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PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

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D 000	Initial Comments The Adult Care Licensure Section and the Davie County Department of Social Services conducted a State Involved Complaint Investigation on 09/18/23. The Complaint Investigation was initiated by the Davie County Department of Social Services on 08/31/23.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide personal care according to the care plan for 1 of 4 sampled residents (Resident #4) related to the resident having oily hair and no documentation of a sponge bath or shower for 10 of 14 days during the 2-week period since being admitted to the facility. The findings are: Review of Resident #4's current FL2 dated 08/04/23 revealed: -Diagnoses included dementia and autism. -Resident #4 was incontinent of bladder. -Resident #4 required assistance with bathing and dressing. Review of Resident #4's Resident Register revealed she was admitted to the facility on	D 269		

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D 269	Continued From page 1 09/01/23. Review of Resident #4's record revealed there was no care plan completed as of 09/14/23. Observation of Resident #4 during the tour of the facility on 09/14/23 at 9:23am revealed: -Resident #4's hair appeared oily and unwashed. -Resident #4's clothes appeared clean and there were no apparent odors. Interview with Resident #4 on 09/14/23 at 9:24am revealed she had not had a shower, but she did not remember how long it had been since she had a shower. Review of Resident #4's personal care record for September 2023 revealed: -There was documentation Resident #4 was to receive a shower on Mondays, Wednesdays, and Fridays on first shift. -Resident #4 required extensive assistance with bathing. -There was documentation Resident #4 refused a sponge bath on first shift on 09/01/23, 09/02/23, 09/03/23, 09/04/23, 09/08/23, 09/09/23, and 09/10/23. -There was documentation Resident #4 received a shower on 09/06/23 and a sponge bath on 09/07/23 and 09/08/23. -There was no documentation that bathing assistance was provided or refused on 09/11/23 through 09/14/23 on first shift. -There was no documentation that bathing assistance was provided or refused on second or third shifts between 09/01/23 through 09/14/23. Review of Resident #4's progress notes revealed: -Resident #4 was assisted with a shower on 09/06/23 after refusing multiple times and on	D 269		

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09/13/23.
-There was no other documentation regarding offering, assistance, or refusals of a shower.

Interview with a medication aide (MA)/personal care aide (PCA) on 09/14/23 at 3:40pm revealed:
-On Resident #4's first day at the facility (09/01/23), she did not adjust well and refused personal care.
-When residents refused showers or sponge baths, the PCA sent another PCA in to attempt a shower or sponge bath.
-If PCAs were not able to assist residents with sponge baths or showers on the scheduled shift, PCAs on a different shift sometimes attempted the sponge bath or shower.
-She completed showers and sponge baths for residents scheduled during her shift unless he PCA from the previous shift told her a resident refused and to attempt on her shift.
-She worked on second shift, had not been requested to, and had not attempted to assist Resident #4 with a shower or sponge bath during her shift.

Interview with a MA/PCA on 09/15/23 at 9:34am revealed:
-Some days were better than others with assisting Resident #4 with personal care including showers and sponge baths.
-If Resident #4 did not have snacks, it was difficult to get her to do anything.
-If a resident refused a shower, 3 different PCAs or MAs were to attempt to assist with a shower at 3 different times.
-If a resident refused a shower scheduled on first shift, staff on second shift attempted to assist with a shower if they had time.
-If a shower or sponge bath were attempted multiple times, the multiple attempts should have

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been documented.

Interview with a PCA on 09/15/23 at 10:00am revealed:
-If Resident #4 refused a shower, the PCA tried 3 times to assist her with a shower.
-If Resident #4 continued to refuse, PCAs were to inform the Director and request for second shift to try to assist her with a sponge bath or a shower.
-She has notice Resident #4 to have an order within the two weeks she has been in at the facility.
-Resident #4's hair was oily when she did not have a shower.
-Residents hair was washed only when they were assisted with showers.
-The only thing staff could do was to notify the Director.

Interview with a second PCA on 09/15/23 at 10:00am revealed:
-Resident #4 refused showers a lot.
-She attempted to assist her with a shower this morning, but she refused.
-Resident #4 did not have a shower on 09/14/23, her scheduled shower day, but she did not know if she refused or not.
-She noticed Resident #4's hair was oily on yesterday and today, but PCAs assisted with washing hair when they assisted with showers.
-If a resident refused a shower, other staff were to ask 3 or 4 different times and second shift was informed that the resident refused on first shift.
-She did not know if residents who refused a shower on first shift were assisted with a shower on second shift.

Interview with the Director on 09/15/23 at 2:58pm revealed:
-If a resident refused a shower, staff was to try

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D 269	Continued From page 4 again and let the next shift know of the refusal. -Usually, staff did not push a resident to take a shower within their first week at the facility. -When a shower was not scheduled, a sponge bath should have been provided. -Resident #4 did not have a shower on 09/15/23, but her hair did not look oily. -If Resident #4 needed assistance with washing her hair on non-shower days, staff should have used dry shampoo. Telephone interview with the Administrator on 09/15/23 at 4:23pm revealed: -Staff should have made a good faith effort to assist Resident #4 with a shower. -Staff should have attempted to assist Resident #4 with a shower more than once and should have documented the attempts to assist.	D 269		
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 for 2 of 5 sampled residents (#2 and #3) including a resident who had aggressive behaviors resulting in the resident physically and verbally	D 270		

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assaulting other residents (#3) and a resident who had multiple falls which resulted in injuries (#2) .

