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MARS HILL RETIREMENT COMMUNITY	170 SOUTH MAIN STREET MARS HILL, NC 28754

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Madison County Department of Social Services completed a follow-up survey and a complaint investigation on 9/12/23 and 9/13/23.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff D) had a criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 05/31/23 as a medication aide (MA). -There was a signed consent to obtain a criminal background check on Staff A. -There was no documentation that a criminal background check had been obtained. Interview with the Business Office Manager (BOM) on 09/13/23 at 2:15pm revealed: -She was responsible for obtaining criminal background checks on new employees upon hire. -She mailed in the criminal background check for Staff A but she did not have any documentation that she had done so. -She recalled receiving the criminal background	D 139		

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D 139	Continued From page 1 results but did not know where the paperwork was. -She completed audits of personnel records for required documentation bimonthly. -She must have missed auditing Staff A's personnel record. Interview with the Administrator on 09/13/23 at 2:25pm revealed: -Criminal background checks were completed upon hire by the BOM. -She thought she had reviewed Staff A's criminal background checks but did not know where the paperwork was. -She did not know audits were conducted on personnel records.	D 139		
D 274	10A NCAC 13F .0902(c)(1) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care; This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to notify the primary care provider (PCP) for 1 of 5 sampled residents (#2) who refused to have her blood pressure taken as ordered.	D 274		

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D 274	Continued From page 2 The Findings are: Review of Resident #2's current FL2 dated 12/28/22 revealed diagnoses included hypertension, heart failure, and apnea. Review of Resident #2's physician's orders dated 08/04/23 revealed there was an order for daily blood pressure checks. Review of Resident #2's August 2023 electronic treatment administration record (eTAR) revealed: -There was an entry for daily blood pressure checks. -There was documentation blood pressures were refused on 08/05/23, 08/10/23, 08/24/23 and 08/26/23. -There was documentation of a medication aide (MA) or a personal care aide (PCA) initials on 08/06/23 through 08/09/23, 08/11/23, 08/14/23, 08/15/23, 08/18/23 and 08/21/23 but there was no documentation of a blood pressure reading. Review of Resident #2's September 2023 eTAR revealed: -There was an entry for daily blood pressure checks. -There was documentation blood pressures were refused on 09/02/23, 09/06/23 and 09/07/23. Review of Resident #2's electronic chart notes revealed there was an entry on 08/10/23 that the resident continued to refuse blood pressure checks after several attempts by different staff members and the information would be passed on to the next shift. Interview with Resident #2 on 09/13/23 at 9:58am revealed:	D 274		

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-She did not mind having her blood pressure taken with a manual cuff, but she did not like having it taken with the machine because it hurt her arm.
-She told several MAs that she wanted the cuff to be used.
-Only a few MAs knew how to properly use the cuff so when the machine was brought into her room she refused to have her blood pressure taken.

Interview with the first shift supervisor on 09/13/23 at 2:20pm revealed:
-MAs should document on the eTAR if Resident #2 refused to have her blood pressure taken.
-The MAs should let the HWD know if a resident was refusing so she could call the residents physician if needed.

Interview with the RCC on 09/13/23 at 2:08pm revealed:
-She was not informed by the PCP or MA that Resident #2 was refusing to have her blood pressure taken.
-After three treatment refusals the PCP should be informed.
-The MA supervisor should have been aware of refusals and informed her or the Health and Wellness Director (HWD).
-She or the HWD would have informed the PCP if they had been aware of the refusals.

Interview with HWD on 09/12/23 at 2:39pm revealed if Resident #2 refused to have her blood pressure taken it should be documented on the eTAR, in the chart notes and the RCC or herself should have been informed so they could inform the PCP.

