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CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a complaint investigation and follow up survey on July 18 - 21, 2023 and July 24, 2023. The complaint investigation was initiated by the New Hanover County Department of Social Services on June 23, 2023.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the environment was free of hazards including bed bugs on the special care unit (SCU) and roaches on the assisted living (AL) halls and the SCU. The findings are: 1. Observations on the special care unit (SCU) on 07/18/23 revealed: -There were 15 residents in the common area. -There were 4 residents who had a visible rash consisting of dry and red skin with pea sized or smaller raised areas, scratch marks and scabbed	D 079		

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areas.
-Several residents were frequently scratching their arms, legs, and torso.

Interview with a medication aide (MA) on 07/18/23 at 9:41am revealed:
-All the residents were seen by the facility's contracted primary care provider (PCP) on 07/12/23.
-The PCP prescribed the same cream for each resident with a rash.
-There were 12 residents on the SCU who were receiving the cream for a rash including Resident #20 and Resident #21.

Interview with the facility's contracted PCP on 07/19/23 at 6:31pm revealed:
-He saw all the residents on the SCU on 07/12/23.
-He prescribed an antifungal and steroid cream for all the residents that had a rash.
-He did not know the cause of the rash.
-The antifungal was to treat any potential disseminated fungal rash and the steroid was to treat potential allergic reactions.
-A steroid cream could also help with itching from bug bites but residents on the SCU did not routinely go outside.

Review of service reports from the facility's contracted pest control company revealed:
-There was an additional visit on 04/17/23 for bed bugs.
-The laundry and clean linen rooms were inspected, and no bed bugs were found.
-There was an additional visit on 05/04/23 for bed bugs.
-Resident room 103, 105 and 113 and the SCU common area was inspected.
-Active bed bugs were found in the bed frame in

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resident room 113; the room was treated.
-There was an additional visit on 06/01/23 for bed bugs.
-Resident room 102 was inspected and no bed bugs were found.
-There was an additional visit on 06/19/23 for bed bugs.
-Resident room 113 and the special care unit (SCU) common area were inspected.
-Resident room 113 was treated for active bed bugs; no activity was found in the common area.
-Chemical treatment to control bed bugs was done.

Telephone interview with a former personal care aide (PCA) on 07/20/23 at 12:38pm revealed:
-She had seen bed bugs in resident rooms 103 and 113.
-She reported seeing the bed bugs to the medication aide (MA)/former Memory Care Director (MCD).
-The residents on the SCU were always itching and scratching.

a. Review of Resident #20's current FL-2 dated 03/08/23 revealed diagnoses included type II diabetes mellitus, dementia, hypertension, hyperlipidemia, and esophageal obstruction.

Review of Resident #20's primary care provider (PCP) visit note dated 07/12/23 revealed:
-The resident was seen at the request of staff to assess a rash.
-The resident reported being itchy and staff reported she developed an erythematous puritic rash.
-She was alert and oriented X's 2 (did not specify person, place, or time).
-She had an erythematous (red and flat) macular (spots) rash noted on her torso and arms in a

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nonspecific pattern.
-She had excoriation due to scratching.
-Lotrisone cream was ordered for her rash.
(Lotrisone is combination of an antifungal and corticosteroid used to treat symptomatic inflammation and fungal rashes.)

Observations of Resident #20's room (103) on 07/18/23 at 10:07am revealed:
-Resident #20 was sitting on the bed by the window in her room.
-There were 3 dead bed bugs in cobwebs at the corner of the wall above the bed by the window.
-There were pea sized brown/black stains resembling blood stains on the blanket and sheets near the pillow.

Observations of Resident #20 on 07/18/23 at 10:07am revealed:
-There were small round areas (pea size) resembling various stages of bug bites on the resident's upper arms with an increased number on the backside of her arms.
-Some were red and raised, some were scabbed, some were various shades of beige and brown resembling skin scarring.
-Her arm skin was dry and slightly red in general.

Interview with Resident #20 on 07/18/23 at 10:07am revealed:
-She saw little bugs on her bed that morning (07/18/23) and daily for the last few days.
-They were brown/black and bloody when you smash them.
-The bugs scared her.
-She had bites on her arms and back that itched all the time.
-Staff gave her a cream for the itching a couple of days ago.

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D 079	Continued From page 4 b. Review of Resident #21's current FL-2 dated 02/15/23 revealed diagnoses included dementia, limited mobility, and chronic kidney disease. Review of Resident #21's primary care provider (PCP) visit note dated 07/12/23 revealed: -The resident was seen for follow up on chronic health conditions. -The resident reported being itchy and staff reported she developed an erythematous puritic rash. -She was alert and oriented X's 2 (did not specify person, place, or time). -She had an erythematous macular rash noted on her torso and arms of uncertain etiology. -She had excoriation due to scratching. -Lotrisone cream was ordered for her rash. (Lotrisone is combination of an antifungal and corticosteroid used to treat symptomatic inflammation and fungal rashes.) Observations of Resident #21's room (103) on 07/18/23 at 10:09am revealed: -Resident #21 was sitting on the bed by the door in her room. -There were small black spots on the blanket resembling blood stains. -There were 2 areas of black spots resembling pest excrement around the seam at the foot of the box spring. -There was a larger area of black spots with 2 bed bugs at seam near the head of the box spring. -The mattress hung over the top of the box spring by approximately 6 inches causing the mattress to dip down at the head of the bed. Interview with Resident #21 on 07/18/23 at 10:09am revealed: -When she would lay in her bed suddenly, she	D 079		

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would feel something crawling on her.
-She did not know what it was, but it was "creepy".

Interview with a housekeeper on 07/18/23 at 10:10am revealed she did not change bed linens; the PCAs did that.

Interview with a PCA on 07/18/23 at 10:14am revealed:
-She did not know if the bed bugs on Resident #21's bed had been seen and reported because she did not make her bed.
-She was told resident room 103 was inspected for bed bugs and did not have any.
-She declined to answer further questions.

Observations of resident room 103 on 07/18/23 at 10:18am revealed:
-The PCA had returned to the room with a large clear plastic garbage bag.
-She started removing bed linens from the bed by the door and placing them in the bag.

Second interview with the PCA on 07/18/23 at 10:18am revealed:
-She was responsible for placing the bed linens in the plastic garbage bag, labeling the bag, and taking it to the laundry room to be cleaned.
-She was responsible for reporting the bed bugs to the maintenance person and that was it.
-She told the maintenance person before bagging the linen that morning (07/18/23).
-She did not know what happened after that.

Interview with the maintenance person on 07/18/23 at 10:50am revealed:
-When staff reported seeing bed bugs, he called the pest control company.
-He called the pest control company a few

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minutes ago.
-While waiting for the pest control company technician to arrive, he treated the room with a chemical solution for bed bugs.
-He allowed the chemical solution to sit on surfaces and work.
-After a while (unspecified) he cleaned the room and wrapped the mattress in plastic.
-The pest control company technician would inspect the room when they came to the facility.
-If bed bugs were found then they would treat the room also.
-If there were active bed bugs found by the pest control company, they returned after a week or two to inspect the room again.
-After a room was treated, he cleaned the room by vacuuming and removing dead bed bugs.

Observations of resident room 103 on 07/18/23 at 10:53am revealed:
-There was a milky white liquid on the surface of the bed by the door.
-There was an industrial size spray container on the floor by the bed.
-There was no label on the spray container.
-Clothing and linens on the bed by the window remained in the room.
-There were no residents in the room.

Observations of resident room 103 on 07/19/23 at 8:03am revealed:
-Resident #21 was lying in her bed by the door.
-Resident #20 was standing in the room near her bed.
-There was no plastic wrapping on the mattress or box spring of the bed by the door.
-The black spot resembling pest excrement was still present at the foot of and near the head of the box spring by the door.
-The 2 bed bugs were still on the seam of the box

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spring near the head of the bed.
-There were still 3 dead bed bugs in cobwebs at the corner of the wall above the bed by the window.
-There was a fresh red blood spot on the sheet below the pillow on the bed by the window.
-There was clothing on the floor around both beds.

Interview with Resident #20 on 07/19/23 at 8:11am revealed:
-She was itching and felt anxious.
-She thought there were bugs in her bed.
-She saw 2 bugs on her bedsheet last night.
-She did not know where the blood on her sheet came from.

Telephone interview with a representative at the facility's contracted pest control company on 07/19/23 at 3:07pm revealed:
-The facility had a general contract to treat average pests including roaches, ants, mice and bed bug inspections and treatment monthly since January 2023.
-There were no visits in July 2023 due to outstanding payments.
-She spoke to the facility's owner and accountant and was told the check was in the mail.
-She had been reaching out to the owner and accountant for a while (unspecified) regarding the outstanding bill.
-Staff called yesterday about bed bug activity in resident rooms 103 and 113.
-The pest control company had not yet received payment but were scheduled to inspect and treat resident rooms 103, 113, and adjacent rooms on 07/20/23 due to the circumstance.
-The circumstance was documentation of check numbers and unspecified paperwork was received from the owner on 07/18/23.

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D 079	Continued From page 8 -This was her understanding of the agreement between the facility owner and the pest control company management. -Staff were instructed to call the pest control company if bed bugs were seen between scheduled visits. -A technician would normally go to the facility and inspect and treat the identified room and adjacent rooms that day or the next day. -The facility was provided a logbook with instructions on preparing for treatment and cleaning during and after treatment. -The instruction sheet included information on how long residents should be out of the room for the treatment, cleaning and vacuuming in the room and removing and laundering clothing and cloth items. -The first call they received on resident room 103 was on 07/18/23 but the pest control company had treated 103 more than once before. -The problem with continued bed bug activity was staff not following containment procedures outlined on the instruction sheet. Interview with the Administrator on 07/19/23 at 4:17pm revealed: -There was no logbook from the pest control company. -He did not have a policy and procedure for bed bug containment practices. Interview with the pest control company technician on 07/20/23 at 2:53pm revealed: -He inspected resident room 113 and found no bed bug activity on 07/20/23. -He inspected resident room 103 and found 9 live bed bugs around the bed by the window on 07/20/23. -The were several live bed bugs behind a wall hanging above the bed and on the underside of	D 079		

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box spring.
-He treated the beds, the perimeter, and electrical outlets in resident room 103 with liquid, aerosol, and powder treatments for bed bugs on 07/20/23.
-The staff were bagging all linens and clothing in the room.
-The residents of room 103 would be out of the room for several (2-4) hours during the treatment.
-It was the most important thing to run the clothing and linens through the dryer to kill any bed bugs and their eggs.
-He was going to wrap the mattresses in resident room 103 in plastic prior to leaving the facility on 07/20/23.
-He did not find any bed bug activity in the bed by the door (new bed and box spring).

Second interview with the Administrator on 07/19/23 at 4:55pm revealed:
-The pest control had been to the facility and treated for bed bugs in the past.
-He thought the bed bug activity at the facility was historical and not current.
-The maintenance person located the pest control logbook but there was no instruction sheet for before and after pest control treatment for bed bugs.
-He had reviewed the service report and it did not have information on what staff should do before and after the pest control company treated for bed bugs.
-The maintenance person treated resident rooms and the laundry room when bed bugs were seen.
-He had purchased a do-it-yourself bed bug treatment chemical the maintenance person used to treat for bed bugs.
-He had the pest control company inspect after the maintenance person treated areas for bed bugs.
-The resident was out of the room for a period

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while the room was treated.
-The maintenance person would know exactly how long.
-If bed bugs were seen when PCAs changed residents' bed linens, they were responsible for reporting to the maintenance person.
-Staff were responsible for washing and drying linens removed from rooms identified with bed bug activity.
-The maintenance person was responsible for treating the room and contacting the pest control company.

2. According to the Centers for Disease Control's (CDC's) Healthy Housing Manual:
-The cockroach is considered an allergen source and an asthma trigger for residents.
-It has been demonstrated to carry Salmonella typhimurium, Entamoeba histolytica, and the poliomyelitis virus.
-Most cockroaches produce a repulsive odor that can be detected in infested areas.
-The sight of cockroaches can cause considerable psychologic or emotional distress in some individuals.
-Cockroaches are primarily nocturnal.
-Daytime sightings may indicate potentially heavy infestations.

Observations of resident room 110 on the special care unit (SCU) on 07/18/23 at 10:42am revealed there was a medium sized roach crawling on the box spring of the bed by the window.

Observation of resident room 212 on the assisted living (AL) side on 07/18/23 at 9:41am revealed an adult-sized roach was crawling across the top of the headboard on the bed near the window.

Interview with a resident residing in room 212 on

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D 079	Continued From page 11 07/18/23 at 9:49am revealed: -He saw 2 or 3 roaches crawling on the floor by the closet door yesterday, 07/17/23. -Staff sometimes came in the room and sprayed for roaches. -He thought someone had come in the room and sprayed for roaches this week but he could not recall the date. Interview with a resident residing in room 211 on 07/18/23 at 10:03am revealed: -He saw roaches in his room every day and last saw some that morning on 07/18/23. -He saw roaches crawling on top of his nightstand. -Sometimes when he opened the drawer on the nightstand, roaches would "scurry around". -There had been roaches in his room since he was admitted to the facility a couple of months ago. -He had never seen anyone spray or treat his room for roaches. Interview with a resident residing in room 213 on 07/18/23 at 10:12am revealed: -Every now and then he saw roaches coming out of the wall air conditioning unit that was next to his bed. -He saw 3 come out of the wall air conditioning unit beside his bed last night and some this morning too. -Sometimes he killed the roaches but sometimes the roaches were too fast and got away. -He had not reported the roaches because staff already knew about it. -A man came and sprayed the room about 3 weeks ago; he told the man to spray around the air conditioning unit. -The spray was supposed to kill all of the roaches but it did not.	D 079		

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D 079	Continued From page 12 Observation of resident room 214 on the AL side on 07/18/23 at 10:23am revealed: -There was a live baby-sized roach on the floor in the bathroom. -There was a second live baby-sized roach on the wall in the corner behind the trash can in the bathroom. -There was a can of roach killer spray sitting on top of the hand grip bar beside the toilet. -There was a small crack in the wall above the sink area. -There was a pile of clothing, boxes, unopened food items, and other personal belongings cluttered on the floor in front of the chest of drawers on the left upon entrance to the room. Interview with a resident residing in room 214 on 07/18/23 at 10:23am revealed: -She saw roaches yesterday, 07/17/23, crawling on her chest of drawer and in the bathroom. -The roach situation had gotten better because a pest control company had sprayed a couple of times (could not recall when). -She kept a can of roach killer spray in the bathroom to spray on the roaches when she saw them. -There were mostly baby roaches in the bathroom and they came out of the crack in the wall around the sink. Interview with a housekeeper on 07/18/23 at 10:50am revealed: -A pest control company was at the facility a couple of months ago and sprayed the whole facility for roaches. -He did not see roaches as often as he saw them before the pest control company sprayed. -In the springtime, he saw roaches in about every other room every day.	D 079		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-Now, he did not see roaches as much and he last saw roaches a couple of weeks ago in a resident's room (could not recall which room).

Interview with the Resident Care Director (RCD)/ former Executive Director (ED) on 07/18/23 at 4:45pm revealed:
-There had been an infestation of roaches in resident room 206 several months ago.
-A resident in room 206 would eat in bed in his room.
-She spoke with the resident's family and asked them to limit the food brought into the resident's room.
-A pest control company treated the room.
-A pest control company treated the facility monthly and as needed when called.
-She had not seen any roaches recently.

Interview with the Administrator on 07/18/23 at 4:45pm revealed:
-The residents had plastic containers to keep food in their rooms.
-If staff went in a resident's room and saw opened food, they were to discard it.
-A pest control company came to the facility each month for standard visits that included treatment for roaches and as needed if called.
-He had not seen any roaches in the facility recently.

Review of service reports from the facility's contracted pest control company revealed:
-There was a scheduled visit on 04/10/23 the exterior of the building, kitchen, dining room, doorways, hallways, restrooms, and resident rooms on the special care unit (SCU) were treated for roaches.
-There was a scheduled visit on 05/23/23 the exterior of the building, kitchen, offices, all

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restrooms, and all resident rooms throughout the building were treated for roaches.
-There was a scheduled visit on 06/15/23 the exterior of the building, kitchen, dining room, laundry area, hallways, restrooms, and resident rooms on the special care unit (SCU) were treated for roaches.

Telephone interview with a representative at the facility's contracted pest control company on 07/19/23 at 3:07pm revealed:
-The facility had a general contract to treat average pests including roaches, ants, and mice monthly since January 2023.
-There were no visits in July 2023 due to outstanding payments.
-She spoke to the facility's owner and accountant and was told the check was in the mail.
-She had been reaching out to the owner and accountant for a while (unspecified) regarding the outstanding bill.

_____

The facility failed to ensure the environment was free of hazards including roaches on both the assisted living (AL) side and special care unit (SCU) and bed bugs on the SCU by not ensuring consistent follow up with the pest control company and post treatment measures to contain and eradicate the bed bugs. The facility's failure to effectively treat the bed bug infestation resulted in Resident #20 and Resident #21 experiencing mental and emotional anguish due to fear of having bed bugs crawl on them at night and sustaining bites which caused constant itching and scratching. The failure of the facility was detrimental to the health, safety, and wellbeing of residents on the SCU and constitutes a Type B Violation.

_____

The facility provided a plan of protection in

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D 079	Continued From page 15 accordance with G.S. 131D-34 on 07/19/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2023.	D 079		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect	D 255		

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D 255	Continued From page 16 the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an assessment was completed for 2 of 7 sampled residents (#2 and #6) who had significant changes in their ability to participate in activities of daily living including transfers, ambulation, eating and significant changes in conditions including difficulty taking medications, aggressive behaviors, falls with injuries such as fractured bones and skin wounds(#2), and decubitus ulcers (#6). The findings are: Review of the facility's undated memory care policies and procedures revealed: -A care coordinator completed a resident assessment prior to admission, with input from caregivers, family members and physician. -A resident profile was completed within 30 days of admission and updated quarterly or when there was a significant change in the resident's condition. 1. Review of Resident #2's current FL-2 dated	D 255		

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D 255	Continued From page 17 04/14/23 revealed diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation. Review of Resident #2's current care plan dated 09/07/22 revealed: -He had significant memory loss and was always disoriented. -He had wandering behaviors. -He was ambulatory and continent of his bladder and bowel. -He was independent with toileting, ambulation, and transfers. -He required staff supervision with eating, bathing, dressing, and grooming. -There was a 90-day review signed by the Memory Care Director (MCD) on 12/06/22. -There was no documentation of an assistive device for ambulation, aggressive behaviors or incontinence care assistance. Review of Resident #2's progress note dated 03/14/23 revealed the Resident Care Director (RCD) (former Executive Director) documented she had spoken with the resident's responsible party to set up a care plan meeting. Review of Resident #2's primary care provider (PCP) visit note dated 05/03/23 revealed: -The resident was being seen at the request of staff for follow up after being seen in the emergency room (ER) for an avulsion fracture of his left ischium. -The resident had a hematoma at the same area with some edema to both lower extremities. -The resident had limited mobility. Review of Resident #2's PCP visit note dated 05/10/23 revealed: -The resident was seen for follow up on his lower	D 255		

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extremity edema.
-Staff report the edema was improved.
-Resident #2 had generalized muscle wasting.

Review of Resident #2's PCP visit note dated 05/17/23 revealed:
-The resident was seen for hospice consideration.
-The resident had declined markedly over the last month.
-Resident #2 had generalized muscle wasting, was not eating well, and was losing weight.

Review of Resident #2's progress note dated 05/18/23 revealed:
-The MCD documented receiving an order for a hospice referral for Resident #2.
-Resident #2 had been "going down as far as his ADLs (activities of daily living)".

Review of Resident #2's PCP visit note dated 06/07/23 revealed:
-The resident was seen for follow up on weight loss and decreased appetite.
-He was eating well after medication added to improve appetite.
-Staff reported the resident was receiving hospice services.

Review of Resident #2's hospice nurse (HN) visit notes dated 05/21/23 through 06/23/23 revealed:
-Resident #2 was admitted to hospice on 05/21/23.
-On 05/24/23 staff reported the resident could be aggressive and uncooperative at times.
-He was ambulatory with a walker.
-He had bladder and bowel incontinence.
-He had scattered bruises and scabs to both upper extremities.
-On 06/23/23 staff and Resident #2 report he fell

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that morning (06/23/23).
-He slipped on the floor in the common area and sustained a minor skin tear to his left mid-arm.

Interview with a medication aide (MA) on 07/24/23 at 12:36pm revealed:
-Resident #2 was wandered at night and frequently went into other resident's rooms.
-Wandering into other resident's rooms sometimes led to altercations between Resident #2 and other residents.
-He was difficult to redirect and staff had to let him wander sometimes.
-He required staff assistance with incontinence brief changes, bathing and dressing.

Telephone interview with a second MA (former Memory Care Director MCD) on 07/24/23 at 3:53pm revealed she had not been able to update Resident #2's assessment and care plan, but his only change was that he was on hospice.

Refer to telephone interview with a medication aide (MA) (former Memory Care Director MCD) on 07/24/23 at 3:53pm.

Refer to interview with the MCD (former Resident Care Director RCD) 0n 07/24/23 at 2:09pm.

Refer to interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm.

2. Review of Resident #6's current FL-2 dated 04/13/23 revealed diagnoses included dementia, Parkinson's disease, vitamin deficiency, closed neck fracture and acute exacerbation of chronic obstructive pulmonary disease.

Review of Resident #6's Resident Register

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revealed the resident was admitted to the facility on 08/19/20.

Review of Resident #6's current care plan dated 12/06/22 revealed:
-He had significant memory loss and was always disoriented.
-He was ambulatory and incontinent of his bladder and bowel.
-He was independent with ambulation and transfers.
-He required staff supervision with eating.
-He required extensive assistance from staff with toileting.
-He was totally dependent on staff for assistance with bathing, dressing, and grooming.
-There was a 90-day review signed by the medication aide (MA)/former Memory Care Director (MCD) on 12/06/22.
-There was no documentation of an assistive device for ambulation, use of oxygen and nebulizer, or requiring staff assistance to eat.

Review of Resident #6's previous FL-2 dated 01/23/23 revealed:
-The resident was re-admitted to the facility on 01/23/23 from skilled nursing rehabilitation for a hip fracture.
-There was an order for continued physical and occupational therapy as needed.

Review of Resident #6's physician's orders dated 04/13/23 revealed:
-There was an order to check oxygen saturation (O2 sat) levels daily and contact the provider for levels less than 90%.
-There was an order to apply oxygen at 2L via nasal canula (NC) for shortness of breath.

Review of Resident #6's licensed health

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professional support (LHPS) evaluation dated 04/24/23 revealed:
-He has LHPS tasks including inhalation medication by machine and oxygen administration and monitoring.
-There was documentation the resident transferred and ambulated independently.

Review of Resident #6's most recent primary care provider (PCP) visit note dated 04/25/23 revealed:
-He was being seen for his 4 month follow on chronic conditions.
-He was in a wheelchair at the time of the appointment.

Review of Resident #6's physician notification dated 05/04/23 revealed:
-The resident was not "grasping the concept" of using his inhaler; he did not understand he needed to inhale.
-There was an order to discontinue the inhaler and start nebulizer treatments every 6 hours.

Review of Resident #6's prescription order dated 05/22/23 revealed:
-There was an order for a hospice consultation.
-There was a faxed stamp indicating the order was faxed to the hospice provider.

Telephone interview with Resident #6's Power of Attorney (POA) on 07/24/23 at 10:40am revealed:
-He needed staff to help him with eating, bathing, and dressing.
-He could walk with a walker and one person assisting him.
-She knew he could because she had walked with him while he used a walker, and she prompted him.
-Sometimes he had oxygen and sometimes he

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D 255	Continued From page 22 did not. Interview with a medication aide (MA) on 07/24/23 at 12:36pm revealed: -Resident #6 was confused and in the later stages of dementia. -He was incontinent and required staff assistance with changing his incontinence brief. -He required staff guidance with dressing and grooming. -He was dependent on staff assistance to eat. -He started declining after he fell and fractured his hip (before 01/23/23). Telephone interview with a second MA (former Memory Care Director MCD) on 07/24/23 at 3:53pm revealed: -Resident #6's assessment and care plan was updated, and the updated copy should have been in his chart. -Resident #6 was ambulatory in 2022 then he fell and broke his hip. -He returned to the facility from rehabilitation and continued with physical therapy (PT). -After PT ended, he started to decline. Upon request on 07/19/23, 07/22/23 and 07/24/23, Resident #6's updated care plan was not provided for review. Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed she was not able to complete the assessment and care planning meeting with the resident's responsible party due to the responsible party going out of town at that time. Refer to telephone interview with a medication aide (MA) (former Memory Care Director MCD) on 07/24/23 at 3:53pm.	D 255		

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D 255	Continued From page 23 Refer to interview with the MCD (former Resident Care Director RCD) 0n 07/24/23 at 2:09pm. Refer to interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm. _____ Telephone interview with a medication aide (MA) (former Memory Care Director MCD) on 07/24/23 at 3:53pm revealed: -She was responsible for completing resident assessments and care plans on admission, annually and when there was a significant change. -She kept a notebook in her office with a list of care plans that needed to be updated. Interview with the MCD (former Resident Care Director RCD) 0n 07/24/23 at 2:09pm revealed: -The former MCD was responsible for completing resident assessments and care plans. -She was responsible for supporting the former MCD if she had questions about resident assessments and care plans. -There was no process of oversight in ensuring the former MCD completed resident assessments and care plans. -The MCD was responsible for her work. Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed: -The MCD was responsible completing resident assessments and care plans when there was a change in condition. -Information on the care needs of residents was communicated when staff were newly hired. -Resident care needs were documented on activity of daily living (ADL) logs.	D 255		

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D 255	Continued From page 24 -She randomly reviewed resident records on the special care unit (SCU) to ensure assessments and care plans were completed annually and with significant changes.	D 255		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 7 sampled special care unit (SCU) residents (#2 and #11) who had identified supervision needs with falls (#11) and for a history of aggressive behaviors towards other residents and 8 incidents including falls and injuires of unknown origin over a 3 month period (#2). The findings are: Review of the facility's undated general policies revealed: -Under section II, services: All residents at the facility were given as much supervision and assistance needed in maintaining personal hygiene, bathing, and grooming. -Residents were also assisted on an individual	D 270		

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D 270	Continued From page 25 basis with their eating, walking, and dressing of necessary. Review of the facility's undated fall prevention policy revealed: -The facility would identify all residents at risk for falls, adequately plan for care and implement procedures to prevent and/or reduce falls. -Any resident who fell was automatically placed at risk for falls. -A plan of care was implemented based on assessed risk factors. -Interventions included: minimize restraint use; encourage resident to ask for help when rising; encourage resident to wear proper shoes and use canes and walkers as instructed; encourage weight bearing when transferring; minimize medications with sedative side effects and do not use sedatives as a fall prevention strategy; encourage residents to rise slowly from a sitting position; maintain adequate hydration, encourage the use of eye glasses to decrease visual impairment; provide adequate light in all rooms and common areas; keep areas free of debris and obstructions; install and properly maintain handrails; and install grab bars in bathrooms and use elevated toilet seats when needed. -Excessive falls would result in implementation of a program such as: Falling Star, Falling Leaf, etc. -The policy did not specify what Falling Star and Falling Leaf programs were. 1. Review of Resident #2's current FL-2 dated 04/14/23 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation. -Medication orders included Eliquis 5mg twice daily. (Eliquis is a blood thinner used to prevent blood clot formation.)	D 270		

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Review of Resident #2's current care plan dated 09/07/22 revealed:
-He had significant memory loss and was always disoriented.
-He was ambulatory.
-He was independent with toileting, ambulation, and transfers.
-He required staff supervision with eating, bathing, dressing, and grooming.
-There was a 90 day review signed by the Memory Care Director (MCD) on 12/06/22.

Review of Resident #2's progress note dated 03/18/23 revealed:
-The former Memory Care Director (MCD) documented the resident was involved in an altercation with another resident.
-Resident #2 had a black mark under his left eye and his arm was bleeding.
-Staff documented they would continue to monitor (unspecified).

Review of Resident #2's progress note dated 03/19/23 revealed:
-The former MCD documented the resident was involved in an altercation with another resident.
-The resident was plundering through the other resident's belongings prior to the altercation.
-Staff redirected and separated the residents.
-Staff were closely monitoring the resident (unspecified)

Interview with a medication aide (MA) on 07/24/23 at 12:36pm revealed:
-Resident #2 wandered at night and frequently went into other resident's rooms.
-Wandering into other resident's rooms sometimes led to altercations between Resident #2 and other residents.
-Resident #2 was strong and had punched her

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before.

Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed:
-She could not remember who the other residents were involved in the altercations with Resident #2 on 03/18/23 and 03/19/23.
-Normally residents were put on every 15 minute checks after an altercation until the resident was calm.

Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed:
-She did not know the residents involved in the altercations with Resident #2 on 03/18/23 and 03/19/23.
-Staff were instructed to monitor the resident more which meant staff should be within reach of Resident #2.
-Staff were instructed to make sure he was not in other residents' rooms because that was usually how the altercations started.

Upon request on 07/19/23 and 07/24/23, Resident #2's incident/accident reports dated 03/18/23 and 03/19/23 were not provided for review.

Review of Resident #2's progress note dated 04/26/23 revealed the resident was sent to the emergency room (ER) for limping, swelling and a bruise on his right upper leg.

Review of Resident #2's incident/accident report dated 04/26/23 revealed:
-At 1:00pm staff noticed the resident was limping.
-There was a bruise and swelling on his right upper leg.
-The resident's primary care provider (PCP) and

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responsible party were notified.

Review of Resident #2's emergency medical services (EMS) report dated 04/26/23 revealed:
-Resident #2 was sitting in the day room with other residents and staff when EMS arrived at 1:05pm.
-The resident was not oriented.
-Staff said they noticed bruising and swelling on the resident's right leg today (04/26/23).
-Staff said today (04/26/23) was the first time they noticed it.
-Staff said there was no one working on that day (04/26/23) who knew anything about Resident #2.
-Staff said they did not know if he fell or how the bruise got there.
-Resident #2's right leg was bruised from his shin to his thigh.
-Some of the bruising was a few days old.
-The resident was able to stand and ambulate with little assistance.

Review of Resident #2's ER discharge instructions dated 04/26/23 revealed:
-The resident was seen for bleeding and bruising and diagnosed with a right leg hematoma, generalized weakness and a closed nondisplaced avulsion fracture of his right ischium (pelvis).
-Laboratory blood tests and x-rays of his femur and pelvis were done.

Interview with a medication aide (MA) on 07/24/23 at 12:36pm revealed:
-She did not remember what happened around 04/26/23; she remembered seeing the large bruise on the outside of his right thigh.
-The bruise went from his hip down to his knee.
-She did not know how he got the bruise on his right leg.
-She did not remember how she found out about

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the bruise.
-She did not remember what was done for Resident #2 when he returned from the ER on 04/26/23.

Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed:
-She did not know how Resident #2 sustained a pelvic fracture on 04/26/23.
-She only found out about the injury after the fact.
-She did not remember what interventions were put in place to reduce falls and injuries.
-Normally residents were put on every 15 minute checks after a fall.

Telephone interview with Resident #2's family member on 07/21/23 at 12:04pm revealed she did not know what happened on 04/26/23.

Interview with the RCD (former ED) on 07/24/23 at 4:33pm revealed:
-She was only recently made aware of Resident #2 having had a pelvic fracture on 04/26/23.
-She was aware of the bruise on his right leg at the time (04/26/23) but did not know it was from a pelvic fracture.

Review of Resident #2's progress note dated 05/03/23 revealed:
-The resident was found on the floor coming out of the bathroom.
-The PCP and responsible party were notified.
-The resident was sent to the ER via EMS.
-There was no documentation of increased supervision or fall prevention measures.

Review of Resident #2's primary care provider (PCP) visit note dated 05/03/23 revealed:
-The resident was being seen at the request of staff for follow up after being seen in the ER for a

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fracture of his pelvic bone.
-The resident had a hematoma at the same area with some edema to both lower extremities.
-The resident had limited mobility.

Review of Resident #2's PCP visit note dated 05/10/23 revealed:
-The resident was seen for follow up on his lower extremity edema.
-Staff report the edema was improved.
-Resident #2 had generalized muscle wasting.

Review of Resident #2's PCP visit note dated 05/17/23 revealed:
-The resident was seen for hospice consideration.
-The resident had declined markedly over the last month.
-Resident #2 had generalized muscle wasting, was not eating well, and was losing weight.

Review of Resident #2's PCP visit note dated 06/07/23 revealed:
-The resident was seen for follow up on weight loss and decreased appetite.
-He was eating well after medication added to improve appetite.
-Staff reported the resident was receiving hospice services.

Review of Resident #2's hospice nurse (HN) visit notes dated 05/21/23 through 06/23/23 revealed:
-Resident #2 was admitted to hospice on 05/21/23.
-On 05/24/23, staff reported the resident could be aggressive and uncooperative at times.
-He was ambulatory with a walker.
-He had scattered bruises and scabs to both upper extremities.
-On 05/26/23, the HN documented the resident

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had scattered bruises on his body.
-On 06/05/23, Resident #2 did not have his walker for ambulation.
-Staff had taken his walker because he used it as a weapon at times.
-He was ambulatory with a slow shuffling gait.
-On 06/14/23, the resident had scattered bruises and open areas that were scabbed that had re-opened.
-Open areas were cleaned and covered.
-On 06/23/23. staff and Resident #2 report he fell that morning (06/23/23).
-He slipped on the floor in the common area and sustained a minor skin tear to his left mid-arm.
-The staff wrapped his arm in gauze.

Review of Resident #2's progress notes revealed:
-There was no documentation of a fall on 06/23/23.
-There was no documentation of increased supervision or fall prevention.

Review of Resident #2's progress note dated 07/01/23 revealed:
-On 07/01/23, staff documented the resident had an unwitnessed fall and had a blue and purple lump on his head.
-Hospice was contacted.
-There was no documentation of increased supervision or fall prevention measures.

Review of Resident #2's incident/accident report dated 07/01/23 revealed:
-After lunch staff noticed a laceration and swelling on the resident's forehead.
-The HN was notified.
-There was no documentation the resident's responsible party was notified.
-The resident was not evaluated by a physician, did not receive first aid and was not sent to the

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D 270	Continued From page 32 ER. Review of Resident #2's hospice nurse (HN) visit notes dated 06/29/23 to 07/05/23 revealed: -On 06/29/23, there was documentation Resident #2 was ambulating down the hall without an assistive device. -He was wearing slip on shoes and walking with a slow and steady gait. -On 07/01/23, there was documentation the resident had an unwitnessed fall and sustained a bruise and bump on his forehead above the left eye. -On 07/03/23, there was documentation the resident had an unwitnessed fall on 07/01/23 and had dark bruises around both eyes, the bridge of his nose and his left forehead and a bump above his left eye. -Resident #2's right arm was swollen, and he was guarding that arm. -The resident rated his pain 9 out of 10. -On 07/05/23, there was documentation pain medication ordered on 07/03/23 but the first dose was not administered until that morning (07/05/23). -The resident's right hand was still swollen and bruised but less swollen than on 07/03/23. -The x-ray done on 07/03/23 showed no fracture or dislocation. -The resident said his arm was still sore and rated his pain 2 out of 10. Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed: -She was not at the facility when Resident #2 last fell because it was on a Saturday (07/01/23). -The MA called her, and she instructed the MA to call hospice and the responsible party. -She returned to work on 07/09/23 and saw the bruises on his face.	D 270		

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-She did not know how Resident #2 developed a swollen and painful right arm and hand on 07/03/23.
-She was no longer working on the SCU after 07/09/23 so she did not know any details about Resident #2 after 07/09/23.
-She did not know if supervision checks were increased or other interventions to reduce falls were implemented for Resident #2 after the 07/01/23 fall.
-PCAs documented every 15 minute checks on a supervision check sheet.

Review of Resident #2's progress notes dated 07/08/23 through 07/09/23 revealed:
-On 07/08/23, staff documented the resident was wandering into other resident's rooms throughout the night.
-There was no documentation of increased supervision.
-The next entry was dated 07/09/23 with documentation Resident #2 was sent to the ER due to a fall and the resident saying his hip hurt.
-The next entry was dated 07/08/23 11:00pm - 7:00am.
-Staff documented the resident was observed sliding from the chair to the floor.
-Resident #2's mobility was checked, and he walked to his room.
-Resident #2 awakened with complaints of left hip pain.
-The next entry was dated 07/08/23 with documentation all scans were negative, and hospice and the Executive Director (ED) were notified.
-The next entry was dated 07/09/23 2nd shift with documentation the resident was walking in and out of other resident's rooms.
-Staff redirected resident all shift.
-At 5:00pm on 07/09/23 the resident was found in

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his room with a skin tear on the left side of his arm.
-The resident was also found in another resident's bathroom.

Review of Resident #2's incident/accident report dated 07/09/23 revealed:
-At 8:39am staff documented the resident stated he fell.
-The left hip on the diagram was circled.
-There was no documentation of the type of injury.
-The resident was sent to the emergency room (ER).
-The resident's primary care provider (PCP) and hospice were notified.
-There was no documentation the responsible party was notified.

Interview with the MA on 07/24/23 at 12:36pm revealed:
-A PCA told her at shift change (11:00pm on 07/08/23) that Resident #2 was on the floor.
-The PCA said he had lost his balance and slid back into the chair and then onto the floor.
-He landed on his bottom not his hip.
-The MA who sent Resident #2 to the ER on 07/09/23 said it was because of the bruise on his left hip and that he was limping.
-The bruise had been on his left hip for at least 1-2 weeks before 07/08/23 and was in the same place the abscess was.
-He was able to move all his extremities and said he was not hurt.
-She and the PCA helped Resident #2 up.
-He was sleepy but able to walk down the hall and get into bed.
-Staff checked on Resident #2 throughout the night (07/08/23 - 07/09/23); staff were always on the hall.

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D 270	Continued From page 35 -She was not working when he fell on 07/01/23 but the knot on his head had gone down when she returned to work. -She did not know of any injury to his right hand. Review of Resident #2's progress note dated 07/18/23 revealed: -Staff documented witnessing the resident slide off the chair onto the floor. -There was no documentation anyone was notified. -There was no documentation of increased supervision or fall prevention measures. Interview with a personal care aide (PCA) on 07/19/23 at 1:12pm revealed: -She kept Resident #2 in a wheelchair to keep him from staggering and falling when he walked. -She did not know of anything else put in place to reduce falls and injuries for the resident. Review of Resident #2's record revealed there was no documentation of an order or recommendation for a wheelchair. Interview with the MA on 07/24/23 at 12:36pm revealed: -It had been hard to monitor the residents because there were several residents with aggressive and wandering behaviors including Resident -Staff normally communicated resident updates like monitoring needs, falls, injuries and change of condition verbally when the shift changed. -MAs used to document events but documentation had fallen through the cracks for some time. -Communicating verbally did not always cover everything because if something happened early in the shift you might forget to mention it.	D 270		

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-MAs were to place resident's name in the hot box when they needed to be monitored.
-Resident #2 was one of the last resident's in the hot box but she did not remember when that was.
-Staff did not always document increased checks and monitoring for Resident #2 after a fall and/or injury.
-The hot box was a dry erase board where resident's names were put for falls, illness, hospital visits, and behaviors.
-Residents listed on the dry erase board were supposed to monitored by staff and a note documented in their chart.
-Normally, MAs were responsible for checking with the staff when an injury was found to find out what happened.
-She also checked the resident's progress notes.
-If there was no note, she faxed a notification to the PCP and notified the Memory Care Director (MCD) or Resident Care Director (RCD).

Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed
-She did not respond to if increased supervision checks had been done for Resident #2 after altercations on 03/18/23 and 03/19/23; and falls/injuries on 04/26/23, 05/03/23 and 07/01/23.
-She did not know of a fall on 06/23/23 or 07/03/23 and would not know what happened after if she was not aware of the fall.

Interview with Resident #2's PCP on 07/19/23 at 6:31pm revealed:
-Resident #2 was receiving hospice services.
-Normally hospice implemented fall prevention measures.
-He saw the resident for urgent matters that came up when he was at the facility each week such a rash.
-Everything else such as falls, injuries and ER

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D 270	Continued From page 37 visits, was reported to and followed up on by hospice. Telephone interview with Resident #2's hospice Director on 07/20/23 at 5:43pm revealed: -Resident #2 was admitted to hospice on 05/20/23. -She did not see any record of fall prevention orders such as a fall mat for Resident #2. -Hospice did not always have all the information related to history of falls at the time a resident was admitted for hospice services. Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed: -The only fall she was aware for Resident #2 was the one that caused the bruises to his face. -She did not know about falls on 05/03/23, 06/23/23, 07/08/23, and 07/18/23 and injuries without documented falls on 04/26/23 and 07/03/23. -On 07/01/23, the HN came to the facility to see the resident. -She presumed hospice would have implemented fall prevention measures such as a fall mat. Interview with the Administrator on 07/21/23 at 4:50pm revealed: -There was a policy for fall management which included a fall risk assessment and 72-hour post fall monitoring and documentation. -The fall risk assessment included staff looking at possible causes of the fall and implementing interventions such as fall mats, high/low bed and bed/chair alarms to reduce falls and injuries. -The 72-hour monitoring was called the hot box. -After a fall, staff were responsible for placing the resident's chart in the hot box at the front desk on the SCU.	D 270		

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-Staff monitored the residents in the hot box each shift and documented a note in the resident's record.
-The need for increased supervision checks was determined by the MCD, RCD and ED.
-He did not know why staff had not followed the policy for Resident #2.

Upon request on 07/19/23, 07/21/23 and 07/24/23, Resident #2's documentation of increased supervision checks between 03/19/23 and 07/18/23 were not provided for review.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.
2. Review of Resident #11's current FL-2 dated 11/16/22 revealed:
-Diagnoses included unspecified dementia, depression unspecified, anemia unspecified, displaced intertrochanteric fracture of the right femur, elevated white blood cells, generalized anxiety disorder, and mild cognitive impairment.
-The resident's current level of care was Special Care Unit (SCU).
-The resident was constantly disoriented.
-She was semi-ambulatory with a walker.
-She was incontinent of bladder and bowel.
-She needed assistance with bathing and dressing.

Review of Resident #11's Resident Register revealed she was admitted to the facility's Special Care Unit (SCU) on 11/14/22.

Review of Resident #11's current care plan dated 11/15/22 revealed:
-She required limited assistance with eating.
-She required extensive assistance with toileting.
-She was totally dependent for ambulation,

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D 270	Continued From page 39 bathing, dressing, grooming, and transferring. Review of Resident #11's incident and accident report dated 05/13/23 revealed: -Resident #11 was found in bathroom on the floor. -She had a facial laceration and swelling. -There was documentation an ice pack was administered as first aid. -She was transported by emergency medical services (EMS) to the local Emergency Room (ER). Review of Resident #11's progress note revealed: -There was an entry at 3:00pm on 5/13/23 that noted resident being returned to the facility with the sitter. -Observed sitter trying to get resident in wheelchair, slightly disoriented, unresponsive to the call of her name. -Unable to walk without assistance, also noticed knot on right side of her forehead. -Called Emergency Medical Services (EMS) and responsible party, -Responsible party ordered to cancel EMS and that resident be monitored. Review of Resident #11's progress note revealed: -There was a 2nd entry on 05/13/23 without a time noted that Resident #11 fell in the bathroom, EMS was called and Resident #11 was sent to the local Emergency Room (ER). -Resident #11's family member was in the facility. -Resident #11 had a laceration on her forehead. Review of Resident #11's ER visit summary dated 05/13/23 revealed: -Resident #11 presented via EMS after an unwitnessed fall in the bathroom at the facility. -She had a 2.5-centimeter linear superficial	D 270		

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laceration to the right forehead repaired with Dermabond (skin glue).
-A CT scan of the head without contrast revealed no acute intracranial abnormality.
-A CT scan of the cervical (neck) spine revealed no fracture or acute abnormality.
-Resident #11 was released back to the facility.

Review of Resident #11's progress notes revealed:
-There was an entry on 05/20/23 with no time noted that Resident complained of pain any time her aide tried to get her up.
-The aide tried to feed her in bed, and she refused.
-There was a 2nd entry on 05/20/23 at 6:00pm that resident was sent to the hospital due to pain in leg.
-The resident was admitted in the hospital and will follow up with family.
-There was 3rd entry on 05/20/23 that Resident #11's family member came to visit around 5:20pm and noticed she was not feeling good and had pain.
-Resident #11's family requested that the resident be sent out via EMS to be evaluated.
EMS arrived around 5:47pm.

Review of Resident #11's Hospital Trauma Surgery History and Physical note dated 05/21/23 revealed:
-Resident #11 presented for back pain.
-She fell approximately a week ago at the facility after a mechanical fall and hit her head.
-No back pain at that time but complaining of back pain today.
-A CT scan of the lumbar spine was performed on 05/21/23 and revealed profound osteopenia (low bone mass) and an acute fracture of the spine and other chronic findings.

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D 270	Continued From page 41 -Assessment: patient with primary history of dementia admitted after mechanical fall 1 week ago sustaining the following injuries: L3 body fracture. Review of Resident #11's Hospital Discharge Summary dated 05/30/23 revealed: -After full trauma work up including labs, x-rays and CT scans, the listed injuries were identified: L3 body fracture. -Neurosurgery was consulted and recommended no surgical intervention and activity as tolerated in a lumbar-sacral orthosis (LSO back brace). -Resident #11 was discharged to a skilled nursing facility with hospice/comfort care. Interview with Resident #11's family member on 07/21/23 at 4:35pm revealed: -Resident #11 had been at the facility for about 6 months. -She had 2 sitters that sat with Resident #11 and took her on outings. -On 5/13/23 one of the sitters took Resident #11 out for ice cream. -While out for ice cream on 05/13/23, the sitter told her Resident #11 became more lethargic, confused, and was unable to hold her ice cream spoon. -The sitter brought the resident back to the facility. -The sitter used a wheelchair to transport Resident #11 from the van into the facility. -She received a call from the Memory Care Director (MCD) saying that Resident #11 was in "bad shape" and had called EMS. -She asked the MCD if she thought Resident #11 was having a stroke and she was told no but she seemed "out of it". -She told the MCD to cancel EMS, put Resident #11 in bed and she would come and see her.	D 270		

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D 270	Continued From page 42 -Resident #11 would sometimes have bad days and would be better after she had some rest. -She arrived at the facility and found Resident #11 sitting in the common area in a wheelchair. -Staff told her that Resident #11 would not stay in bed. -Resident #11 was mumbling and reaching out for things and not herself. -She usually took Resident #11 to the bathroom herself but on this day, she asked staff for assistance since Resident #11 seemed weaker. -She asked the medication aide (MA) to take Resident #11 to the bathroom. -The MA took Resident #11 to the common bathroom across the hall from her room. -The family member was in Resident #11's room hanging up clothes. -She heard a loud crash and went into the common bathroom and found Resident #11 lying on the floor with no staff present. -There were 4 staff at the nurses' desk talking. -The MA returned and said, "she usually waits until I get back to get up". -Resident #11 was a fall risk. -Resident #11 was sent to the ER. -She saw Resident #11 the next day, 5/14/23 and said she was bruised. -She saw her on 05/15/23 and she was sleeping. -She asked the facility to have the Primary Care Provider (PCP) see Resident #11 on his next visit. - The PCP saw Resident #11 on 05/17/23 in her presence, Resident #11 was rubbing her right hip and back, the PCP pushed on her right ankle, and she winced. -The PCP felt pain was related to her to right ankle and that it was "just sore". -The PCP ordered tramadol (a pain reliever) for Resident #11, and she thought Resident #11 took it a few times. -She called to get verbal reports on 05/18/23 and	D 270		

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05/19/23 and was told Resident #11 was some better but still in pain.
-She next saw Resident #11 on 05/20/23 and she complained of hip and back pain, and she asked that she be sent to the ER.
-EMS was called and Resident #11 was sent to the local ER.
-While at the ER, Resident #11 had a lumbar CT scan that revealed a lumbar fracture, and she was hospitalized.
-She was told Resident #11 was too old for surgery and was treated with a brace and was currently in a skilled nursing facility for rehabilitation and physical therapy.

Interview with another MA on 07/24/23 at 10:37am revealed:
-She was in the facility parking lot on 05/13/23 and saw Resident #11's sitter getting her out of her van into a wheelchair and Resident #11 was slumped over in the wheelchair.
-She asked the MCD to evaluate Resident #11.
-The MCD wanted to send Resident #11 to the ER, but the resident's family member did not want her to go out.
-She was working on the Assisted Living side and later heard that Resident #11 was taken to the hall bathroom and fell but did not know which staff were involved.

Interview with the personal care aide (PCA)/former MA on 07/21/23 at 10:32am revealed:
-The residents in the SCU required assistance with activities of daily living, ambulation, toileting, dressing and grooming and some needed assistance with feeding.
-She was the MA in the Special Care Unit (SCU) on 5/13/23 for the 3pm to 11pm shift.
-Resident #11 was ambulatory and required

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assistance with toileting.
-Resident #11 had gone out earlier in the day on 05/13/23 with her sitter.
-When Resident #11 returned she was "not acting right" but was unable to describe how she was "not acting right".
-The MCD called EMS for Resident #11 and called Resident #11's family member and the family member asked the MCD to cancel EMS and she would come and see the resident.
-Resident #11's family member came to facility.
-Resident #11's family member asked her to take the resident to the bathroom.
-She took Resident #11 to the common bathroom.
-Resident #11 had soiled her undergarment and she left the resident in the bathroom to retrieve a clean undergarment.
-The family member was not present in the bathroom but was in the hall.
-There was no other staff in the bathroom with Resident #11.
-She returned to the bathroom and Resident #11's family member was "screaming" that Resident #11 fell and hit her head.
-Resident #11 was on the floor and had hit her head but she did not think she was bleeding.
-EMS was contacted and Resident #11 was sent to the ED.
-She should not have left Resident #11 alone in the bathroom.

Interview with the MA, former Memory Care Director on 07/21/23 at 11:20am revealed:
-The SCU residents required "full care" that included assistance with activities of daily living (ADLs), toileting, medications and feeding assistance if needed.
-Resident #11 was ambulatory but required assistance with ADLs, toileting, dressing, and

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grooming.
-She was the MCD on 05/13/23.
-She was in the facility on 05/13/23 for a staff cookout but was not on the clock.
-Resident #11 had sitters that would take her on outings.
-Resident #11 had gone out with her sitter on 05/13/23.
-She was alerted by another staff member that Resident #11 was not herself when she returned with the sitter.
-Resident #11 was leaning forward in the wheelchair, would answer questions but seemed "off" and was seemed more sluggish.
-She called EMS and was on the phone with Resident #11's family member when EMS arrived.
-Resident #11's family member asked her if she thought Resident #11 was having a stroke and she said she did not think so.
-Resident #11's family member asked her to cancel EMS and she would come to the facility.
-Resident #11's family member arrived about an hour later.
-The MCD left the facility.
-She received a text message from Resident #11's family member later that evening.
-Resident #11 had been left in the bathroom alone and fell and hit her head.
-Resident #11 required more assistance and that was why she wanted to send her out earlier in the day.
-Resident #11 returned to facility from the ER later 05/13/23 with bruising.
-She was not sure if Resident #11 saw the primary care provider after she returned.
-Resident #11 was sent to the ER again on 05/20/23 she thought for complaints of leg or hip pain and was admitted to the hospital.
-She contacted Resident #11's family member on 05/22/23 and was told Resident #11 had a

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fractured vertebrae in her back, because she had been left alone in the bathroom and fell.
-She expected all residents to be supervised by staff.

Interview the Resident Care Director (RCD)/former Executive Director (ED) on 07/24/23 at 4:23pm revealed:
-She was the ED on 05/13/23.
-The SCU staff were expected to provide residents with assistance with ADLs, ambulation, dressing, toileting, grooming and feeding.
-Residents were to be checked on every 30 minutes and every 2 hours for toileting.
-She was aware of the incident with Resident #11's fall in the bathroom on 05/13/23.
-She would have expected staff to have all the supplies that were needed to assist residents with toileting and to not leave the residents unattended.

Interview with the Administrator on 07/24/23 at 5:30pm revealed:
-He expected staff to provide supervision to the residents that required it.
-If a resident required full assistance, then they should not be left alone.
-If a resident required some assistance and staff had to leave them, staff should return quickly.

Interview with Resident #11's PCP on 07/19/23 at 7:07pm:
-Resident #11 was a long-time patient of his.
-He was aware of the fall she had on 05/13/23.
-He saw Resident #11 on 05/17/23 after her fall for complaint of headache.
-He prescribed Tramadol as needed for pain.
-He was aware that Resident #11 was admitted to the hospital on 05/20/23 and no longer at the facility.

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D 270	Continued From page 47 -He was not aware that a CT of the Lumbar spine on 5/21/23 revealed an acute L3 vertebral body fracture. -He described the time frame for acute as being within a week or so. -He said it was possible, the lumbar fracture could have been caused by the 5/13/23 fall if she had hit her back or buttocks with her history of osteopenia. The facility failed to provide supervision for 2 of 7 sampled special care unit (SCU) residents (#2 and #11). The facility's failure to supervise Resident #11 who had an identified supervision need with toileting resulted in the resident being left unattended and falling off the toilet and sustaining a head laceration. The facility's failure to provide supervision for Resident #2 who had a history of aggressive behaviors towards other residents and falls resulted in 2 documented altercations with other residents, 5 documented falls, 2 emergency room (ER) visits, and injuries including a pelvic fracture, head laceration, facial contusions, right arm and hand pain and swelling, and skin tears. The facility's failure resulted in substantial risk of neglect, serious injury and death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 23, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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D 273	Continued From page 48 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to notify the primary care provider (PCP) for a left hip hematoma, inability to take medications on multiple occasions and follow up with an orthopedic surgeon after a pelvic fracture (#2) and identify and notify the PCP of grossly overgrown and thickened toenails (#12). The findings are: Review of the facility's undated general policies and regulations revealed: -Under section II, services: Medical care was provided as deemed necessary. -When a resident appeared sick, he was taken to a doctor's office. -In cases of extreme illness, individuals were sent or taken directly to the hospital, and the family was notified as soon as possible. 1. Review of Resident #2's current FL-2 dated 04/14/23 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation. -Medication orders included Eliquis 5mg twice daily. (Eliquis is a blood thinner used to prevent blood clot formation.) Review of Resident #2's physician's order dated 07/03/23 revealed an order to discontinue Eliquis 5mg twice daily.	D 273		

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a. Interview with a hospice nurse (HN) on 07/19/23 at 8:06am revealed:
-She was the on-call HN and was called in due to a bleeding wound.
-Resident #2 had a wound on his left hip that bled onto the sheets.
-The wound was from a hematoma that came from a fall a week ago Sunday (07/09/23).
-He was sent to the emergency room (ER) for the hematoma.
-The hematoma was drained at the ER, but it filled again and continued to ooze.
-He was on antibiotics for the left hip wound, but she thought it was worse than it seemed.
-His family did not want him sent out to the ER so hospice was trying to keep him comfortable.

Observations of Resident #2 on 07/19/23 at 1:56pm revealed:
-Emergency Medical Service (EMS) technicians were with the resident in the hallway on the special care unit (SCU).
-The EMS technicians assisted the resident with transferring from his wheelchair to the stretcher.
-As the resident stood, a dark wet spot approximately the diameter of a large orange was visible on his left hip.

Review of Resident #2's hospital record dated 07/19/23 revealed:
-The resident was admitted to the hospital on 07/19/23.
-He was seen initially for a check of a known wound to his left hip with purulent drainage.
-Code sepsis was activated by EMS.
-The resident presented to the ER with hypotension, hypothermia and a left lower extremity wound infection.
-A computed topography (CT) scan done on 07/19/23 showed a 4.5 x 10 x 20 cm collection at

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the left posterior pelvic/gluteal soft tissues.
-A wound culture obtained on 07/14/23 was positive for numerous staphylococcus aureus.
-The infection was being treat with intravenous Vancomycin. (Vancomycin is used to treat serious infections for which other medications may not work. It is most powerful antibiotic known to treat staphylococcus aureus.)

Interview with the Memory Care Director (MCD) (former Resident Care Director) on 07/19/23 at 1:56pm revealed:
-A personal care aide (PCA) was assisting Resident #2 to the bathroom.
-The resident stood and just started bleeding from his left hip.
-She had contacted hospice and was told it was okay to send the resident to the ER.
-Originally, Resident #2's responsible party did not want him sent to the ER.

Interview with a PCA on 07/19/23 at 1:12pm revealed:
-The wound on Resident #2's left hip was some type of abscess that popped open on it's own.
-The first time she remembered seeing the abscess was before Mother's Day (05/14/23).
-She was told by a medication aide (MA) that the primary care provider (PCP) said it was a hematoma on his left hip, not an abscess.
-Resident #2 went to the ER earlier in the week (07/14/23) to have it drained.
-Everyone (staff) saw the abscess; she could not remember who contacted the PCP or when, but that was how he saw it.