The findings are:

1. Review of Resident #3's current FL2 dated 07/14/23 revealed:
-Diagnoses included Alzheimer's dementia, anxiety, depression, and hyperlipidemia.
-Resident #3 was constantly confused.
-Resident #3 was ambulatory and had wandering behaviors.

Review of Resident #3's care plan dated 07/14/23 revealed:
-Resident #3 had no problems with ambulation.
-Resident #3 required supervision with ambulation and transferring.

a. Review of Resident #3's progress notes dated 06/05/23 revealed Resident #3 got aggravated a few times with other residents and staff.

Interview with the medication aide (MA)/personal care aide (PCA) who documented the 06/05/23 progress note on 09/15/23 at 10:00am revealed:
-Resident #3 never hit anyone.
-Sometimes he walked down the hall fussing and yelling at other residents and staff.
-She told the Director he needed an as needed medication for agitation and behaviors.
-She watched Resident #3 more after behaviors, but there were no scheduled increased supervision or safety checks.
-She would just check on him when she passed him in the hallway.
-Staff checked on all residents every hour.

Review of Resident #3's record revealed there

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was no documentation of any increased supervision after his behaviors on 06/05/23.

b. Review of Resident #3's progress note dated 06/19/23 at 2:36pm revealed Resident #3 became aggressive towards another resident while in the sunroom; staff redirected the residents to the bedroom.

Interview with the MA/PCA who documented the 06/19/23 at 2:36pm progress note on 09/14/23 at 3:40pm revealed:
-Resident #3 yelled at residents and staff at times when he became agitated.
-She usually gave Resident #3 a snack to divert his attention or took him outside or to the lobby area.
-She was not aware of any increased supervision or safety checks implemented after his behaviors on 06/19/23.

Review of Resident #3's record revealed there was no documentation of any increased supervision after his incident on 06/19/23.

c. Review of Resident #3's progress notes dated 06/19/23 at 3:29pm revealed Resident #3 was behaving aggressively and slamming doors around the facility.

Interview with the MA/PCA who documented the 06/19/23 at 3:29pm progress note on 09/14/23 at 3:40pm revealed:
-Resident #3 became upset when his family left from visiting.
-Resident #3 randomly slammed doors throughout the facility.
-She was not aware of any increased supervision or safety checks implemented after his behaviors on 06/19/23 at 3:40pm.

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Review of Resident #3's record revealed there was no documentation of any increased supervision after his behaviors on 06/19/23.

d. Review of Resident #3's progress notes dated 07/29/23 revealed:
-Resident #3 got violent with another resident.
-He went up behind another resident and grabbed him, was shaking him, and screamed and cursed at the other resident for no reason.
-Later in the shift, a resident was asleep on the couch and Resident #3 grabbed the resident and was screaming and cursing at the resident.
-Resident #3 charged at other residents throughout the day and yelled at staff.
-The MA tried to defer the situation and distract him, but nothing worked.

Interview with the MA who documented the 07/29/23 progress note on 09/15/23 at 12:04pm revealed:
-When Resident #3 was aggressive, it was difficult to distract him.
-When she came in on the morning of 07/29/23, third shift staff told her Resident #3 was in an aggressive mood.
-Resident #3 came to the nurse's station that morning and cursed staff.
-After breakfast, Resident #3 went up behind another resident, placed him in a bear hug, and began shaking him.
-She was in the dining hall when the other resident came to her upset and told her what happened.
-After lunch between 1:30pm and 2:00pm, the same resident was sitting on the couch and Resident #3 grabbed his thighs and yelled at him.
-Resident #3 got angry for no reason.
-Later in the day, Resident #3 slammed the door

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that separated the front sitting area and the hallway outside the Director's office.
-He then got in another resident's face and began yelling at her.

Review of Resident #3's record revealed there was no documentation of any increased supervision after his behaviors on 07/29/23.

_____
Interview with Resident #3's primary care provide (PCP) on 09/15/23 at 12:39pm revealed:
-The facility notified her Resident #3 had experienced increased aggression.
-Resident #3 became frustrated because he was not able to communicate.
-She expected staff to redirect Resident #3.
-Staff "kept eyeballs" on him because he stayed in the hallways.
-If Resident #3 was not walking in the hallways, she expected staff to know where he was.

Interview with the Director on 09/15/23 at 2:58pm revealed:
-Resident #3 became upset because he had trouble communicating.
-When Resident #3 became upset, he did not direct his frustration or aggression towards anyone in particular.
-He usually turned and walked away, but there were a couple times he would yell at other residents.
-He was always on the move up and down the hallways.
-Resident #3 was not on scheduled safety checks or increased supervision.
-There were not any scheduled safety checks or increased supervision implemented for any residents who have had behaviors.