Interview with Resident #2's PCP on 09/13/23 at

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D 274	Continued From page 4 10:05am revealed: -Resident #2 had pulmonary hypertension, apnea and heart failure and was ordered blood pressure checks to monitor the hypertension. -No one from the facility had informed him that Resident #2 was refusing to have her blood pressure taken. Interview with the Administrator on 09/13/23 at 2:08pm revealed: -She did not know Resident #2 was refusing to have her blood pressure taken. -The MA supervisor should inform the RCC or HWD of treatment refusals. -She expected the RCC or HWD to inform the PCP of any treatment refusals.	D 274		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews the facility failed to ensure physician's orders were implemented for 2 of 5 sampled residents (#2 and #4) related to oxygen administration, monthly weight and daily blood pressure (#2) and weekly vitals (#2 & #4).	D 276		

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The findings are:

1. Review of Resident #2's current FL2 dated 12/28/22 revealed diagnoses included hypertension, heart failure, and apnea.

a. Review of Resident #2's physician's orders dated 08/04/23 revealed there was an order for 2 liters of continuous oxygen.

Observation during initial tour on 09/12/23 at 9:59am revealed:
-Resident #2's feet were blue and she was short of breath.
-There was no oxygen concentrator or portable oxygen in Resident #2's room.

Observation of Resident #2's room on 09/12/23 at 11:15am revealed no oxygen concentrator or portable oxygen was available in the room.

Observation of Resident #2 and her room on 09/13/23 from 9:58am until 10:35am revealed:
-She was sitting on the side of her bed putting on her pants.
-Her feet and lips were blue.
-The oxygen concentrator that was in the room the previous day was no longer there.
-A MA took Resident #2's oxygen saturation level at the request of her PCP on 09/13/23 at 10:05am and it varied from 83-85% over a 5 minute period.

Interviews with Resident #2 on 09/12/23 at 9:59am during initial tour revealed:
-She had orders for oxygen off and on in the past.
-When she mentioned needing supplemental oxygen to the Medication Aide (MA) last week, she was told she could not have it because it required a physician's order.

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D 276	Continued From page 6 Other interviews with Resident #2 on 09/12/23 at 1:57pm and on 09/13/23 at 9:58am revealed: -Her physical therapist (PT) explained to her last week what would happen to her body if she did not wear oxygen and encouraged her to start wearing it again. -She had an oxygen concentrator in the past, but she called the contract company a few months ago and requested they pick up all her equipment because she thought the tubing was a trip hazard and she did not need oxygen at that time. -If she had a portable oxygen tank she would not trip on the tubing. -The facility did not have portable oxygen tanks available that she knew of. -The company that she contracted with to provide the oxygen supplies left a few portable tanks with her when they picked up all the other supplies, but she had used those up quickly and she put the empty tanks in her coat closet. -When she returned the oxygen supplies she did not tell anyone at the facility because she did not think she needed to, as it was a contract she had with the company. -Someone from the facility put an oxygen concentrator in her room around lunchtime on 09/12/23. -Someone came to her room a few hours later and took the oxygen concentrator, telling her that it was an extra one and they would get her one that belonged to her. -The PT spoke with a MA last week about getting her oxygen. -She requested oxygen from several different staff members but she could not remember the name of the person she asked. Interview with an MA on 09/12/23 at 1:35pm revealed:	D 276		

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-Resident #2 had an oxygen concentrator for a while but a few months ago Resident #2 returned it.
-Resident #2 said she did not need her oxygen recently and she would not wear it anyway.
-Her PT requested she wear it last week because she was having some dizzy spells and he was trying to figure out if wearing her oxygen would help.
-She had observed Resident #2 being dizzy recently.
-No one else knew she returned her oxygen equipment.
-She generally was non-compliant but started being compliant 09/08/23 when her PT encouraged her to use oxygen.

Interview with a second MA on 09/12/23 at 2:18pm revealed:
-A therapist was here last week and told staff he wanted Resident #2 to start using oxygen.
-She thought about 4 weeks ago she had someone take her portable tanks away.
-She used to have an oxygen concentrator but that was taken away.
-She did not remember how long ago Resident #2 sent her oxygen back to the contract company..
-She has an order for oxygen on her electronic treatment administration record.(eTAR) but she did not have oxygen available to wear.
- The doctor would have to write another order before the oxygen supply company would deliver it again.
-She noticed that an oxygen concentrator was put in Resident #2's room on 09/12/23.