Interview with a MA on 07/21/23 at 9:01am revealed:
-The wound on Resident #2's left hip was like a cyst or a boil; it was swollen, red and hot.

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-It came up on his upper left leg near the hip about a month ago.
-She did not know if the resident's PCP or hospice was notified but there were notes from other staff in the resident's progress notes when it first appeared.
-When it opened, she called hospice, and they sent a HN out to look at it.
-The (HN) sent Resident #2 to the ER and they drained it (07/14/23).
-He came back from the ER and the wound started draining through his pants, so she sent him back to the ER (07/15/23).
-The opening was approximately half an index finger in depth.

Review of Resident #2's progress notes dated 03/14/23 through 07/09/23 revealed:
-There was no documentation of any injury, mark or bruise to the residents left hip or left lower extremity between 03/14/23 and 07/05/23.
-There was no entry between 07/05/23 and 07/09/23.
-On 07/09/23, there was documentation Resident #2 was sent to the ER due to a fall and the resident saying his hip hurt.
-The next entry was a late entry dated 07/08/23 11:00pm - 7:00am.
-Staff documented the resident was observed sliding from the chair to the floor.
-Resident #2's mobility was checked, and he walked to his room.
-Resident #2 awakened with complaints of left hip pain.

Review of Resident #2's incident/accident report dated 07/09/23 revealed:
-At 8:39am staff documented the resident stated he fell.
-The left hip on the diagram was circled.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 52 -There was no documentation of the type of injury. -The resident was sent to the ER. -The resident's primary care provider (PCP) and hospice were notified. -There was no documentation the responsible party was notified. Attempted telephone interview on 07/21/23 at 11:01am with the medication aide (MA) that completed Resident #2's incident/accident report dated 07/09/23, was unsuccessful. Review of Resident #2's hospice nurse (HN) visit notes dated 05/21/23 to 07/09/23 revealed: -On 07/01/23, there was documentation the resident had an unwitnessed fall and sustained a bruise and bump on his forehead above the left eye. -On 07/03/23, there was documentation the resident had an unwitnessed fall on 07/01/23 and had dark bruises around both eyes, the bridge of his nose and his left forehead and a bump above his left eye. -Resident #2's right arm was swollen, and he was guarding that arm. -On 07/09/23, there was documentation the resident was sent to the ER for a large bruise on his left hip. -Staff did not witness a fall. -There was no documentation of an abscess on the resident's left leg/hip. -There was no documentation of a bruise on Resident #2's left hip prior to 07/09/23. Review of Resident #2's primary care provider (PCP) visit note dated 07/12/23 revealed: -The resident was seen at the request of staff for follow up after being seen in the ER for hip pain and evaluation for evidence of abuse.	D 273		

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D 273	Continued From page 53 -Resident #2 fell last week and the PCP did not see him after the fall because the resident received hospice services. -Resident #2 was unable to answer simple questions and had generalized muscle wasting. -The resident had extensive bruising on his face from the previous fall. -The resident had superficial skin tears on both arms and an erythema pruritic rash on his torso and both arms. -There were excoriations from around the rash due to scratching. -The cause of the rash was unknown and there were multiple residents with the same rash. -He ordered Lotrisone cream to treat the rash. -The resident's extensive bruising/injuries were consistent with falling and striking his face on the floor. -There was no documentation of a hematoma, abscess, boil, cyst or wound on the resident's left hip. Second interview with the MA on 07/24/23 at 12:36pm revealed: -She saw the left hip wound when she was assisting Resident #2 or one of the personal care aides (PCAs) told her and she went and looked. -Other staff on duty said it had been there. -He was also sent to the ER for his left hip (07/09/23). -Staff normally communicated resident updates like monitoring needs, falls, injuries and change of condition verbally when the shift changed. -MAs used to document events but documentation had fallen through the cracks. -Communicating verbally did not always cover everything because if something happened early in the shift staff might forget to mention it. -MAs were to place the resident's name in the hot box when they needed to be monitored.	D 273		

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-The hot box was a dry erase board where resident's names were put for falls, illness, hospital visits, and behaviors.
-Residents listed on the dry erase board were supposed to monitored by staff and a note documented in their chart.
-A PCA told her at shift change (11:00pm) on 07/08/23 that Resident #2 was on the floor.
-The PCA said he had lost his balance and slid back into the chair and then onto the floor.
-He landed on his bottom not his hip.
-The MA who sent Resident #2 to the ER on 07/09/23 said it was because of the bruise on his left hip and that he was limping.
-The bruise had been on his left hip for at least 1-2 weeks before 07/08/23 and was in the same place the abscess was.
-She knew it was an abscess about 2 days before he was sent to the ER (07/07/23).
-She did not know if Resident #2's PCP or hospice was notified because she normally worked third shift.
-She did not notify the PCP or hospice.
-Normally, MAs were responsible for checking with the staff when an injury was found to find out what happened.
-She also checked the resident's progress notes.
-If there was no note, she faxed a notification to the PCP and notified the MCD or Resident Care Director (RCD).
-He was able to move all his extremities and said he was not hurt.
-She and the PCA helped him up.
-He was sleepy but able to walk down the hall and get into bed.

Telephone interview with Resident #2's family member on 07/21/23 at 12:04pm revealed:
-She found out Resident #2 had been in the hospital on 07/14/23, 07/15/23 and was currently

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in the hospital when the hospice nurse (HN) contacted her on 07/19/23.
-The HN told her that the resident had an ulcer on his left hip that erupted from the inside on 07/15/23.
-The HN explained that blood pooled, accumulated and hardened under the skin which caused an abscess.
-The HN said it was not bandaged properly and he had to return to the hospital on 07/15/23.
-The HN said the ulcer was from a fall, but she did not know when the resident fell.
-The HN mentioned a fall causing the left hip wound when she called on 07/19/23, but she did not say if it was a new fall since 07/01/23.

Review of Resident #2's progress note dated 07/14/23 revealed:
-The resident was seen by the HN.
The HN instructed staff to send the resident to the ER because the "abscess popped on 07/13/23".

Review of Resident #2's hospital record dated 07/14/23 revealed:
-The resident was seen for a large left hip mass.
-A CT scan of his abdomen and pelvis showed a superficial abscess lateral to the hip joint.
-The left hip site was warm to touch, red and draining.
-An image of the left hip showed a raised area approximately the diameter of an orange.
-The skin was raised, taught and shiny with an unopened pustule at the center of the raised area.
-The resident had a complicated abscess and was diagnosed at discharge with a hematoma of his left hip, anticoagulated and lower extremity cellulitis.

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Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed:
-The bruise or abscess on Resident #2's left hip had been present for approximately 2 weeks prior to 07/09/23 (06/25/23).
-There were hospice aides that bathed Resident #2 3 times per week and saw his skin.
-There were hospice nurses (HNs) that saw him 3 times per week also.
-She thought the HN and hospice aide were responsible for reporting the wound on his left hip to the PCP.
-She did not know if Resident #2 was seen by his primary care provider (PCP) for his left hip.

Interview with Resident #2's PCP on 07/19/23 at 6:31pm revealed:
-On 07/19/23, he was notified about Resident #2's left hip.
-The wound on the left hip was apparently a boil which had purulent and bloody drainage.
-He was seen in the ER a few days ago.
-The boil was drained at the ER but they did not place a bandage, so he was sent right back.
-He was Resident #2's PCP and saw him when he was at the facility at staff request for things such as a rash; everything else was reported to hospice.

Telephone interview with Resident #2's hospice Director on 07/20/23 at 5:43pm revealed:
-Resident #2 was admitted to hospice on 05/20/23.
-Facility staff were instructed to call hospice whenever there was a concern for Resident #2 or a change in his condition.
-There was no documentation in the resident's hospice notes of a wound, cyst, boil, or abscess on his left hip prior to 07/14/23.
-The first note was dated 07/14/23 where the staff

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called the hospice on-call number and the on-call HN went to the facility.
-Resident #2 was sent to the ER for a bruise on his left hip on 07/09/23.
-Staff reported there was no witnessed fall.

Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed:
-Resident #2 was sent to the ER for his left hip on 07/09/23.
-She did not know anything about the left hip before 07/09/23.
-Resident #2 was able to walk around so she did not understand how staff could say it was there before 07/09/23.
-Hospice instructed staff to call hospice first before sending a resident to the ER.

b. Review of Resident #2's physician's orders dated 06/28/23 revealed:
-Medication orders included: acetaminophen 650mg twice daily (anti-inflammatory), divalproex 250mg twice daily (mood stabilizer), Eliquis 5mg twice daily (blood thinner), levothyroxine 125mcg (thyroid hormone), melatonin 3mg at bedtime (insomnia), metoprolol 12.5mg twice daily (heart medication), potassium chloride 20mEq daily (replacement), furosemide 20mg daily (diuretic), mirtazapine 15mg at bedtime (insomnia), and prenatal vitamin daily (supplement).

Review of Resident #2's May 2023 electronic medication administration record (eMAR) revealed:
-On 05/01/23 and 05/26/23 there was documentation the resident was unable to take his medications at 6:30am and 8:00am.
-Medications the resident was unable to take included levothyroxine, acetaminophen,

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divalproex, Eliquis, metoprolol, potassium chloride, and prenatal vitamin.
-On 05/03/23, 05/16/23, 05/17/23, 05/19/23, 05/26/23, 05/27/23, 05/28/23 and 05/30/23 there was documentation the resident was unable to take his 8:00pm medications.
-Medications included acetaminophen, divalproex, Eliquis, melatonin, metoprolol, and mirtazapine.
-On 05/06/23 there was documentation the resident was unable to take his 6:30am levothyroxine.

Review of Resident #2's June 2023 eMAR revealed:
-On 06/08/23 there was documentation the resident was unable to take his 6:30am levothyroxine.
-On 06/06/23, 06/08/23, 06/25/23, 06/28/23 and 06/29/23 there was documentation the resident was unable to take his 8:00am medications.
-Medications the resident was unable to take included acetaminophen, divalproex, Eliquis, furosemide, metoprolol, potassium chloride, and prenatal vitamin.
-On 06/13/23, 06/19/23, 06/21/23, 06/24/23, and 06/27/23 there was documentation the resident was unable to take his 8:00pm medications.
-Medications the resident was unable to take included acetaminophen, divalproex, Eliquis, melatonin, metoprolol, and mirtazapine.

Review of Resident #2's July 2023 eMAR revealed:
-On 07/01/23, 07/02/23, 07/03/23, and 07/04/23 there was documentation the resident was unable to take his 6:30am levothyroxine.
-On 07/03/23, 07/04/23, and 07/05/23 there was documentation the resident was unable to take his 8:00am medications.

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-Medications the resident was unable to take included acetaminophen, divalproex, Eliquis, furosemide, metoprolol, potassium chloride, and prenatal vitamin.
-On 07/03/23, 07/08/23, 07/10/23, 07/11/23, and 07/15/23 there was documentation the resident was unable to take his 8:00pm medications.
-Medications the resident was unable to take included acetaminophen, divalproex, Eliquis, melatonin, metoprolol, and mirtazapine.

Review of Resident #2's progress note dated 07/08/23 revealed:
-Staff documented the resident was unable to take his 8:00pm medications.
-The event was documented and reported to the next shift.
-There was no documentation the primary care provider (PCP) or hospice was notified.

Review of Resident #2's progress note dated 07/15/23 revealed:
-Staff documented the resident was unable to take his night medications.
-The resident took an as needed medication (unspecified) earlier that day (07/15/23) and was too tired to get up to receive medications.

Interview with a medication aide (MA) on 07/24/23 at 2:06pm revealed:
-She had administered a pain medication earlier in the day on 07/15/23 to Resident #2 per the hospice nurse's instruction.
-The resident was drowsy and unable to take his medications that night.
-She documented it in the resident's progress note.
-She was responsible for documenting in the resident's progress notes and reporting to the MCD (former Resident Care Director RCD) or the

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D 273	Continued From page 60 RCD (former Executive Director ED). -The MCD or RCD notified the PCP or hospice. -She told the MCD or RCD the next day when they came in. Review of Resident #2's May, June and July 2023 progress notes revealed there was no documentation the PCP or hospice was notified the resident was unable to take his medications. Interview with a second MA on 07/06/23 at 10:19am revealed: -She thought some of the medications were "messing" with Resident #2, although she wasn't a doctor and didn't know for sure. -She made decisions to withhold medications after being around the resident and seeing how they were acting. -She documented on the eMAR resident was unable to take the medications when she withheld medications (05/01/23, 05/16/23, 05/17/23, 05/19/23, 05/26/23, 05/27/23, 05/28/23, 06/06/23, 06/08/23, 06/13/23, 06/15/23, 06/19/23, 06/21/23, 06/24/23, 06/25/23, 06/28/23, 06/29/23, 07/03/23, 07/04/23, 07/05/23, 07/10/23 and 07/11/23). -She had not called the PCP about withholding medications for Resident #2. -The PCP visited the facility every week, so she was "pretty sure" she told him she withheld medications at times. -She had not documented communication with the PCP about withholding medications in the progress notes, but it seemed like she needed to start doing this. -She did not hold medications all the time. -She did not know if that was a facility policy or not. -She was "pretty sure" she spoke with the MA (former MCD) and the RCD (former ED) about withholding medications.	D 273		

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-The former MCD would tell her it was okay when the MA reported withholding medications.
-The former MCD never told her to call the PCP.
-She withheld medications when Resident #2 acted like he couldn't walk, was a zombie, about to fall or was asleep.
Review of Resident #2's May, June and July 2023 progress notes revealed there was no documentation the PCP or hospice was notified the resident was unable to take his medications.

Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed:
-Anything that she saw or that was reported to her she reported to the former ED.
-Resident #2 not being able to take his medications was not reported to her.
-The MAs should have told her.

Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed:
-There should be an order to hold medications that were held; for example, hold for sedation.
-The MA was responsible for notifying the PCP if a resident refused medications for 3 consecutive doses of a medication.
-MAs were responsible for notifying the PCP if a resident was unable to take medications for reasons such as not being able to swallow.

Attempted telephone interview with a third medication aide (MA) on 07/21/23 at 11:01am was unsuccessful.

c. Review of Resident #2's progress note dated 04/26/23 revealed the resident was sent to the emergency room (ER) for limping, swelling and a bruise at his right upper leg.

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Review of Resident #2's ER discharge instructions dated 04/26/23 revealed:
-The resident was seen for bleeding and bruising and diagnosed with a right leg hematoma, generalized weakness and a closed nondisplaced avulsion fracture of his right ischium (pelvis).
-There was an order to call the orthopedic surgeon on 04/27/23 for follow up and re-evaluation.

Telephone interview with the orthopedic surgeon's office on 07/21/23 at 1:40pm revealed:
-Resident #2 was not seen by the orthopedic surgeon.
-The office staff was not able to say the consequence of no follow up because the office did not have any record of Resident #2.

Interview with the Memory Care Director (MCD) (former Resident Care Director) on 07/20/23 at 11:15am revealed:
-The appointment with the orthopedic surgeon should have been made.
-The MCD or RCD were responsible for reviewing ER discharge instructions and giving the transportation person a copy for all referral appointments.
-The transportation person was responsible for scheduling the appointments.

Interview with the transportation person on 07/21/23 at 12:24pm revealed:
-He normally received orders for follow up appointments and referrals when he took residents for appointments or picked them up from the hospital.
-He got referral and follow up orders from the RCD when emergency medical services (EMS) brought the residents back to the facility from the hospital.

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D 273	Continued From page 63 -He did not remember getting a referral and follow up appointment for Resident #2 to see an orthopedic surgeon on 04/26/23. -He had not scheduled any appointments for Resident #2. -He had not taken Resident #2 to any appointments since 04/26/23. Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed: -She did not remember Resident #2 having a referral to an orthopedic surgeon on his ER discharge instructions dated 04/26/23. -ER discharge instructions received by the medication aides (MAs) were faxed to the pharmacy and slid under the Executive Director's (ED's) door. -She, the RCD or ED took care getting a copy to the transportation person and to the primary care provider's (PCP's) mailbox. -The transportation person was responsible for scheduling all referral appointments. -ER discharge instructions including referrals were placed in the transportation person's mailbox. -The entire discharge summary went into the PCP's mailbox to review and initial before being filed in the resident's chart. Interview with the RCD (former Executive Director) on 07/24/23 at 4:33pm revealed: -ER discharge summaries were given to her, the MCD or the RCD. -Either she, the MCD or RCD gave a copy of the ER discharge summary to the transportation person to schedule. -She did not remember an orthopedic surgeon referral on the ER discharge instructions for Resident #2. -She did not know what happened with contacting	D 273		

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the orthopedic surgeon's office for Resident #2.
-There was no system to follow up and ensure the appointment was made and the resident went.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

2. Review of Resident #12's current FL2 dated 05/11/23 revealed:
-The resident's diagnoses included dementia, hypertension, and hyperlipidemia.
-The resident was constantly disorientated and semi-ambulatory.
-Her level of care was special care unit.

Observation of Resident #12 on 06/30/23 at 10:10am revealed the resident's toenails on both feet were long, thick, curved and discolored.

Review of Shower Forms for Resident #12 between 05/10/23 through 06/23/23 revealed:
-The Shower Form had a line for "Nail Care Y__ N____."
-The Shower Form also had a section for "Problems/Concerns".
-There was no documentation of problems or concerns for nailcare on any of the 11 Shower Forms reviewed.

Interview with the MA (former MCD) on 6/30/23 at 10:10am revealed:
-Resident #12 was put on the list this week to see the podiatrist on 07/12/23.
-The resident's family member usually came in and cut the resident's toenails.
-The family member told the MA (former MCD) 1-2 weeks ago that the resident's toenails were too curvy for her to cut.

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D 273	Continued From page 65 -The MA (former MCD) observed the resident's toenails at the time. -She was not aware of any concerns with resident's toenails prior to this. -She did not know the last time the family member cut the resident's toenails -The facility's protocol for nail care was referral for podiatry visits every two months. Interview with Resident #12's family member on 06/30/23 at 12:53pm revealed: -She spoke with the MA (former MCD) on 06/27/23 about getting the resident's toenails cut due to the "very long" length. -The resident's toenails were long for about 3 months prior. -She did not notice because the resident had socks on when she visited. -The family member spoke with the resident's RP who said the registered nurse (RN) should be able to cut them. -The MA (former MCD) told the family member the RN did not want to cut them because they were curved, and she did not want to touch them. -The family member did not take the resident out to the salon for nail care due to the condition of her toenails. Observation of Resident #12 on 07/05/23 at 10:27am revealed the resident's toenails were in the same condition as during observation on 06/30/23. Interview with a personal care aide (PCA) on 07/05/23 at 10:27am revealed: -The podiatrist came to the facility once each month. -Resident #12 was on the list to be seen in July. -The PCAs completed Shower Forms and should document toenail concerns on the form.	D 273		

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-Resident #12 was ambulatory in January when the PCA started working there but used a wheelchair now.
-The PCA told the MA (former MCD) two weeks ago that she needed to look at the resident's feet and toenails after noticing the toenails were long and needed to be cut.
-The MA (former MCD) said she had tried to contact the resident's Guardianship SW (RP) for consent for a podiatry referral.

Interview with a MA on 07/05/23 at 11:10am revealed:
-She first noticed Resident #12's toenails were long 2 months ago, but the resident did not complain of pain.
- She told the former MCD about the resident's long toenails.
-The former MCD said she would call the resident's social worker (RP) to get permission for the resident to be seen by podiatry.
- She did not know the process to get the resident on the podiatry list, but never followed up once she told the former MCD.
-She did not call the RP about the resident's feet and toenails.
-The PCAs documented things like skin tears and rashes on Shower Forms.
-Nail care concerns would be documented in the progress notes by the MAs or staff who did the follow up.
-She had not documented any toenail concerns in the progress notes.

Interview with a 2nd MA on 07/06/23 at 10:09am revealed:
-She noticed Resident #12's toenails around Memorial Day when a PCA brought it to her attention and asked if they needed to tell the former MCD or put the resident on the podiatry

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list.
-The PCA wanted to cut them, but the MA told her to wait and tell the former MCD.
-The PCA talked to the former MCD about Resident #12's toenails.
-She never followed up on the resident's toenails because she thought the former MCD handled the situation.

Interview with a MA (former MCD) on 07/24/23 at 4:00pm revealed:
-She wrote a statement on 07/07/23 at the request of the administrator.
-The family member would visit the resident and take her on outings in the community including the nail salon to get manicures and pedicures.
-The family member stopped taking her out about a month ago due to resident's declining health.
-Staff notified the MA and the family member about the resident's nails.
-She quickly put her on the podiatry list to get her feet taken care of.
-The family member was fine with this.

Interview with Resident #12's RP on 07/05/23 at 1:17pm revealed:
-She was a guardianship social worker (SW) with DSS and served as the resident's legal guardian/RP.
-She last saw the resident on 05/16/23 at the facility.
-The resident was laying in bed covered up, so the RP did not see her feet during the visit.
-She was not aware of any concerns about the resident's toenails until she was informed about the investigation.
-She did not receive any calls from the facility about a podiatry referral.
-The facility would not need consent for a podiatry referral since it is considered basic care.

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-She received texts from the MA (former MCD) requesting the RP to call.
-The MA (former MCD) never mentioned podiatry care during their phone conversations.
-If the MA (former MCD) was unable to reach her, she knew to call the DSS's main phone number as there was always a social worker on call.

Interview with the RCC (former ED) on 07/05/23 at 10:43am revealed:
-She called the podiatrist on 06/30/23.
-The earliest they could see Resident #12 was 07/12/23 at the facility.
-She had not documented this conversation in the progress notes but planned to.

Interview with the Podiatrist's office manager and nurse on 07/07/23 at 10:02am and 12:34 revealed:
-A resident had to be in a facility for 90 days before they could be seen by podiatry due to insurance requirements.
-The facility would let the office know when a resident needed to be seen, and the office would collect the necessary information at the visit.
-The facility should obtain a consent for outside services at a resident's admission so residents could be seen quarterly.
-Prior to each facility visit, the podiatrist office sent a list of residents scheduled to be seen.
-The facility could add a resident to the list at any time, if needed, and fax the information back to the office.
-Communication was usually with the former RCC or former MCD.
-The office received a phone call from the facility's transportation person on 07/05/23.
-Per the office notes, the transportation person did not know Resident #12's admission date but thought she had been at the facility over 90 days

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and was in desperate need of getting her nails trimmed.
-The podiatrist would be at the facility on 07/12/23 and would see her then.
-The office never saw Resident #12 or received a referral for services prior to the 07/05/23 phone call from the facility's transportation person.
-The office notified the RCC (former ED) on 07/07/23 that Resident #12 would be seen on 07/12/23.

Review of an email from the Administrator on 07/13/23 at 2:56pm revealed:
-The podiatrist was able to see Resident #12 on 07/11/23.
-A copy of the podiatrist's report (Mycotic Nail Evaluation) was attached.

Review of Mycotic Nail Evaluation dated 07/11/23 for Resident #2 revealed:
-Resident had painful, thickened, discolored nails and painful calluses bilateral.
-Clinical findings included 5-6mm nail thickness of yellow, brown, gray, and white color, crumbly, subungual debris (debris under the toenails) and onycholysis (fungal infection of the toenails).

_____

The facility failed to ensure medical evaluation and follow up for a resident on the special care unit (SCU) for treatment of a left hip hematoma which resulted in an infection which required hospitalization and treatment with a powerful antibiotic and lack of follow up with an orthopedic surgeon after an emergency room (ER) visit in April 2023 with an identified fracture in the resident's pelvic bone (Resident #2). This failure resulted in serious physical harm and constitutes a Type A1 Violation.

_____

The facility provided a plan of protection in

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D 273	Continued From page 70 accordance with G.S. 131D-34 on 06/30/23 with revisions on 07/21/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 23, 2023.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 5 residents on the special care unit (SCU) (#1, #2, #3, #10 and #23) were treated with respect and dignity and free from mental and physical abuse involving 2 staff (A and I) where Staff I hit Resident #10 on the back of her head several times; Staff A was observed speaking in a harsh and disrespectful voice with condescending words to Resident #3 and Resident #23; and staff in general on the SCU scolded Resident #1, Resident #2 and Resident #3 for maladaptive behaviors such as not sitting when told; and failed to ensure Resident #6 received appropriate care and services for a significant change in condition and rapid decline in health (#6). The findings are: 1. Review of Resident #10's current FL2 dated 06/14/23 revealed:	D 338		

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-Diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus, and hyperglycemia.
-The resident was semi-ambulatory.
-She was constantly disoriented.
-She was special care unit level of care.

Review of Resident #10's care plan dated 03/28/23 revealed:
-The resident had significant memory loss and must be directed.
-The resident used a wheelchair and required extensive assistance with ambulation.
-The resident was totally dependent on assistance for all other activities of daily living including eating, toileting, bathing, dressing, grooming /personal hygiene and transferring.

Review of Client Coordination Notes Report for Resident #10 revealed resident was enrolled with Hospice effective 04/04/23 based on diagnoses of Alzheimer's disease and late onset dementia.

Interview with a medication aide (MA)/former Memory Care Director (MCD) on 06/23/23 at 12:20pm revealed:
-On 06/20/23, Staff I, a personal care aide (PCA) was pushing Resident #10 in her wheelchair when the resident tried to stop the wheelchair with her feet.
-Staff I "hit" the resident in the back of the head with her hand.
-A MA who witnessed the incident reported it to the former MCD the next day (06/21/23).
-The MA witnessed the incident when she was leaving her shift around 7:00am on 06/20/23.
-She did not report it sooner because she needed to go home and get some sleep to return later for another shift.
-She reported the information to the Resident

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Care Director (RCD)/former Executive Director (ED) so they could review the facility camera footage.
-She and the RCD (former ED) reviewed the camera footage together.
-She saw that Resident #10 was trying to stop the wheelchair with her feet, when Staff I pushed the resident in the back of her head causing her head to fall forward.
-The resident lifted her arms and the Staff I pushed her in the back of her head again.
-The RCD (former ED) stated Staff I was going to be terminated.
-Staff I did not come to work as scheduled the next day.

Review of Staff I's timecard dated 06/30/23 revealed:
-Her last entry was on 06/20/23 from 6:38am to 3:13pm.
-She did not return to work at the facility after this shift.

Interview with the RCD (former ED) on 6/23/23 at 1:33pm revealed:
-The MA (former MCD) informed her on 06/21/23 at 5:30pm of the allegation that Staff I hit Resident #10 on 06/20/23.
-She looked at the camera footage on 06/21/23, the same day it was reported to her.
-The camera footage showed a MA (who reported the incident) exiting the special care unit at the end of her shift.
-As the MA was exiting the unit, Staff I was talking to Resident #10 while pushing her in her wheelchair toward her room.
-Staff I pushed Resident #10 on the back of her head and the resident's head fell forward due to the push.
-She tried to save the camera footage but was

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unable to.
-It was no longer available for review by DSS as it stayed in the system 3 days and was recorded over.
-She went to check on the resident and saw no signs of injury.
-Staff I was not at work and was scheduled off the following day.
-She planned to terminate the Staff I but thought she still needed to hear her side of the story.
-She left Staff I a phone message and did not receive a return call.
-Staff I never returned to work.
-She was terminated and had no further contact with any facility residents.

Interview with law enforcement (LE) on 07/16/23 at 1:15pm revealed:
-She had opened an investigation regarding the allegations of abuse against Resident #10.
-While leaving the special care unit, a MA witnessed Staff I assault the resident by pushing her forcefully in the back of her head.
-The MA who witnessed it informed the former MCD, who asked the RCD (former ED) to review the camera footage.
-The RCD (former ED) reviewed the camera footage on 06/21/23 and saw the incident had occurred.
-On 06/27/23, the LE officer interviewed Staff I.
-During the interview Staff I wanted to focus on other things about the facility.
-She was told she was under investigation and taken off the schedule.
-Staff I denied the allegation she hit or pushed Resident #10.
-Staff I was charged with a misdemeanor for assault on a handicapped person.

Interview with Staff I on 07/20/23 at 12:25pm

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revealed:
-She was charged with a misdemeanor for hitting Resident #10.
-Management never called her or showed her the video of the incident.
-She did not work with Resident #10 often because, while she typically worked in the special care unit, the resident was not in her typical assigned group of residents.
-The day she supposedly assaulted the resident, she had wheeled the resident back to her room and laid her in bed.
-The resident could walk but was in a wheelchair because her legs were weak.
-Resident #10 would lift her feet while being wheeled.
-The resident did not need help to transfer from her wheelchair and was not combative.

