visit.

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-The PCP's office would provide information about the visit to the assisted living facility if requested.
-The assisted living facility needed to have copies of physician's orders on his medical record so the facility would know his plan of care.

Interview with the Administrator on 05/05/22 at 10:48am revealed:
-She was not aware Resident #7 did not have any orders in his medical record.
-It was concerning to her because that meant the facility did not have any orders to treat Resident #7 or to get medication refills when needed.
-Resident #7's PCP was across the street and the facility could have easily obtained the orders.

D 358 — 10A NCAC 13F .1004(a) Medication Administration — D 358

10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's medication administration policies for 2 of 2 residents (#4, #5) observed during the medication pass including errors with two different medications used to treat mental/mood disorders (#4, #5), a method of blood glucose

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monitoring with parameters (#5), and a medication used to treat hypothyroidism, a medication used to treat and prevent ulcers in the intestines, and a medication to treat moderate to severe pain (#4); and for 1 of 3 sampled residents (#1) for record review including errors with medications for low magnesium levels, low Vitamin B12 levels, and a medication for symptoms associated with enlarged prostate.

The findings are:

1. The medication error rate was 19% as evidenced by the observation of 6 errors out of 31 opportunities during the morning medication pass on 05/03/22.

a. Review of Resident #4's current FL-2 dated 03/08/22 revealed:
-Diagnoses included type 2 diabetes, essential hypertension, chronic obstructive pulmonary disease, insomnia, bipolar disorder, major depressive disorder, sleep apnea and gastroesophageal reflux disease.
-There was an order for Levothyroxine 25mcg 1 tablet once daily at 7:00am. (Levothyroxine is used to treat hypothyroidism. Levothyroxine requires gastric acidity and is not absorbed properly unless taken on an empty stomach.)

Observation of the morning medication pass on 05/03/22 revealed:
-Resident #4 was administered her morning medications, including Levothyroxine, at 8:54am.
-The medication aide (MA) did not ask the resident if she had eaten her breakfast that morning.

Review of Resident #4's May 2022 electronic medication administration record (eMAR)

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revealed:
-There was an electronic entry for Levothyroxine 25mcg 1 tablet once a day, scheduled for administration at 7:00am.
-Levothyroxine was documented as administered to the resident on 05/03/22 at 7:00am.

Interview with the medication aide (MA) on 05/03/22 at 1:15pm revealed:
-She administered the Levothyroxine with the other medications scheduled for 7:00am-9:00am because it popped up on the eMAR to be administered at that time.
-She was not aware of an order for Levothyroxine to be administered at 7:00am.

Interview with Resident #4 on 05/03/22 at 8:50am revealed:
-She usually got her medications at the same time in the morning between 8:00 and 9:00am.
-She ate her breakfast at 8:00am that morning, prior to receiving her medications.

Refer to interview with the Administrator on 05/03/22 at 1:07pm.

b. Review of Resident #4's current FL-2 dated 03/08/22 revealed:
-Diagnoses included gastroesophageal reflux disease.
-There was an order for Sucralfate 1gm 1 tablet four times a day at 7:30am, 11:30am, 4:30pm and 9:00pm. (Sucralfate is an antacid used to treat and prevent ulcers in the intestines. Sucralfate is most effective when taken 30 minutes before eating.)

Observation of the morning medication pass on 05/03/22 revealed:
-Resident #4 was administered her morning

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medications, including Sucralfate, at 8:54am.
-The medication aide (MA) did not ask the resident if she had eaten her breakfast that morning.

Review of Resident #4's May 2022 electronic medication administration record (eMAR) revealed:
-There was an electronic entry for Sucralfate 1gm 1 tablet four times a day.
-Sucralfate was scheduled for administration at 7:30am.
-Sucralfate was documented as administered to the resident on 05/03/22 at 7:30am.

Interview with the medication aide (MA) on 05/03/22 at 1:15pm revealed:
-She administered the Sucralfate with the other medications scheduled for 7:00am-9:00am because it popped up on the eMAR to be administered at that time.
-She was not aware of an order for Sucralfate to be administered at 7:30am.

Interview with Resident #4 on 05/03/22 at 8:50am revealed:
-She usually got her medications at the same time in the morning between 8:00 and 9:00am.
-She ate her breakfast at 8:00am that morning, prior to receiving her medications.

