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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 09/06/23 through 09/08/23.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Type A2 Violation Based on observations, record reviews, and interviews, the facility failed to provide supervision and post-fall evaluations with interventions per the facility policy for 1 of 5 (#5) sampled residents who had 14 falls within a 5-month period which resulted in skin tears, abrasions, a head injury and two visits to the emergency room. The findings are: Resident #5's current FL-2 dated 04/13/23 revealed: -Diagnoses included hypertension, dementia due to Parkinson's Disease and acute encephalopathy. -The resident was semi-ambulatory with the assistance of a wheelchair. -The resident was intermittently disoriented. -The resident resided on the Assisted Living (AL) unit.	D 270		

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D 270	Continued From page 1 -The resident was admitted to the facility on 04/08/23. Review of the facility's Falls Management Policy dated 10/20/13 revealed: -A fall risk evaluation was to be completed at the time of move-in of a resident. -Residents who sustained a fall should have a post fall evaluation completed to consider interventions to reduce the potential for future falls and injury which included increased monitoring and supervision. Review of the facility's fall risk evaluation for Resident #5 revealed: -A fall risk evaluation was completed for the resident. -The level of fall risk was scored from lowest (level one) to the highest (level 3) risk for a fall. -Resident #5 scored a level 3, the highest level for fall risk. Review of Resident #5's Incident/Accident (I/A) reports revealed: -On 05/22/23, the resident had a documented unwitnessed fall in his room at 2:20pmthat resulted in a skin tear to the right lower leg. -On 05/28/23, the resident had a documented unwitnessed fall in his room at 3:30pm that resulted in no injury. -On 07/14/23, the resident had a documented unwitnessed fall in his room at 10:00pm that resulted in injury to both knees and resident was sent to the emergency room (ER). -On 07/23/23, the resident had a documented unwitnessed fall in his room at 2:15pm that resulted in injury to the forehead. -On 08/08/23, the resident had a documented unwitnessed fall in his room at 10:20pm that resulted in an injury to both knees (carpet burn).	D 270		

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-On 08/09/23, the resident had a documented unwitnessed fall in his room at 2:25pm that resulted in no injury.
-On 08/22/23, the resident had a documented unwitnessed fall in his room at 1:10pm with no injury.
-On 08/22/23, the resident had a documented witnessed fall (a family member was in the room) at 6:30pm that resulted in skin tears to both elbows.
-On 08/22/23, the resident had a documented witnessed fall (a family member was in the room) at 7:30pm, the resident was sent to the ER at the request of the family member due to fidgeting and restlessness.
-On 08/28/23, the resident had a documented unwitnessed fall in his room at 9:45am that resulted in a scrape/abrasion to the left forehead.
-On 08/28/23, the resident had a documented unwitnessed fall in his room at 3:20pm that resulted in skin tears to the right elbow.
-On 08/28/23, the resident had a documented unwitnessed fall in his room at 10:15pm that resulted in no injury.
-On 09/01/23, the resident had a documented unwitnessed fall in his room at 2:59pm that resulted in no injury.
-On 09/05/23, the resident had a documented unwitnessed fall (family member discovered resident on the floor) in his room at 5:19pm with physical signs of a head injury.
-There were 14 falls (2 witnessed and 12 unwitnessed) and 2 ER visits because of the falls.

Review of Resident #5's Post Fall Evaluations revealed:
-There was a post fall evaluation completed on 08/22/23 that had scheduled toileting plan listed as an intervention.
-There was a post fall evaluation completed on

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08/24/23 that had increased frequency of monitoring as an intervention.
-There was a post fall evaluation completed on 08/29/23 that had the notation "resident's meds are being reviewed and adjusted, and the resident was more agitated, restless, and anxious, resident had severe cognitive impairment, short term memory loss and unable to comprehend.
-There were no post fall evaluations completed for 11 of the 14 falls.

Interview with the family member on 09/06/23 at 3:30pm revealed:
-She placed Resident #5 in the facility due to multiple falls at home and her inability to continue to care for him.
-She found the resident on the floor when she visited on 09/05/23.
-She observed one PCA and one MA assisting in the dining room for dinner when she visited.
-She and another family member got the resident up off the floor and into the bed.
-She expected the facility to provide more supervision to the resident due to multiple falls.
-There were not enough staff to check on the resident more frequently, that may have contributed to the falls.
-After the ER visit due to a fall on 08/24/23, the resident's mobility and cognition had declined significantly.
-The resident was placed in hospice care on 08/24/23.