Interview with the Resident Care Coordinator (RCC) on 09/12/23 at 2:29pm revealed:
-When she started working at the facility in July 2023, Resident #2 had an order for oxygen, but

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she did not realize until earlier in the day that she did not have an oxygen concentrator or portable oxygen tanks available to use.
-A MA told her earlier in the day that the oxygen concentrator was returned to the supply company by the resident a few months ago because she did not want to wear it anymore.
-She expected the Personal Care Aides (PCAs) and MAs to tell her or the Health & Wellness Director (HWD) that the oxygen was returned.

Interview with the HWD on 09/12/23 at 2:39pm revealed:
-She was not aware that Resident #2 had returned her oxygen until the RCC informed her on 09/12/23.
-She expected the PCAs and MAs to tell her or the RCC that the oxygen was not available.

Telephone interview with a local oxygen supply company on 09/12/23 at 2:50pm revealed:
-Resident #2 had a previous contract with the company for oxygen supplies but that contract ended on 06/01/23 when she called and requested all her supplies be picked up.
-If Resident #2 needed oxygen supplies again they would need a new order from her Primary Care Provider (PCP).

Telephone interview with Resident #2's physical therapist on 09/13/23 at 9:27am revealed:
-He started treating Resident #2 about 6 weeks ago.
-At the initial visits Resident #2 did not want to wear her oxygen and told him it was a trip hazard.
-About a week after his initial visit he discovered she did not even have oxygen available to her.
-The MA that usually worked on the 3rd floor told him she knew Resident #2 did not have her oxygen concentrator anymore.

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-When he was performing therapy with the resident she was short of breath, lacked energy, had difficulty walking very far and when he tested her oxygen saturation levels they were frequently below 90%.
-He spoke with a MA on 07/21/23 about Resident #2 using her oxygen again.
-A MA told him on 09/08/23 that she would get the PCP to order oxygen again.
-Resident #2's heart could not circulate blood well without oxygen. a condition called hypoxia.
-Hypoxia could cause lack of clear thinking, disorientation, and loss of balance that could result in falls.

Telephone interview with Resident #2's PCP on 09/13/23 at 10:05am revealed:
-Resident #2 had an order for supplemental oxygen due to a diagnosis of pulmonary hypertension, sleep apnea and heart failure.
-Resident #2 left a message at his office on 09/11/23 requesting an order for oxygen but he thought she already had it ordered.
-He did not know until she called him that she was not using her oxygen as ordered.
-She could become hypoxic (the absence of oxygen in the tissues to sustain bodily functions) if she did not have supplemental oxygen.
-He could not remember if he had seen her since she moved to the facility.
-He requested a MA obtain her oxygen saturation level and report back to him and he would decide what to do.

Review of the World Health Organization's oxygen saturation guidelines revealed:
-Oxygen saturation was currently referred to as oxygen level.
-A normal oxygen saturation level varied from 97-99% with a lower acceptable limit of 94%.

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D 276	Continued From page 10 Interview with a third MA on 09/13/23 at 10:27am revealed: -Resident #2's PT spoke with her on 09/08/23 about getting an order for supplemental oxygen. -She informed the HWD who said she would take care of it. -Resident #2 was suppose to be on oxygen and staff signed off on it on the eTAR even though she did not have it available. -She knew Resident #2 returned the oxygen concentrator to the supply company a few months ago. -When she had the oxygen concentrator she frequently refused to use it. -On 09/08/23 she became aware Resident #2 wanted to use oxygen again. Interviews with the RCC on 09/13/23 at 10:38am and 11:19am revealed: -She thought the oxygen concentrator that she moved into Resident #2's room was currently in the room and did not know who removed it. -The oxygen concentrator that was moved to Resident #2's room belonged to another resident and when it was moved she did not think about the other resident's need for oxygen through the night and that it would need to be removed from Resident #2's room, leaving her again without oxygen; she was just trying to remedy the current situation. -She just found out on 09/12/23 by a MA that Resident #2 had sent her oxygen back to the company a few months ago. -She did not know that an MA spoke with the HWD on 09/08/23 about ordering supplemental oxygen. -When informed that Resident #2's oxygen saturation had varied between 83-85% she immediately attempted to contact the PCP to see	D 276		

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if the resident needed to be send to the hospital but was only able to leave a message for him.
-Resident #2 could not get oxygen from the supply company without a new order and she had not asked the PCP for a new order yet.