Attempted Interview on 07/06/23 at 10:09am with the MA who witnessed the assault against Resident #10 was unsuccessful.

Interview with Resident #10's responsible party (RP) on 07/19/23 at 10:45am revealed:
-She had no knowledge of the incident of abuse until she was informed by the DSS Adult Home Specialist on 06/23/23.
-She received a telephone message from the MA (former MCD) on 06/28/23 and they spoke on 06/29/23.
-She visited Resident #10 and communicated with hospice staff.
-There was no indication resident sustained any injuries from being pushed.
-She was aware that the employee was no longer at the facility.

Interview with the Administrator on 07/12/23 at 12:00pm revealed:

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D 338	Continued From page 75 -Once the RCD (former ED) viewed the camera footage and saw Staff I's abuse of Resident #10, she should have been terminated immediately. -There would have been no need to hear her side of the story. -Staff I was terminated and never returned to work after the incident. 2. Review of Resident #23's current FL-2 dated 05/02/23 revealed: -Diagnoses included vascular dementia, seizure disorder, hyperlipidemia, obstructive sleep apnea, and benign prostatic hypertrophy. -The resident was documented as constantly disoriented. Review of Resident #23's admission record form revealed the resident was admitted to the facility into the special care unit (SCU) on 12/20/21. Observation in the SCU on 07/19/23 at 8:53am revealed: -Resident #23 was seated in the common living room. -The medication aide (MA) (Staff A) was administering medications to Resident #23. -Resident #23 spit the medications out on the floor. -Staff A spoke in a raised, stern, and scolding voice, "[Resident #23's name], if you didn't want the pills you could have just put them in my hands; you didn't have to spit them on the floor". -Staff A walked away from the living room and back to the medication cart without picking up the medications from the floor. -Staff A spoke loudly and told the Memory Care Director (MCD)/ former Resident Care Director (RCD) that Resident #23 spit all of his medications out. -The MCD/ former RCD came from the dining	D 338		

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room into the living room and asked Resident #23 why he spit out the medications.
-Resident #23 told the MCD/ former RCD that the medications were "poison".
-The MCD/ former RCD picked up the medications from the floor.

Observation in the SCU on 07/19/23 at 9:24am revealed:
-Resident #23 was sitting in the dining room and said something (could not hear specific words) in a normal tone to Staff A.
-Staff A told Resident #23 in a raised, stern voice, "I gave you medicine for that this morning; remember what you did with it".
-Staff A walked away from the resident after commenting and shrugged her shoulders.
-Resident #23 was sitting in the dining room with his head down.

Interview with Resident #23 on 07/19/23 at 9:28am revealed:
-His back hurt bad because he had a bad back and had broken his neck in the past.
-His back hurt every day.
-When asked about his medications or the way staff spoke to him, the resident did not answer.
-The resident kept talking about his back hurting.

Review of Resident #23's facility progress notes dated 07/19/23 (no time) revealed:
-The MA documented the resident refused medications.
-The resident spit them out at the MA.

Interview with Staff A on 07/19/23 at 9:31am revealed:
-She had worked at the facility as a MA for 1 year and 4 months.
-She was running behind with her work, there was

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a lot going on with the residents, and it was hot in the facility today.
-The "state" was here; "It's a lot" and "a little stressful".
-It was very unusual for Resident #23 to spit out his medications.
-Resident #23 did certain things when he knew there were "extra eyes on him".
-For example, if there was an audience (like outside visitors), Resident #23 would throw himself on the floor or the resident would say someone was beating him.
-That morning when Resident #23 was in the dining room, the resident told her his back was itching.
-She told the resident that she tried to give him some medication for it.
-The way she spoke with Resident #23 that morning was her normal tone of voice and she could not change her tone of voice.
-To calm herself down, she just walked away from residents.
-She was stressed that morning because some of the morning medications were not in place where they should be.
-She was frustrated and it had nothing to do with the residents or the state survey.
-A lot of people did not know how to work with residents with dementia.
-She thought some staff needed visual or video training.
-She had video training at another facility but no videos or hands on training at this facility.
-There was a lack of communication between facility management staff and facility staff and that was why she got so frustrated.
-It was like that every day and nothing changed.

Interview with the MCD/ former RCD on 07/19/23 at 4:49pm revealed:

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D 338	Continued From page 78 -She observed the way Staff A talked to Resident #23 that morning when she was coming out of the dining room in the SCU. -She heard Staff A tell Resident #23 that he did not have to spit those pills on the floor and he could have handed them back to her. -She felt like Staff A's tone of voice was stern and inappropriate. -This was the first day she had observed Staff A with an attitude and speaking to a resident in that tone. -As a manager, she was trained to separate staff from a resident in that situation. -She should have pulled Staff A to the side and addressed her tone of voice at that time but she retrieved the pills the resident spit out and discarded them. -She thought Staff A had calmed down after that so she did not pull her to the side. -A few minutes later when she observed Staff A talking to state surveyors with an attitude, she went and got the Administrator at that point. -She reported to the Administrator about Staff A's tone of voice with Resident #23 and that Staff A was being rude to the state surveyors. -The Administrator told her to count off the medication carts with Staff A and exchange the keys. -The Administrator told her to tell Staff A to go see him once they complete the medication cart exchange. Interview with the Administrator on 07/19/23 at 9:57am revealed: -When he got to the facility that morning around 8:30am - 8:45am, Staff A was at the copy machine. -Staff A said the medication pass was not going like it was supposed to. -Staff A said she could not talk because she was	D 338		

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late and she walked out of the office.
-He assumed Staff A was panicking because she was running late with administering medications.
-He asked the Resident Care Director (RCD)/ former Executive Director (ED) to speak with Staff A to calm her down and tell her to follow the process.
-About 20 minutes later, the Memory Care Director (MCD)/ former RCD came and reported Staff A's attitude was not good.
-The MCD/former RCD reported Staff A "has lost it" and was "freaking out".
-The MCD/former RCD reported Staff A spoke to Resident #23 in an inappropriate way and she was not treating the residents like she was supposed to.
-He told the MCD/former RCD to get the medication cart keys from Staff A and count the medications for the key exchange.
-The MCD/former RCD was to tell Staff A to go to his office once they finished with the medication cart key exchange.
-He expected the RCD and MCD to intervene if they observed inappropriate behavior by staff with any resident and make sure to remove the staff from the situation.
-Then the RCD and MCD should report it to him.

A second interview with the Administrator on 07/19/23 at 10:49am revealed:
-He spoke with Staff A about that morning and Staff A said she got stressed out and panicked.
-He explained and went over facility protocol with Staff A during the meeting.
-He told Staff A she was separated from employment at the facility.

3. Review of Resident #3's current FL-2 dated 04/21/23 revealed:
-Diagnoses included dementia with behavioral

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disturbance, dysphagia, vitamin deficiency, metabolic encephalopathy, and pneumonia.
-The resident was documented as constantly disoriented.
-The resident was documented as having wandering behaviors.
-The resident was ambulatory and required assistance with dressing.

Review of Resident #3's admission record form revealed the resident was admitted to the facility into the special care unit (SCU) on 02/10/22.

Review of Resident #3's assessment and care plan signed by the assessor on 07/24/23 revealed:
-The resident had wandering behaviors.
-The resident had no problems with ambulation.
-The resident was always disoriented, had significant memory loss, and must be directed.
-The resident required supervision by staff for eating.
-The resident required extensive assistance by staff for ambulation and transferring.
-The resident required total assistance by staff for toileting, bathing, dressing, and grooming.

Observation in the SCU on 07/19/23 from 8:20am - 8:31am revealed:
-At 8:20am, Resident #3 was walking around barefooted with her head down in the common living room area near the nurses' station in the SCU.
-At 8:24am, Resident #3 walked behind the desk at the nurses' station and was looking through a pile of papers.
-The medication aide (MA) (Staff A) told Resident #3 in a raised, stern voice, "you can't be back here".
-Staff A assisted Resident #3 to sit in a straight

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back chair behind the nurses' station.
-Staff A pulled the straight back chair from behind the nurses' station into the walkway outside of the nurses' station that led to the common living area on one side and the medication carts and hallway to the residents' rooms on the other side.
-Resident #3 was sitting upright in the straight back chair while Staff A pulled the chair quickly and abruptly into the walkway.
-Staff A did not verbally warn or notify Resident #3 that she would be pulling the chair into the walkway.
-After a few seconds, Resident #3 got up from the chair and walked down the hallway toward the locked exit door with her head down.
-At 8:29am, Resident #3 walked from the hallway back into the common area near the medication carts and nurses' station.
-Resident #3 walked up to a tall trash can in the common area near the window at the nurses' station and began touching the rim of the trash can with her head down and staring into the trash can.
-Staff A walked abruptly to the trash can and pulled the trash can quickly and abruptly out of Resident #3's hands and moved the trash can to another part of the common area.
-Staff A did not try to redirect Resident #3 away from the trash can or explain to Resident #3 that she was going to take the trash can away while the resident was still holding onto it.
-At 8:31am, a personal care aide (PCA) came and took Resident #3 by the hand and led the resident into the dining room.

Interview with Staff A on 07/19/23 at 9:31am revealed:
-She had worked at the facility as a MA for 1 year and 4 months.
-She was running behind with her work, there was

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a lot going on with the residents, and it was hot in the facility.
-The "state" was here; "It's a lot" and "a little stressful".
-Resident #3 was all over the place; she usually let Resident #3 walk until she got tired of walking.
-If she tried to interfere with Resident #3, the resident would hit her with an open hand or a fist.
-For most of the residents, that was their "normal".
-She slid the chair Resident #3 was sitting in from behind the nurses' station to get the resident away from behind the desk.
-She moved the resident in the chair to keep from touching the resident.
-That was when the resident hit her.
-That behavior was routine for Resident #3; nothing worked for the resident's behaviors and the provider was aware.
-There used to be a gate at the nurses' station that prevented the residents from coming in but Resident #3 and another resident broke the gate months ago.
-A lot of people did not know how to work with residents with dementia.
-She thought some staff needed visual or video training.
-She had video training at another facility but no videos or hands on training at this facility.
-There was a lack of communication between facility management staff and facility staff and that was why she got so frustrated.
-It was like that every day and nothing changed.
-The way she spoke with Resident #3 that morning was her normal tone of voice and she could not change her tone of voice.
-To calm herself down, she just walked away from residents.
-She was stressed that morning because some of the morning medications were not in place where

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they should be.
-She was frustrated and it had nothing to do with the residents or the state survey.

Interview with the MCD/ former RCD on 07/19/23 at 4:49pm revealed:
-She did not see the interaction between Staff A and Resident #3 that morning.
-Resident #3 wandered around the SCU and she liked to plunder in the paperwork at the nurses' station.
-Resident #3 had taken staff's drinks and had even taken staff's keys in the past.
-It did not work when staff told Resident #3 not to do something because the resident would do it anyway.
-Resident #3 had to be redirected with her attention on something else.
-When Resident #3 went behind the nurses' station, if she was told she could not be back there, the resident would eventually come out.
-Resident #3 had to do things at her own pace.
-She was concerned to hear that Staff A pulled Resident #3 in the chair from behind the nurses' station.
-It was not the appropriate way to redirect the resident.
-She was concerned it was a safety issue because the resident could have fallen out of the chair or scraped her feet because the resident was always barefooted because she refused to wear shoes.
-For the incident with Resident #3 holding the trash can, Staff A should explain to the resident that she was going to move the trash can instead of just pulling it out of the resident's hand.
-She reported to the Administrator about Staff A's tone of voice being stern with another resident she had observed.
-The Administrator told her to count off the

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medication carts with Staff A and exchange the keys.
-The Administrator told her to tell Staff A to go see him once they complete the medication cart exchange.

Interview with the Administrator on 07/19/23 at 9:57am revealed:
-When he got to the facility that morning around 8:30am - 8:45am, Staff A was at the copy machine.
-Staff A said the medication pass was not going like it was supposed to.
-Staff A said she could not talk because she was late and she walked out of the office.
-He assumed Staff A was panicking because she was running late with administering medications.
-He asked the Resident Care Director (RCD)/ former Executive Director (ED) to speak with Staff A to calm her down and tell her to follow the process.
-About 20 minutes later, the Memory Care Director (MCD)/ former RCD came and reported Staff A's attitude was not good.
-The MCD/former RCD reported Staff A "has lost it" and was "freaking out".
-The MCD/former RCD reported Staff A was not speaking to or treating the residents like she was supposed to.
-He told the MCD/ former RCD to get the medication cart keys from Staff A and count the medications for the key exchange.
-The MCD/ former RCD was to tell Staff A to go to his office once they finished with the medication cart key exchange.
-He expected the RCD and MCD to intervene if they observed inappropriate behavior by staff with any resident and make sure to remove the staff from the situation.
-Then the RCD and MCD should report it to him.

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D 338	Continued From page 85 A second interview with the Administrator on 07/19/23 at 10:49am revealed: -He spoke with Staff A about that morning and Staff A said she got stressed out and panicked. -He explained and went over facility protocol with Staff A during the meeting. -He told Staff A she was separated from employment at the facility. Telephone interview with a former personal care aide (PCA) on 07/20/23 at 12:38pm revealed: -Staff talked "aggressively" (referring to tone of voice) to residents in the SCU, especially Resident #3. -Staff got a little irritated with residents in the SCU. -For example, staff may yell at a resident and tell them to "sit down, you're not going back to your room". -About 2 months ago, the former ED had a meeting and told staff to stop yelling at residents in the SCU. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. 4. Review of Resident #1's current FL-2 dated 03/16/23 revealed: -Diagnoses included dementia with behavioral issues and schizophrenia. -The admission date for Resident #1 was documented as 08/30/13. -The current and recommended level care was listed as special care unit (SCU). -The resident was constantly disoriented, exhibited inappropriate wandering behavior, semi-ambulatory using a wheelchair, incontinent of bowel and bladder, and required total care with	D 338		

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personal care assistance including bathing, feeding, and dressing.

Review of Resident #1's care plan dated 09/07/22 revealed:
-She was always disoriented.
-There was significant memory loss and the resident must be directed.

Review of Resident #1's progress notes from 03/14/23 through 07/14/23 revealed:
-On 04/12/23, Resident #1 got a few cuts on her face.
-On 04/19/23, Resident #1 was upset, aggressive, and screaming at staff.
-On 07/08/23, staff observed redness to Resident #1's right eye.

Confidential resident interview revealed:
-"Mess goes on here".
-There were staff that were "not so good" working at the facility.
-Staff gave residents short answers when asked questions or for assistance.
-There was "drama everyday" between residents and staff.
-There was a female staff working at the facility that did not handle residents right.
-The resident identified Staff E as a staff who "toys with" the residents.
-The resident did not provide specific incidents or dates of "drama, mess, not so good, toys with".

Interview with a law enforcement official on 07/19/23 at 1:15pm revealed:
-Staff C reportedly sat on residents to make them stay seated.
-She spoke to another former staff who stated Staff C "hits patients on arms and pinches them specifically [Resident #1 and [another resident]]."

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D 338	Continued From page 87 -The former staff did not know why the residents were hit or pinched, residents did not listen to her, and Staff C would "sit on patients to make them stay seated". -The former staff reported she saw Staff C "pop" the resident. Confidential staff interview revealed: -Staff C would "pop" another resident "on her bottom" in a playful manner after the resident would pop Staff C. -She had never seen anything maliciously occur. Telephone interview with the former staff on 07/20/23 at 12:25pm revealed -She saw Staff C "pop" Resident #1. -Her family member that had worked on another shift "was telling me stuff." Telephone interview with a second former staff on 07/20/23 at 12:38pm revealed: -She worked at the facility for 2 - 3 months on 7am-3pm shift. -Staff "did use to abuse residents - pushing on the couch." -She saw a staff sit a resident down on the couch and "kind of pushed them" and "not really abusing but agressive." -Staff (no specific named staff) yelled at residents. -Staff talked aggressive and would get irritated, mostly with Resident #1 and another resident, when the residents did not do what the staff wanted done. -The staff would say "sit down, you not going back there" in an aggressive tone. Interview with Staff E on 07/20/23 at 1:11pm revealed: -She was employed in January 2023.	D 338		

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D 338	Continued From page 88 -She worked the 7am -3pm shift and sometimes 3pm to 11pm shift. -She usually worked in the SCU. -Staff could be less stern in the tone of voice used. -Sometimes is sounded like "like scolding a child". -She was not sure if facility management was aware of the tone of voice used by staff when staff talked to a resident. -She was not aware of any management addressing staff tone of voice. -She attended inservice twice since being hired when a lady came to the facility. -She did not know why she had not told management about another staff's tone of voice but had talked to another MA (name not provided) about it. Interview with the Administrator on 07/18/23 at 2:33pm revealed: -He received a telephone call from the RCD/former Executive Director (ED) on 06/23/23 reporting that the county Department of Social Services (DSS) and local sheriff department were at facility investigating abuse of another resident. -He had not received any reports of abuse from any staff or resident prior to DSS reporting on 06/23/23. Interview with the Administrator on 07/19/23 at 10:02am revealed: -He expected the former MCD/former Resident Care Director and RCD/former Executive Director (ED) to respond to inappropriate staff interactions with a resident. -He expected the former MCD and RCD to speak to staff and remove them from the situation. Interview with the Administrator on 07/21/23 at	D 338		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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4:41pm revealed:
-He was not aware of any allegation of Staff C "popping" Resident #1.
-Of all the people he had interviewed, none said they had witnessed Staff C "pop" Resident #1.
-There was a facility code of conduct which provided instructions of what was to be done in the event allegations of abuse or witnessed abuse.
-The former Resident Care Director (RCD), former Memory Care Director (MCD), or medication aides (MA) were responsible for documenting in the resident record.

Interview with the RCD/former Executive Director (ED) on 07/24/23 at 8:39am revealed:
-No one had ever reported observing Staff C pop, push, or hit Resident #1.
-She never saw Staff C be abusive in any way to a resident.
-If she saw any abuse occurring, she would take action by completing a 24-hour report, suspending the staff while investigating, and call the sheriff department.

Telephone interview with Staff C (MA/former Memory Care Director) on 07/24/23 at 10:50am revealed:
-She started working as the memory care director in February 2022 and her main focus at that time was medications.
-She was not trained for the role of memory care director.
-She had previous experience working in a SCU.
-She denied ever hitting or popping Resident #1.
-She had no knowledge of anybody popping or hitting Resident #1.
-She never saw anybody put their hands on Resident #1.
-She did not do hands on care with the residents.

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D 338	Continued From page 90 -She might help a resident to stand up or sit. -Resident #1 was a resident who required assistance with most of her personal care without incident except when she was "in a mood - screaming, shouting, smearing [feces]" and required two-person assistance. Interview with the facility's contracted primary care provider (PCP) on 07/19/23 at 6:31pm revealed: -He did not have a concern for staff being abusive on the SCU. -He thought the words they used and their approach to residents with dementia was concerning. -He thought care was completely different with dementia (SCU) than with assisted living. -There was a cognitive decline where behaviors were like a toddler, but in a full-grown adult body. -He thought staff on the SCU were possibly inappropriate and disrespectful in how they communicated to residents on the SCU. -Training for dementia care was not realistic or effective for the needs of the residents. -Staff received training for the ideal and were not prepared for the reality of caring for persons with dementia and dementia related behaviors. -Since the pandemic and the rise in staffing shortages, many staff were inexperienced in dementia care. Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable. 5. Review of Resident #2's current FL-2 dated 04/14/23 revealed diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation.	D 338		

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Review of Resident #2's current care plan dated 09/07/22 revealed:
-He had significant memory loss and was always disoriented.
-He was ambulatory.
-He was independent with toileting, ambulation, and transfers.
-He required staff supervision with eating, bathing, dressing, and grooming.
-There was a 90 day review signed by the Memory Care Director (MCD) on 12/06/22.

Interview with a medication aide (MA) on 07/24/23 at 12:36pm revealed:
-Resident #2 wandered at night and frequently went into other resident's rooms.
-Wandering into other resident's rooms sometimes led to altercations between Resident #2 and other residents.
-Resident #2 was strong and had punched her before.

Review of Resident #2's hospice nurse (HN) visit notes dated 05/21/23 through 06/14/23 revealed:
-Resident #2 was admitted to hospice on 05/21/23.
-On 05/24/23, staff reported the resident could be aggressive and uncooperative at times.
-He was ambulatory with a walker and assistance from staff.
-He had scattered bruises and scabs to both upper extremities.
-On 05/26/23, the HN documented the resident had scattered bruises on his body.
-On 06/05/23, Resident #2 did not have his walker for ambulation.
-Staff had taken his walker because he used it as a weapon at times.
-He was ambulatory with a slow shuffling gait.
-On 06/14/23, the resident had scattered bruises

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and open areas that were scabbed that had re-opened.

Telephone interview with Resident #2's family member on 07/21/23 at 12:04pm revealed:
-She was truly disturbed after seeing Resident #2 on 07/03/23.
-He looked like he had been beaten up.
-She kept feeling as if someone at the facility was hurting Resident #2.
-He has had gashes on his arm when family members visited (April - July 2023).
-The family members cleaned and wrapped the gashes.
-She knew some of the gashes were from his age and being on blood thinners, but not all of them.

Interview with a resident on the special care unit (SCU) on 07/18/23 at 10:23am revealed:
-Staff on the SCU were one way one day and another way the next day.
-One day they were happy and laughing with you, the next day they were angry and mad you.
-If the room to your door was closed, they did not come in and check on you.

Interview with a personal care aide (PCA) on 07/20/23 at 1:12pm revealed:
-There was a generally stern culture in how staff talked to residents on the SCU.
-Stern meant the tone of voice; staff spoke to residents almost like scolding a young child.
-She was not aware of management addressing how staff spoke to residents on the SCU.
-She did not think management was aware because staff changed how they spoke to residents in front of managers.
-One PCA ran the SCU like it was a prison.
-Resident #2 liked to wander around the SCU and did not like to sit down.

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D 338	Continued From page 93 -The PCA would yell at him and tell him to "sit down" in a loud, stern tone of voice while standing right next to him. -If Resident #2 did not sit down, the PCA would physically try to assist him in sitting down. -She did not report how the PCA talked to and treated residents to the Executive Director (ED) or Administrator. -She had not talked to the PCA about how she talked to and treated residents. Interview with the facility's contracted primary care provider (PCP) on 07/19/23 at 6:31pm revealed: -He did not have a concern for staff being abusive on the SCU. -He thought the wording they used and their approach to residents with dementia was concerning. -He thought care was completely different with dementia (SCU) than with assisted living. -There was a cognitive decline where behaviors were like a toddler, but in a full-grown adult body. -He thought staff on the SCU were possibly inappropriate and disrespectful in how they communicated to residents on the SCU. -Training for dementia care was not realistic or effective for the needs of the residents. -Staff received training for the ideal and were not prepared for the reality of caring for persons with dementia and dementia related behaviors. -Since the pandemic and the rise in staffing shortages, many staff were inexperienced in dementia care. Interview with the Administrator on 07/20/23 at 4:50pm revealed: -He was not previously aware that staff on the SCU spoke in raised stern voices. -He was not previously aware there were staff	D 338		

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constantly telling residents to sit down and assisting them to sit down in the common area.
-He expected all staff to treat residents with respect.
-Due to concerns brought to his attention by DSS and law enforcement when the investigation started on 06/23/23, he frequently reminded staff to talk to residents respectfully and treat them with dignity.
-Since the start of the investigation on 06/23/23, he had been present in the building daily Monday through Friday each week.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

6. Review of Resident #6's current FL-2 dated 04/13/23 revealed diagnoses included dementia, Parkinson's disease, vitamin deficiency, closed neck fracture and acute exacerbation of chronic obstructive pulmonary disease.

Review of Resident #6's death certificate revealed the resident died at 2:58pm on 05/25/23 at the facility of end stage Alzheimer's dementia.

Review of Resident #6's emergency room (ER) provider note dated 04/07/23 revealed:
-The resident was seen in the ER for decreased activity and fatigue.
-The resident's laboratory results were suggestive of mild dehydration.
-The resident was given fluid resuscitation (2 liters (L) of normal saline intravenous fluid) with significant improvement in his overall appearance.
-Diagnoses included dehydration and fatigue.

Review of Resident #6's ER provider note dated

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D 338	Continued From page 95 04/13/23 revealed: -The resident was seen for "favoring" his left leg with no known fall or injury. -The resident was typically in a wheelchair per emergency medical services (EMS). -The resident had a small abrasion over the left costal margin (lower rib cage near the sternum or center of chest) which appeared new. -The resident had multiple areas of ecchymosis (bruises) across the skin in various stages of healing likely related to multiple remote traumas. Review of Resident #6's ER Technician note dated 04/13/23 revealed the resident's level of hygiene was poor with dirty teeth and ill fitting clothes. Review of Resident #6's physician's orders dated 04/13/23 revealed: -There was an order to check oxygen saturation (O2 sat) levels daily and contact the provider for levels less than 90%. -There was an order to apply oxygen at 2L via nasal canula (NC) for shortness of breath. Review of Resident #6's most recent primary care provider (PCP) visit note dated 04/25/23 revealed: -He was being seen for his 4 month follow up on chronic conditions. -He felt well, had no complaints and a good energy level. -He was in a wheelchair at the time of the appointment. -There were no lesions, bruises, or scars on the resident's skin. -The PCP recommended follow up in 4 months. -There was no documentation acknowledging follow up after ER visits on 04/07/23 and 04/13/23.	D 338		

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D 338	Continued From page 96 Review of Resident #6's progress notes dated 04/07/23 through 05/23/23 revealed: -On 04/07/23, staff documented the resident was sent to the ER for a change in his mental status. -On 04/08/23, staff documented the resident returned with no new orders. -On 05/20/23, a medication aide (MA) documented Resident #6 fought 2 personal care aides (PCAs) to get up for breakfast. -It took 3 PCAs to get Resident #6 up for lunch because he was stiff and agitated. -On 05/21/23, the MA documented Resident #6 fought the PCA to get up (unclear if the resident did get up for breakfast). -The PCA tried again at lunch but the resident was still combative. -On 05/22/23, the former MCD documented the resident was agitated with getting up for meals and required staff assistance to eat. -Resident #6 required staff cues to complete other activities of daily living (ADLs) (unspecified) also. -The MCD contacted the PCP and and Power of Attorney (POA) for a hospice evaluation. -On 05/23/23, staff documented the resident took his medications and required staff assistance to eat lunch and dinner. -There were no entries after 05/23/23. -There was no documentation of any wounds or abrasions on Resident #6. Review of Resident #6's prescription order dated 05/22/23 revealed: -There was an order for a hospice consultation. -There was a faxed stamp indicating the order was faxed to the hospice provider. Interview with a medication aide (MA) on 07/24/23 at 12:36pm revealed:	D 338		

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-She did not remember ever seeing bruises or abrasions on Resident #6.
-He was thin, and his rib cage would stick up when he was lying flat on his back.
-She saw a wound on one of his heels 2-3 days before he died.
-Then he had the heel protector booties.
-Resident #6 did not have any other sores or wounds on his body.
-In the last few weeks of his life, Resident #6 was sore, in a lot of pain and it was hard to get him up.
-It took 2-3 staff to get him out of the bed because of his hip pain.
-He would holler whenever staff lifted his right leg.
-He was getting pain medication as needed.