Observation of Resident #5 on 09/07/23 at 3:30pm revealed:
-He was lying in a hospital bed with an assist rail attached to the top right side of the bed, and there was a floor mat beside the bed.
-He was agitated, anxious and moving a lot in the

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bed.
-He had healed skin tears/abrasions on both elbows, both knees, lower left leg and there was a band-aid on the left side of his forehead.
-Two family members were in the room.

Interview with a personal care aide (PCA) on 09/07//23 8:30am at revealed:
-She worked on the first shift on the AL unit from 7:00am to 3:00pm.
-She was aware Resident #5 had a lot of falls.
-She was not instructed after Resident #5's falls to provide more supervision, but she tried to check on Resident #5 more than every two hours per facility policy, but often she could not.
-She was the only PCA on the floor that provided personal care for 29 residents on that unit.
-There were five residents, including Resident #5 and one who was blind, who required a lot of care with ambulating, bathing, grooming, dressing, and incontinent care.
-She was aware Resident #5 had a fall on 09/05/23 on second shift and all staff were helping in the dining room.
-She had requested more help on the unit from management for the last couple of months.

Interview with a second PCA on 09/07/23 at 4:00pm.revealed:
-She worked on the second shift on the AL unit from 3:00pm to 11:00pm.
-She knew Resident #5 had a lot of falls since he was admitted to the facility.
-The MAs and PCAs were required to assist in the dining room during mealtimes.
-If a resident was left on the room during mealtimes, they were unattended.
-The facility's policy was for staff to check on residents at least every two hours.
-If a resident had a fall, she was told to keep "a

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closer eye" on them.
-She did not know what "a closer eye" meant, but may be it meant more than every 2 hours per facility policy.

Interview with a medication aide (MA) on 09/07/23 at 9:45am revealed:
-She worked on the first shift on the AL unit from 7:00am to 3:00pm.
-She and the PCA were the only two staff on the unit that provided care to the 29 residents in the unit.
-She was responsible for administering medications to the residents and assisted the PCA whenever possible.
-Resident #5 had more falls that were documented because when he first came to the facility, he would call a family member from his cell phone when he had fallen and he got up by himself.
-Staff were unaware of the falls until the family member visited and would tell staff the resident had contacted the family member regarding falls.
-Resident #5 had a lot of agitation and anxiety and moved a lot in the bed.
-There had been numerous medication changes to manage his agitation and anxiety.
-Most of the falls were due to him trying to get out of the bed unattended.
-We needed "more eyes" on the unit to check on Resident #5 more frequently.
-She had requested more help on the unit from management, but was told the facility could not hire a third person until there were 30 residents in the unit.

Interview a second MA on 09/07/23 at 3:40pm revealed
-She usually worked on the second shift on the AL unit from 3:00pm to 11:00pm.

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-She and the PCA were the only two caregivers on the floor for 29 residents.
-She was responsible for administering medications to the residents.
-She was aware Resident #5 was found lying on the floor by a family member during dinner time when the PCA went to take Resident #5 his dinner.
-She and the PCA were assisting in the dining room at the time.
-She was aware Resident #5 had a lot of falls because he was constantly agitated and moved a lot in the bed that would cause him to slide out.
-She did not recall being told to increase the frequency of monitoring and supervision for the resident.
-There were not enough staff to monitor Resident #5 more frequently than every two hours.

Interview with the Hospice Nurse on 09/07/23 at 3:10pm revealed:
-Resident #5 came into hospice care on 08/24/23 due to a referral from an ER visit.
-Hospice was aware of Resident #5's fall history.
-Hospice ordered the fall mat on 08/29/23 and the hospital bed with a scoop mattress.
-The hospice nurse came to the facility 2 times a week.
-The hospice personal care aide came to the facility 2 times a week.
-The hospice physician adjusted Resident #5's medications to manage his agitation and anxiety.

Interview with the Health and Wellness Coordinator (HWC) on 09/07/23 at 10:45am revealed:
-She was aware Resident #5 had a lot of falls.
-She was aware of the resident's fall on 09/05/23 when caregiver staff were assisting in the dining room.