Telephone interview with the HWD on 09/13/23 at 12:58pm revealed:
-No one had informed her on 09/08/23 that Resident #2 needed oxygen.
-She did not know anything about Resident #2's oxygen problem until the morning of 09/12/23 when she reported for work.
-She and the RCC took another residents' oxygen concentrator to Resident #2 around lunchtime so she could have oxygen until they could get another order to the oxygen supply company.
-She returned the oxygen concentrator to the other resident about 6:00pm on 09/12/23 and told a MA to get a portable oxygen tank for Resident #2.
-She did not know if the MA got the portable tank from the storage room or borrowed it from another resident who never used her portable tanks.
-When she left at the end of her shift on 09/12/23, she thought Resident #2 was set up with oxygen for the night.

Review of Resident #2's August 2023 eTAR revealed:
-There was an entry for 2 liters continuous oxygen.
-There were boxes to document the administration of Oxygen on each shift with staff initials.
-Oxygen was documented as administered for 88 of 93 opportunities but there was no oxygen equipment in the facility for Resident #2 to use.

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Review of Resident #2's September 2023 eTAR revealed:
-There was an entry for 2 liters continuous oxygen.
-There were boxes to document the administration of Oxygen on each shift with staff initials.
-Oxygen was documented as administered for 33 of 33 opportunities but there was no oxygen equipment in the facility for Resident #2 to use.

Review of Resident #2's chart notes revealed:
-There was documentation on 06/21/23 that Resident #2 fell in the living room and bumped her head but refused to go to the hospital.
-There was documentation on 07/21/23 that Resident #2's therapist informed the MA that she needed to wear her oxygen.
-There was documentation on 08/28/23 that Resident #2 lost her balance and fell but did not sustain any injuries.

Review of Resident #2's Incident Accident Report dated 08/28/23 revealed Resident #2 lost her balance at 9:40am in her bedroom and fell.

Interview with a PCA on 09/13/23 at 2:05pm revealed:
-If a resident was having any trouble breathing the PCA would let the medication aide know.
-She had assisted Resident #2 several times and was not aware of any oxygen in Resident #2's room.

Interview with a fourth MA on 09/13/23 at 2:10pm revealed he was not aware of Resident #2 having or needing oxygen.

Interview with the first shift supervisor on 09/13/23 at 2:20pm revealed:

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D 276	Continued From page 13 -The facility had extra portable oxygen tanks located at each of the three nurses stations. -The portable tanks could be used if a resident's oxygen tank became empty or if there was an emergency. -Staff had to borrow portable tanks from one resident for another resident at times when they had someone who was out of there portable tanks but would replace it when the new portable tank was delivered. -Staff should not be using any residents oxygen concentrator for another resident. -She was not aware of anyone having to borrow any portable tanks recently. -Resident #2 was supposed to be using oxygen. -Resident #2 had refused her oxygen for about 45 minutes on 09/13/23 during the noon meal but after encouragement put it back on.. Interview with a fifth MA on 09/13/23 at 2:50pm revealed: -Resident #2 used to have oxygen but she had sent it back to the company that had provided it in June 2023 because she did not want to trip over it and did not always need it. -Resident #2 told her and several other staff in June 2023 she had sent the oxygen back. -She had observed Resident #2 being short of breath but could not recall specific dates since June 2023. Interview with the Administrator on 09/13/23 at 2:08pm revealed: -She never knew Resident #2 had orders for oxygen. -The MAs were responsible for ensuring the oxygen was available. -The MA, supervisor, RCC or HWD were all	D 276		

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capable of reordering oxygen when needed.
-If the MAs knew oxygen was not available they should have informed the RCC or HWD.

b. Review of Resident #2's physician's orders dated 08/04/23 revealed there was an order for daily blood pressure checks.