Telephone interview with the Administrator on

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D 270	Continued From page 9 09/05/23 at 4:23pm revealed he expected staff to provide increased supervision when residents were exhibiting behaviors and to consult with the residents' PCP or mental health provider. 2. Review of Resident #2's current FL-2 dated 06/09/23 revealed: -Diagnoses included Type ll diabetes mellitus, acute kidney failure, primary hypertension, hypomagnesemia, hyperlipidemia, coronary arteriosclerosis and dementia. -Resident #2 was constantly disoriented. -Resident #2 was ambulatory. -Resident #2 was incontinent of bowel and bladder and needed assistance with bathing and dressing. Review of Residnet #2's care plan dated 07/14/23 revealed: -She required supervision with eating, ambulation and transferring. -She required extensive assistance with toileting, bathing, and grooming. Review of Resident #2's Incident and Accident reports revealed: -On 07/19/23, Resident #2 was found on the floor of her room. There were no injuries found and no complaints of pain. -07/26/23, Resident #2 was standing at the desk and fell to the floor. Resident #2 had a skin tear on her left arm and first aid was administered. -There was no Incident and Accident report available for review for the 08/01/23 falls. -There was no Incident and Accident report available for review for the 08/06/23 fall Review of Resident #2's progress note dated 07/29/23 revealed Resident #2 had a fall and her family member came to the facility and took the	D 270		

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resident to the hospital.

Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed:
-Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23.
-Resident #2's ED visit diagnoses included fall and skin tear of the right forearm.
-The skin tear to the right forearm was 2 to 3 centimeters.
-There were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemia.
-There was an x-ray of Resident #2's left hip with no findings.
-There were no other injuries documented.

Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, bruising on her left hip and a black eye.

Review of Resident #2's progress note dated 08/01/23 revealed Resident #2 had 2 falls today and her family member picked her up at the facility and took her to the hospital.

Review of Resident #2's progress note dated 08/06/23 revealed:
-At 5:13 am, staff was taking the resident to the bathroom and the resident slipped and hit her leg on her walker.
-First aid was applied.

Review of Resident #2's record revealed there was no documentation of interventions or increased supervision after the documented falls on 07/19/23, 07/26/23, 2 falls on 08/01/23, and 08/06/23.

Review of Resident #2's Emergency Medical

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Services (EMS) report dated 08/08/23 revealed:
-EMS arrived to meet facility staff who advised Resident #2 had been tired for the last week.
-EMS assessed Resident #2 to have bruising on her face above the left eye, across the forehead, and the top and back of her head from previous falls.

Review of Resident #2's hospital summary report dated 08/08/23 revealed:
-Resident #2 was admitted to and discharged from the ED on 08/08/23.
-The paramedic presented Resident #2's history and reported Resident #2 had a fall a few days ago and was seen at a different hospital.
-Resident #2 had discolored bruising noted to the left side of her forehead and left eye.
-The bruising to the left side of the forehead had some greenish/grayish discoloration which suggested an older timeframe of injury.
-There was a small skin tear noted to the right forearm.
-Resident #2 presented from the facility via EMS for evaluation of lethargy, generalized weakness, and worsening mental status.
-This had gradually worsened for the last 3 to 4 days and it was not clear if Resident #2 was on any chronic medication or if any medications were changed recently.
-No electronic medication administration records (eMAR) were sent with her.
-Resident #2's blood work was reviewed and she had mild anemia, but no significant leukocytosis (an elevated white blood cell count).
-Comparison of a current creatinine level of 1.26 compared to a creatinine level of 1.23 (normal reference range is 0.6-1.1 mg/dl) in 2023 gave no indication of acute kidney injury.
-Her magnesium level was low at a level of 1.2 (normal reference range is 1.7-2.2 mg/dl).

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-Chest X-rays showed no evidence of pneumonia or intracranial hemorrhage and or acute stroke, and a head computed tomography (CT) scan did not show evidence of acute stroke.
-Resident #2's only symptom was generalized weakness and fatigue and her vital signs were stable.

Review of Resident #2's hospital discharge summary dated 08/25/23 revealed:
-Resident #2 was admitted to the hospital on 08/25/23.
-The chief complaints were manic behavior and hyperglycemia.
-Resident #2 presented to the ED with dementia, type 2 diabetes, hypertension with complaints from EMS that Resident #2 seemed more agitated and confused.
-EMS had an elevated blood sugar reading documented as read high.
-Resident #2 was initially admitted with significant agitation and severe dementia with hyperosmolar hyperglycemic state, and dehydration with acute kidney injury (AKI) and hypernatremia.
-Resident #2's AKI resolved and intravenous fluids were discontinued.
-Initially, with Resident #2's AKI, her medications were held including metformin.
-Resident #2 was not having significantly high blood pressures.
-On 08/28/23, Resident #2's blood sugar was at a normal level of 150 and her vital signs were stable.
-Resolved hospital problems included AKI superimposed on chronic kidney disease, Type 2 diabetes mellitus with hyperosmolar hyperglycemic state, and dehydration with hypernatremia.

Telephone interview with Resident #2's family

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member on 08/31/23 at 2:17pm revealed Resident #2 was declining and a hospice provider was called in to provide comfort care.

Telephone interview with Resident #2's family member on 09/05/23 at 9:46am revealed Resident #2 passed away on 09/04/23 at a hospice facility.