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-The MA's documented for 72 hours after each fall in the electronic medication administration record (eMAR) each shift.
-It appeared that any resident left on the floor during mealtimes were unattended.
-She had requested more help on the unit for better "continuity of care."

Interview with the Executive Director (ED) on 09/07/23 at 4:20pm revealed:
-She was not aware Resident #5 had 14 falls until now.
-Per the facility's Falls Policy, post fall evaluations were supposed to be completed on Resident #5 after each fall with interventions put in place by the Health and Wellness Director (HWD), including increased supervision and monitoring.
-She did not know why the post fall evaluations were not completed on Resident #5 for all the falls.
-She expected the Falls Policy to be followed.
-The facility's policy was to monitor residents every 2 hours.
-She expected increased supervision after each fall and for the resident to be monitored every hour or every 30 minutes depending on fall.
-The requirement was for there to be enough staff based on census, not acuity (based on severity of resident illness).
-The facility had enough staff on each shift based on census.

Telephone interview with Resident #5's primary care provider (PCP) on 09/09/23 at 2:00pm revealed:
-He was the resident's PCP prior to the resident being admitted to hospice on 08/24/23.
-He was notified of the resident's multiple falls.
-He did not receive any communications from the facility regarding guidance or recommendations

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D 270	Continued From page 8 on fall prevention. -He expected fall precautions to be implemented for the resident and interventions put in place to reduce falls and injuries. -He expected the resident to be checked on at least every hour due to being at high risk for falls and a history of falls. Based on observation, record reviews, and interviews, it was determined Resident #5 was not interviewable. _____ The facility failed to provide supervision for 1 of 5 (#5) sampled residents diagnosed with Parkinson's Disease who had 14 falls within a 5-month period, resulting in skin tears, abrasions, and a head injury and had visits to the emergency room. This failure placed the resident at risk for serious physical harm and neglect which constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/08/23 for this violation CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 8, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 273		

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reviews, the facility failed to ensure health care referral and follow up for 2 of 5 sampled residents (#4, #2) including failing to notify the provider of a resident with parameters to notify the provider of blood glucose levels less than 90 (#4) and failing to notify a mental health provider of gait changes and falls per ordered instuctions after a medication that could cause sedation was prescribed (#2).

The findings are:

1. Review of Resident #4's current FL-2 dated 01/12/23 revealed:
-Diagnoses included type II diabetes.
-There was an order for blood sugars to be obtained before each meal with parameters to notify the physician for blood glucose readings less than 90.
-There was an order to administer Humalog Kwikpen 100 units/ml per sliding scale.

Review of Resident #4's electronic medication administration record (eMAR) for July 2023 revealed:
-There was an entry for humalog Kwikpen per sliding scale before meals per physicians order and scheduled for 6:30am, 11:30am and 4:30pm.
-There were no instructions to include notification to provider for blood less than 90.
-The blood glucose level was documented as 78 on 07/28/23 at 6:30am.

Review of Resident #4's electronic medication administration record (eMAR) for August 2023 revealed:
-There was an entry for humalog Kwikpen per sliding scale before meals per physicians order and scheduled for 6:30am, 11:30am and 4:30pm.
-There were no instructions to include notification

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to provider for blood less than 90.
-The blood glucose level was documented as 87 on 08/08/23 and 08/27/23 at 6:30am.

Interview with a medication aide (MA) on 09/08/23 at 11:16am revealed:
-Resident #4 was ordered finger stick blood sugars three times each day.
-There were no parameters for notifying the provider of blood glucose levels on the eMAR but she would notify the PCP if the glucose level was over 400.
-She was able to find the order for parameters by looking at Resident #4's order set in the computer but she did not look in the order set at each medication pass.

Telephone interview with Resident #4's PCP on 09/08/23 at 2:00pm revealed:
-Staff did not inform him Resident #4 had blood glucose levels less than 90.
-Parameters for FSBS were ordered when Resident #4 was admitted to the facility to track trends in glucose levels.
-Blood glucose readings were sent to Resident #4's endocrinologist each month.
-FSBS levels over 70 were not a concern when taken prior to breakfast.

Interview with the Health and Wellness Coordinator (HWC) on 09/08/23 at 11:30am revealed:
-She was not aware of Resident #4 blood glucose levels less than 90.
-She had not notified Resident #4's PCP of FSBS levels less than 90.
-She faxed Resident #4's FSBS levels to her endocrinologist monthly.
-The order for notification less than 90 was written on admission for tracking and trending

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purposes.