Review of Resident #2's August 2023 electronic treatment administration record (eTAR) revealed:
-There was an entry for daily blood pressure checks.
-There was documentation blood pressure was obtained 12 of 31 opportunities.
-There was documentation blood pressures were refused 4 times by Resident #2.
-There was documentation an MA or a PCA initialed the eTAR but did not document a blood pressure reading.

Review of a note posted in the third floor MA station revealed:
-The note was updated on 8/25/23.
-Resident #2 was not documented as a resident who needed daily blood pressures.

Interview with Resident #2 on 09/13/23 at 9:58am revealed staff attempted to take her blood pressure about two times per week.

Refer to the interview with a PCA on 09/13/23 at 2:05pm.

Refer to the interview with an MA on 09/13/23 at 2:10pm.

Refer to the interview with the first shift supervisor on 09/13/23 at 2:20pm.

Refer to the interview with an MA on 09/13/23 at

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D 276	Continued From page 15 2:50pm. Refer to the interview with the RCC on 09/13/23 at 11:19am Refer to the telephone interview with the HWD on 09/13/23 at 12:58pm. Refer to the interview with the Administrator on 09/13/23 at 2:08pm. c. Review of Resident #2's physician's orders dated 08/04/23 revealed there was an order for monthly weights. Review of Resident #2's August 2023 electronic treatment administration record (eTAR) revealed: -There was an entry for monthly weights. -There was no documentation weights were obtained. Review of Resident #2's September 2023 eTAR revealed: -There was an entry for monthly weights. -There was no documentation weights were obtained. Interview with Resident #2 on 09/13/23 at 9:58am revealed staff checked her weight very infrequently, not even monthly. Refer to the interview with a PCA on 09/13/23 at 2:05pm. Refer to the interview with an MA on 09/13/23 at 2:10pm. Refer to the interview with the first shift supervisor on 09/13/23 at 2:20pm.	D 276		

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Refer to the interview with an MA on 09/13/23 at 2:50pm.

Refer to the interview with the RCC on 09/13/23 at 11:19am

Refer to the telephone interview with the HWD on 09/13/23 at 12:58pm.

Refer to the interview with the Administrator on 09/13/23 at 2:08pm.

d. Review of Resident #2's physician's orders dated 08/04/23 revealed there was an order weekly vitals.

Review of Resident #2's August 2023 eTAR revealed:
-There was an entry for weekly vitals.
-There was documentation vitals were taken on 08/04/23.
-There were staff initials on 08/11/23, 08/18/23 and 08/25/23 but there was no documentation of the vital signs.

Interview with Resident #2 on 09/13/23 at 9:58am revealed she did not know how often staff took her vital signs.

Refer to the interview with a PCA on 09/13/23 at 2:05pm.

Refer to the interview with an MA on 09/13/23 at 2:10pm.

Refer to the interview with the first shift supervisor on 09/13/23 at 2:20pm.

Refer to the interview with an MA on 09/13/23 at 2:50pm.

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D 276	Continued From page 17 Refer to the interview with the RCC on 09/13/23 at 11:19am Refer to the telephone interview with the HWD on 09/13/23 at 12:58pm. Refer to the interview with the Administrator on 09/13/23 at 2:08pm. _____ Interview with a PCA on 09/13/23 at 2:05pm revealed: -The PCA had never been asked to take vitals for a resident. -The MAs usually took vitals, weights and blood pressures. -If a resident was having trouble breathing the PCA would let the medication aide know. Interview with an MA on 09/13/23 at 2:10pm revealed: -He was responsible to take vital signs, blood pressures and weights for residents as they were ordered. -The eTAR would alert him to get vital signs, blood pressures or weights for the particular resident on the specific date it was due. -After he had completed the task he would then sign off on the eTAR the task had been completed. -There was also a list in each of the 3 nurses stations with the day of week weekly vital signs were due for each of the resident. -All weekly vital signs were completed by second shift staff unless the first shift staff had a specific order to complete vital signs. Interview with the first shift supervisor on 09/13/23 at 2:20pm revealed: -Weekly vital signs were completed by the	D 276		