Refer to interview with the Administrator on 05/03/22 at 1:07pm.

c. Review of Resident #4's current FL-2 dated 03/08/22 revealed:
-There was an order for Tramadol HCL 50mg 1 tablet once a day. (Tramadol is an opioid used to help relieve chronic moderate to severe pain.)

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Observation of the morning medication pass on 05/03/22 revealed:
-Resident #4 was administered her morning medications at 8:54am.
-Resident #4 inquired if her Tramadol was available for her to receive during the morning medication pass.
-Tramadol was not administered with Resident #4's other morning medications.

Review of Resident #4's May 2022 electronic medication administration record (eMAR) revealed:
-There was an electronic entry for Tramadol HCL 50mg 1 tablet once a day.
-Tramadol was scheduled for administration at 9:00am.
-Tramadol was documented as not administered to the resident from 05/01/22 - 05/03/22 at 9:00am because it was on order from the pharmacy.

Interview with the medication aide (MA) on 05/03/22 at 1:15pm revealed:
-Resident #4's Tramadol was not on the medication cart or in the medication room.
-The resident had been out of her Tramadol for approximately 4 days from 04/30/22 to 05/03/22.
-The facility was waiting on the medication to be refilled by the pharmacy.
-She did not know when the refill for Tramadol was requested by the facility.
-MAs ordered a refill through the eMAR system when the medication was down to a 3 to 5-day supply.

A second interview with the MA on 05/03/22 at 1:26pm revealed:
-Resident #4's Tramadol was delivered to the facility on 05/02/22 between 6:00pm - 7:00pm.

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-She did not know Tramadol was available for the resident during the morning medication pass.

Interview with Resident #4 on 05/03/22 at 8:50am revealed:
-She usually got her Tramadol in the morning with her other medications.
-She takes Tramadol for her chronic lower back pain.

Telephone interview with the facility's contracted pharmacy on 05/04/22 at 3:42pm revealed:
-The facility requested a refill for Tramadol on 05/02/22.
-The pharmacy refilled Resident #4's Tramadol and delivered a 30-day supply to the facility on 05/02/22 at 6:05pm.
-The facility requested a refill for Tramadol on 03/30/22.
-The pharmacy refilled Resident #4's Tramadol and delivered a 30-day supply to the facility on 03/30/22.

Review of Resident #4's control substance log for Tramadol filled on 03/30/22 revealed the resident received 1 tablet each day for 30 days from 03/31/22 to 04/29/22.

Refer to interview with the Administrator on 05/03/22 at 1:07pm.

d. Review of Resident #4's current FL-2 dated 03/08/22 revealed:
-Diagnoses included insomnia, bipolar disorder, major depressive disorder.
-There was an order for Ziprasidone HCL 60mg 1 capsule twice daily with meals. (Ziprasidone HCL is an antipsychotic used to treat bipolar disorder. Ziprasidone HCL is not absorbed properly unless taken with food.)

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Observation of the morning medication pass on 05/03/22 revealed:
-Resident #4 was administered her morning medications, including Ziprasidone HCL, at 8:54am.
-The medication aide (MA) did not ask the resident if she had eaten her breakfast that morning.
- Ziprasidone HCL was not administered with a meal as ordered.

Review of Resident #4's May 2022 electronic medication administration record (eMAR) revealed:
-There was an electronic entry for Ziprasidone HCL 60mg 1 capsule twice daily with meals.
-Ziprasidone HCL was scheduled for administration at 8:00am.
-Ziprasidone HCL was documented as administered to the resident on 05/03/22 at 8:00am.

Interview with the medication aide (MA) on 05/03/22 at 9:00am revealed:
-She administered the Ziprasidone HCL with the other medications scheduled for 7:00am-9:00am because it popped up on the eMAR to be administered at that time.
-She was not aware of an order for Ziprasidone HCL to be administered with a meal.

Interview with Resident #4 on 05/03/22 at 8:50am revealed:
-She usually got her medications at the same time in the morning between 8:00 and 9:00am.
-She ate her breakfast at 8:00am that morning, prior to receiving her medications.

Refer to interview with the Administrator on

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05/03/22 at 1:07pm.

e. Review of Resident #5's current FL-2 dated 01/19/22 revealed:
-There was an order for Risperidone 0.5mg 1 tablet twice a day. (Risperidone is an antipsychotic used to treat schizophrenia, bipolar disorder, and irritability caused by autism.)