Interview with a personal care aide (PCA) on 09/15/2023 at 10:00 am revealed:
-She was aware Resident # 2 had falls but was unsure of dates.
-She was present for one fall (07/26/23) when the resident slipped out of her chair at the front desk and had a skin tear on her arm.
-Staff were supposed to do 30-minute checks after a resident fell.
-Resident #2 had a black eye, bruising over her eye and swelling to her face on 07/30/23 when Resident #2 returned from the hospital and she notified the Director.

Interview with a second PCA on 09/15/2023 at 9:30 am revealed:
-She was aware Resident #2 had been falling but was not sure of dates.
-She had not witnessed any of Resident #2's falls.
-Staff were supposed to do 30-minute checks after a resident fell.

Interview with Resident #2's primary care provider (PCP) on 09/15/23 at 2:10pm revealed:
-She was aware Resident # 2 had falls and she attributed her falls to Resident #2's decline in health.
-She should have been notified by the Director of all of Resident #2's falls resulting in injuries and the expectation would have been for staff to increase supervision of Resident #2.

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-She was aware of Resident #2's black eye and bruising to Resident #2's face.
-The bruise looked like Resident #2's face was pressed against a bedrail like what was on a hospital bed.

Interview with the Director on 09/15/23 at 3:20pm revealed:
-She was aware Resident #2 had a few falls, but she was not aware Resident #2 had a total of 5 falls.
-Staff were supposed to do 30-minute checks after a fall and if falls continued, staff were supposed to do 15-minute checks.
-The PCP should be notified of all injuries.
-Resident #2 had a black eye, bruising over her eye and swelling to her face when she returned from the hospital on 07/30/2023.
-She notified the PCP about the black eye, bruising over her eye and swelling to her face when she returned from the hospital on 07/30/2023.

Interview with the Administrator on 09/15/23 at 4:25pm revealed:
-She was not aware Resident #2 had 5 falls.
-She expected the staff to document all falls, notify the ED and notify the PCP if there were multiple falls for any resident and keep a closer eye on the resident after falls.

_____

The facility failed to provide supervision for 2 of 5 sampled residents (#2 and #3) resulting in a resident physically and verbally assaulting other residents by placing a resident in a bear hug, shaking, and grabbing the resident's legs, and yelling at other residents (#3) and a resident having falls resulting in a skin tear on her left leg and arm, a knot on her head, bruising on her left hip and a black eye, with multiple visits to the ED

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D 270	Continued From page 15 (#2). This failure placed the residents 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 09/15/23 for this violation CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to notify the primary care provider (PCP) for 2 of 5 sampled residents (#1 and #2) related to medications not being available for administration and a 21 pound weight loss over a 3 month period (#1), and refusals of medications and an 18.5 pound weight loss over a 3 month period (#2). The findings are: 1. Review of Resident #2s current FL-2 dated 06/09/23 revealed diagnoses included dementia, Type ll diabetes mellitus, primary hypertension, hypomagnesemia, hyperlipidemia, and coronary arteriosclerosis.	D 273		

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a. Review of Resident #2's physician's order dated 05/24/23 revealed medication orders for Memantine 5mg (used to treat memory loss) at 8:00am twice daily for morning routine.

Review of Resident #2's May 2023 (05/25/23 to 05/31/23) eMAR revealed:
-There was an entry for Memantine 5mg twice daily at 8:00am and 8:00pm.
-There was documentation Memantine was not administered on 05/27/23 at 8:00am with the reason documented as physically unable to take (refused).

Review of Resident #2's June 2023 eMAR revealed:
-There was an entry for Memantine 5mg twice daily at 8:00am and 8:00pm.
-There was documentation Memantine was refused for 4 out of 30 opportunities on 06/04/23, 06/06/23, 06/28/23 and on 06/29/23 at 8:00am.

Review of Resident #2's physician's order dated 07/14/23 revealed an order to change the administration time of morning medications to anytime between 7:00am-3:00pm while the resident was awake.

Review of Resident #2's July 2023 eMAR revealed:
-There was an entry for Memantine 5mg twice daily at 8:00am and 8:00pm.
-There was no entry to change the administration time of morning medications to anytime between 7:00am-3:00pm while the resident was awake.
-There was documentation Memantine was refused or the resident would not wake up for 9 out of 31 opportunities on 07/15/23, from 07/17-07/22/24, 07/28/23, and on 07/31/23 at 8:00am.

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Review of Resident #2's record and eMARs revealed there was no documentation the PCP was notified of the resident refusing Memantine.

b. Review of Resident #2's physician's order dated 05/24/23 revealed medication orders for Metformin 500mg (used to treat elevated blood sugar levels) twice daily at 8:00am and 8:00pm.

Review of Resident #2's May 2023 (05/25/23 to 05/31/23) electronic medication administration record (eMAR) revealed:
-There was an entry for Metformin 500mg twice daily at 8:00am and 8:00pm.
-There was documentation metformin was refused or physically unable to take for 2 out of 7 opportunities on 05/25/23 and on 05/27/23 at 8:00am.

Review of Resident #2's physician's orders dated 06/09/23 revealed an order for fingerstick blood sugars (FSBS) once daily if FSBS less than 80 or greater than 450 call the PCP; if FSBS less than 60 give 8 ounces of orange juice or glucose gel and recheck FSBS in 15 minutes.