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D 276	Continued From page 18 second shift MAs. -The MAs were responsible for obtaining vital signs, any blood pressures, weights. -The PCAs could be asked to assist in getting these task but ultimately the MAs were responsible. -The MAs were expected to document on the eTAR as soon as the task was completed. -The RCC and the HWD were responsible to ensure these were completed. -She was responsible to ask if the MAs were able to get their daily task completed and she would assist as needed but she did not specifically ask about vital signs, weights or blood pressures. -Weights were due the first of the month. -The eTAR would alert the MA's when they needed to get a blood pressure, weights or vital signs. -The MAs should also let the HWD know if a resident refused so she can call the resident's physician if needed. Interview with an MA on 09/13/23 at 2:50pm revealed: She was responsible for getting vital signs, blood pressures and weights for her residents as they came up on the residents eTAR. After she completed the task she would document them on the eTAR. -She did not ask the PCAs to assist with vital signs, weights or blood pressures, as she was responsible. -Most blood pressure checks and weights have a parameter as to when to notify the physician. -If the physician needed to be notified she would inform the RCC or the HWD and they would notify them. -At times, if the RCC or the HWD was busy, they might ask her to notify the physician but that was only if they were busy.	D 276		

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D 276	Continued From page 19 -If the eTAR was not signed, then the MA did not do the task. Interview with the RCC on 09/13/23 at 11:19am revealed the MAs and PCAs were not always taking blood pressures, weights and vitals as ordered and there was a meeting about it on 09/08/23. Telephone interview with the HWD on 09/13/23 at 12:58pm revealed: -The PCAs were responsible for obtaining blood pressures, weights and vitals and documenting the results on the eTAR. -Weights were scheduled to be taken the first week of each month. -Signs were posted to remind staff to take weights, vitals and blood pressures. Interview with the Administrator on 09/13/23 at 2:08pm revealed: -The MA, or supervisor working that shift, assigned a PCA to obtain blood pressure readings, weights and vitals and they were then responsible for documenting the information in the eTAR. -The PCAs have access to the eTAR so they can document. -She did not know blood pressures, weights and vital signs were not being taken as ordered until the HWD had a meeting with all the staff on 09/08/23 reminding them to follow orders. -She expected the PCAs to follow instructions from the MA or supervisors. -If the RCC and HWD looked at the eTAR as well as the eMAR when they did the chart audits, errors would have been identified earlier than 09/12/23. 2. Review of Resident #4's FL2 dated 08/02/23	D 276		

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revealed:
-There were diagnoses of type II diabetes, hypertension, hyperlipidemia.
-There was documentation the resident experienced intermittent confusion.

Review of Resident #4's physician orders dated 06/29/23 revealed there was an order for weekly vital signs.

Review of Resident #4's electronic treatment administration record (eTAR) dated August 2023 revealed:
-There was an entry for weekly vital signs.
-There were no vital signs documented on 08/11/23 or 08/18/23.
-Vital signs were documented on 08/04/23 and 08/25/23.

Review of Resident #4's eTAR dated September 2023 revealed:
-There was an entry for weekly vital signs.
-There were no vitals taken from 09/01/23-09/13/23.

Telephone interview with the Health and Wellness Director (HWD) on 09/13/23 at 1:15pm revealed:
-Resident #4 was compliant and did not refuse medications or treatments.
-The medication aides (MAs) should be documenting the weekly vital signs for Resident #4.
-She was not aware staff were not documenting weekly vital signs for Resident #4.

Interview with a personal care aide (PCA) on 09/13/23 at 2:05pm revealed:
-The PCA had never been asked to take vitals for a resident.
-The MA usually took vitals.