Review of Resident #5's physician orders dated 03/08/22 revealed:
-Diagnoses included major depressive disorder and insomnia.
-There was an order for Risperidone 0.5mg 1 tablet twice a day, and instructions to administer at 8:00am and 5:00pm.

Observation of the morning medication pass on 05/03/22 revealed Resident #5 was administered his morning medications, including Risperidone, at 9:21am.

Review of Resident #5's May 2022 electronic medication administration record (eMAR) revealed:
-There was an electronic entry for Risperidone 0.5mg 1 tablet twice a day with instructions to administer at 8:00am and 5:00pm.
-Risperidone was scheduled for administration at 8:00am.
-Risperidone was documented as administered to the resident on 05/03/22 at 8:00am.

Interview with the medication aide (MA) on 05/03/22 at 1:12pm revealed:
-She administered the Risperidone with the other medications scheduled for 7:00am-9:00am because it popped up on the eMAR to be administered at that time.
-She was aware the order for Risperidone

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instructed the medication to be administered at 8:00am.
-She did not know she was expected to administer at the specific time instructed in the orders..

Refer to interview with the Administrator on 05/03/22 at 1:07pm.

f. Review of Resident #5's current FL-2 dated 01/19/22 revealed diagnoses included dementia and diabetes.

Review of Resident #5's physician orders dated 03/08/22 revealed:
-Diagnoses included type 2 diabetes mellitus.
-There was an order to check blood sugar before breakfast with instructions if blood sugar is less than 60 give 8 ounces of orange juice and recheck blood sugar in 15 minutes, if blood sugar is still less than 60 then repeat and notify the provider, and notify the provider if blood sugar is greater than 400.
-The blood sugar check was scheduled daily at 7:30am.

Observation of the morning medication pass on 05/03/22 revealed:
-The medication aide (MA) checked Resident #5's blood sugar at 9:20am.
-The MA did not ask the resident if he had eaten his breakfast that morning.

Review of Resident #5's May 2022 electronic medication administration record (eMAR) revealed:
-There was an order to check blood sugar before breakfast with instructions if blood sugar is less than 60 give 8 ounces of orange juice and recheck blood sugar in 15 minutes, if blood sugar

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is still less than 60 then repeat and notify the provider, and notify the provider if blood sugar is greater than 400.
-The blood sugar check was scheduled at 7:30am.
-A blood sugar result of 244 was documented at 7:30am.

Interview with Resident #5 on 05/03/22 at 9:25am revealed he had raisin bran cereal with milk for breakfast that morning.

Interview with the MA on 05/03/22 at 1:12pm revealed she usually checked Resident #5's blood sugar before breakfast, but the resident was already in the dining room at 7:30am this morning.

Refer to interview with the Administrator on 05/03/22 at 1:07pm.

____

Interview with the Administrator on 05/03/22 at 1:07pm revealed:
-The medication aide (MA) should have administered the morning medications within 1 hour of the scheduled time.
-The MA should have followed the order instructions and administered the medications at the specified time within the order instructions.
-MAs were expected to reorder medications when the resident's supply is down to a 3-day supply on hand.

2. Review of Resident #1's current FL-2 dated 03/17/22 revealed diagnoses included urinary tract infection, altered mental status, dementia, benign prostate hypertrophy, hyperlipidemia, hypertension, type II diabetes mellitus and acute kidney injury.

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D 358	Continued From page 81 Review of Resident #1's charting note dated 03/17/22 revealed: -The resident's family member was contacted regarding 3 new medications prescribed by the hospital physician. -The family member agreed to have the facility's contracted pharmacy fill all except one (doxazosin) due to the cost. -The prescription order was taken to the Veteran's Administration (VA) and the family member would pick up and bring to the facility. Review of Resident #1's charting notes dated 03/17/22 through 05/03/22 revealed there was no further documentation of medication refills and/or contact with the resident's PCP. a. Review of Resident #1's hospital discharge documentation dated 03/17/22 revealed an order for doxazosin 1mg daily at bedtime. (Doxazosin is used to treat urinary problems caused by an enlarged prostate.) Review of Resident #1's March 2022 electronic medication administration records (eMARs) revealed: -There was an entry for doxazosin 1mg daily at bedtime beginning on 03/17/22. -There was documentation doxazosin was administered 03/18/22 through 03/31/22. -There were no refusals or missed doses documented. Review of Resident #1's April 2022 eMARs revealed: -There was an entry for doxazosin 1mg daily at bedtime. -There was documentation doxazosin was administered 04/01/22 through 04/30/22. -There were no refusals or missed doses	D 358		

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documented.