Telephone interview with Resident #6's Power of Attorney (POA) on 07/24/23 at 10:40am revealed:
-She dreaded Resident #6's return to the facility after completing rehabilitation in January 2023 because she thought he would not get the care he had been getting.
-She visited at random times each week and Resident #6 was always looked unkempt and as though he had not showered for days.
-His hair was stringy, and his nails were dirty.
-She spoke with staff each time; each time the staff was different staff, and the staff were rude.
-She did not complain further because she feared retaliation towards Resident #6.
-She was afraid the staff would neglect and/or mistreat Resident #6.
-She had lunch with Resident #6 approximately 2 weeks before he died, and he was out of the bed in his wheelchair.
-He looked sick and frail 2 weeks before he died.
-Every time she visited, she struggled coming and going because she was afraid to face leaving because she did not think they would take care of

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him.
-Staff did not get him up out of bed because it was too much work.
-She thought it was too much work because he had dementia and needed staff to cue or prompt him.
-He needed staff to help him with eating, bathing, and dressing.
-He could walk with a walker and one person assisting him.
-She knew he could because she had walked with him while he used a walker, and she prompted him.
-Approximately one week before he died, the former Memory Care Director (MCD) told her the staff was unable to move him to a hospital bed.
-They were unable to move him because he had sores all over his body.
-The MCD told her the sores were bad and the MCD did not want her to look at the sores.
-She did not know how long the sores were there because no one ever reported anything to her.
-He died a slow death.
-On Monday (05/22/23) he could not open his eyes.
-On Tuesday and Wednesday (05/23/23 and 05/24/23) when she called to check on him the staff said his condition was unchanged.
-On Thursday (05/25/23) he had the death rattle when she arrived at the facility.
-Sometimes he had oxygen and sometimes he did not.
-On 05/25/23, the staff had not done anything to make him comfortable.
-A second family member had to ask for a washcloth to put on his head.
-The MCD was at the desk eating her lunch while Resident #6 died.
-A nurse arrived just before he died on 05/25/23.
-She could not remember much about the nurse

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D 338	Continued From page 99 and thought she might have been from hospice. Telephone interview with the hospice nurse (HN) on 07/25/23 at 2:01pm revealed: -Her agency had received the referral for Resident #6 on 05/22/23. -She spoke with the resident's POA on 05/23/23. -The POA requested to be present during the hospice evaluation and assessment and her earliest availability was 05/25/23. -She had never been to the facility prior to 05/25/23 and was not familiar with the staff and routine. -She was met at the door by the former Memory Care Director (MCD) who told her she was not with the hospice provider the facility normally worked with. -The MCD she was on the phone with the facility's preferred hospice provider when the resident's POA said she wanted me to see the resident. -Resident #6 was febrile and actively dying. -He had a gurgling sound when he was breathing and periods of apnea (not breathing). -There were 2 family members in the room with resident. -There was no facility staff in the room with resident. -There were no comfort measures in place for the resident such as cool cloth for the fever or oxygen to ease his breathing. -She left the room to see about getting a cool washcloth and some oxygen and found the MCD at the front desk eating her lunch. -The staff were not assistive to Resident #6; they just left the family members in the room with him. -She was returning to the room when the POA came to the doorway and said she thought he had died. -She was only with Resident #6 and the family	D 338		

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members for approximately 10 minutes before the resident died.
-The POA had provided a brief background in the few minutes before the resident died.
-He had been up in his wheelchair the week before (05/18/23) and then had a rapid decline.
-She did not know if the resident had seen his PCP for the rapid change in his condition.
-The POA was very distraught after Resident #6 died.
-She did know if treatment for his change in condition was discussed with his POA.
-She did not get a chance to perform an assessment of Resident #6 and admit him to hospice before he died.

Upon request on 07/19/23 and 07/24/23, documentation of Resident #6's O2 sat levels daily from 04/13/23 through 05/25/23 were not provided for review.

Telephone interview with Resident #6's PCP's Registered Nurse (RN) on 07/24/23 at 11:32am revealed:
-Resident #6 was last seen in the PCP's office on 04/25/23.
-There was no documentation of concerns for bruises or abrasions as documented in the ER note dated 04/13/23.
-There were no reported falls or injuries noted in the resident's chart.
-Resident #6 was not seen by the PCP between 04/25/23 and 05/25/23.
-There was a note requesting nebulizer treatments on 05/04/23 and a request for a hospice evaluation on 05/22/23.
-There was no other communication from staff.
-The PCP would have wanted to know about any changes in Resident #6's condition.

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D 338	Continued From page 101 Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed: -Resident #6 was ambulatory in 2022 then he fell and broke his hip. -He returned to the facility from skilled nursing rehabilitation and continued with physical therapy (PT). -After PT ended, he started to decline. -He had an appointment with his PCP (04/25/23) but continued to decline so she contacted the PCP requesting a hospice evaluation. -She did not have a response for who was responsible for a medical evaluation prior to determining the need for hospice. -She was not aware of any bruises or abrasion as noted on the ER note dated 04/13/23. -If staff did not report concerns to her, she did not know to follow up on it. -On the day Resident #6 died, a PCA on duty told her that he had a bad sore on his thigh. -The PCA sent a photo of the wound to her phone at approximately 6:00am on 05/25/23. -He had wounds on his right hip, both legs and his feet. -The PCA reported the wounds to the MA who said they were skin tears. -When she saw Resident #6's wounds she knew they did not just get there, they looked as if they had been there for a while (unspecified amount of time). -She did not know about them previously because she did not go behind staff and check. -Staff were expected check residents' skin when they bathed them. -Staff were supposed to fill out a shower sheet and document skin concerns like bruises, abrasions, and wounds. Upon request on 07/24/23, the photo of Resident #6's wounds was not provided for review.	D 338		

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D 338	Continued From page 102 Upon request on 07/19/23 and 07/24/23, Resident #6's shower sheets and activity of daily living (ADL) log from 04/01/23 through 05/25/23 was not provided for review. Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed: -She was not aware of the sores on Resident #6's body when he died on 05/25/23 at the facility. -The MCD only said he had a sore. -PCAs were responsible for looking for marks, bruises, abrasions, wounds on residents' skin and notifying the MA, MCD or her directly. -Residents had standing orders to apply barrier cream with each incontinence brief change. -She did not know if that had been done for Resident #6. -She did not know anything about bruises or abrasions on Resident #6. -Staff should have seen and reported to the MA, MCD or me directly. Attempted telephone interview on 07/21/23 at 11:01am with the medication aide (MA)/Staff A who documented Resident #6's progress notes dated 05/20/23 and 05/21/23 was unsuccessful. _____ The facility failed to ensure 5 residents on the special care unit (SCU) (#1, #2, #3, #10 and #23) were treated with respect and dignity and free from mental and physical abuse involving 4 staff (A, C, E, and I).The facility's failure resulted in Resident #10 being hit on the back of her head several times; and Resident #1, Resident #2, Resident #3 and Resident #23 experiencing verbal abuse including harsh and disrespectful tones of voice and scolding and condescending words for unwanted behaviors such as not sitting	D 338		

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D 338	Continued From page 103 down. The facility failed to ensure appropriate care and services for Resident #6 which resulted in neglect of identifying and reporting wounds to the primary care provider (PCP) for treatment and end of life comfort measures. The facility's failure resulted in serious physical and mental abuse for SCU residents and neglect for Resident #6 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/28/23 with revisions on 07/19/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 23, 2023.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents (#18, #19) observed during the medication pass including errors with an antidepressant (#18) and a topical cream used to treat fungal infections	D 358		

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and inflammation (#19); and for 5 of 5 residents (#2, #12, #15, #16, #17) sampled for record review including errors with a dialysis medication used to lower phosphorus levels (#15), eye drops for glaucoma and inflammation (#15), a narcotic pain reliever (#16), an antidepressant (#17), a medication to prevent heart disease (#17), medications used to lower blood pressure (#2, #12, #17), medications for sleep and/or appetite (#2, #12, #17), medications for mood disorders (#2, #12), anti-anxiety medications (#12, #17), a blood thinner (#2), diuretics for swelling (#2, #12), a thyroid medication (#2), a medication to lower cholesterol (#12), a potassium supplement (#2), a medication for mild pain or fever (#2), and vitamin supplements (#2, #12, #17).

The findings are:

1. The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication pass on 07/19/23.

a. Review of Resident #18's current FL-2 dated 05/12/23 revealed:
-Diagnoses included Alzheimer's dementia, generalized anxiety disorder, and insomnia.
-There was an order for Celexa 10mg (no amount to be administered or frequency was documented). (Celexa is an antidepressant used to treat depression and anxiety.)

Review of Resident #18's admission record report revealed the resident was admitted to the facility on 05/01/23.

Review of Resident #18's physician's order sheet dated 05/12/23 revealed an order for Celexa 10mg take 1 tablet every day.

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D 358	Continued From page 105 Observation of the 8:00am medication pass on 07/19/23 revealed: -At 7:52am, the medication aide (MA) started searching in the medication cart for Resident #18's medication. -There was an entry on the electronic medication administration record (eMAR) computer screen indicating Celexa 10mg was due to be administered at 8:00am for Resident #18. -No Celexa was administered to Resident #18. Interview with the MA on 07/19/23 at 7:52am revealed: -She reported that she could not find Celexa in the medication cart for Resident #18. -Resident #18's family usually brought medications to the facility for the resident. -She would call the resident's family "later". Review of Resident #18's July 2023 eMAR revealed: -There was an entry for Celexa 10mg 1 tablet every day scheduled at 8:00am. -Celexa 10mg was documented as not administered on 07/17/23 due to waiting on order. -Celexa 10mg was documented as administered on 07/18/23. -Celexa 10mg was documented as a missed dose on 07/19/23. Interview with the Memory Care Director (MCD)/ former Resident Care Director (RCD) on 07/19/23 at 2:09pm revealed: -Resident #18 had a supply of Celexa 20mg in the medication cart. -The MA told her that she needed an order for Resident #18's Celexa that morning on 07/19/23. -The MA did not tell her that the strength of Celexa in the medication cart did not match the strength listed on the eMAR.	D 358		

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-The MAs were supposed to notify her if the eMAR and the medication label did not match.
-Resident #18's eMAR needed to be corrected to show that the resident was receiving Celexa 20mg not 10mg.
-Resident #18 should have received Celexa 20mg that morning, 07/19/23.
-She would get a copy of the resident's current Celexa dosage faxed from the primary care provider's (PCP's) office.

Interview with a MA/ former MCD on 07/19/23 at 2:09pm revealed:
-Resident #18 had some medications with her when she was admitted to the facility in May 2023.
-There was no documentation of what medications the resident brought to the facility upon admission.

Observation of Resident #18's medications on hand on 07/19/23 at 2:09pm revealed:
-There were 90 Celexa 20mg tablets dispensed on 05/05/23 by a local retail pharmacy.
-There were 41 of 90 tablets remaining.

Review of Resident #18's physician's order dated 05/05/23 faxed from the PCP's office on 07/19/23 revealed:
-There was a prescription dated 05/05/23 for Celexa 20mg take 1 tablet every day.
-The prescription was written for 90 tablets to be dispensed.

Interview with the RCD/ former Executive Director (ED) on 07/19/23 at 3:05pm revealed:
-The MAs should check the eMAR and medication label and if they did not match, the MA should notify the MCD or RCD.
-She was not aware of the discrepancy with

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D 358	Continued From page 107 Resident #18's Celexa order. Telephone interview with a Registered Medical Assistant with Resident #18's PCP's office on 07/20/23 at 12:05pm revealed: -Resident #18 had orders for Celexa 10mg once daily in August 2022. -The order was changed on 05/05/23 to Celexa 20mg once daily. -There had been no changes in Resident #18's Celexa order since 05/05/23. -The resident should be receiving Celexa 20mg daily. -She spoke with the PCP and the PCP did not have an immediate concern one missed dose on 07/19/23. Based on observations, interviews, and record reviews, it was determined that Resident #18 was not interviewable. b. Review of Resident #19's current FL-2 dated 02/22/23 revealed diagnoses included Alzheimer's dementia, Vitamin B12 deficiency, and mixed hyperlipidemia. Review of Resident #19's primary care provider (PCP) order dated 07/12/23 revealed an order for Lotrisone cream to be applied to rash twice a day until clear. (Lotrisone cream is used treat topical fungal infections and inflammatory conditions of the skin.) Observation of the 8:00am medication pass on 07/19/23 at 7:56am revealed: -Resident #19 had a flat red rash on his stomach, back, and forearms. -The resident was scratching his arms. -The medication aide (MA) applied Lotrisone cream to the resident's back and stomach.	D 358		

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D 358	Continued From page 108 -The MA did not apply Lotrisone cream to the rash on the resident's forearms. Observation of Resident #19's medications on hand on 07/19/23 at 1:00pm revealed: -There was a 45 gram tube of Lotrisone cream dispensed on 07/13/23. -The instructions were to apply to rash twice a day until clear. Review of Resident #19's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Lotrisone cream apply to rash twice a day until clear scheduled for 8:00am and 8:00pm. -Lotrisone cream was documented as administered from 07/14/23 (8:00pm) - 07/19/23 (8:00am). Interview with the Administrator on 07/19/23 at 10:49am revealed the MA assigned to the special care unit (SCU) on 07/19/23 was no longer employed with the facility. Interview with the Memory Care Director (MCD)/ former Resident Care Director (RCD) on 07/19/23 at 12:59pm revealed: -The MAs were expected to apply the Lotrisone cream to any part of the resident's body that had the rash, including his forearms. -The resident's rash started last week and the resident had complained about the rash itching since he got the rash. Interview with Resident #19's PCP on 07/19/23 at 7:15pm revealed: -He wrote the order for Lotrisone cream to be applied to resident's rash to ensure all areas with the rash were treated with the cream in case the	D 358		

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rash spread.
-Not applying Lotrisone to all areas with the rash could cause incomplete resolution of the rash and could contribute to the resident being uncomfortable with itching.

Based on observations, interviews, and record reviews, it was determined that Resident #19 was not interviewable.

2. Review of Resident #15's current FL-2 dated 02/22/23 revealed diagnoses included chronic renal insufficiency, renal failure, dialysis, cerebrovascular accident, dementia, and hypertension.

a. Review of Resident #15's current FL-2 dated 02/22/23 revealed:
-There was an order for Sevelamer 800mg take 1 tablet 3 times a day with meals. (Sevelamer is used to lower phosphorus levels in dialysis patients.)
-There was a second order for Sevelamer 800mg take 1 tablet 3 times a day with snacks.

Review of Resident #15's dialysis provider order dated 06/16/23 revealed:
-There was an order for Sevelamer 800mg 2 tablets 3 times a day with meals.
-There was a second order for Sevelamer 800mg 1 tablet 3 times a day with snacks.

Review of Resident #15's June 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Sevelamer 800mg take 2 tablets (1600mg) 3 times a day with meals scheduled for 8:00am, 2:00pm, and 8:00pm.
-Sevelamer 1600mg was documented as administered at 2:00pm and 8:00pm (snack times

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instead of meal times) from 06/22/23 - 06/30/23.
-There was a second entry for Sevelamer 800mg 1 tablet 3 times a day with snacks scheduled for 12:00pm, 5:00pm, and 8:00pm.
-Sevelamer 800mg was documented as administered at 12:00pm and 5:00pm (meal times instead of snack times) from 06/22/23 - 06/30/23.
-Sevelamer 1600mg and 800mg (total of 2400mg) was documented as administered at 8:00pm for both entries from 06/22/23 - 06/30/23.

Review of Resident #15's July 2023 eMAR revealed:
-There was an entry for Sevelamer 800mg take 2 tablets (1600mg) 3 times a day with meals scheduled for 8:00am, 2:00pm, and 8:00pm.
-Sevelamer 1600mg was documented as administered at 2:00pm and 8:00pm (snack times instead of meal times) from 06/22/23 - 06/30/23.
-There was a second entry for Sevelamer 800mg 1 tablet 3 times a day with snacks scheduled for 12:00pm, 5:00pm, and 8:00pm.
-Sevelamer 800mg was documented as administered at 12:00pm and 5:00pm (meal times instead of snack times) from 07/01/23 - 07/21/23.
-Sevelamer 1600mg and 800mg (total of 2400mg) was documented as administered at 8:00pm for both entries from 07/01/23 - 07/21/23.

Observation of Resident #15's medications on hand on 07/20/23 at 4:14pm and 4:35pm revealed:
-There was a supply of Sevelamer dispensed on 04/04/23 from a Veteran's Administration (VA) pharmacy with instructions to take 1 tablet 6 times a day with meals and snacks.
-There was a second supply of Sevelamer dispensed on 06/26/23 from a VA pharmacy with

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D 358	Continued From page 111 instructions to take 1 tablet 6 times a day with meals and snacks. Interview with the medication aide (MA)/ former Memory Care Director (MCD) on 07/20/23 at 4:43pm revealed: -The facility's contracted pharmacy usually entered medication orders into the eMAR system and either she or the Resident Care Director (RCD) or the Executive Director (ED) reviewed and approved the orders in the eMAR system. -Resident #15's meal time Sevelamer (1600mg) should be administered at the facility meal times of 8:00am, 12:00pm, and 5:00pm. -Resident #15's snack time Sevelamer (800mg) should be administered at 10:00am, 2:00pm, and 8:00pm. -The MAs should have reported the discrepancy so the times could be adjusted in the eMAR system. -She had not noticed the discrepancies when she administered Sevelamer to Resident #15. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/21/23 at 4:30pm revealed: -The pharmacy usually entered the order for Resident #15's medications into the eMAR system for profiling purposes because most of the resident's medications were dispensed by another pharmacy. -The facility staff reviewed and acknowledged orders entered into the eMAR system and the facility staff also had access to enter orders into the eMAR system independently. -The facility staff had access to and could change the scheduled medication times in the eMAR system to coordinate with the facility's meal times and snack times.	D 358		

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D 358	Continued From page 112 Attempted telephone interview with Resident #15's VA pharmacy provider on 07/21/23 at 1:32pm was unsuccessful. Telephone interviews with the Nurse Manager at Resident #15's dialysis provider's office on 07/21/23 at 12:19pm and 07/24/23 at 12:11pm revealed: -The dialysis provider was responsible for ordering Resident #15's Sevelamer. -The dialysis provider changed the Sevelamer order in June 2023 because the resident's phosphorus level was too high at 6.4 (reference range 3.5 - 5.0). -The resident was supposed to receive Sevelamer 800mg 2 tablets 3 times a day with meals and 1 tablet 3 times a day with snacks. -The Sevelamer was used to prevent the resident's phosphorus levels from getting too high. -They checked the resident's phosphorus levels once a month. -The resident's last phosphorus level was 5.2 on 07/05/23. -If the phosphorus level was greater than 5.5, the provider would change the resident's dose of Sevelamer. -When the resident's phosphorus levels were not within the normal range, the resident could have a loss of appetite, irregular heartbeat, or general weakness. Interview with Resident #15 on 07/20/23 at 5:54pm revealed: -He had dialysis 3 times a week. -The dialysis provider ordered his Sevelamer. -Sometimes he got 2 tablets at a time and sometimes he got 1 tablet. -He received 1 tablet of Sevelamer today at supper time on 07/20/23.	D 358		

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D 358	Continued From page 113 -He was usually tired especially after dialysis. b. Review of Resident #15's current FL-2 dated 02/22/23 revealed: -There was an order for Latanoprost 0.005% instill 1 drop into each eye at bedtime. (Latanoprost is used to treat glaucoma.) -There was an order for Prednisolone 1% solution instill 1 drop into each eye twice a day. (Prednisolone eye drops are used to treat inflammatory eye conditions.) Interview with Resident #15 on 07/20/23 at 5:54pm revealed: -He had been out of his night time eye drops (referring to Latanoprost) for at least a week. -He had been out of his Prednisolone eye drops the week before. -He thought his eye drops came from a Veteran's Administration (VA) pharmacy but he was not sure. -He had eye surgery about 2 years ago and he was not currently having any symptoms with his eyes to his knowledge. -He was supposed to be getting eye drops since his surgery but the facility sometimes ran out of his eye drops. -He could not recall when he last saw his eye care provider. Review of Resident #15's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Latanoprost 0.005% eye drops instill 1 drop in each eye at bedtime scheduled for 8:00pm. -Latanoprost was documented as not administered on 05/03/23, and 05/04/23 due to waiting on pharmacy.	D 358		

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CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 114 Review of Resident #15's June 2023 eMAR revealed: -There was an entry for Latanoprost 0.005% eye drops instill 1 drop in each eye at bedtime scheduled for 8:00pm. -Latanoprost was documented as not administered on 06/09/23, 06/11/23, 06/12/23, and 06/25/23 due to waiting on refill. -There was an entry for Prednisolone 1% suspension instill 1 drop into each eye twice a day scheduled for 8:00am and 8:00pm. -Prednisolone was documented as not administered at 8:00am on 06/29/23, and at 8:00pm on 06/26/23, 06/29/23, and 06/30/23 due to waiting on refill. Review of Resident #15's July 2023 eMAR revealed: -There was an entry for Latanoprost 0.005% eye drops instill 1 drop in each eye at bedtime scheduled for 8:00pm. -Latanoprost was documented as not administered on 07/07/23, 07/10/23, and 07/13/23 due to waiting on medication. -There was an entry for Prednisolone 1% suspension instill 1 drop into each eye twice a day scheduled for 8:00am and 8:00pm. -Prednisolone was documented as not administered at 8:00am from 07/12/23 - 07/17/23, 07/20/23, and 07/21/23 due to waiting on refill. -Prednisolone was documented as not administered at 8:00pm on 07/02/23, 07/03/23, 07/05/23, 07/08/23, 07/09/23, and from 07/11/23 - 07/16/23 due to waiting on refill. Observation of Resident #15's medications on hand on 07/20/23 at 4:14pm and 4:35pm revealed: -There was a bottle of Latanoprost 0.005% eye drops dispensed by the facility's contracted	D 358		

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pharmacy on 06/09/23.
-There was a sticker on the Latanoprost label with date opened handwritten as 07/20/23.
-There was no seal on the bottle of Latanoprost and the bottle was approximately ¾ full of medication.
-There was no Prednisolone 1% suspension available for administration for the resident.

Interview with a medication aide (MA) on 07/20/23 at 5:40pm revealed:
-She thought one of Resident #15's eye drops came from the facility's contracted pharmacy and one from a VA pharmacy.
-She was not sure which eye drop came from each pharmacy.
-The resident had not been getting his eye drops (could not say how long).
-She had not followed up with the pharmacy about the resident's eye drops because she had been out on vacation.

Interview with a second MA on 07/24/23 at 1:41pm revealed:
-She was not sure why Prednisolone was sometimes documented as administered and sometimes documented as unavailable except the MAs may be clicking it on the eMAR as administered by mistake.
-She had called the facility's contracted pharmacy last week and ordered some Prednisolone, but it did not come in the pharmacy delivery tote.
-The pharmacy was supposed to send the Prednisolone with the next delivery but she asked them to send it through the back up pharmacy.
-She thought the Latanoprost usually came from a VA pharmacy but she was not sure.
-The Latanoprost was supposed to be kept in the refrigerator so if a MA did not check the refrigerator, they may have thought it was

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unavailable.
-The MAs were supposed to let the Resident Care Director (RCD) know when Resident #15's medications were getting low so they could be ordered from a VA pharmacy.

Interview with the MA/ former Memory Care Director (MCD) on 07/20/23 at 4:43pm revealed:
-Someone from the facility's contracted pharmacy had audited their medication carts earlier today and found Resident #15's Latanoprost eye drops that were dispensed on 06/09/23.
-The Latanoprost bottle had not been opened but she opened it that morning on 07/20/23 and administered it to the resident.
-When asked about Latanoprost being scheduled for administration at 8:00pm only, she stated she had not actually administered it but opened the bottle and wrote today's date as the open date.
-She could not explain why she broke the new seal on the bottle if she was not going to start administering the drops.
-She could not find any Prednisolone eye drops for Resident #15 and she was not aware he was out of the medication.
-The MAs were supposed to let her know if they were out of a medication.
-Resident #15's medications were mailed to the facility from a VA pharmacy but sometimes a medication may come from their contracted pharmacy.
-She was not sure which pharmacy dispensed Resident #15's Prednisolone eye drops.

Review of Resident #15's pharmacy dispensing records from the facility's contracted pharmacy for 04/01/23 - 07/21/23 revealed:
-There was one 2.5ml bottle (25-day supply) of Latanoprost dispensed on 05/02/23.
-There was one 2.5ml bottle (25-day supply) of

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Latanoprost dispensed on 06/09/23.
-There was one 5ml bottle (25-day supply) of Prednisolone 1% suspension dispensed on 07/20/23.

Review of the facility's contracted back up pharmacy dispensing receipts for Resident #15 revealed one 5ml bottle of Prednisolone 1% suspension was dispensed on 07/21/23.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/21/23 at 4:30pm revealed:
-The pharmacy usually entered the order for Resident #15's medications into the eMAR system for profiling purposes because most of the resident's medications were dispensed by another pharmacy.
-The pharmacy dispensed one 2.5ml bottle of Latanoprost 0.005% eye drops on 06/09/23.
-The pharmacy dispensed one bottle of Prednisolone eye drops for Resident #15 on 03/13/23.
-The pharmacy dispensed one bottle of Prednisolone eye drops on 07/20/23 but the facility staff said they were not in the delivery tote, so another bottle was dispensed on 07/21/23.

Attempted telephone interview with Resident #15's VA pharmacy provider on 07/21/23 at 1:32pm was unsuccessful.

Attempted telephone interview with Resident #15's eye care provider on 07/24/23 at 11:52am was unsuccessful.

3. Review of Resident #16's current FL-2 dated 10/05/22 revealed:
-Diagnoses included metastatic breast cancer, osteoarthritis, anxiety, depression, hypertension,

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and anemia.
-There was an order for Oxycodone 10mg 1 tablet every 6 hours prn (as needed) for pain. (Oxycodone is a controlled substance used to treat moderate to severe pain.)

Review of Resident #16's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone 10mg 1 tablet every 6 hours prn pain.
-The prn Oxycodone was documented as administered on 63 occasions from 05/01/23 - 05/31/23.
-The prn Oxycodone was documented as administered less than every 6 hours on 5 occasions.
-Oxycodone was documented as administered on 05/01/23 at 8:19am and 1:31pm, 48 minutes too soon; 05/02/23 at 8:04am and 1:07pm, 57 minutes too soon; 05/20/23 at 12:38pm and 5:35pm, 1 hour and 3 minutes too soon; 05/23/23 at 7:36am and 1:20pm, 16 minutes too soon; and 05/25/23 at 7:15am and 1:05pm, 10 minutes too soon.

Review of Resident #16's June 2023 eMAR revealed:
-There was an entry for Oxycodone 10mg 1 tablet every 6 hours prn pain.
-The prn Oxycodone was documented as administered on 37 occasions from 06/01/23 - 06/30/23.
-The prn Oxycodone was documented as administered less than every 6 hours on 4 occasions.
-Oxycodone was documented as administered on 06/07/23 at 8:32am and 2:02pm, 30 minutes too soon; 06/12/23 at 8:14am and 2:04pm, 10 minutes too soon; 06/30/23 at 8:57am and

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D 358	Continued From page 119 1:57pm, 1 hour too soon; and 06/30/23 1:57pm and 7:21pm, 36 minutes too soon. Review of Resident #16's July 2023 eMAR revealed: -There was an entry for Oxycodone 10mg 1 tablet every 6 hours prn pain. -The prn Oxycodone was documented as administered on 34 occasions from 07/01/23 - 07/19/23. -The prn Oxycodone was documented as administered less than every 6 hours on 6 occasions. -Oxycodone was documented as administered on 07/08/23 at 7:49am and 1:09pm, 40 minutes too soon; 07/13/23 at 8:32am and 1:40pm, 52 minutes too soon; 07/13/23 at 1:40pm and 7:30pm, 10 minutes too soon; 07/14/23 at 7:49am and 1:23pm, 26 minutes too soon; 07/15/23 at 2:01pm and 5:18pm, 43 minutes too soon; and 07/17/23 at 7:58am and 1:20pm, 38 minutes too soon. Interview with a medication aide (MA) on 07/24/23 at 1:41pm revealed: -Resident #16 would ask for the Oxycodone earlier than it was supposed to be administered. -The MAs were not supposed to administer it any sooner than every 6 hours. Interview with a second MA on 07/24/23 at 5:09pm revealed: -She had administered prn Oxycodone to Resident #16. -She usually checked the eMAR system before she administered it to make sure it was time for the resident to receive it again. Interview with the MA/ former Memory Care Director (MCD) on 07/20/23 at 5:51pm revealed:	D 358		

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D 358	Continued From page 120 -Resident #16's prn Oxycodone should be administered at least every 6 hours apart. -She and the current Resident Care Director (RCD) and the current MCD had just started monitoring the eMARs for accuracy. -They had not reviewed all residents eMARs yet. -She was not aware the MAs were administering Resident #16's prn Oxycodone more frequently than it was ordered. Interview with Resident #16 on 07/20/23 at 6:04pm revealed: -She had an order to receive prn Oxycodone every 6 hours. -She usually received Oxycodone about 3 times a day in the morning, around 2:00pm, and around 8:00pm. -The Oxycodone helped with her pain and she did not feel like it made her drowsy. Telephone interview with a nurse at Resident #16's oncology provider's office on 07/24/23 at 1:55pm revealed: -Resident #16's oncology provider was out of town and unavailable for interview. -Resident #16 had breast cancer that had metastasized to her bones. -The resident took Oxycodone for the pain associated with the cancer. -Due to the resident's chronic use of Oxycodone, the resident could probably tolerate it if the Oxycodone was administered too soon but there was a potential for sedation. 4. Review of Resident #17's current FL-2 dated 11/30/22 revealed diagnoses included bipolar disorder, depression, anxiety, emphysema, gastroesophageal reflux disease, and dysphagia. a. Review of Resident #17's current FL-2 dated	D 358		

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D 358	Continued From page 121 11/30/22 revealed: -There was an order for Aspirin 81mg chewable 1 tablet every day. (Aspirin is used to prevent heart disease.) -There was an order Desvenlafaxine 50mg ER 1 tablet every morning. (Desvenlafaxine is an antidepressant.) -There was an order of for Lisinopril 5mg 1 tablet every day. (Lisinopril lowers blood pressure.) -There was an order for Vitamin D3 2000 units 1 tablet every day. (Vitamin D is a supplement used to treat Vitamin D deficiency.) Interview with Resident #17 on 07/18/23 at 10:49am revealed: -She only received 2 medications during the morning medication pass instead of 6 medications. -She was told by facility staff that the other medications would not be in the facility until 07/20/23 because of the pharmacy. -She could not recall the names of the 4 medications she did not receive. Review of Resident #17's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg chewable 1 tablet every day scheduled at 8:00am. -Aspirin 81mg was documented as not administered on 07/18/23 due to "waiting". -There was an entry for Desvenlafaxine 50mg ER 1 tablet every morning scheduled at 8:00am. - Desvenlafaxine 50mg ER was documented as not administered on 07/18/23 due to "waiting". -There was an entry for Lisinopril 5mg 1 tablet every day scheduled at 8:00am. -Lisinopril 5mg was documented as not administered on 07/18/23 due to "waiting". -There was an entry for Vitamin D3 2000 units 1	D 358		

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tablet every day scheduled at 8:00am.
- Vitamin D3 2000 units was documented as not administered on 07/18/23 due to "waiting".