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D 276	Continued From page 21 Interview with an MA on 09/13/23 at 2:10pm revealed: -He was responsible to take vital signs for residents as ordered. -The eTAR would alert him to get vital signs for the particular resident on the specific date it was due. -After he had completed the task he would then sign off on the eTAR the task had been completed. -There was also a list in each of the 3 nurses stations with the day of week weekly vital signs were due for each of the resident. -All weekly vital signs were completed by second shift staff unless the first shift staff had a specific order to complete vital signs. -If there was no documentation on the eTAR of the vitals then the vitals were not done. Interview with the first shift supervisor on 09/13/23 at 2:20pm revealed: -Weekly vital signs were completed by the second shift MAs. -The MAs were responsible for obtaining vital signs. -The PCAs could be asked to assist in this task but ultimately the MAs were responsible. -The MAs were expected to document on the eTAR as soon as a task was completed. -The Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible to ensure vitals were completed. -She was responsible to ask if the MAs were able to get their daily task completed and she would assist as needed but she did not specifically ask about vital signs. -The eTAR would alert the MAs when they needed to get vital signs. -The MAs should also let the HWD know if a	D 276		

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resident refused so she can call the resident's physician if needed.

Interview with a second MA on 09/13/23 at 2:50pm revealed:
She was responsible for getting vital signs for her residents as they came up on the residents eTAR.
After she completed the task she would document them on the eTAR.
-She did not ask the PCAs to assist with vital signs because she was responsible.
-If the physician needed to be notified she would inform the RCC or the HWD and they would notify them.
-At times, if the RCC or the HWD was busy, they might ask her to notify the physician but that was only if they were busy.
-If the eTAR was not signed, then the MA did not do the task.

Interview with the RCC on 09/13/23 at 11:19am revealed the MAs and PCAs were not always getting vital signs as ordered and there was a meeting about it on 09/08/23.

Telephone interview with the HWD on 09/13/23 at 12:58pm revealed:
-The PCAs were responsible for obtaining vital signs and documenting the results on the eTAR.
-Signs were posted to remind staff to obtain vital signs.

Interview with the Administrator on 09/13/23 at 2:08pm revealed:
-The MA or supervisor working that shift, assigned a PCA to obtain vital signs and they were then responsible for documenting the information in the eTAR.
-The PCAs had access to the eTAR so they could

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D 276	Continued From page 23 document. -She did not know vital signs were not being taken as ordered until the HWD had a meeting with all the staff on 09/08/23 reminding them to follow orders. -She expected the PCAs to follow instructions from the MA or supervisors. -If the RCC and HWD looked at the eTAR as well as the eMAR when they did the chart audits, errors would have been identified earlier than 09/12/23. _____ The facility failed to ensure Resident #2 was administered oxygen as ordered and failed to contact the PCP to obtain orders for five days after they were told she did not have oxygen equipment available. This failure resulted in Resident #2 developing hypoxia with an oxygen saturation levels of 83-85% which resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/13/23. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED October 13, 2023.	D 276		
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;	D 367		

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(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:
Based on interviews and record reviews the facility failed to ensure the electronic Treatment Administration Record (eTAR) was accurate for 1 of 5 sampled residents (#2) related to oxygen administration.

The findings are:

Review of Resident #2's current FL2 dated 12/28/22 revealed diagnoses included hypertension, heart failure, and apnea.

Review of Resident #2's physician's orders dated 08/04/23 revealed there was an order for 2 liters of continuous oxygen.

Interviews with Resident #2 on 09/12/23 at 9:59am and 1:57pm and on 09/13/23 at 9:58am revealed:
-She had orders for oxygen off and on in the past.
-She had an oxygen concentrator in the past, but she called the contract company a few months

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ago and requested they pick up all her equipment because she thought the tubing was a trip hazard and she did not need oxygen at that time.
-When she returned the oxygen supplies she did not tell anyone at the facility because she did not think she needed to, because oxygen delivery was a contract she had with the company.

Observation during initial tour on 09/12/23 at 9:59am revealed there was no oxygen concentrator or portable oxygen in Resident #2's room.