Interview with the Clinical Specialist on 09/08/23 at 3:10pm revealed:
-Parameters and instructions for notification should be put on the eMAR so MAs would know when to make notifications to the providers.
-It was the responsibility of the MAs to notify the providers based on the parameters to ensure safety.
-The HWC was responsible for entering the orders, including parameters and instructions on the eMAR.

Attempted telephone interview with Resident #4's endocrinologist on 09/08/23 at 11:55am was unsuccessful.

2. Review of Resident #2's current FL-2 dated 02/12/23 revealed diagnoses included dementia.

Review of medication orders from Resident #2's mental health (MH) provider, dated 07/20/23, revealed an order for Lorazepam (an anti-anxiety medication) .5 mg, give ½ tablet (.25mg) twice daily as needed for agitation and anxiety. Hold for sedation. Please alert (MH) provider for gait disturbances, changes in mood, and sedation.

Review of Resident #2's electronic medication administration record (eMAR) for August, 2023 and September 1-5, 2023, revealed:
-There was an entry for instructions to hold Lorazepam for sedation.
-There were not instructions to alert the MH provider for gait disturbances, changes in mood, and sedation for the Lorazepam.
-The facility administered Lorazepam to Resident #2 on 34 occasions between 08/01/23 and

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D 273	Continued From page 12 09/05/23. Review of Resident #2's Progress Notes, "Post-Fall Evaluations", physician communications and provider visit notes revealed: -Resident #2 had three falls. -On 08/10/23, staff found Resident #2 on the floor near her bed at 2:01pm. Staff documented risk factors included, "Resident trips, stumbles and sits on floor [due to] cognitive impairment". -On 08/18/23, Resident #2 fell in the outdoor courtyard at 3:00pm. Staff documented the resident was "walking in the courtyard" and "the resident lost her balance in the courtyard and fell". -On 09/01/23, Resident #2 had an unwitnessed fall in another resident's room. Staff sent the resident to the ER for further evaluation of a possible head injury. Staff documented "the resident had trouble ambulating to the gurney". -There was no documentation that Resident #2's MH provider was notified of the falls or changes in gait. Interview with a first shift MA on 09/07/23 at 9:19am revealed: -The MA reviewed the eMAR and stated the order for Lorazepam directed staff to hold Lorazepam for sedation but did not include the directions to notify the MH provider of gait disturbances, changes in mood, and sedation and she was not aware of those directions. -The facility's policy was to notify the residents' primary care provider (PCP) of falls, but the staff would not know of the instructions to notify the MH provider unless those instructions were included in the eMAR. -The facility's process for entering orders into the eMAR was the facility's Licensed Practical Nurse	D 273		

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(LPN) or Registered Nurse (RN) were responsible for entering orders into the eMAR, unless the orders were submitted after hours and then the MAs did have the ability to enter orders into the eMAR.
-She had only administered Lorazepam to Resident #2 on a couple of occasions and she had not noticed any side effects, but since starting the medication the resident seemed to walk a little slower.

Interview with another MA on 09/07/23 at 4:30pm revealed:
-She was with a group of residents in the courtyard on 08/18/23 when Resident #2 fell.
-The resident was walking and lost her balance and fell.
-The MA notified Resident 1's PCP, per the facility's policy
-She had noticed Resident #2 was walking slower since starting Lorazepam.

Interview with Resident #2's MH provider on 09/07/23 at 10:25am revealed:
-The most recent mental health visit for Resident #2 was made on 08/03/23.
-On 07/20/23, she wrote medication orders for Resident #2 to start Lorazepam, as needed (PRN) related to symptoms of anxiety and/or agitation with instructions to hold for sedation and please alert MH provider for gait disturbances, changes in mood, and sedation.
-Potential side effects of Lorazepam included changes in gait, changes in mood and sedation.
-Changes in gait would include changes in the way a person walks, which could include falls.
-She expected the facility to notify her of falls, as indicated in the order for Lorazepam, so that she would know to reassess the resident and review medications for potential side effects.