Review of the facility's pharmacy packing slip for delivery dated 07/17/23 revealed:
-There were 28 Aspirin 81mg tablets delivered to the facility for Resident #17.
-There were 28 Desvenlafaxine 50mg ER tablets delivered to the facility for Resident #17.
-There were 28 Lisinopril 5mg tablets delivered to the facility for Resident #17.
-There were 28 Vitamin D3 2000 units tablets delivered to the facility for Resident #17.
-There was no signature or date at the bottom of the page.

Review of the facility's pharmacy packing slip for delivery dated 07/18/23 revealed:
-There were 2 Aspirin 81mg tablets delivered to the facility for Resident #17.
-There were 2 Desvenlafaxine 50mg ER tablets delivered to the facility for Resident #17.
-There were 2 Lisinopril 5mg tablets delivered to the facility for Resident #17.
-There were 2 Vitamin D3 2000 units tablets delivered to the facility for Resident #17.
-There was no signature or date at the bottom of the page.

Observation of Resident #17's medications on hand on 07/20/23 at 4:43pm revealed:
-There was a supply of Aspirin 81mg chewable tablets dispensed on 07/20/23 with 27 of 28 tablets remaining.
-There was a supply of Desvenlafaxine 50mg ER tablets dispensed on 07/20/23 with 28 of 28 tablets remaining.
-There was a supply of Lisinopril 5mg tablets dispensed on 07/20/23 with 27 of 28 tablets

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remaining.
-There was a supply of Vitamin D3 2000 units tablets dispensed on 07/20/23 with 27 of 28 tablets remaining.

A second interview with Resident #17 on 07/20/23 at 6:02pm revealed:
-The four morning medications that she did not receive on 07/18/23 came in the next day.
-She missed one dose of each of those medications (referring to Aspirin, Desvenlafaxine, Lisinopril, and Vitamin D).

Interview with a medication aide (MA) on 07/24/23 at 1:41pm revealed:
-The pharmacy usually sent scheduled medication on a 28-day cycle fill.
-If a medication was accidentally dropped or contaminated, they would come up short before the next cycle fill started, causing missed doses at times.

Interview with the Resident Care Director (RCD)/ former Executive Director (ED) on 07/20/23 at 6:37pm revealed:
-The facility received scheduled medications on a 28-day cycle fill from the contracted pharmacy.
-The prn (as needed) medications and controlled substances had to be ordered because they were not on a cycle fill.
-The MAs were responsible for ordering medications.
-If the MAs could not get a medication from the pharmacy, they were supposed to notify the RCD, Memory Care Director (MCD), or ED.

Attempted telephone interview with Resident #17's primary care provider (PCP) on 07/24/23 at 7:10pm was unsuccessful.

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b. Review of Resident #17's current FL-2 dated 11/30/22 revealed an order for Lorazepam 0.5mg 1 tablet 3 times a day for anxiety. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #17's June 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet 3 times a day for anxiety scheduled for 8:00am, 2:00pm, and 8:00pm.
-Lorazepam 0.5mg was documented as not administered on 06/06/23 at 8:00pm due to "refill".

Review of Resident #17's controlled substance (CS) records for Lorazepam 0.5mg for June 2023 revealed:
-There was no dose of Lorazepam 0.5mg documented as administered and declined from the CS count for 06/06/23 at 8:00pm or 06/07/23 at 8:00am.
-Those 2 doses of Lorazepam were not declined from the CS count and administered as ordered.

Review of Resident #17's pharmacy dispensing records from the facility's contracted pharmacy for 04/01/23 - 07/21/23 revealed:
-There were 90 Lorazepam 0.5mg tablets dispensed on 04/21/23.
-There were 90 Lorazepam 0.5mg tablets dispensed on 05/16/23.
-There were 90 Lorazepam 0.5mg tablets dispensed on 06/17/23.
-There were 90 Lorazepam 0.5mg tablets dispensed on 07/17/23.

Observation of Resident #17's medications on hand on 07/20/23 at 4:43pm revealed there was a supply of Lorazepam 0.5mg tablets dispensed on

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D 358	Continued From page 125 06/17/23 with 20 of 30 tablets remaining. Interview with a medication aide (MA) on 07/24/23 at 1:41pm revealed: -The pharmacy usually sent scheduled medication on a 28-day cycle fill. -If a medication was accidentally dropped or contaminated, they would come up short before the next cycle fill started, causing missed doses at times. Interview with Resident #17 on 07/20/23 at 6:02pm revealed: -She was supposed to receive Lorazepam 3 times a day. -She did not recall running out of Lorazepam. Interview with the Resident Care Director (RCD)/ former Executive Director (ED) on 07/20/23 at 6:37pm revealed: -The facility received scheduled medications on a 28-day cycle fill from the contracted pharmacy. -The controlled substances had to be ordered because they were not on a cycle fill. -The RCD, Memory Care Director (MCD), and the MAs could order controlled substances. -If the MAs could not get a medication from the pharmacy, they were supposed to notify the RCD, MCD, or ED. Attempted telephone interview with Resident #17's primary care provider (PCP) on 07/24/23 at 7:10pm was unsuccessful. c. Review of Resident #17's physician's order dated 04/05/23 revealed an order for Ambien 5mg 1 tablet at bedtime. (Ambien is a controlled substance used to treat insomnia.) Review of Resident #17's May 2023 electronic	D 358		

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medication administration record (eMAR) revealed:
-There was an entry for Ambien 5mg 1 tablet at bedtime scheduled for 8:00pm.
-Ambien 5mg was documented as not administered from 05/12/23 - 05/15/23 due to waiting on refill.

Review of Resident #17's June 2023 eMAR revealed:
-There was an entry for Ambien 5mg 1 tablet at bedtime scheduled for 8:00pm.
-Ambien 5mg was documented as not administered on 06/12/23 due to "refill".

Review of Resident #17's CS records for Ambien 5mg for May 2023 and June 2023 revealed:
-There was no dose of Ambien 5mg documented as administered and declined from the CS count for 05/10/23 - 05/15/23 and for 06/12/23.
-Those 7 doses of Ambien were not declined from the CS count and administered as ordered.

Review of Resident #17's pharmacy dispensing records from the facility's contracted pharmacy for 04/01/23 - 07/21/23 revealed:
-There were 30 Ambien 5mg tablets dispensed on 04/11/23.
-There were 30 Ambien 5mg tablets dispensed on 05/15/23.
-There were 30 Ambien 5mg tablets dispensed on 06/09/23.
-There were 30 Ambien 5mg tablets dispensed on 07/09/23.

Observation of Resident #17's medications on hand on 07/20/23 at 4:43pm revealed there was a supply of Ambien 5mg tablets dispensed on 07/09/23 with 23 of 30 tablets remaining.

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Interview with a medication aide (MA) on 07/24/23 at 1:41pm revealed:
-The pharmacy usually sent scheduled medication on a 28-day cycle fill.
-If a medication was accidentally dropped or contaminated, they would come up short before the next cycle fill started, causing missed doses at times.

Interview with Resident #17 on 07/20/23 at 6:02pm revealed:
-She did not recall running out of Ambien.
-The Ambien usually helped her sleep.

Interview with the Resident Care Director (RCD)/ former Executive Director (ED) on 07/20/23 at 6:37pm revealed:
-The facility received scheduled medications on a 28-day cycle fill from the contracted pharmacy.
-The controlled substances had to be ordered because they were not on a cycle fill.
-The RCD, Memory Care Director (MCD), and the MAs could order controlled substances.
-If the MAs could not get a medication from the pharmacy, they were supposed to notify the RCD, MCD, or ED.

Attempted telephone interview with Resident #17's primary care provider (PCP) on 07/24/23 at 7:10pm was unsuccessful.

5. Review of Resident #2's current FL-2 dated 04/14/23 revealed diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation.

a. Review of Resident #2's physician's orders dated 06/28/23 revealed:
-Medication orders included: acetaminophen 650mg twice daily (pain treatment), divalproex

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D 358	Continued From page 128 250mg twice daily (mood stabilizer), Eliquis 5mg twice daily (blood thinner), levothyroxine 125mcg (thyroid hormone), melatonin 3mg at bedtime (insomnia), metoprolol 12.5mg twice daily (heart medication), potassium chloride 20mEq daily (replacement), furosemide 20mg daily (diuretic), mirtazapine 15mg at bedtime (insomnia), and prenatal vitamin daily (supplement). Observations of Resident #2's medications on hand on 07/20/23 at 4:10pm revealed: -There were bubble packs with pharmacy labels indicating the medications were dispensed on 07/20/23 for the following: acetaminophen, divalproex, Eliquis, levothyroxine, melatonin, metoprolol, furosemide, mirtazapine, and prenatal vitamin. -The medication aide (MA) checked for potassium chloride tablets. -After prompt that it was a powder, she searched through 3 medication cart drawers before finding the plastic baggie. -There was a plastic baggie with a pharmacy label indicating 28 packets of potassium chloride 20mEq was dispensed for Resident #2 on 05/25/23. -There were 13 packets of potassium chloride 20mEq remaining in the plastic baggie. Interview with a medication aide (MA) on 07/06/23 at 10:19am revealed: -She thought some of the medications were "messing" with Resident #2, although she was not a doctor and did not know for sure. -She made decisions to withhold medications after being around the resident and seeing how they were acting. -She documented on the eMAR resident was unable to take the medications when she withheld medications (05/01/23, 05/16/23, 05/17/23,	D 358		

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D 358	Continued From page 129 05/19/23, 05/26/23, 05/27/23, 05/28/23, 06/06/23, 06/08/23, 06/13/23, 06/15/23, 06/19/23, 06/21/23, 06/24/23, 06/25/23, 06/28/23, 06/29/23, 07/03/23, 07/04/23, 07/05/23, 07/10/23 and 07/11/23). -She had not called the PCP about withholding medications for Resident #2. -The PCP visited the facility every week, so she was "pretty sure" she told him she withheld medications at times. -She had not documented communication with the PCP about withholding medications in the progress notes, but it seemed like she needed to start doing this. -She did not hold medications all the time. -She did not know if that was a facility policy or not. -She was "pretty sure" she spoke with the MA (former MCD) and the RCD (former ED) about withholding medications. -The former MCD would tell her it was okay when the MA reported withholding medications. -The former MCD never told her to call the PCP. -She withheld medications when Resident #2 acted like he could not walk, was a zombie, about to fall or was asleep. Review of Resident #2's May 2023 electronic medication administration record (eMAR) revealed: -On 05/01/23 and 05/26/23 there was documentation the resident was unable to take his medications at 6:30am and 8:00am. -Medications the resident was unable to take included levothyroxine, acetaminophen, divalproex, Eliquis, metoprolol, potassium chloride, and prenatal vitamin. -On 05/03/23, 05/16/23, 05/17/23, 05/19/23, 05/26/23, 05/27/23, 05/28/23 and 05/30/23 there was documentation the resident was unable to take his 8:00pm medications.	D 358		

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D 358	Continued From page 130 -Medications the resident was unable to take included acetaminophen, divalproex, Eliquis, melatonin, metoprolol, and mirtazapine. -On 05/06/23 there was documentation the resident was unable to take his 6:30am levothyroxine. Review of Resident #2's June 2023 eMAR revealed: -On 06/08/23 there was documentation the resident was unable to take his 6:30am levothyroxine. -On 06/06/23, 06/08/23, 06/25/23, 06/28/23 and 06/29/23 there was documentation the resident was unable to take his 8:00am medications. -Medications the resident was unable to take included acetaminophen, divalproex, Eliquis, furosemide, metoprolol, potassium chloride, and prenatal vitamin. -On 06/13/23, 06/19/23, 06/21/23, 06/24/23, and 06/27/23 there was documentation the resident was unable to take his 8:00pm medications. -Medications included acetaminophen, divalproex, Eliquis, melatonin, metoprolol, and mirtazapine. -On 06/10/23 there was documentation the 8:00pm medications were on hold. -Medications included acetaminophen, divalproex, Eliquis, melatonin, metoprolol, and mirtazapine. Interview with a second MA on 07/20/23 at 1:00pm revealed: -She could not remember why she documented medications were on hold on 06/10/23. -She did not usually click hold when documenting on eMAR. -She only held medications for a short period of time for example if a resident did not take the medications and she had to go back and try	D 358		

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again.
-There was no hold order from the PCP or hospice on 06/10/23.
-She did not usually have a problem with Resident #2 taking his medications.
-She was sure he took his medications on 06/10/23.

Review of Resident #2's July 2023 eMAR revealed:
-On 07/01/23, 07/02/23, 07/03/23, and 07/04/23 there was documentation the resident was unable to take his 6:30am levothyroxine.
-On 07/03/23, 07/04/23, and 07/05/23 there was documentation the resident was unable to take his 8:00am medications.
-Medications the resident was unable to take included acetaminophen, divalproex, Eliquis, furosemide, metoprolol, potassium chloride, and prenatal vitamin.
-On 07/03/23, 07/08/23, 07/10/23, 07/11/23, and 07/15/23 there was documentation the resident was unable to take his 8:00pm medications.
-Medications the resident was unable to take included acetaminophen, divalproex, Eliquis, melatonin, metoprolol, and mirtazapine.

Review of Resident #2's progress note dated 07/08/23 revealed:
-Staff documented the resident was unable to take his 8:00pm medications.
-The event was documented and reported to the next shift.
-There was no documentation the PCP or hospice was notified.

Review of Resident #2's progress note dated 07/15/23 revealed:
-Staff documented the resident was unable to take his night medications.

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-The resident took an as needed medication (unspecified) earlier that day (07/15/23) and was too tired to get up to receive medications.

Interview with a second MA on 07/24/23 at 2:06pm revealed:
-She had administered a pain medication earlier in the day on 07/15/23 to Resident #2 per the hospice nurse's instruction.
-The resident was drowsy and unable to take his medications that night.
-She documented it in the resident's progress note.

Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed:
-Anything that she saw or that was reported to her she reported to the ED.
-Resident #2 not being able to take his medications was not reported to her.
-The MAs should have told her.

Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed:
-There should be an order to hold medications that were held; for example, hold for sedation.
-MAs were responsible for notifying the PCP if a resident was unable to take medications for reasons such as not being able to swallow.
-MAs were responsible to administer medications as ordered by the PCP and entered on the eMAR.

Telephone interview with Resident #2's hospice Director on 07/20/23 at 5:43pm revealed:
-Staff were expected to notify hospice anytime multiple doses of medications were missed.
-Hospice should have been made aware Resident #2 was unable to take medications.
-If hospice was made aware, the provider would

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have reviewed the resident's medications to see if some could have been discontinued.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

6. Review of Resident #12's current FL2 dated 05/11/23 revealed:
-Diagnoses included dementia, hypertension, and hyperlipidemia.
-Medication orders included: carvedilol 12.5mg twice daily (hypertension), vitamin D3 super strength 2000 units daily (vitamin d supplement), divalproex 125mg twice daily (mood stabilizer), hydrochlorothiazide 25mg twice daily (hypertension), lisinopril 40mg daily (hypertension), lorazepam 0.25mg twice daily hold for sedation (anti-anxiety), mirtazapine 15mg at bedtime (appetite), and pravastatin 20mg daily (cholesterol).

Interview with a medication aide (MA) on 07/06/23 at 10:19am revealed:
-Resident #12 was sometimes like a zombie or asleep, so she did not give her lorazepam and some of her other medications.
-She thought some of the medications were "messing" with the resident, although she was not a doctor and did not know for sure.
-She made decisions to withhold medications after being around the resident and seeing how they were acting.
-She documented on the eMAR resident was unable to take the medications when she withheld medications.
-She had not called the PCP about withholding medications for Resident #12.
-The PCP visited the facility every week, so she was "pretty sure" she told him she withheld

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medications at times.
-She had not documented communication with the PCP about withholding medications in the nurse's notes, but it seemed like she needed to start doing this.
-She did not hold medications all the time.
-She did not know if that was a facility policy or not.
-She was "pretty sure" she spoke with the MA (former MCD) and the RCD (former ED) about withholding medications.
-The former MCD told her it was okay when the MA reported withholding medications.
-The former MCD never told her to call the PCP.
-She withheld medications when Resident #12 acted like she could not walk, was a zombie, about to fall or was asleep.

Review of Resident #12's May 2023 electronic medication administration record (eMAR) revealed:
-On 05/24/23, 05/26/23, 05/29/23 and 05/31/23 there was documentation the resident was unable to take her medication at 8:00am.
-Medications included carvedilol, vitamin D3 super strength, hydrochlorothiazide, lisinopril, lorazepam and pravastatin.

Review of Resident #12's June 2023 electronic medication administration record (eMAR) revealed:
-On 06/08/23, 06/15/23, 06/16/23, 06/19/23, 06/22/23, 06/24/23, 06/25/23, 06/27/23, 06/29/23, and 06/30/23 there was documentation the resident was unable to take her medication at 8:00pm.
-Medications included carvedilol, divalproex, lorazepam, and mirtazapine.
-On 06/21/23, 06/24/23, 06/25/23, and 06/28/23, there was documentation the resident was unable

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to take her medication at 8:00am.
-Medications included carvedilol, vitamin D3 super strength, divalproex, hydrochlorothiazide, lisinopril, lorazepam, and pravastatin.

Review of Resident #12's July 2023 electronic medication administration record (eMAR) revealed:
-On 07/03/23 and 07/04/23 there was documentation the resident was unable to take her medication at 8:00am.
-Medications included carvedilol, vitamin D3 super strength, divalproex, hydrochlorothiazide, lisinopril, lorazepam, and pravastatin.
-On 07/03/23, 07/04/23, and 07/05/23 there was documentation the resident was unable to take her medication at 8:00pm.
-Medications included carvedilol, divalproex, lorazepam, and mirtazapine.

Review of Resident #12's physician orders revealed:
-There were no orders to hold any medications except lorazepam 0.25mg twice daily hold for sedation.
-There were no orders related to the resident being unable to take her medication.

Review of Resident #12's progress notes revealed:
-There was no supporting documentation for holding any of the resident's medications, including lorazepam, for May 2023 - July 2023.
-The was no documentation of communication with the PCP regarding the resident being unable to take her medication.

Interview with the PCP on 07/12/23 at 3:45pm and 07/19/23 at 6:30pm revealed:
-The PCP was notified of issues through fax

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D 358	Continued From page 136 communication from the facility. -Once received, he would review it, document as needed and sign the communication confirming his review and/or order. -He had no documentation concerning withholding medications from Resident #12 based on the MA's own discretion. -He would expect medications to be administered as prescribed. -Resident #12 had experienced some decline in her activities of daily living but he had seen her several times recently. -He could not attribute any medical outcomes for the resident to the MA withholding medications but would expect orders to be followed. Interview with the administrator on 07/18/23 at 2:35pm revealed: -MAs were not licensed health care providers and were expected to follow PCP orders for medication administration. -The facility's policy was that if a resident was not acting like themselves and there was a concern about administering medication, the MA should notify the resident's PCP. -The MA should document any communication with the PCP in the nurse's notes and follow all orders provided. -The MA did not notify the former MCD or the PCP of any concerns about medication administration for Resident #12. -She was taken off the medication cart for not following the systems that were in place for proper medication administration. _____ The facility failed to administer medications as ordered to 2 of 5 resident observed during the medication pass on 07/19/23 and 5 of 5 residents sampled for record review. Resident #19 was not administered a topical medication for fungal	D 358		

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D 358	Continued From page 137 infections and inflammatory skin conditions to his forearms resulting in the resident having itching and scratching his arms. Resident #15, who was on dialysis, did not receive a medication used to lower phosphorus levels as ordered putting the resident at risk of loss of appetite, irregular heartbeat, and general weakness. Resident #16 who had metastatic breast cancer was administered a prn controlled substance for pain too close together putting the resident at risk of sedation. Resident #17 missed 7 doses of a medication used to treat insomnia and 2 doses of an anti-anxiety medication due to the medications being unavailable. Resident #2 and Resident #12 had multiple medications withheld without orders in May, June, and July 2023. Medications held without orders included a blood thinner and medications for high blood pressure, mood disorders, anxiety, thyroid disease, insomnia, high cholesterol, swelling, pain, potassium supplement, and vitamins. The failure of the facility to administer medications as ordered placed the residents at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 23, 2023.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 366		

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D 366	Continued From page 138 (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed residents take their medications for 3 of 6 residents (#19, #22, #24) observed including 2 residents (#19, #22) who resided in the in the special care unit (SCU) and 1 resident (#24) who resided in the assisted living (AL) side of the facility. The findings are: Review of the facility's Medication Policy and Procedure Manual (undated) revealed staff will provide documentation on the medication administration record (MAR) after observing the residents taking the medications and before administration to another resident. 1. Review of Resident #22's current FL-2 dated 07/22/22 revealed: -Diagnoses included dementia with behavioral disturbances, insomnia, hypertension, hypothyroidism, and hyperlipidemia. -The resident was documented as constantly disoriented and had wandering behaviors. -The resident's level of care was documented as special care unit (SCU). Observation of the 8:00am medication pass in the SCU on 07/19/23 revealed:	D 366		

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D 366	Continued From page 139 -The medication aide (MA) prepared Levothyroxine 75mcg (for underactive thyroid disease); Amlodipine 5mg (for blood pressure); Donepezil 10mg (for Alzheimer's dementia); Aspirin 81mg (used to prevent heart disease); Folic Acid 1mg, Vitamin B1 100mg, and Vitamin B12 100mcg (vitamin supplements). -The MA handed a medication cup with those 7 pills to Resident #22. -Resident #22 took the cup of pills and walked away from the MA and the medication cart. -The MA did not try to stop the resident and the MA continued to face the medication cart and clicked on the electronic medication administration record (eMAR). -Resident #22 walked toward the nurse's station desk and took the 7 medications at 7:43am and threw the empty cup in the trash can behind the nurse's station. -The MA never turned around to look at the resident and did not observe the resident take the medications. -The MA then prepared one Lorazepam 0.5mg tablet (controlled substance for anxiety) and handed the medication cup to Resident #22. -Resident #22 walked toward the nurse's station desk and took the Lorazepam tablet at 7:45am and threw the empty cup in the trash can behind the nurse's station. -The MA never turned around to look at the resident and did not observe the resident take the medication. Interview with the MA on 07/19/23 at 9:31am revealed: -She did not watch all of the residents take their medications because some would take medication on their own and some would not. -Resident #22 would take her medications. -"There are certain ones you know will take their	D 366		

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medications".
-She knew who she had to watch.
-When asked about the residents in the SCU having dementia, she did not answer.

Interview with the Administrator on 07/19/23 at 9:57am revealed:
-He had training with the MAs recently and they were trained to observe residents swallow their medications.
-The MAs were supposed to take the medication cup back from the resident to make sure it was empty.
-The MA who administered medications in the SCU that morning participated in that training and knew she was supposed to observe residents take their medications.
-The MA should have observed Resident #22 take her medications.

2. Review of Resident #19's current FL-2 dated 02/22/23 revealed:
-Diagnoses included Alzheimer's dementia, mixed hyperlipidemia, and Vitamin B12 deficiency.
-The resident was documented as intermittently disoriented.
-The resident's level of care was documented as special care unit (SCU).

Observation of the 8:00am medication pass in the SCU on 07/19/23 revealed:
-The medication aide (MA) prepared Donepezil 10mg and Namenda 10mg (both for Alzheimer's dementia); Risperdal 0.5mg (an antipsychotic); Crestor 10mg (for high cholesterol); and Vitamin B12 1000mcg (vitamin supplement).
-The MA handed a medication cup with those 5 pills to Resident #19.
-Resident #19 took the cup of pills and walked away from the MA and the medication cart.

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-The MA did not try to stop the resident and the MA continued to face the medication cart and clicked on the electronic medication administration record (eMAR).
-Resident #19 took the 5 medications at 7:54am.
-The MA never turned around to look at the resident and did not observe the resident take the medications.

Interview with the MA on 07/19/23 at 9:31am revealed:
-She did not watch all of the residents take their medications because some would take medication on their own and some would not.
-"There are certain ones you know will take their medications".
-She knew who she had to watch.
-When asked about the residents in the SCU having dementia, she had no response.

Interview with the Administrator on 07/19/23 at 9:57am revealed:
-He had training with the MAs recently and they were trained to observe residents swallow their medications.
-The MAs were supposed to take the medication cup back from the resident to make sure it was empty.
-The MA who administered medications in the SCU that morning participated in that training and knew she was supposed to observe residents take their medications.
-The MA should have observed Resident #19 take his medications.

3. Review of Resident #24's current FL-2 dated 05/11/23 revealed diagnoses included aftercare following joint replacement, type 2 diabetes mellitus, chronic obstructive pulmonary disease, anxiety disorder, major depression, hypertension,

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D 366	Continued From page 142 and schizophrenia. Review of Resident #24's current physician's orders revealed: -There was a physician's order dated 05/18/23 for Aspercreme with Lidocaine (a white topical cream used to treat pain) apply a thin layer to affected area four times a day as needed. -There were physician's orders dated 05/11/23 for Diclofenac Gel 1% (used to treat pain) apply 2 grams topically to left foot three times a day. *Do not exceed 32 grams over all joints in 24 hours; Nystatin Cream 100000 (used to treat yeast/fungal infections) apply to groin/vaginal area topically twice a day for rash; Calcipotriene Cream 0.005% (used to treat psoriasis of the skin and scalp) apply to rash twice a day until gone; and Clobetasol Ointment 0.05% (a topical steroid used to treat skin inflammation) apply to affected areas of extremities twice a day as needed for rash/itching. Observations of an unattended rollator walker labeled for Resident #24 on 07/21/23 at 5:21pm revealed: -The unattended rollator walker was parked in the hallway next to the closed beauty shop door. -There was a clear graduated medication cup with a white creamy substance inside the cup that measured 5 cc's. Interview with a medication aide (MA) on 07/21/23 at 5:21pm, who was seated at the opposite end of the hall, revealed: -The MA immediately approached the rollator walker, upon request of the surveyor, and stated she did not know what was in the medication cup. -The MA identified the rollator walker as belonging to Resident #24.	D 366		

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D 366	Continued From page 143 Interview with Resident #24, with the Administrator, on 07/21/23 at 5:25pm revealed: -The rollator walker belonged to her. -The white creamy substance in the medication cup on her walker was her "pain medicine" and was given to her the morning of 07/21/23 "about 7:30". -When medication was administered, she went to the medication cart, the MA gave her medicine and she left the medication cart to go to the dining room. Observations of Resident #24's topical medications on hand on 07/21/23 at 6:00pm with the medication aide (MA) and on 07/24/23 with a second MA revealed: -There was a tube of Diclofenac Gel 1%, a clear topical gel, with instruction to apply 2 grams topically to left foot three times a day. *Do not exceed 32 grams over all joints in 24 hours. -There was a tube of Nystatin Cream 100000, a beige color cream, with instructions to apply to groin/vaginal area topically twice a day for rash; -There were three tubes (two partially used tube and one full tube) of Calcipotriene Cream 0.005%, a white cream, with instructions to apply to rash twice a day until gone; -There was a tube of and Clobetasol Ointment 0.05%, a clear gel substance, with instructions to apply to affected areas of extremities twice a day as needed for rash/itching. -There was no topical Aspercreme with Lidocaine on hand. Interview with the MA on 07/24/23 at 11:59am revealed: -She did not know anything about the topical Aspercreme. -The resident had Aspercreme Lido 4% Pads for use that were provided by the resident's family.	D 366		

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D 366	Continued From page 144 Interview with Resident #24 on 07/24/23 at 12:05pm revealed: -She did not have any creams in her room to apply. -The white cream in the medication cup observed on her rollator walker on 07/21/23 was pain medication given to her by the MA. -She did not know the name of the MA that gave her the white creamy substance in the medication cup on 07/21/23. -She usually asked the MAs for the cream used for pain. -The MAs take it out of the medication cart, put some in a cup, and give it to her. -She always applied the pain cream to her left shoulder when her shoulder started to hurt bad. -Sometimes she had to put the pain cream on her right hip. Interview with a MA on 07/24/23 at 12:14pm revealed: -She sometimes put creams in the medication cup for the resident to apply. -She thought because the resident was in assisted living, the resident could "do for themselves." -She had not seen an order for Resident #24 to self-administer medications. -She did not think there was a need for a self-administer order for a resident to apply creams but knew the MAs had to watch a resident take their pills. -She was trained to apply everything on the special care unit (SCU) but on the assisted living unit to give creams to the residents. -SCU residents "minds are not stable." -Assisted living unit residents have "stable minds." -She thought Resident #24's "mind is pretty	D 366		

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D 366	Continued From page 145 stable." Interview with the MCD/former Resident Care Director on 07/24/23 at 1:00pm revealed: -Resident #24 did not have any physician orders to self-administer topical cream medications. -The MAs were not supposed to give Resident #24 the creams to self-administer. Interview with the Administrator on 07/24/23 at 2:20pm revealed: -He expected the MAs to apply creams/ointments or observe the resident applying it if no physician orders to self-administer. -Creams and ointments should be administered just like pills if there were no physician orders to self-administer.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering	D 367		

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the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 3 of 5 sampled residents (#2, #15, #16) including inaccurate documentation for controlled substances used to treat moderate to severe pain (#2, #16) and eye drops for inflammatory eye conditions (#15).