Review of Resident #1's May 2022 eMARs revealed:
-There was an entry for doxazosin 1mg daily at bedtime.
-There was documentation doxazosin was administered 05/01/22 and 05/02/22.
-There were no refusals or missed doses documented.

Observation of Resident #1's medications on hand on 05/03/22 at 4:25pm revealed there was no doxazosin on hand and available for administration.

Interview with a medication aide (MA) on 05/04/22 at 4:30pm revealed the order for doxazosin came from the hospital discharge orders dated 03/17/22 not the Veteran's Administration (VA).

Telephone interview with the facility's contracted pharmacy on 05/05/22 at 3:20pm revealed the pharmacy dispensed a 30-day supply of doxazosin on 03/17/22 for Resident #1.

Based on interview with the facility's contracted pharmacy and review of Resident #1's March and April 2022 eMARs, the 30 day supply of doxazosin would have lasted from 03/18/22 through 04/17/22.

b. Review of Resident #1's hospital discharge documentation dated 03/17/22 revealed an order for magnesium 400mg one half tablet daily. (Magnesium is used as a supplement to replace a crucial mineral.)

Review of Resident #1's March 2022 electronic

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medication administration records (eMARs) revealed:
-There was an entry for magnesium 400mg one half tablet daily beginning on 03/17/22.
-There was documentation magnesium was administered 03/18/22 through 03/31/22.
-There were no refusals or missed doses documented.

Review of Resident #1's April 2022 eMARs revealed:
-There was an entry for magnesium 400mg one half tablet daily.
-There was documentation magnesium was administered 04/01/22 through 04/30/22.
-There was documentation a dose was refused on 04/23/22.

Review of Resident #1's May 2022 eMARs revealed:
-There was an entry for magnesium 400mg one half tablet daily.
-There was documentation magnesium was administered 05/01/22 through 05/03/22.
-There were no refusals or missed doses documented.

Observation of Resident #1's medications on hand on 05/03/22 at 4:25pm revealed there was no magnesium on hand and available for administration.

Interview with a medication aide (MA) on 05/04/22 at 4:30pm revealed the order for magnesium came from the hospital discharge orders dated 03/17/22 not the Veteran's Administration (VA).

Second telephone interview with a MA on 05/05/22 at 1:26pm revealed the magnesium

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came from the facility's contracted pharmacy in a bubble pack the day after Resident #1 returned from the hospital (03/18/22).

Telephone interview with the facility's contracted pharmacy on 05/05/22 at 3:20pm revealed the pharmacy dispensed a 30-day supply of magnesium on 03/17/22 for Resident #1.

Based on interview with the facility's contracted pharmacy and review of Resident #1's March and April 2022 eMARs, the 30 day supply of magnesium would have lasted from 03/18/22 through 04/17/22.

c. Review of Resident #1's hospital discharge documentation dated 03/17/22 revealed an order for vitamin B12 1000mcg daily. (Vitamin B12 is used as a supplement to replace a crucial vitamin.)

Review of Resident #1's March 2022 electronic medication administration records (eMARs) revealed:
-There was an entry for vitamin B12 1000mcg daily beginning on 03/17/22.
-There was documentation vitamin B12 was administered 03/18/22 through 03/31/22.
-There were no refusals or missed doses documented.

Review of Resident #1's April 2022 eMARs revealed:
-There was an entry for vitamin B12 1000mcg daily.
-There was documentation vitamin B12 was administered 04/01/22 through 04/30/22.
-There was documentation a dose was refused on 04/23/22.

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Review of Resident #1's May 2022 eMARs revealed:
-There was an entry for vitamin B12 1000mcg daily.
-There was documentation vitamin B12 was administered 05/01/22 through 05/03/22.
-There were no refusals or missed doses documented.

Observation of Resident #1's medications on hand on 05/03/22 at 4:25pm revealed there was no vitamin B12 on hand and available for administration.

Interview with a medication aide (MA) on 05/04/22 at 4:30pm revealed the order for vitamin B12 came from the hospital discharge orders dated 03/17/22 not the Veteran's Administration (VA).

Second telephone interview with a MA on 05/05/22 at 1:26pm revealed the Vitamin B12 came from the facility's contracted pharmacy in bubble pack the day after Resident #1 returned from the hospital (03/18/22).