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D 273	Continued From page 14 -She was not aware Resident #2 fell on 08/10/23, 08/18/23 and 09/05/23. -The facility had not notified her of any falls or potential adverse side effects of the Lorazepam. Interview with the Health and Wellness Coordinator on 09/07/23 at 1:40pm revealed: -The instructions to follow up with the MH provider for gait disturbances, changes in mood, and sedation were not included in Resident #2's eMAR. - Facility staff had not notified the resident's MH provider of any potential side effects of the medication or of Resident #2's falls. Interview with the Executive Director on 09/07/23 at 3:30pm revealed she was not aware the facility failed to follow-up with Resident #2's MH provider related to the order instructions for Lorazepam and Resident #2's falls and gait disturbances.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the	D 280		

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D 280	Continued From page 15 tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure quarterly licensed health professional support (LHPS) evaluations had been completed by an appropriate licensed professional for 3 of 5 sampled residents with LHPS tasks of positioning and emptying a urinary catheter bag and collecting and testing of finger stick blood sugar samples (#1), transferring a semiambulatory resident and using an assistive device for ambulating that required staff assistance (#3) and tasks not being listed on the LHPS review and evaluation for a resident that required assistance with ambulation in his wheelchair and transfers . (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 06/06/23 revealed -Diagnoses included post procedure complication and disorder of the genitourinary system, obstructive and reflux uropathy, Type II diabetes and vision loss. -He had an indwelling urinary catheter. -There was an order for fingerstick blood sugars	D 280		

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D 280	Continued From page 16 (FSBS) to be completed twice daily. Review of Resident #1's Personal Service Plan dated 07/06/23 revealed he required staff assistance for emptying his catheter bag. Review of Resident #1's Resident Record on 09/06/23 revealed there was no Licensed Health Professional Support (LHPS) evaluation. Interview with the Executive Director (ED) on 09/06/23 at 3:45pm revealed the last LHPS for Resident #1 was in the facility's computer system and was completed in May 2023. Review of Resident #1's LHPS evaluation dated 09/07/23 revealed tasks included emptying his foley catheter bag each shift and collecting blood sample for FSBS testing and was signed by the Clinical Specialist. Interview with Resident #1 on 09/07/23 at 9:20am revealed: -He was diagnosed with kidney and bladder cancer in April 2023 and a catheter was placed because he was unable to urinate on his own. -He lost his sight approximately 2 years prior. -The staff emptied his catheter bag for him about 3 times each day. -He thought he could empty the bag himself but he could not see and did not want to make a mess. Interview with a personal care aide (PCA) on 09/08/23 at 11:00am revealed a PCA or medication aide (MA) emptied Resident #1's catheter bag for him each shift. Review of Resident #1 electronic medication administration record (eMAR) for July 2023	D 280		

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revealed:
-There was an entry for FSBS to be completed twice daily.
-There was documention FSBS was checked each day at 6:00am and 8:00pm from 07/01/23 through 07/31/23.

Review of Resident #1's eMAR for August 2023 revealed:
-There was an entry for FSBS to be completed twice daily.
-There was documention FSBS was checked each day at 6:00am and 8:00pm from 08/01/23 through 08/31/23.

Review of Resident #1' eMAR for September 1st through September 6th 2023 revealed:
-There was an entry for FSBS to be completed twice daily.
-There was documention FSBS was checked each day at 6:00am and 8:00pm from 09/01/23 through 09/06/23.

Interview with a medication aide (MA) on 09/08/23 at 11:16am revealed FSBS were completed twice daily for Resident #1.

Interview with the Clinical Specialist on 09/08/23 at 3:10pm revealed she completed an LHPS for Resident #1 on 09/07/23.

Refer to interview with the Administrator on 09/06/23.

Refer to interview with the Health and Wellness Coordinator on 09/08/23 at 2:45pm.

Refer to interview with the Clinical Specialist on 09/08/23 at 3:10pm.

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2. Review of Resident #3's current FL-2 dated 10/11/22 revealed:
-Diagnoses included dementia with behavioral disturbance, weakness, restlessness and agitation and adult failure to thrive.
-He was non-ambulatory.

Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 05/15/23 revealed tasks included ambulation with an assistive device.

Review of Resident #3's Resident Record on 09/06/23 revealed there was no current LHPS evaluation.

Observation of Resident #3 on 09/08/23 at 11:00am revealed he was asleep in a wheelchair on top of the pad for a hoyer lift.

Interview with a personal care aide (PCA) on 09/08/23 at 11:00am revealed Resident #3 required 2 staff for transfering to his wheelchair with the hoyer lift.

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

Refer to interview with the Executive Director (ED) on 09/06/23.