The findings are:

1. Review of Resident #16's current FL-2 dated 10/05/22 revealed:
-Diagnoses included metastatic breast cancer, osteoarthritis, anxiety, depression, hypertension, and anemia.
-There was an order for Oxycodone 10mg 1 tablet every 6 hours prn (as needed) for pain. (Oxycodone is a controlled substance used to treat moderate to severe pain.)

Review of Resident #16's controlled substance (CS) records for Oxycodone for May 2023 revealed Oxycodone was documented as administered on 86 occasions from 05/01/23 - 05/31/23.

Review of Resident #16's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone 10mg 1 tablet every 6 hours prn pain.
-The prn Oxycodone was documented as administered on 63 occasions from 05/01/23 -

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D 367	Continued From page 147 05/31/23. -There were 23 doses of Oxycodone documented as administered on the CS record that were not documented on the May 2023 eMAR. -The eMAR did not accurately reflect the administration of Oxycodone. Review of Resident #16's CS records for Oxycodone for June 2023 revealed Oxycodone was documented as administered on 55 occasions from 06/01/23 - 06/30/23. Review of Resident #16's June 2023 eMAR revealed: -There was an entry for Oxycodone 10mg 1 tablet every 6 hours prn pain. -The prn Oxycodone was documented as administered on 37 occasions from 06/01/23 - 06/30/23. -There were 18 doses of Oxycodone documented as administered on the CS record that were not documented on the June 2023 eMAR. -The eMAR did not accurately reflect the administration of Oxycodone. Review of Resident #16's CS records for Oxycodone for July 2023 revealed: -Oxycodone was documented as administered on 24 occasions from 07/01/23 - 07/19/23. -There was no CS record for doses administered between 07/07/23 - 07/17/23. Review of Resident #16's July 2023 eMAR revealed: -There was an entry for Oxycodone 10mg 1 tablet every 6 hours prn pain. -The prn Oxycodone was documented as administered on 34 occasions from 07/01/23 - 07/19/23. -Documentation for the administration of	D 367		

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D 367	Continued From page 148 Oxycodone on the eMAR did not match the CS records. Interview with a MA on 07/24/23 at 1:41pm revealed: -The MAs were supposed to document the administration of the Oxycodone in the eMAR system and on the paper controlled substance log. -Resident #16's Oxycodone did not pop up on the eMAR since it was a prn. -The MA would have to manually click on the prn Oxycodone when the resident requested it in order to document it as administered in the eMAR system. -The MAs sometimes forgot to sign off on the eMAR or the CS log when administering controlled substances. Interview with a second MA on 07/24/23 at 5:09pm revealed: -The MAs were supposed to document the administration of the Oxycodone in the eMAR system and on the paper CS record. -There had been times when the MAs had forgotten to sign either the CS record or document on the eMAR. Interview with a medication aide (MA)/ former Memory Care Director (MCD) on 07/20/23 at 5:51pm revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS records. -She and the current RCD and the current MCD had just started monitoring the eMARs for accuracy. -They had not reviewed all residents eMARs yet. 2. Review of Resident #15's current FL-2 dated	D 367		

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D 367	Continued From page 149 02/22/23 revealed: -Diagnoses included chronic renal insufficiency, renal failure, dialysis, cerebrovascular accident, dementia, and hypertension. -There was an order for Prednisolone 1% solution instill 1 drop into each eye twice a day. (Prednisolone eye drops are used to treat inflammatory eye conditions.) Interview with Resident #15 on 07/20/23 at 5:54pm revealed: -He had been out of his eye drops for at least a week. -He thought his eye drops came from a Veteran's Administration (VA) pharmacy but he was not sure. -He had eye surgery about 2 years ago and he was not currently having any symptoms with his eyes to his knowledge. -He was supposed to be getting eye drops since his surgery but the facility sometimes ran out of his eye drops. Review of Resident #15's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisolone 1% suspension instill 1 drop into each eye twice a day scheduled for 8:00am and 8:00pm. -Prednisolone was documented as not administered at 8:00am on 06/29/23, and at 8:00pm on 06/26/23, 06/29/23, and 06/30/23 due to waiting on refill. -Prednisolone was documented as administered on all other occasions from 06/01/23 - 06/30/23. Review of Resident #15's July 2023 eMAR revealed: -There was an entry for Prednisolone 1% suspension instill 1 drop into each eye twice a day	D 367		

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scheduled for 8:00am and 8:00pm.
-Prednisolone was documented as not administered at 8:00am from 07/12/23 - 07/17/23, 07/20/23, and 07/21/23 due to waiting on refill.
-Prednisolone was documented as not administered at 8:00pm on 07/02/23, 07/03/23, 07/05/23, 07/08/23, 07/09/23, and from 07/11/23 - 07/16/23 due to waiting on refill.
-Prednisolone was documented as administered on all other occasions from 07/01/23 - 07/19/23.

Observation of Resident #15's medications on hand on 07/20/23 at 4:14pm and 4:35pm revealed there was no Prednisolone 1% suspension available for administration for the resident.

Interview with a medication aide (MA) on 07/20/23 at 5:40pm revealed:
-Resident #15 had two eye drops he was supposed to receive.
-She thought one of Resident #15's eye drops came from the facility's contracted pharmacy and one from a VA pharmacy.
-She was not sure which eye drop came from each pharmacy.
-The resident had not been getting his Prednisolone eye drops (could not say how long) because there was none on hand.
-She could not explain why the Prednisolone eye drops were documented as administered on some days when there was none available to administer.

Interview with a second MA on 07/24/23 at 1:41pm revealed:
-She was unsure how long Resident #15 had been out of Prednisolone eye drops.
-She had called the facility's contracted pharmacy last week and ordered some Prednisolone, but it

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did not come in the pharmacy delivery tote.
-She was not sure why Prednisolone was sometimes documented as administered and sometimes documented as unavailable except the MAs may be clicking it on the eMAR as administered by mistake.
-There was no Prednisolone available to administer.

Interviews with the MA/ former Memory Care Director (MCD) on 07/20/23 at 4:43pm and 5:51pm revealed:
-She could not find any Prednisolone eye drops for Resident #15 and she was not aware he was out of the medication.
-The MAs were not supposed to document a medication was administered if none was available to administer.
-She and the current RCD and the current MCD had just started monitoring the eMARs for accuracy.
-They had not reviewed all residents eMARs yet.
-She was not aware the MAs were documenting the Prednisolone was administered when none was available.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/21/23 at 4:30pm revealed:
-The pharmacy dispensed one 5ml bottle (25-day supply) of Prednisolone eye drops for Resident #15 on 03/13/23.
-The pharmacy dispensed one 5ml bottle (25-day supply) of Prednisolone eye drops on 07/20/23 but the facility staff said they were not in the delivery tote, so another bottle was dispensed on 07/21/23.

Attempted telephone interview with Resident #15's VA pharmacy provider on 07/21/23 at

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D 367	Continued From page 152 1:32pm was unsuccessful. 3. Review of Resident #2's current FL-2 dated 04/14/23 revealed diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation. Review of Resident #2's physician's order dated 07/03/23 revealed an order for tramadol 50mg every 8 hours as needed (PRN) for moderate pain. (Tramadol is a schedule IV-controlled substance used to treat pain.) Observations of Resident #2's medications on hand on 07/20/23 at 4:10pm revealed: -There was a bubble pack with a pharmacy label indicating 30 tramadol 50mg tablets were dispensed for Resident #2 on 07/04/23. -There were 21 tablets remaining in the bubble pack. Review of Resident #2's controlled drug record (CDR) dated 07/04/23 revealed: -There was a pharmacy label on the CDR with the resident's name and instructions for tramadol 50mg every 8 hours PRN for pain. -The label indicated 30 tablets were dispensed on 07/04/23. -The first entry was documented "back up" with no tablet removed and 30 tablets remaining. -A total of 9 tablets were documented as removed on the following dates: 07/05/23 at 8:00am, 07/06/23 at 8:00am, 07/08/23 at 8:00am, 07/09/23 at 8:00am, 07/10/23 at 8:00am, 07/11/23 at 1:10am, 07/13/23 at 12:00pm, 07/15/23 at 10:00pm and 07/18/23 at 2:00am. -The CDR had documentation there were 21 tablets remaining. Review of Resident #2's July electronic	D 367		

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D 367	Continued From page 153 medication administration record (eMAR) revealed: -The was an entry for tramadol 50mg every 8 hours PRN for pain. -There was documentation tramadol 50mg was administered on 07/11/23 at 1:10am, 07/13/23 at 12:41pm, 07/15/23 at 10:36am and 07/19/23 at 2:04am. -There was no documentation tramadol 50mg was administered on 07/05/23, 07/06/23, 07/08/23, 07/09/23 and 07/10/23 on Resident #2's eMAR as documented on the CDR. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 3 residents (#16) sampled with orders for a controlled substance used to treat moderate to severe pain. The findings are:	D 392		

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D 392	Continued From page 154 Review of Resident #16's current FL-2 dated 10/05/22 revealed: -Diagnoses included metastatic breast cancer, osteoarthritis, anxiety, depression, hypertension, and anemia. -There was an order for Oxycodone 10mg 1 tablet every 6 hours prn (as needed) for pain. (Oxycodone is a controlled substance used to treat moderate to severe pain.) Review of Resident #16's pharmacy dispensing records for Oxycodone for June 2023 - July 2023 revealed: -There were 30 Oxycodone 10mg tablets dispensed on 06/02/23. -There were 30 Oxycodone 10mg tablets dispensed on 06/10/23. -There were 30 Oxycodone 10mg tablets dispensed on 06/25/23. -There were 30 Oxycodone 10mg tablets dispensed on 07/06/23. -There were 30 Oxycodone 10mg tablets dispensed on 07/17/23. Review of Resident #16's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone 10mg 1 tablet every 6 hours prn pain. -The prn Oxycodone was documented as administered on 37 occasions from 06/01/23 - 06/30/23. Review of Resident #16's controlled substance (CS) records for Oxycodone for June 2023 revealed Oxycodone was documented as administered on 55 occasions from 06/01/23 - 06/30/23. Review of Resident #16's July 2023 eMAR	D 392		

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revealed:
-There was an entry for Oxycodone 10mg 1 tablet every 6 hours prn pain.
-The prn Oxycodone was documented as administered on 34 occasions from 07/01/23 - 07/19/23.

Review of Resident #16's CS records for Oxycodone for July 2023 revealed:
-Oxycodone was documented as administered on 24 occasions from 07/01/23 - 07/19/23.
-There was no CS record for doses administered between 07/07/23 - 07/17/23.
-The missing CS record was for 30 Oxycodone tablets dispensed on 07/06/23.

Review of Resident #16's July eMAR and CS record for Oxycodone revealed:
-The CS record for 30 Oxycodone tablets dispensed on 07/06/23 was not available for review.
-There were 22 doses of Oxycodone documented as administered during the time period that supply of Oxycodone would have been used.
-There were 8 of 30 doses not documented as administered on the eMAR and there was no CS record to accurately account for those tablets.

Interview with a medication aide (MA)/ former Memory Care Director (MCD) on 07/20/23 at 5:51pm revealed:
-Resident #16's prn Oxycodone should be administered at least every 6 hours apart.
-She and the current RCD and the current MCD had just started monitoring the eMARs for accuracy.
-They had not reviewed all residents eMARs yet.

Interview with a MA on 07/24/23 at 1:41pm revealed:

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D 392	Continued From page 156 -The MAs were supposed to document the administration of the Oxycodone in the eMAR system and on the paper controlled substance log. -The MAs sometimes forgot to sign off on the CS log when administering controlled substances. -She was not aware of any missing controlled substances. Interview with a second MA on 07/24/23 at 5:09pm revealed: -The MAs were supposed to document the administration of the Oxycodone in the eMAR system and on the paper CS record. -There had been time when the CS record did not match the amount of Oxycodone on hand because the MAs had forgotten to sign either the CS record or document on the eMAR. -She was not aware of any missing controlled substances or CS records. Interview with the MCD/ former Resident Care Director (RCD) on 07/24/23 at 12:45pm revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the CS records. -There was currently no system to check the CS records other than the MAs did shift counts of the controlled substances at change of shift. -There had been no missing controlled substances to her knowledge. Interview with the RCD/ former Executive Director (ED) on 07/24/23 at 6:30pm revealed: -There should be a CS record for Resident #16's Oxycodone dispensed on 07/06/23. -She had been unable to locate the missing CS record.	D 392		

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D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 24 Hour Initial and 5 Day Investigative reports were completed for injuries of unknown origins for 4 special care unit (SCU) residents (#2, #3, #6 and #12); and a 24 Hour Initial report was submitted within 24 hours of becoming aware of a staff (I) hitting a resident (#10) on the back of the head several times. The findings are: Review of the facility's undated abuse policy and procedure revealed: -When an incident or suspected incident of resident abuse, neglect, misappropriation of resident property or injury of an unknown source is reported, the Resident Care Director/Designee will begin an investigation. -The investigation shall consist of: (1) a review of the initial report, (2) an interview with the person reporting the incident, (3) interviews with witnesses, (4) interview with the resident, (5) review of the medical record, (6) interview with staff members having contact with the resident during the period of the alleged incident, (7) a review of the alleged perpetrator's file for past	D 438		

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history of allegations and (8) a review of all circumstances surrounding the incident.
-The Administrator/Designee will follow all regulatory requirements for reporting to the appropriate agencies to include the Health Care Personnel Registry. A 24-hour initial report is made to the Health Care Personnel Registry and a completed investigation report is submitted within 5 days of the initial report.

1. Review of Resident #12's current FL2 dated 05/11/23 revealed:
-The resident's diagnoses included dementia, hypertension, and hyperlipidemia.
-The resident was constantly disorientated and semi-ambulatory.
-Her level of care was special care unit.

Review of progress notes for Resident #12 dated 06/27/23 revealed:
-The resident's family member notified the medication aide (MA) (former Memory Care Director) of a mark on the resident's face and head.
-The MA (former MCD) informed resident's family member the primary care provider (PCP) would be in the building the next day and would see the resident.
-The resident's family member was okay with that, and facility would continue to monitor the resident.

Review of an Incident/Accident Report for Resident #12 dated 06/27/23 revealed:
-The MA (former MCD) noticed a small bump on resident's head and mark on her left eye at 1:30pm.
-The responsible party was notified on 06/27/23.
-The PCP was notified and saw the resident on 06/28/23.

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D 438	Continued From page 159 Review of PCP notes for Resident #12 dated 06/28/23 revealed: -Staff reported a small bruise noted on resident's forehead of unknown origin. -Staff reported no witnessed falls or injury. -The resident was unable to provide any meaningful information due to dementia. -Follow up instructions included continue current medications and keep follow-up appointment with PCP. Interview with a law enforcement officer on 07/19/23 at 1:15pm revealed: -She was at the facility on 06/30/28 after receiving an adult protective services (APS) referral from the department of social services (DSS). -She noticed a knot on Resident #12's forehead and a black eye. -The officer contacted the responsible party (RP), who expressed concern about potential neglect based on the resident's injuries and the condition of her toenails, which prompted LE to contact 911 and have resident taken to the emergency department (ED) for re-evaluation. Review of the ED After Visit Summary for Resident #12 dated 06/30/23 revealed: -Resident was seen for re-evaluation of a medical problem. -There was concern resident had a hematoma on the left side of her head, and she had a small bump on her left temple. -Facility staff did not think she fell. -Resident presented with a swollen area on her scalp as well as bruising around her left eye. -A family member accompanied her and said she noticed the bruising 3 days ago. -The family member was unsure how it got there. -The family member also noticed a bump on the	D 438		

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left of the resident's head she never saw before and was unsure if the bruising and bump were related.
-Imaging test results showed no acute facial fracture detected, and left preseptal periorbital and left lateral frontal scalp small soft tissue hematoma.
-The final impressions were facial contusion, initial encounter, and epidermal inclusion cyst (small abnormal growth in the top layers of the skin, no infection).
-The emergency department recommended follow up with resident's PCP as needed.

Interview with Resident #12's PCP on 07/19/23 at 6:30pm revealed:
-The PCP evaluated the resident on 06/28/23 for a knot on her forehead and bruising.
-The knot looked like a hematoma but had since resolved.
-The bruising looked old with some discoloration.
-He saw no skin lacerations and no emergent need that required an emergency room visit.

Interview with Resident #12's Responsible Party (RP) on 07/05/23 at 1:17pm revealed:
-She was a guardianship social worker (SW) with DSS who served as the resident's legal guardian.
-She last saw the resident on 05/16/23 at the facility.
-She was aware the resident LE called to have the resident transported to the ED on 06/30/23 due to a knot on her head and mark on her eye reported by the facility on 06/27/23.
-She was concerned there was no known cause for the injuries.

Interview with a medication aide (MA) on 07/05/23 at 11:32am revealed:
-In the event of a fall, MAs were responsible for

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completing incident reports, leaving them in the Executive Director's (ED) office or under the door, and contacting the PCP and RP.
-The MA was not aware of Resident #12 having a fall.
-She first became aware of the knot and bruise on the resident's face/head on 06/27/23 when the family member asked her about it.
-The facility policy was to automatically send a resident to the ED for evaluation if they hit their head.
-She informed the former MCD of the family member's concerns.
-The MA (former MCD) handled the situation from there.

Interview with MA (former MCD) on 07/24/23 at 4:00pm revealed:
-Resident #12's family member was talking with a personal care aide (PCA) about the resident's eye.
-She was informed by the PCA that Resident #12 had a knot and swollen left eye.
-She informed resident's family member the PCP would be at the facility the next day, 06/28/23, and would see the resident.
-She was unaware of how the resident sustained the injury.
-She was not aware of the resident having a fall, but the resident could have picked herself up from a fall.
-She completed an incident report but did not send Resident #12 to the ED for evaluation despite the facility's policy was to send a resident to the ED for evaluation if they hit their head.
-The resident did not complain of pain and the PCP was coming to the building the next day.
-The PCP had no concerns when he saw her on 06/28/23 and there were no signs of a fall.
-An incident report was completed noting a bump

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on the forehead and a mark on resident's eye.
-No staff person was aware of Resident #12 having a fall or any other incident to account for the injury.
-The MAs were primarily responsible for completing incident reports, but the Resident Care Director (RCD) and the MCD could also complete the reports.
-The incident reports were given to the Executive Director (ED) who was responsible for sending them to DSS if it was a reportable incident that required a resident to be sent out for medical care.
-She was not responsible for reporting to the HCPR.
-HCPR reporting was the responsibility of the ED.

Interview with Resident Care Director (former Executive Director) on 07/05/23 at 11:43am revealed:
-The MA (former MCD) notified her on 06/28/23 that Resident #12 had a small bump on her eye, the eye was swollen, and the resident had a "goose egg" on her head.
-The MA (former MCD) called Resident #12's PCP who said he would see her on 06/28/23.
-The facility's policy was to send residents with an injury to their head out for evaluation immediately.
-Resident #12 should have been sent to the ED for evaluation immediately since it was an unknown injury to her head as evidenced by the swollen and bruised eye and knot on her forehead.
-The resident was seen by the PCP on 06/28/23 with no new orders.
-On 06/30/23, LE called 911 to have the resident transported to the ED for re-evaluation after seeing the knot on her head and mark on her eye, even though she was already seen by the PCP on 06/28/23.

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-The Emergency Department After Visit Summary noted resident had a facial contusion and a cyst, not a fall.
-She also spoke with the ED charge nurse about the contusion who stated it could have been caused by the cyst.
-The RCD (former ED) did not have the name of the nurse with whom she spoke.
-An incident report was completed noting a bump on the forehead and a mark on resident's eye.
-Staff was asked about the injury and no one knew how resident sustained the injuries.
-No staff person was aware of Resident #12 having a fall or any other incident to cause the injury.
-The resident was able to get herself out of bed.
-Although the resident's injuries were first noticed on 06/27/23, she had not completed a 24-hour report to HCPR as of 06/30/23 when DSS initiated a complaint investigation because she got sidetracked with other things she had to handle.

Review of an Initial Allegation Report dated 07/10/23 revealed the current Administrator completed the initial 24-hour report to HCPR for Resident #12's injury of unknown origin on 07/10/23.

2. Review of Resident #10's current FL2 dated 06/14/23 revealed:
-Diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus, and hyperglycemia.
-The resident was semi-ambulatory.
-She was constantly disoriented.
-She was special care unit level of care.

Review of Resident #10's care plan dated 03/28/23 revealed:

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CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

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D 438	Continued From page 164 -Resident had significant memory loss and must be directed. -Resident used a wheelchair and required extensive assistance with ambulation. -Resident was totally dependent on assistance for all other activities of daily living including eating, toileting, bathing, dressing, grooming /personal hygiene and transferring. Review of hospice documentation for Resident #10 revealed resident was enrolled with Hospice effective 04/04/23 based on diagnosis of Alzheimer's disease and late onset dementia. Interview with a Medication Aide (MA)/former Memory Care Director (MCD) on 06/23/23 at 12:20pm revealed: -On 06/20/23, Staff I (a personal care aide) was pushing Resident #10 in her wheelchair when the resident tried to stop the wheelchair with her feet. -Staff I "hit" the resident in the head with her hand. -A medication aide (MA) who observed the incident reported it to the former MCD the next day. -The MA (former MCD) reported the information to the Resident Care Director (RCD)/former Executive Director (ED) the same day so they could review the facility camera footage. -The MA (former MCD) and the RCC (former ED) saw that Resident #10 was trying to stop the wheelchair with her feet, Staff I pushed the resident in the back of her head causing her head to fall forward. -The resident lifted her arms, and Staff I pushed her in the back of her head again. -The RCD (former ED) stated Staff I was going to be terminated. Interview with the RCD (former ED) on 06/28/23	D 438		

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D 438	Continued From page 165 at 12:18pm revealed: -The MA (former MCD) came to her at 5:30pm on 06/21/23 to inform her that Staff I "hit" Resident #10 on 06/20/23. -She looked at the camera on 06/21/23, the same day it was reported to her. -The camera footage showed a MA (who reported the incident) exiting the special care unit as Staff I was talking to Resident #10 while pushing her in her wheelchair toward her room. -Staff I pushed Resident #10 on the back of her head and the resident's head fell forward due to the push. -She went to check on the resident and saw no signs of injury. -Staff I was not at work on 06/21/23. -She planned to terminate Staff I the next day but wanted to hear her side of the story. -She left Staff I a phone message on 06/21/23 and did not receive a return call. -Staff I never returned to work on 6/22/23 and was immediately terminated. -She had no further contact with any facility residents after leaving work on 06/20/23 at 3:13pm. -Although she learned of the abuse allegations against Resident #10 on 06/21/23, she had not completed the 24-hour report to HCPR prior to DSS's visit on 06/23/23 because she got sidetracked with other things she had to handle. -The 24-hour report was submitted to HCPR on 06/28/23 after DSS provided receiving technical assistance because of problems with the fax submission. Interview with law enforcement (LE) on 07/19/23 at 1:15pm revealed: -LE learned of the allegations of abuse of Resident #10 by Staff I during a facility visit on 06/23/23 for an unrelated APS referral received	D 438		

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from the department of social services (DSS).
-She had an open investigation regarding the resident being pushed in the back of the head by Staff I.
-Upon completion of her investigation, Staff I was charged with a misdemeanor for assault on a handicapped person.

Interview with Staff I on 07/20/23 at 12:40pm revealed:
-Staff I denied pushing Resident #10 in the back of her head.
-She never returned to work after learning she was going to be fired.
-Staff I obtained a new job in another adult care facility.

3. Review of Resident #3's current FL-2 dated 04/21/23 revealed:
-Diagnoses included dementia with behavioral disturbance, dysphagia, vitamin deficiency, metabolic encephalopathy, and pneumonia.
-The resident was documented as constantly disoriented.
-The resident was documented as having wandering behaviors.
-The resident was ambulatory and required assistance with dressing.

Review of Resident #3's admission record form revealed the resident was admitted to the facility into the special care unit (SCU) on 02/10/22.

Review of Resident #3's handwritten hospice provider note dated 04/10/23 revealed:
-Resident #3 was seen by the hospice registered nurse (RN).
-The resident was asleep in a chair in the common area.
-The resident had old bruises to bilateral

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shoulders and arms.
-There were no open areas to the skin.
-The resident had no falls.
-The resident did not appear to be in any pain.
-The hospice RN reminded facility staff to call with any changes, concerns, or falls.

Review of Resident #3's hospice plan of care report dated 05/08/23 revealed:
-The resident has had some bruising noted to the tops of both shoulders and bilateral arms in various stages of healing.
-The facility staff reported they did not know where the bruises could have come from.
-The facility staff reported no falls.

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

Telephone interview with the Hospice Director for Resident #3's hospice provider agency on 07/24/23 at 2:07pm revealed:
-The hospice RN who wrote visit notes dated 04/10/23 and 05/08/23 for Resident #3 no longer worked with their agency.
-The hospice RNs usually reviewed information about each hospice resident with facility staff during their on-site visits to the facility.

Interview with the Administrator on 07/24/23 at 11:02am revealed:
-He was not aware of Resident #3 having any injuries of unknown origin in April or May 2023 as documented by the hospice RN.
-The Resident Care Director (RCD)/ former Executive Director (ED) would have been responsible at that time for reporting Resident #3's injuries of unknown origin to the Health Care Personnel Registry (HCPR).