Review of Resident #2's June 2023 eMAR revealed:
-There was an entry for Metformin 500mg twice daily and 8:00am and 8:00pm.
-There was documentation Metformin was refused for 4 out of 30 opportunities on 06/04/23, 06/06/23, 06/28/23 and on 06/29/23 at 8:00am.
-There was an entry for FSBS once daily at 6:30 am, if FSBS less than 80 or greater than 450 call the PCP; if FSBS less than 60 give 8 ounces of orange juice or glucose gel and recheck FSBS in 15 minutes.
-There was documentation FSBS checks were

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refused or the resident would not wake up for 14 out of 22 opportunities from 06/17/23 to 06/30/23.
-There was no documentation of FSBS checks with blank spaces from 06/09/23 to 0/16/23.

Review of Resident #2's physician's order dated 07/14/23 revealed an order to change the administration time of morning medications to anytime between 7:00am-3:00pm while the resident was awake and to change FSBS to once weekly.

Review of Resident #2's July 2023 eMAR revealed:
-There was an entry for Metformin 500mg twice daily at 8:00am and 8:00pm.
-There was an entry to change administration of morning medications to 7:00am-3:00pm daily while the resident was awake.
-There was documentation Metformin was refused or the resident would not wake up for 9 out of 31 opportunities on 07/03/23, from 07/08/23-07/09/23, 07/11/23, 07/22/23, 07/24/23, 07/28/23, 07/30/23 and on 07/31/23 at 8:00am.
-There was documentation Metformin was refused or the resident would not wake up for 2 out of 31 opportunities on 07/28/23, and on 07/29/23 at 8:00pm.
There was an entry for FSBS once daily at 6:30 am, if FSBS less than 80 or greater than 450 call the PCP; if FSBS less than 60 give 8 ounces of orange juice or glucose gel and recheck FSBS in 15 minutes.
-There was documentation FSBS checks were refused or the resident would not wake up for 12 out of 15 opportunities from 07/01/23 -07/04/23, on 07/06/23, and from 07/08/23-07/14/23 at 6:30 am.
-There was documentation FSBS was not obtained with a blank space on 07/05/23 at 6:30

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am and with documentation as obtained on 7/07/23 with no FSBS result documented.
-There was an entry to check FSBS once weekly between 7:00am to 3:00pm with a start date of 07/14/23.
-There was no documentation FSBS checks were obtained from 07/15/23 to 07/31/23.

Review of Resident #2's August 2023 eMAR revealed:
-There was an entry for Metformin 500mg twice daily at 8:00am and 8:00pm.
-There was documentation Metformin was administered at 8:00am and 8:00 pm 08/01/23 to 08/24/23.
-There was an entry to check FSBS once weekly between 7:00am to 3:00pm with a start date of 07/14/23.
-There was documentation FSBS checks were refused on 08/04/23 and 8/18/23.
-There was documentation of 2 FSBS checks on 08/11/23 with a FSBS result of 105 and on 08/25/23 with a FSBS result of 142.
-There was documentation the resident was out of the facility from 08/25/23 to 08/31/23.

Review of Resident #2's record and eMARs revealed there was no documentation the PCP was notified of the resident refusing Metformin and FSBS checks.

c. Review of Resident #2's physician's order dated 05/24/23 revealed medication orders for Hydralazine 25mg (used to treat high blood pressure) at 8:00am daily for morning routine.

Review of Resident #2's May 2023 (05/25/23 to 05/30/23) eMAR revealed:
-There was an entry for Hydralazine 25mg every 8 hours at 6:00am, 2:00pm and 10:00pm.

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-There was documentation Hydralazine was refused or the medication was not in the facility for 2 of 7 opportunities on 05/25/23 and on 05/30/23 at 6:00am.
-There was documentation Hydralazine was refused for 2 of 7 opportunities on 05/29/23 and on 05/30/23 at 2:00pm.

Review of Resident #2's June 2023 eMAR revealed:
-There was an entry for Hydralazine 25mg every 8 hours at 6:00am, 2:00pm and 10:00pm.
-There was documentation Hydralazine was refused for 19 out of 30 opportunities from 06/01/23-06/03/23, from 06/05/23-06/08/23, 06/10/23, 06/12/23, 06/13/23, from 06/15/23-06/18/23, from 06/20/23-06/22/23 and from 06/24/23-06/30/23 at 6:00am.
-There was documentation Hydralazine was refused for 3 out of 30 opportunities on 06/25/23, 06/29/23 and on 06/30/23 at 2:00pm.

Review of Resident #2's physician's order dated 07/14/23 revealed an order to change the administration time of morning medications to anytime between 7:00am-3:00pm while the resident was awake.

Review of Resident #2's July 2023 eMAR revealed:
-There was an entry for Hydralazine 25mg every 8 hours at 2:00am, 2:00pm and 10:00pm.
-There was no entry to change administration of morning medications to 7:00am-3:00pm daily while the resident was awake.
-There was documentation Hydralazine was refused or the resident would not wake up for 28 out of 31 opportunities from 07/01/23-07/04/23, 07/06/23, from 07/08/23-07/15/23, and from 07/17/23-07/31/23 at 6:00am.