Refer to interview with the Health and Wellness Coordinator on 09/08/23 at 2:45pm.

Refer to interview with the Clinical Specialist on 09/08/23 at 3:10pm.
3. Resident #5's current FL-2 dated 04/13/23 revealed:
-Diagnoses included hypertension, dementia due

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to Parkinson's Disease and acute encephalopathy.
-The resident was semi-ambulatory with the assistance of a wheelchair.
-The resident was intermittently disoriented.
-The resident was admitted to the facility on 04/08/23.

Review of Resident #5's Resident Register (no signature or date) revealed no admission date.

Review of Resident #5's Licensed Health Professional Support (LHPS) Initial Evaluation dated 04/26/23 revealed:
-The resident's primary diagnosis was hypertension.
-The resident's secondary diagnosis was dementia with Parkinson's Disease.
-There were no LHPS tasks listed for Resident #5.
-The resident was a very pleasant gentlemen with a recent decline in his Parkinson's contributing to loss of balance and increased falls.
-The resident was currently utilizing his wheelchair for mobility; a new and lighter weight wheelchair had been ordered.
-The resident was provided with a pendant to call for assistance and pull cords were being moved to better position for the resident.
-There was no subsequent LHPS review and evaluation completed on Resident #5 after 04/26/23.

Review of Resident #5's Personal Service Plan dated 04/04/23 revealed:
-The resident was on medications for dementia and Parkinson's Disease.
-The resident's Parkinson's Disease had gotten to the point where he needed more assistance.

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-The resident needed assistance to take a shower.
-The resident was a one person assist with ambulation and transfers.

Interview Resident #5 family on 09/06/23 at 3:30pm revealed:
-She placed Resident #5 in the facility due to multiple falls at home and her inability to continue to care for him.
-Resident #5 used a wheelchair when he was first admitted to the facility in April 2023.
-He used to be able to propel himself in the wheelchair but had declined since he had been at the facility and needed more assistance from staff.
-He required assistance from staff in ambulation, transferring between the bed and wheelchair, transferring between the wheelchair and the recliner, and transferring between the wheelchair and the toilet.

Interview with a personal care aide (PCA) on 09/07/23 at 8:30am revealed:
-When Resident #5 was first admitted to the facility, he used a wheelchair for ambulation and could propel himself.
-Staff provided assistance to the resident in transferring between the bed and the wheelchair, the wheelchair and his recliner, and the wheelchair and the toilet due to falls and a decline in his balance.

Interview with a second PCA on 09/07/23 at 4:00pm revealed:
-Resident #5 used a wheelchair when he first came to the facility
-She provided assistance to Resident #5 with his wheelchair and transferring because he could pivot and turn at that time.

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-The resident now required more assistance from staff with pushing the wheelchair and transfers due to his decline and falls.

Interview with a medication aide (MA) on 09/07/23 at 9:45am revealed:
-Resident #5 used a wheelchair and required assistance from staff with ambulation.
-Because his balance was "off" and he was high risk for falls, he required assistance with transferring to his bed, recliner, and the toilet.

Interview with a second MA on 09/07/23 at 3:40pm revealed :
-Resident #5 had a wheelchair when he was first admitted to the facility.
-Staff assisted the resident with pushing his wheelchair and transferring.

Interview with the Health and Wellness Coordinator HFC on 09/07/23 at 10:45am revealed.
-She was a Licensed Practical Nurse (LPN).
-There was a LHPS Registered Nurse who was responsible for completing the LHPS review and evaluations for Resident #5, who was no longer employed at the facility.
-Resident #5 had tasks performed by staff that included transferring and assistive device assistance.

Interview with the Executive Director (ED) on 09/07/23 at 4:20pm revealed:
-The LHPS Registered Nurse was responsible for completing the LHPS review and evaluation.
-There should have been tasks listed on the LHPS review and evaluation for Resident #5.
-She did not know know why there were no tasks identified.
-Resident #5 required assistance with ambulating