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D 438	Continued From page 168 Interview with the RCD/ former ED on 07/24/23 at 11:15am revealed: -She was not aware of any documentation of Resident #3 having bruises of unknown origin in April or May 2023. -The personal care aides (PCAs) or medication aides (MAs) should have reported Resident #3's bruises to the RCD or the Memory Care Director (MCD) at that time. -The RCD or MCD should have reported Resident #3's injuries of unknown origin to her because she was the ED at that time. -She was the ED in April and May 2023 but she did not report Resident #3's injuries of unknown origin to the HCPR or investigate the injuries because she was not aware of the bruising. Interview with the MCD/ former RCD on 07/24/23 at 12:45pm revealed: -She was not the MCD in April or May 2023 so she was not aware of Resident #3's bruising on her shoulders and arms. -She usually reviewed hospice notes and notified the ED of any concerns. Telephone interview with a MA/ former MCD on 07/24/23 at 3:53pm revealed: -She was the MCD in April and May 2023. -She was never aware of any bruising on the top of Resident #3's shoulders or arms. -She had not seen Resident #3's hospice notes with documentation of bruising. -She did not review hospice notes; whoever received the hospice notes from the hospice provider reviewed them to her knowledge. -If she had known about any bruises, she would have contacted hospice and notified the ED. 4. Review of Resident #2's current FL-2 dated	D 438		

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D 438	Continued From page 169 04/14/23 revealed diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation. a. Review of Resident #2's progress note dated 04/26/23 revealed: -The resident was sent to the emergency room (ER) for limping, swelling and a bruise on his right upper leg. -The entry prior to 04/26/23 was dated 03/19/23. -There was no documentation how the resident sustained the bruise on his right upper leg. Review of Resident #2's incident/accident report dated 04/26/23 revealed: -At 1:00pm staff noticed the resident was limping. -There was a bruise and swelling on his right upper leg. -The resident's primary care provider (PCP) and responsible party were notified. Review of Resident #2's emergency medical services (EMS) report dated 04/26/23 revealed: -Resident #2 was sitting in the day room with other residents and staff when EMS arrived at 1:05pm. -The resident was not oriented. -Staff said they noticed bruising and swelling on the resident's right leg today (04/26/23). -Staff said today (04/26/23) was the first time they noticed it. -Staff said there was no one working on that day (04/26/23) who knew anything about Resident #2. -Staff said they did not know if he fell or how the bruise got there. -Resident #2's right leg was bruised from his shin to his thigh. -Some of the bruising was a few days old. -The resident was able to stand and ambulate with little assistance.	D 438		

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D 438	Continued From page 170 Review of Resident #2's ER discharge instructions dated 04/26/23 revealed: -The resident was seen for bleeding and bruising and diagnosed with a right leg hematoma, generalized weakness and a closed nondisplaced avulsion fracture of his right ischium (pelvis). -Laboratory blood tests and x-rays of his femur and pelvis were done. Interview with a medication aide (MA) on 07/24/23 at 12:36pm revealed: -She did not remember what happened around 04/26/23; she remembered seeing the large bruise on the outside of Resident #2's right thigh. -The bruise went from his hip down to his knee. -She did not know how he got the bruise on his right leg. -She did not remember how she found out about the bruise. -Staff normally communicated resident updates like monitoring needs, falls, injuries and change of condition verbally when the shift changed. -MAs used to document events but documentation had fallen through the cracks for some time. -Communicating verbally did not always cover everything because if something happened early in the shift staff might forget to mention it. -Normally, MAs were responsible for checking with the staff when an injury was found to find out what happened. -She also checked the resident's progress notes. -If there was no note, she faxed a notification to the PCP and notified the Memory Care Director (MCD) or Resident Care Director (RCD). Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed: -She did not know how Resident #2 sustained a	D 438		

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pelvic fracture on 04/26/23.
-She only found out about the bruise after the fact.
-She did not investigate what caused the bruise on Resident #2's right thigh.
-The Executive Director (ED) was responsible for completing 24 hour initial and 5 day investigation reports.

Telephone interview with Resident #2's family member on 07/21/23 at 12:04pm revealed she did not know what happened on 04/26/23.

Interview with the RCD (former ED) on 07/24/23 at 4:33pm revealed:
-She was only recently made aware of Resident #2 having had a pelvic fracture on 04/26/23.
-She was aware of the bruise on his right leg at the time (04/26/23) but did not know it was from a pelvic fracture.
-She did not have a response to the EMS note dated 04/26/23, of staff not knowing Resident #2's history, how he sustained the bruise on his right thigh or how long the bruise had been there.
-She might have asked staff about the bruise, but she did not investigate or complete and submit 24 hour initial and 5 day investigation reports.
-She was responsible for completing all 24 hour initial and 5 day investigation reports prior to 07/14/23.

b. Review of Resident #2's progress notes dated 07/01/23 through 07/08/23 revealed:
-On 07/01/23 staff documented the resident had an unwitnessed fall and had a blue and purple lump on his head.
-Hospice was contacted.
-There was no documentation from staff after the entry on 07/01/23 until 07/08/23.
-There was no documentation of pain or swelling

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of the resident's right arm and right hand.

Review of Resident #2's hospice nurse (HN) visit notes dated 07/01/23 to 07/09/23 revealed:
-On 07/01/23 there was documentation the resident had an unwitnessed fall and sustained a bruise and bump on his forehead above the left eye.
-On 07/03/23 there was documentation the resident had an unwitnessed fall on 07/01/23 and had dark bruises around both eyes, the bridge of his nose and his left forehead and a bump above his left eye.
-Resident #2's right arm was swollen, and he was guarding that arm.

Telephone interview with Resident #2's family member on 07/21/23 at 12:04pm revealed:
-She saw that his right hand was swollen when she was visiting on 07/03/23.
-She spoke with the HN while she was at the facility and x-ray was ordered.
-The resident's right hand was painful to touch on 07/03/23 and was still swollen.

Interview with a medication aide (MA) on 07/24/23 at 12:36pm revealed she did not know of any injury to Resident #2's right hand.

Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed:
-The Hospice provider came to see Resident #2 a few days later when his hand was swollen (07/03/23).
-An x-ray was ordered for his right hand which was negative for a fracture.
-Resident #2's right arm was not bruised; it was just swollen.
-The facility's policy was for staff to check the

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resident each shift for pain, injury, and changes in condition for 72 hours after a fall.
-The MA was responsible for documenting a monitoring note in the resident's progress notes every shift for 72 hours after a fall.
-She did not investigate the cause of his right arm and right hand swelling and pain on 07/03/23 because the resident fell on 07/01/23.
-She did not investigate or complete and submit 24 hour initial and 5 day investigation reports for Resident #2's right arm and hand.
-She was responsible for completing all 24 hour initial and 5 day investigation reports prior to 07/14/23.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

5. Review of Resident #6's current FL-2 dated 04/13/23 revealed diagnoses included dementia, Parkinson's disease, vitamin deficiency, closed neck fracture and acute exacerbation of chronic obstructive pulmonary disease.

Review of Resident #6's death certificate revealed the resident died at 2:58pm on 05/25/23 at the facility of end stage Alzheimer's dementia.

Review of Resident #6's progress notes dated 04/07/23 through 05/04/23 revealed:
-There was an entry on 04/07/23 that the resident was sent to the hospital for a change in mental status.
-The next entry was dated 04/08/23 that the resident returned.
-The next entry was dated 05/04/23.
-There was no documentation of Resident #6 being sent to the emergency room (ER) on 04/13/23.

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D 438	Continued From page 174 Review of Resident #6's ER provider note dated 04/13/23 revealed: -The resident was seen for "favoring" his left leg with no known fall or injury. -The resident was typically in a wheelchair per emergency medical services (EMS). -The resident had a small abrasion over the left costal margin (lower rib cage near the sternum or center of chest) which appeared new. -The resident had multiple areas of bruises across the skin in various stages of healing likely related to multiple remote traumas. Review of Resident #6's most recent primary care provider (PCP) visit note dated 04/25/23 revealed: -He was being seen for his 4 month follow on chronic conditions. -There were no lesions, bruises, or scars on the resident's skin. -The PCP recommended follow up in 4 months. -There was no documentation acknowledging follow up after ER visits on 04/07/23 and 04/13/23. Telephone interview with Resident #6's PCP's Registered Nurse (RN) on 07/24/23 at 11:32am revealed: -Resident #6 was last seen in the PCP's office on 04/25/23. -There was no documentation of concerns for bruises or abrasions as documented in the ER note dated 04/13/23. -There were no reported falls or injuries noted in the resident's chart. Telephone interview with a medication aide (MA) (former Memory Care Director) on 07/24/23 at 3:53pm revealed:	D 438		

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D 438	Continued From page 175 -She was not aware of any bruises or abrasion as noted on the ER note dated 04/13/23. -If staff did not report concerns to her, she did not know to follow up on it. -She did not go behind staff and check. -Staff were expected check residents' skin when they bathed them. -Staff were supposed to fill out a shower sheet and document skin concerns like bruises, abrasions, and wounds. Interview with the Resident Care Director (RCD) (former Executive Director) on 07/24/23 at 4:33pm revealed: -PCAs were responsible for looking for marks, bruises, abrasions, wounds on residents' skin and notifying the MA, MCD or me directly. -She did not know anything about bruises or abrasions on Resident #6 to investigate. -Staff should have seen and reported to the MA, MCD or me directly. -She was responsible for completing 24 hour initial and 5 day investigation reports. _____ Interview with RCD (former ED) on 06/23/23 at 1:33pm revealed: -The RCD (former ED) was responsible for ensuring the HCPR investigations were completed and preparing and sending the HCPR 24-Hour Initial and 5 Working Day Reports. -The RCD (former ED) planned to complete and send the HCPR 24-Hour Initial Reports for Staff I and J on 06/23/23 but had not done so prior to the Department of Social Services' Adult Home Specialist initiating a complaint investigation on 06/23/23. Interview with the current Administrator on 07/18/23 at 2:35pm revealed:	D 438		

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CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 438	Continued From page 176 -The RCD (former ED) was responsible for investigating injuries of unknown origin and submitting the reports to the HCPR. -The HCPR reporting was delayed. -A 24-hour initial report should have been submitted to HCPR followed by a completed investigation report within 5 days of the initial report, in accordance with facility policy. _____ The facility failed to ensure 24 Hour Initial and 5 Day Investigative reports were completed for injuries of unknown origins for 4 special care unit (SCU) residents (#2, #3, #6 and #12); and 1 staff (I) for assaulting a resident (#10). The facility's failure resulted in delayed reporting and investigation of potential cause and prevention of further injuries including pelvic fractures (#2), top of shoulder bruises (#3), head contusions (#12), rib cage abrasions and scattered bruising (#6); and delayed protection and prevention of abuse and neglect by staff in care facilities. The facility's failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/28/23 with revisions on 06/30/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 23, 2023.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 451	Continued From page 177 incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the county Department of Social Services (DSS) of accidents or incidents resulting in injuries to 2 of 5 residents sampled (#1, #2) that required emergency medical treatment at a local hospital, including head injury and facial laceration (#2) and (#1). The findings are: Review of the facility's Accidents and Incidents Policy revealed: -All accidents and incidents shall immediately be reported to the Resident Care Director (RCD)/designee. -The RCD/designee shall insure proper referral and follow up for all incidents and accidents. This shall include notification of the physician, mental health provider and making necessary emergency management calls. -The RCD/designee shall ensure that proper documentation and notification is completed. -The RCD/designee shall notify the residents responsible party immediately for accidents/incidents that require emergency management calls. -Incidents that require more than first aid treatment shall be faxed to the county department of social services with 48 hours of the incidents. -When there has been an allegation of abuse, neglect, exploitation or an injury of unknown origin the Administrator/designee shall notify Health Care Personnel Registry (HCPR) within 24	D 451		

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D 451	Continued From page 178	D 451		

hours and complete and submit a five-day investigation summary to HCPR.
-All abuse shall immediately be reported to the county Department of Social Services and the police.
-Staff shall be trained on the policy of accident and incident upon hire and annually.

1. Review of Resident #1's current FL-2 dated 03/16/23 revealed:
-Diagnoses included dementia with behavioral issues and schizophrenia.
-The admission date for Resident #1 was documented as 08/30/13.
-The current and recommended level care was listed as special care unit (SCU).
-The resident was constantly disoriented, exhibited inappropriate wandering behavior, semi-ambulatory using a wheelchair, incontinent of bowel and bladder, and required total care with personal care assistance including bathing, feeding, and dressing.

Review of Resident #1's progress notes from 03/14/23 through 07/14/23 revealed:
-On 05/20/23, the resident fell out of bed.
-On 06/28/23, the resident was sent to the hospital after falling out of the bed.
-There was no documentation of notification to Resident #1's primary care provider.
-There was no documentation of notification to Resident #1's responsible party.
-There was no documentation of notification the local county DSS was notified.

Review of a hospital emergency room after visit summary for Resident #1 dated 05/20/23 revealed:
-The reason for Resident #1's visit to the emergency room was for a fall.

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D 451	Continued From page 179 -The resident's diagnoses were injury of head and facial laceration. Review of a hospital emergency room encounter for Resident #1 dated 06/28/23 revealed: -Resident #1 was seen for a witnessed fall out of bed. -The resident sustained an abrasion on her left forehead. -The resident complained of some right breast pain. Review of accident/incident reports for Resident #1 from 01/2023 through 07/2023 revealed there were no accident/incident reports available for review for 05/20/23 or 06/28/23. Interview with the local county DSS Adult Home Specialist on 07/20/23 at 11:39am revealed the local county DSS had not received any incident/accident reports for Resident #1 dated 05/20/23 and 06/28/23. Telephone interview with the Medication Aide (MA)/former Memory Care Director (MCD) on 07/24/23 at 3:55pm revealed: -If there was an issue on the special care unit, she expected the MAs to report it to her. -She reported everything to the Resident Care Director (RCD)/former Executive Director (ED). -She did not have any control over what was reported to DSS after she reported findings to the former ED. -The former ED was responsible for signing off on incident/accident reports. -She did not have access to the reporting information to DSS. Interview with the Resident Care Director (RCD)/former Executive Director (ED) on	D 451		

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D 451	Continued From page 180 07/24/23 at 6:35pm revealed no documentation of incident/accident reports with appropriate notifications of Resident #1's hospital emergency room visits for evaluation and medical treatment for injuries sustained on 05/20/23 and 06/28/23 were available. 2. Review of Resident #2's current FL-2 dated 04/14/23 revealed diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation. a. Review of Resident #2's incident/accident report dated 07/01/23 revealed: -After lunch staff noticed a laceration and swelling on the resident's forehead. -The hospice nurse (HN) was notified. -There was no documentation the resident's responsible party was notified. -The resident was not evaluated by a physician, did not receive first aid and was not sent to the emergency room (ER). -Staff who witnessed the event and completed the report were not identified. -There was no documentation the county Department of Social Services (DSS) was notified. -The Resident Care Director (RCD)(former Executive Director) signed the report on 07/07/23. Review of Resident #2's hospice nurse (HN) visit notes dated 06/29/23 to 07/05/23 revealed: -On 07/01/23, there was documentation the resident had an unwitnessed fall and sustained a bruise and bump on his forehead above the left eye. -On 07/03/23, there was documentation the resident had an unwitnessed fall on 07/01/23 and had dark bruises around both eyes, the bridge of his nose and his left forehead and a bump above	D 451		

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D 451	Continued From page 181	D 451		

his left eye.
-Resident #2's right arm was swollen, and he was guarding that arm.
-The resident rated his pain 9 out of 10.
-On 07/05/23, there was documentation the resident's right hand was still swollen and bruised but less swollen than on 07/03/23.
-The x-ray done on 07/03/23 showed no fracture or dislocation.
-The resident said his arm was still sore and rated his pain 2 out of 10.

b. Review of Resident #2's incident/accident report dated 07/09/23 revealed:
-At 8:39am staff documented the resident stated he fell.
-The left hip on the diagram was circled.
-There was no documentation of the type of injury.
-The resident was sent to the emergency room (ER).
-The resident's primary care provider (PCP) and hospice were notified.
-There was no documentation the responsible party was notified.
-There was no documentation the county Department of Social Services (DSS) was notified.

Review of Resident #2's progress notes dated 07/08/23 through 07/09/23 revealed:
-The next entry was dated 07/09/23 with documentation Resident #2 was sent to the ER due to a fall and the resident saying his hip hurt.
-The next entry was dated 07/08/23 11:00pm - 7:00am.
-Staff documented the resident was observed sliding from the chair to the floor.
-Resident #2's mobility was checked, and he walked to his room.

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D 451	Continued From page 182 -Resident #2 awakened with complaints of left hip pain. -The next entry was dated 07/08/23 with documentation all scans were negative, and hospice and the Executive Director (ED) were notified. Interview with the medication aide (MA) on 07/24/23 at 12:36pm revealed: -A personal care aide (PCA) told her at shift change (11:00pm on 07/08/23) that Resident #2 was on the floor. -The PCA said he had lost his balance and slid back into the chair and then onto the floor. -He landed on his bottom not his hip. -The MA who sent Resident #2 to the ER on 07/09/23 said it was because of the bruise on his left hip and that he was limping. -When there was a fall on 3rd shift, she completed incident/accident reports and put them under the door of the ED's office. -She faxed the PCP and would only let the phone ring a couple of times when it was late at night. -If the voicemail came on, she would leave a message. Interview with the Department of Social Services (DSS) Adult Home Specialist (AHS) on 07/20/23 at 11:39am revealed: -She did not receive incident/accident reports dated 07/01/23 through 07/03/23 and 07/09/23 for Resident #2. -The Resident Care Director (RCD) (former Executive Director) may have verbally said there was incident. -She still expected to receive a scanned copy of the actual accident/incident report for review for residents sent to the ER or requiring medical treatment other than first aid.	D 451		

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D 451	Continued From page 183 Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed: -Accident and incident reports were completed by the MA on duty and either given to or placed under the door to the Executive Director's (ED's) office. -The RCD or ED faxed incident/accident reports to the DSS. -MAs were responsible for contacting the PCP and family member. Interview with the RCD (former ED) on 07/24/23 at 4:33pm revealed: -She was responsible for reviewing accident/incident reports and faxing or emailing them to DSS. -There was a lot of things going on at the facility related to investigations since 06/23/23 and some things may have been missed while addressing urgent issues. -She thought she might have told DSS when the AHS was at the facility during the investigation. Attempted telephone interview on 07/21/23 at 11:01am with a medication aide (MA) who completed the incident report dated 07/09/23 was unsuccessful.	D 451		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.	D 453		

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D 453	Continued From page 184	D 453		

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

Based on interviews and record reviews the facility failed to immediately notify the county DSS and LE for 1 of 1 resident (#10) residing in the special care unit, who the Resident Care Director (RCD)/ former Executive Director (ED) viewed on camera being pushed in the back of the head twice by Staff I.

The findings are:

Review of the facility's Accidents and Incidents Policy revealed:
-The RCD/designee shall insure that proper documentation and notification is completed.
-All abuse shall immediately be reported to the DSS and LE.

Review of Resident #10's current FL2 dated 06/14/23 revealed:
-Diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus, and hyperglycemia.
-The resident was semi-ambulatory.
-She was constantly disoriented.
-She was special care unit level of care.

Review of Resident #10's care plan dated 03/28/23 revealed:
-Resident had significant memory loss and needed to be directed.
-Resident used a wheelchair and required extensive assistance with ambulation.
-Resident was totally dependent on assistance for all other activities of daily living including eating,

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D 453	Continued From page 185 toileting, bathing, dressing, grooming/personal hygiene and transferring. Review of hospice documentation for Resident #10 revealed resident was enrolled with Hospice effective 04/04/23 based on diagnosis of Alzheimer's disease and late onset dementia. Interview with a medication aide (MA) (also the former Memory Care Director) on 06/23/23 at 12:20pm and 07/24/23 at 4:00pm revealed: -On 06/20/23, Staff I (a PCA) was pushing Resident #10 in her wheelchair when the resident tried to stop the wheelchair with her feet. -Staff I "hit" the resident in the head with her hand. -A MA who observed the incident reported it to her the next day. -She reported the information to the Resident Care Director (RCD)/former Executive Director (ED) the same day and they reviewed the facility camera footage together. -She and the RCD (former ED) saw that while Staff I was pushing Resident #10 in her wheelchair, the resident tried to stop the wheelchair with her feet. -Staff I pushed the resident in the back of her head causing her head to fall forward. -The resident lifted her arms, and Staff I pushed her in the back of her head again. -The RCD (former ED) stated Staff I would be terminated. Interview with the RCD (former ED) on 06/23/23 at 1:33pm and 6/28/23 at 12:15pm revealed: -The MA (former MCD) reported to her at 5:30pm on 06/21/23 the allegation that Staff I "hit" Resident #10 in the head on 06/20/23. -She looked at the camera on 06/21/23, the same day it was reported to her.	D 453		

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D 453	Continued From page 186 -The camera footage showed a MA (who reported the incident) exiting the special care unit as Staff I was talking to Resident #10 while pushing her in her wheelchair toward her room on 06/21/23. -Staff I pushed Resident #10 on the back of her head and the resident's head fell forward due to the push. -She went to check on the resident and saw no signs of injury. -Staff I had already left work for the day. -She planned to terminate Staff I but wanted to hear her side of the story. -She left Staff I a phone message and did not receive a return call. -Staff I never returned to work. -She was terminated and had no further contact with facility residents. -The MA who witnessed the incident was responsible for completing the incident report, but she was unsure if it was done. -The MA was off work, and she had not had a chance to speak with her about the incident as of 06/23/23. -The MA (former MCD) was responsible for notifying the responsible party (RP). -She was responsible for sending the incident report to DSS, notifying LE, and completing the Health Care Personnel Registry investigation and reporting. -Although she learned of the abuse on 06/21/23, she did not get the chance to notify DSS or LE about the abuse because other things kept happening that she had to handle. -She reported it to DSS on 06/23/23 when the adult home specialist was in the facility for a complaint investigation. -It was also reported to LE on 06/23/23, who was at the facility based on an unrelated referral from adult protective services (APS).	D 453		

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D 453	Continued From page 187 Review of DSS's records revealed no incident report or verbal notification was received for the 06/20/23 abuse of Resident #10 by Staff I. Interview with a LE Detective on 07/19/23 at 1:15pm revealed: -LE learned of the 06/20/23 abuse of Resident #10 from interviews during a facility visit on 06/23/23 while initiating an investigation based on an unrelated APS referral. -As a result, the detective opened an investigation regarding the allegations of abuse against Resident #10 by Staff I. -Upon completion of LE's investigation, Staff I was charged with a misdemeanor for assault on a handicapped person. -The facility did not report the abuse to LE until the 06/23/23 visit. Interview with Resident #10's RP on 07/19/23 at 10:45am revealed: -She had no knowledge of the incident of abuse until she was informed by the DSS Adult Home Specialist on 06/23/23. -She received a telephone message from the MA (former MCD) on 06/28/23 and they spoke on 06/29/23. -She visited resident and communicated with hospice staff. -There was no indication resident sustained any injuries from being pushed in the back of the head. Interview with the Staff I on 07/20/23 at 12:40pm revealed: -Staff I denied abusing Resident #10. -She never returned to work after learning she was going to be terminated. -She was charged with a misdemeanor for abuse.	D 453		

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D 453	Continued From page 188 Interview with the Administrator on 07/18/23 at 2:35pm revealed: -The RCD (former ED) was responsible for investigating and reporting incidents of abuse and neglect. -Notification to DSS and LE should have been completed immediately by the designated staff person in accordance with facility policy. -The notifications were not done until DSS and LE's facility visit on 06/23/23. _____ The facility failed to ensure that DSS and LE were immediately notified of abuse of a special care unit resident (Resident #10) by Staff I that occurred on 06/20/23 but was not reported until 06/23/23 when DSS and LE visited the facility for an unrelated referral. Staff I was eventually charged with a misdemeanor for assault on a handicapped person after pushing the resident in the back of the head twice. This failure was detrimental to the health, safety and welfare of the residents and constituted a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/28/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 8, 2023.	D 453		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a	D 454		

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D 454	Continued From page 189 resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the responsible party for 2 of 6 sampled special care unit (SCU) residents (#1 and #2) for falls, injuries, and emergency room (ER) evaluations. The findings are: Review of the facility's Accidents and Incidents Policy revealed: -All accidents and incidents shall immediately be reported to the Resident Care Director (RCD)/designee. -The RCD/designee shall ensure proper referral and follow up for all incidents and accidents. This	D 454		

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	HAL065035	A. BUILDING: _____ B. WING _____	R-C 07/24/2023

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shall include notification of the physician, mental health provider and making necessary emergency management calls.
-The RCD/designee shall insure that proper documentation and notification is completed.
-The RCD/designee shall notify the residents responsible party immediately for accidents/incidents that require emergency management calls.
-Incidents that require more than first aid treatment shall be faxed to the county department of social services with 48 hours of the incidents.
-When there has been an allegation of abuse, neglect, exploitation or an injury of unknown origin the Administrator/designee shall notify Health Care Personnel Registry (HCPR) within 24 hours and complete and submit a five-day investigation summary to HCPR.
-All abuse shall immediately be reported to the county Department of Social Services and the police.
-Staff shall be trained on the policy of accident and incident upon hire and annually.
-There was a facility code of conduct which provided instructions of what was to be done in the event allegations of abuse or witnessed abuse.
-The Resident Care Director (RCD), Memory Care Director (MCD), or Medication Aides (MA) were responsible for documenting in the resident record.

1. Review of Resident #2's current FL-2 dated 04/14/23 revealed diagnoses included Alzheimer's dementia with behavioral disturbances and atrial fibrillation.

Review of Resident #2's incident/accident report dated 07/01/23 revealed:
-After lunch staff noticed a laceration and swelling

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on the resident's forehead.
-The hospice nurse (HN) was notified.
-There was no documentation the resident's responsible party was notified.
-The resident was not evaluated by a physician, did not receive first aid, and was not sent to the emergency room (ER).
-Staff who witnessed the event and completed the report were not identified.
-The Resident Care Director (RCD)(former Executive Director) signed the report on 07/07/23.

Telephone interview with Resident #2's family member on 07/21/23 at 12:04pm revealed:
-The facility did not contact her when he fell or was sent to the hospital.
-The staff did not call her about his first fall on 07/01/23.
-Staff called her on 07/03/23 while she was at the facility visiting the resident.
-She found out Resident #2 had been in the hospital on 07/14/23, 07/15/23 and was currently in the hospital when the hospice nurse (HN) contacted her on 07/19/23.
-Staff had not told her of any falls since 07/01/23.
-The HN mentioned a fall causing the left hip wound when she called on 07/19/23, but she did not say if it was a new fall since 07/01/23.

Interview with the medication aide (MA) on 07/24/23 at 12:36pm revealed:
-A personal care aide (PCA) told her at shift change (11:00pm on 07/08/23) that Resident #2 was on the floor.
-The PCA said he had lost his balance and slid back into the chair and then onto the floor.
-He landed on his bottom not his hip.
-The MA who sent Resident #2 to the ER on 07/09/23 said it was because of the bruise on his left hip and that he was limping.

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D 454	Continued From page 192 -When there was a fall on 3rd shift, she completed incident/accident reports and put them under the door of the ED's office. -She faxed the PCP. -She called the family member and would only let the phone ring a couple of times when it was late at night. -If the voicemail came on, she would leave a message. Telephone interview with a second MA (former MCD) on 07/24/23 at 3:53pm revealed: -She was not at the facility when Resident #2 last fell because it was on a Saturday (07/01/23). -The MA called her, and she instructed the MA to call hospice and the responsible party. -Accident and incident reports were completed by the MA on duty and either given to or placed under the door to the Executive Director's (ED's) office. -MAs were responsible for contacting the PCP and family member. 2. Review of Resident #1's current FL-2 dated 03/16/23 revealed: -Diagnoses included dementia with behavioral issues and schizophrenia. -The admission date for Resident #1 was documented as 08/30/13. -The current and recommended level care was listed as special care unit (MCU). -The resident was constantly disoriented, exhibited inappropriate wandering behavior, semi-ambulatory using a wheelchair, incontinent of bowel and bladder, and required total care with personal care assistance including bathing, feeding, and dressing. Review of a hospital emergency room after visit summary for Resident #1 dated 05/20/23	D 454		

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revealed:
-The reason for Resident #1's visit to the emergency room was for a fall.
-The resident's diagnoses were injury of head and facial laceration.

Review of a hospital emergency room encounter for Resident #1 dated 06/28/23 revealed:
-Resident #1 was seen for a witnessed fall out of bed.
-The resident sustained an abrasion on her left forehead.
-The resident complained of some right breast pain.

Review of Resident #1's progress notes from 03/14/23 through 07/14/23 revealed:
-On 05/20/23, the resident fell out of bed.
-On 06/28/23, the resident was sent to the hospital after falling out of the bed.
-There was no documentation of notification to Resident #1's responsible party.

Attempted telephone call to Resident #1's responsible party on 07/20/23 at 8:35am was unsuccessful.

Attempted telephone call to Resident #1's responsible party on 07/24/23 at 11:31am was unsuccessful.

Telephone interview with the Medication Aide (MA)/former Memory Care Director (MCD) on 07/24/23 at 3:55pm revealed:
-If there was an issue on the memory care unit, she expected the MAs to report it to her.
-She reported everything to the former Executive Director (ED).
-She did not have any control over what was reported after she reported findings to the former

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D 454	Continued From page 194 ED. Interview with the Memory Care Director (MCD)/former Resident Care Director (RCD) on 07/24/23 at 6:35pm revealed no documentation of incident/accident reports with appropriate notifications of Resident #1's hospital emergency room visits for evaluation and medical treatment for injuries sustained on 05/20/23 and 06/28/23 were available.	D 454		