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-There was documentation Hydralazine was refused for 8 out of 31 opportunities on 07/08/23, 07/14/23, 07/15/23, 07/19/23, and from 07/28/23-07/31/23 at 2:00pm.
-There was documentation Hydralazine was refused for 1 out of 31 opportunities on 07/28/23 at 10:00pm.
-There was documentation of of a blood pressure reading of 124/76 on the eMAR.

Review of Resident #2's August 2023 (08/01/23 to 08/24/23) eMAR revealed:
-There was an entry for Hydralazine 25mg every 8 hours at 2:00am, 2:00pm and 10:00pm.
-There was no entry to change administration of morning medications to 7:00am-3:00pm daily while the resident was awake.
-There was documentation Hydralazine was refused or the resident would not wake up for 17 out of 24 opportunities from 08/01/23 - 08/08/23, 08/10/23, 08/12/23, 08/14/23, 08/15/23, 08/17/23, 08/20/23, 08/21/23, 08/22/23, and 08/24/23 at 6:00am.
-There was documentation Hydralazine was refused for 2 out of 24 opportunities on 08/19/23 and 08/23/23 at 2:00pm.
-There was documentation Hydralazine was refused for 1 out of 24 opportunities on 08/05/23 at 10:00pm
-There was no documentation (a blank space) of administration on 08/02/23 and 08/07/23 at 10:00pm.
-There was documentation of of a blood pressure reading of 112/75 on the eMAR.

Review of Resident #2's record revealed there was no documentation the PCP was notified of the resident refusing Hydralazine in August 2023.

d. Review of Resident #2's physician's order

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dated 05/24/23 revealed medication orders for Losartan 50mg (used to treat high blood pressure) at 8:00am daily.

Review of Resident #2's June 2023 eMAR revealed:
-There was an entry for Losartan 50mg daily at 8:00am.
-There was documentation Losartan was refused or the resident would not wake up for 4 out of 30 opportunities on 06/04/23, 06/06/23, 06/28/23 and on 06/29/23.

Review of Resident #2's physician's order dated 07/14/23 revealed an order to change the administration time of morning medications to anytime between 7:00am-3:00pm while the resident was awake.

Review of Resident #2's July 2023 eMAR revealed:
-There was an entry for Losartan 50mg daily at 8:00am.
-There was documentation Losartan was refused or the resident would not wake up for 7 out of 31 opportunities on 07/03/23, 07/07/23-07/09/23, 07/11/23, 07/22/23 and on 07/30/23.
-There was no entry to change the administration time of morning medications to anytime between 7:00am-3:00pm while the resident was awake.
-There was documentation of a blood pressure reading of 124/76 on the eMAR.

Review of Resident #2's record revealed there was no documentation the PCP was notified of the resident refusing Losartan.

Telephone interview with Resident #2's family member on 09/14/23 at 6:58pm revealed:
-A medication aide (MA) gave her eMARs

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showing where Resident #2 had refused medications.
-Resident #2 had not been given her medications like they should have been given.
-She thought Resident #2 had declined in health due to not taking her medications.

_____

Interview with a MA on 09/14/23 at 3:42pm revealed:
-She was aware of the new order from the PCP on 07/14/23 to change Resident #2's administration of morning medication from 8:00am to between 7:00am-3:00pm.
-She was aware Resident #2 continued to not wake up and refused morning medications.
-She notified the Director each time Resident #2 continued to not wake up and refused medications.
-The Director was responsible to notify the PCP and other staff were not allowed to notify the PCP.

Interview with a second MA on 09/15/23 at 9:34am revealed:
-She was aware of the new order from the PCP dated 07/14/23 to change Resident #2's administration of morning medications from 8:00am to between 7:00am-3:00pm.
-She was aware Resident #2 continued to not wake up and refused morning medications.
-Any resident that refused medications for 3 days, staff were supposed to notify the Director and the Director was supposed to notify the PCP.

Interview with Resident #2's PCP on 09/15/23 at 12:30pm revealed:
-She was aware Resident #2 was missing medications due to sleeping.
-She wrote orders to accommodate Resident #2 with her sleep pattern in July 2023.

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-The order dated 07/14/23 was written for morning medications to be administered between 7:00am-3:00pm.
-She had not been informed Resident #2 continued refusing medications and was not administered medications after 07/14/23.
-She would have wanted to be informed of Resident #2's refusals of medications.

Interview with the Director on 09/15/23 at 3:07pm revealed:
-She was aware of the new order from the PCP dated 07/14/23 to change Resident #2's administration of morning medications from 8:00am to between 7:00am-3:00pm.
-She was notified by staff Resident #2 continued to not wake up and refused her morning medications
-She notified the PCP that Resident #2 was continuing to not wake up and refused medications every day, but it was not documented.

Interview with the Administrator on 09/15/23 at 4:25pm revealed he was not aware of Resident #2 refusing medications and would advise staff to do whatever it would take to be in compliance with physician's orders.

e. Review of Resident #2's physician's order dated 05/24/23 revealed an order for monthly vital signs and weight to be checked and recorded on the 12th of the month.

Review of Resident #2's hospital discharge summary dated 05/24/23 revealed Resident #2's weight was 164 pounds (lbs).