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D 280	Continued From page 22 in his wheelchair and transferring due to his decline in health status and falls. Based on observations, record reviews, and interviews, it was determined Resident #5 was not interviewable. Refer to interview with the Executive Director (ED) on 09/06/23. Refer to interview with the Health and Wellness Coordinator on 09/08/23 at 2:45pm. Refer to interview with the Clinical Specialist on 09/08/23 at 3:10pm. _____ Interview with the Executive Director (ED) on 09/06/23 at 3:45pm revealed there was no current LHPS evaluation for Resident #1, #3 and #5 but she would ensure they were completed. Interview with the Health and Wellness Coordinator (HWC) on 09/08/23 at 2:45pm revealed: -A Registered Nurse (RN) had to complete LHPS evaluations and she was an LPN. -The Health and Wellness Director (HWD) was an RN and responsible for ensuring LHPS evaluations were completed quarterly. -The previous HWD left employment in May 2023. -Clinical Specialists were sent o te facility for fulfill RN tasks until the position of HWD could be filled. -There was a tracking system that outlined when Resident Record items required updating that included the LHPS evaluations. -She and the Clinical Specialist that were sent in had access to the computer tracking system. Interview with th Clinical Specialist on 09/08/23 at	D 280		

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D 280	Continued From page 23 3:10pm revealed: -Clinical Specialists were sent into the facility for 1-2 weeks at the time since the previous HWD left employment in May 2023. -The Clinical Specialists that were sent to the facility had access to the tracking system and the LHPS evaluations should have been completed before she arrived to the facility a few days prior. -The HWD or the Clinical Specialists were responsible for ensuring LHPS evaluations were completed quarterly.	D 280		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by:	D 367		

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Based on observations, interviews and record reviews, the facility failed to ensure the medication administration records for 2 of 5 sampled residents accurate including parameters for notification of blood glucose readings ordered by a physician (#4) and instructions for notification of side effects for an anti-anxiety medication (#2).

The findings are:

1. Review of Resident #4's current FL-2 dated 01/12/23 revealed:
-Diagnoses included type II diabetes.
-There was an order for blood sugars to be obtained before each meal with parameters to notify the physician for blood glucose readings less than 90.
-There was an order to administer Humalog Kwikpen 100 units/ml per sliding scale.

Review of Resident #4's electronic medication administration record (eMAR) for July 2023 revealed:
-There was an entry for humalog Kwikpen per sliding scale before meals per physicians order and scheduled for 6:30am, 11:30am and 4:30pm.
-There were no instructions to include notification to provider for blood less than 90.
-The blood glucose level was documented as 78 on 07/28/23 at 6:30am.

Review of Resident #4's electronic medication administration record (eMAR) for August 2023 revealed:
-There was an entry for humalog Kwikpen per sliding scale before meals per physicians order and scheduled for 6:30am, 11:30am and 4:30pm.
-There were no instructions to include notification to provider for blood less than 90.

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D 367	Continued From page 25 -The blood glucose level was documented as 87 on 08/08/23 and 08/27/23 at 6:30am. Interview with a medication aide (MA) on 09/08/23 at 11:16am revealed: -Resident #4 was ordered finger stick blood sugars three times each day. -There were no parameters for notifying the provider of blood glucose levels on the eMAR but she would notify the PCP if the glucose level was over 400. -She was able to find to order for parameters by looking at Resident #4's order set in the computer but she did not look in the order set at each medication pass. -Parameters and instructions should have been on the eMAR and she did not know why they were not. Interview with the Clinical Specialist on 09/08/23 at 3:10pm revealed: -Parameters and instructions for notification should be put on the eMAR so MAs would know when to make notifications to the providers. -The HWC was responsible for entering the orders, including parameters and instructions on the eMAR. Refer to interview with the Health and Wellness Coordinator (HWC) on 09/07/23 at 1:40pm. 2. Review of Resident #2's current FL-2 dated 02/12/23 revealed diagnoses included dementia. Review of medication orders from Resident #2's mental health (MH) provider dated 07/20/23 revealed: -There was an order for Lorazepam .5 mg, give ½ tablet (.25mg) twice daily as needed for agitation	D 367		

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and anxiety.
-There were instructions to hold for sedation and alert the provider for gait disturbances, changes in mood, and sedation.

Review of Resident #2's electronic medication administration record (eMAR) for August 2023 and September 1-5, 2023, revealed:
-The eMAR included the instruction to hold Lorazepam for sedation.
-The eMAR did not include instructions to alert the MH provider for gait disturbances, changes in mood, and sedation for the Lorazepam.
-The facility administered Lorazepam to Resident #2 on 34 occasions between 08/01/23 and 09/05/23.