Telephone interview with the facility's contracted pharmacy on 05/05/22 at 3:20pm revealed the pharmacy dispensed a 30-day supply of vitamin B12 on 03/17/22 for Resident #1.

Based on interview with the facility's contracted pharmacy and review of Resident #1's March and April 2022 eMARs, the 30 day supply of vitamin B12 would have lasted from 03/18/22 through 04/17/22.

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Interview with a medication aide (MA) on 05/04/22 at 4:30pm revealed Resident #1 would have to wait for the follow up appointment with

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the urologist on 05/11/22 to see if the medications ordered from the hospital would be refilled or discontinued.

Telephone interview with the facility's contracted pharmacy on 05/05/22 at 3:20pm revealed there were no refills because the family member used the VA and did not allow the pharmacy to refill medications because they would not provide a refill without seeing the resident.

Interview with the Resident Care Coordinator (RCC) of a nearby sister facility on 05/04/22 at 4:29pm revealed:
-Resident #1's family member took care of medication refills because he used the Veteran's Administration (VA) pharmacy.
-The facility's contracted pharmacy filled immediate prescription needs such as antibiotics.

Interview with the RCC of a nearby sister facility on 05/04/22 at 4:50pm revealed:
-She did not know if the hospital discharge paperwork from 03/17/22 was sent to Resident #1's primary care provider related to the new medications.
-He had not seen his PCP at VA since discharge from the hospital on 03/17/22.
-Doxazosin, magnesium and vitamin B12 were prescribed from the hospital admission in March 2022 for Resident #1.
-The pharmacy required a refill order and the resident would have to be seen by his PCP or the urologist before there was a refill order.
-Refills for Resident #1 came from the VA so the family member was contacted when refills were needed.
-She contacted the VA yesterday (05/03/22) requesting information and signed orders.
-She had not faxed any information to the PCP at

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the VA.

Telephone interview with the Administrator on 05/05/22 at 1:53pm revealed:
-The RCC managed medication refills from the VA and made sure medications were in the facility.
-Resident #1's family member got the medications from the VA and brought them to the facility.
-Hospital discharge orders were supposed to be faxed to the resident's PCP with a follow up confirmation call by the RCC.
-The RCC could delegate faxing paperwork to the PCP and the staff who contacted the PCP should document the task was done in the resident's charting notes.
-She did not know Resident #1 was out of any medications.
-She would have directed staff to the facility's contracted pharmacy for refills.

Attempted interview with the Veteran's Administration (VA) pharmacy on 05/04/22 at 4:34pm was unsuccessful.

Attempted telephone interview with Resident #1's PCP on 05/03/22 at 3:45pm and was unsuccessful.

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

D912 G.S. 131D-21(2) Declaration of Residents' Rights D912

G.S. 131D-21 Declaration of Residents' Rights
Every resident shall have the following rights:
2. To receive care and services which are

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D912	Continued From page 88 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and management of facilities. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations, as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to personal care and supervision, and health care [Refer to Tag 176, 10A NCAC 13F .0601(a) Management of Facilities (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the healthcare needs for 3 of 3 sampled residents (#1, #2, #3) related to failure to follow-up with physical therapy, occupational therapy and an orthopedic specialist as ordered for a resident who had multiple falls and bilateral pelvic fractures (#3); failure to refer three diabetic residents who had long, thick and curved toenails to podiatry (#1, #2, #3); failure to follow-up with a urology specialist for a resident with an indwelling urinary catheter and a hematology specialist for treatment of anemia (#1); failure to follow-up with an ophthalmologist for a resident's glass eye	D912		

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D912	Continued From page 89 replacement (#2); and for not notifying the provider of a resident's refusal of multiple doses of vitamin supplements and medications to treat nerve pain, depression, high blood pressure, and urinary tract infections (#3) [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of mental and physical abuse, neglect, and exploitation related to personal care and supervision. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide personal care for 2 of 3 sampled residents (#1, #3) related to catheter care (#1), and feeding assistance being completed, hair being neatly groomed, facial hair being neatly groomed, bathing, incontinence care, and repositioning being completed (#3), and nails being neatly trimmed and clean, being neatly dressed (#1, #3) [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care & Supervision (Type A2 Violation)].	D914		

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D914	Continued From page 90 2. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#3) with a history of a falls resulting in rib contusions and 4 subsequent falls within a 7 week time-frame in which she sustained injuries including a pelvis fracture and an arm laceration [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A1 Violation)].	D914		