Review of Resident #2's May 2023 (05/24/23 to 05/31/23) eMAR revealed there was no entry for

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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 25 monthly vital signs or weights. Review of Resident #2's June 2023 eMAR revealed: -There was no entry for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight. -There was no weight documented for 06/12/23. Review of Resident #2's July 2023 eMAR revealed: -There was an entry for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight. -The weight documented was 152 lbs on 07/12/23. Review of Resident #2's August 2023 eMAR (08/01/23-08/24/23) revealed: -There was an entry for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight. -The weight documented was 145.5 pounds on 08/12/23. Review of Resident #2's weights documented on the eMARs revealed Resident #2 had a weight loss of 18.5 lbs in 3 months. Review of Resident #2's record revealed there was no documentation the primary care provider (PCP) was notified of the resident's weight loss of 18.5 lbs in 3 months. Interview with a medication aide (MA) on 09/14/23 at 3:42 revealed: -The eMARs included an entry for weight on the 12th of each month for Resident #2. -There was a history section which included documentation of the previous month's weight.	D 273		

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	HAL030010	A. BUILDING: _____ B. WING _____	C 09/15/2023

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-She was not aware Resident #2 did not have a weight documented for June 2023.
-She notified the Director that Resident #2 was losing weight.
-The Director was the only staff who communicated with the PCP, so she did not know if the weight loss had been reported to Resident #2's PCP.

Interview with a second MA on 09/15/23 at 9:34am revealed:
-There was an entry on the eMARs for weights to be obtained on the 12th of each month for Resident #2.
-There was a history section on the eMAR with documentation of the previous month's weight.
-She was not aware Resident #2 did not have weight documented for June 2023.
-She was not aware of Resident #2's weight loss.

Interview with Resident #2's PCP on 09/15/23 at 12:30pm revealed:
-She was not informed Resident #2 was losing weight.
-She would have wanted to be notified when there was a 10-pound weight loss within 2 to 3 months.
-She normally placed residents on nutritional supplements if there was weight loss or if a resident was not eating meals.
-She could have placed Resident #2 on nutritional supplements because she slept through some of her meals.

Interview with the Director on 09/15/23 at 3:07pm
-She was aware of Resident #2's weight loss
-She was notified by staff that Resident #2 was having weight loss.

Telephone interview with Resident #2's family

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member on 09/14/23 at 6:58pm revealed:
-Resident #2 weighed 180 pounds when she was admitted to the facility.
-She felt like facility staff was not feeding Resident #2 and she lost weight during her stay there.
-She walked in the dining hall on multiple occasions and Resident #2 was sitting alone and had not eaten any of her food.

Interview with the Administrator on 09/15/23 at 4:25pm revealed he was not aware of Resident #2's weight loss and would advise staff to inform the PCP of any weight loss.

2. Review of Resident #1's FL2 dated 03/30/2023 revealed diagnoses of schizophrenia, diabetes mellitus, anxiety and insomnia.

a. Review of Resident #1's physician's order dated 04/10/23 revealed an order for Lorazepam 0.5mg (used to treat anxiety) twice daily.

Review of Resident #1's June 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg twice daily at 8:00am and 8:00pm.
-There was documentation Lorazepam was not administered on 06/13/23, 06/14/23, 06/15/23 and 06/16/23 with the reason documented as not in the facility.
-There was no documentation the primary care provider (PCP) was notified of Lorazepam not being available for administration.

Interview with a medication aide (MA) on 09/15/23 at 9:25am revealed:
-She was aware Lorazepam was not administered because the medication was not in

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the facility on 06/13/23, 06/14/23, 06/15/23 and 06/16/23.
-She notified the Director (unsure of the date) that Resident #1's Lorazepam was not in the facility, needed to be reordered and documented in the notes on the eMAR.
-The Director was the only staff that ordered medications.

Interview with a second MA on 09/15/23 at 10:00am revealed:
-She was aware Resident #1's Lorazepam was not administered because the medication was not in the facility on 06/13/23, 06/14/23, 06/15/23 and 06/16/23.
-There were problems with the pharmacy not getting medications to the facility on time.
-She notified the Director (unsure of the date) that Resident #1's medication was not in the facility and needed to be reordered.
-The Director was the only staff that ordered medications, but she could now order medications effective this month, September 2023.

Interview with Resident #1's PCP on 09/15/23 at 12:39pm revealed:
-The PCP was not aware Resident #1 was not administered medication due to the medication not being in the facility.
-The PCP was aware there were problems getting medications delivered from the pharmacy since switching to a new pharmacy.
-She should have been notified by the Director if the resident did not receive medications.
-Missing five doses of Lorazepam (which was given for anxiety) would not be life threatening, but could possibly cause some shakiness from withdrawals.

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b. Review of Resident #1's physician's order dated 04/10/23 revealed an order for Losartan 50mg (used to treat high blood pressure) take once daily at 8:00am for morning routine.

Review of Resident #1's June 2023 electronic eMAR revealed:
-There was an entry for Losartan 50mg one daily at 8:00am.
-There was documentation Losartan was not administered on 06/13/23, 06/14/23, 06/15/23 and 06/16/23 with the reason documented as not in the facility.
-There was no documentation the PCP was notified of Losartan not being available for administration.