Review of Resident #2's progress notes, "Post-Fall Evaluations", physician communications and provider visit notes revealed:
-Resident #2 had three falls.
-On 08/10/23, staff found Resident #2 on the floor near her bed at 2:01pm. Staff documented risk factors included, "Resident trips, stumbles and sits on floor [due to] cognitive impairment".
-On 08/18/23, Resident #2 fell in the outdoor courtyard at 3:00pm. Staff documented the resident was "walking in the courtyard" and "the resident lost her balance in the courtyard and fell".
-On 09/01/23, Resident #2 had an unwitnessed fall in another resident's room. Staff sent the resident to the ER for further evaluation of a possible head injury. Staff documented "the resident had trouble ambulating to the gurney".

Interview with a first medication aide (MA) on 09/07/23 at 9:19am revealed:

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	HAL070005	A. BUILDING: _____ B. WING _____	R 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 367	Continued From page 27	D 367		

-The MA reviewed the eMAR and stated the order for Lorazepam directed staff to hold Lorazepam for sedation but did not include the directions to notify the MH provider of gait disturbances, changes in mood, and sedation and she was not aware of those directions.
-The facility's Licensed Practical Nurse (LPN) or Registered Nurse (RN) were responsible for entering orders into the eMAR, unless the orders were submitted after hours and then the MAs had the ability to enter orders into the eMAR.

Interview with the Health and Wellness Coordinator (HWC) on 09/07/23 at 1:40pm revealed:
-The instructions to alert Resident #2's MH provider for gait disturbances, changes in mood, and sedation were not included in eMAR.
-Staff had not notified the resident's MH provider of any potential side effects of the medication or of Resident #2's falls.
-The facility's LPN or RN were responsible for entering orders into the eMAR, unless the orders were submitted after hours and then the MAs had the ability to enter orders into the eMAR.
-The facility's former RN had entered the orders for Resident #2's Lorazepam in the eMar and the HWC was not aware of the instructions to alert the MH provider for gait disturbances, changes in mood, and sedation.
-She was not sure why the former RN did not enter the instructions for Lorazepam.
-The facility had planned to implement a two-step order verification process to ensure accuracy of eMARS, but this process had not been implemented as of 09/07/23.

Interview with the Executive Director (ED) on 09/07/23 at 3:30pm revealed she was not aware of the incomplete eMAR instructions for

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D 367	Continued From page 28 Lorazepam.	D 367		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure disclosures and pre- admission screenings were completed upon admission for 2 of 2 sampled residents that were admitted to the Special Care Unit (SCU) (#3,#2). 1. Review of Resident #3's current FL-2 dated 10/11/22 revealed: -Diagnoses included dementia with behavioral	D 463		

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D 463	Continued From page 29	D 463		

disturbance, weakness, restlessness and agitation and adult failure to thrive.
-He was non-ambulatory.
-There was documentation that Memory Care was the recommended level of care.

Review of Resident #3's Resident Register revealed an admission date of 11/04/23.

Review of Resident #3's Resident Record revealed there was no SCU pre-screening or disclosure.

Interview with the Executive Director (ED) on 09/06/23 revealed she was unable to locate the SCU pre-screening or disclosure for Resident #3.

Attempted telephone interview with Resident #3's Power of Attorney on 09/07/23 at 2:18pm was unsuccessful.

Refer to interview with the Clinical Specialist on 09/08/23 at 3:10pm.

2. Review of Resident #2's facility records revealed:

-Diagnoses included dementia.
-An admission date of 08/15/2022.
-There was no documentation that a pre-admission screening had been completed.
-There was no documentation that written disclosure information had been provided to Resident #2's family members.

Interview with the Special Care Coordinator (SCC) on 09/08/23 at 12:20pm revealed:
-The facility's Licensed Practical Nurse (LPN) or Registered Nurse (RN) were responsible for completing the pre-admission screening prior to

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D 463	Continued From page 30 admission and the Marketing Director completed the disclosure form with residents' families. Interview with the Clinical Specialist on 09/08/23 at 3:10pm revealed: -The Registered Nurse (RN) for the facility was responsible for ensuring the SCU pre-screening and disclosure were completed. -The pre-screening and disclosure should be completed prior to a resident moving into the SCU. Interview with the Executive Director on 09/07/23 at 1:30pm, revealed the facility did not have documentation showing the pre-admission screening or disclosure was completed for Resident #2.	D 463		