Interview with a MA on 09/15/23 at 9:25am revealed:
-She was aware Losartan was not administered because the medication was not in the facility on 06/13/23, 06/14/23, 06/15/23 and 06/16/23.
-She notified the Director on 06/13/23 that Resident #1's Losartan was not in the facility, needed to be reordered and documented in the notes on the eMAR.
-The Director was the only staff that ordered medications.

Interview with a second MA on 09/15/23 at 10:00am revealed:
-She was aware Resident #1's Losartan was not administered because the medication was not in the facility on 06/13/23, 06/14/23, 06/15/23 and 06/16/23.
-There were problems with the pharmacy not getting medications to the facility on time.
-She notified the Director (unsure of the date) that Resident #1's medication was not in the facility and needed to be reordered.

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-The Director was the only staff that ordered medications, but she could now order medications effective this month September 2023.

Interview with Resident #1's PCP on 09/15/23 at 12:39pm revealed:
-The PCP was not aware Resident #1 was not administered medication due to the medication not in the facility.
-The PCP was aware there were problems getting medications delivered from the pharmacy since switching to a new pharmacy.
-She should have been notified by the Director if Resident #1 did not receive medications.
-Missing five doses of Losartan (which was given to treat high blood pressure) would not be life threatening but could possibly cause a slight headache.

_____
Interview with the Director on 09/15/23 at 3:20pm
-She was not aware Resident #1 did not have medications for 06/13/23, 06/14/23, 06/15/23 and 06/16/23, due to medications not in the facility.
-She should have been notified by staff when a resident had 8 remaining doses of medication so she could place an order for the medication.
-There were problems with the new pharmacy not getting medications to the facility on time.

Interview with the Administrator on 09/15/23 at 4:25pm revealed:
-He was not aware Resident #1 did not get medications for four days.
-His expectations would be for the Director to notify the PCP and call the pharmacy for an override to ensure the resident got their medications on time.
-If that did not resolve the issue, the expectation

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was to have a conversation with someone in management.

c. Review of Resident #1's physician's order dated 04/04/23 revealed an order for monthly vital signs and weight to be checked and recorded on the 12th of the month.

Review of Resident #1's June 2023 eMAR revealed:
-There was an entry for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight.
-The weight documented on 06/12/2023 was 180.5 pounds (lbs).

Review of Resident #1's July 2023 eMAR revealed:
- There was an entry for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight.
-The weight documented on 07/12/2023 was 172.5 lbs.

Review of Resident #1's August 2023 eMAR revealed there was no documentation for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight.

Review of Resident #1's September 2023 eMAR revealed:
- There was an entry for monthly vital signs which included temperature, pulse, respiration, blood pressure and weight.
-The weight documented on 09/12/2023 was 159 lbs.

Based on review of the June-September 2023 eMARs revealed Resident #1 had a 21 lb. weight loss in 3 months.

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D 273	Continued From page 32 Interview with a MA on 09/15/23 at 9:35am revealed: -The eMAR generated a record of Resident #1's weights on the 12th or 13th of each month. -She was aware Resident #1 had lost weight but was unsure of the amount of weight. -The only way to monitor weight was to look at the history of previous month weights on the eMAR system, which she did not do. -She was not aware Resident #1 did not have a documented weight for July 2023. Interview with a second MA on 09/15/23 at 10:00am revealed: -She was aware Resident #1 had lost weight but was unsure of the amount of weight. -She would have to check the history of previous months weights on the eMAR system to know if the weight changed, which she did not do. -She was not aware Resident #1 did not have a documented weight for July 2023. Interview with the Resident #1's PCP on 09/15/23 at 12:40pm revealed: -The PCP was not informed Resident #1 had lost 21 lbs. in 4 months. -She should have been notified if a resident lost or gained 10 lbs. within 2 to 3 months. -If she had been notified, she would have ordered laboratory work to ensure nothing medical was causing the weight loss. Interview with the Director on 09/15/23 at 3:20pm -She was not aware of Resident #1's weight loss. -Staff were supposed to notify her immediately and document on the eMAR and progress notes. -She was responsible for obtaining vital signs and weights when a resident was admitted to the facility and weight was to be monitored monthly	D 273		

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D 273	Continued From page 33 by the MAs. Interview with the Administrator on 09/15/23 at 4:25pm revealed: -He was not aware of any resident having weight loss and the Director or PCP not being notified. -He expected MAs to monitor residents' weights monthly and notify the Director if there was a "drastic" weight gain or loss. -He would like to see better communication between the staff, the Director and the PCP. _____ The facility failed to ensure physician notification of medication refusals for Resident #2 who refused multiple medications and had a hospitalization which could have resulted in the resident's decline in health, refusing Lorazepam which placed the resident at risk for withdrawal symptoms, refusing Losartan and Hydralazine which placed the resident at risk for headaches and elevated blood pressure, refusing Memantine which placed the resident at risk for increased memory loss, and refusing Metformin which placed the resident at risk for hyperglycemia, and the resident had an 18.5 pound weight loss in 3 months; and Resident #1 who did not have medications available for administration for 4 days which placed the resident at risk for withdrawal symptoms such as shakiness and headaches, and the resident had a 21 pound weight loss in 3 months which could have been the result of underlying health issues. This failure placed the residents 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 09/15/23 for this violation	D 273		

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D 273	Continued From page 34 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2023.	D 273		