Observation of Resident #2's room on 09/12/23 at 11:15am revealed no oxygen concentrator or portable oxygen was available in the room.

Review of Resident #2's August 2023 eTAR revealed:
-There was an entry for 2 liters continuous oxygen.
-There was a place to document the administration of Oxygen on each shift.
-Oxygen was documented as administered for 88 of 93 opportunities.

Review of Resident #2's September 2023 eTAR revealed:
-There was an entry for 2 liters continuous oxygen.
-There was a place to document the administration of oxygen on each shift.
-Oxygen was documented as administered for 33 of 33 opportunities.

Interview with a medication aide (MA) on 09/12/23 at 1:35pm revealed:
-Resident #2 had an oxygen concentrator for a while, but a few months ago she returned it.
-If she documented on the eTAR that Resident #2

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was wearing oxygen, she must have had it on or she would not have documented it that way.

Interview with a second MA on 09/12/23 at 2:18pm revealed:
-Resident #2 had an order for oxygen on her eTAR but she did not have oxygen available.
-When she documented oxygen administration on the eTAR, the resident was not wearing oxygen because she did not have any available.
-All the MAs and personal care aides (PCAs) had been documenting oxygen administration even though they knew it was not available.
-She should have notified the Resident Care Coordinator (RCC) or the Health and Wellness Director (HWD) that oxygen was not available but it was still on the eTAR.

Interview with the RCC on 09/12/23 at 2:29pm revealed:
-She was not aware staff were documenting on the eTAR that they were administering oxygen when there was no oxygen available to administer.
-She would not have documented administration 12 times in August 2023 if it was not available, so she must have seen her wearing it.
-Staff should have brought it to Administrations attention that oxygen was not available but it was still on the eTAR.

Interviews with the HWD on 09/12/23 at 2:39pm and 2:50pm revealed:
-She was not aware the MAs were documenting administration of oxygen when Resident #2 had returned it and and it was unavailable to administer.
-When she documented on the eTAR on 08/20/23 that she administered Resident #2's oxygen, she must have been wearing it or she would not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL057011	A. BUILDING: _____ B. WING _____	R-C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARS HILL RETIREMENT COMMUNITY	170 SOUTH MAIN STREET MARS HILL, NC 28754

(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		

documented it that way.
-She would not expect the MAs to document administration if oxygen was not available.
-She expected the PCAs and MAs to inform their supervisor, the RCC or herself of any task on the eTAR that was not possible to do.

Interview with a third MA on 09/13/23 at 10:27am revealed:
-She knew Resident #2 returned the oxygen concentrator to the supply company a few months ago and did not have any to administer.
-Staff signed off on it on the eTAR even though she did not have oxygen available.
-She "guessed" she was not paying attention when she documented on the eTAR.
-She knew better than to sign for something that was not done; she just did not have an answer as to why she did it.

Interview with the RCC on 09/13/23 at 11:19am revealed:
-She conducted chart audits weekly but she never checked treatments, just confirmed that medications were available.
-If she had checked the eTAR she would have discovered oxygen was being documented inaccurately.

Interview with the Administrator on 09/13/23 at 2:08pm revealed:
-She expected the MAs and PCAs to inform the RCC or HWD oxygen administration was on the eTAR but oxygen was not available.
-MAs and PCAs should not document anything they did not do.
-The RCC and HWD conducted chart audits but she did not realize they only checked medications but not treatments.
-If treatments were also checked during the

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D 367	Continued From page 28 audits the oxygen administration error would have been found.	D 367		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report an allegation of verbal abuse to the Health Care Personnel Registry (HCPR) related to Staff A yelling and cursing at Resident #1. The findings are: Review of the facility's Abuse Policy and Procedure revised on 08/15/17 revealed: -When a report of abuse was made an investigation should be initiated. -A report and/or notification should be made to the appropriate licensing/regulatory agency (HCPR). Review of Resident #1's current FL2 dated 10/26/22 revealed diagnoses included Parkinson's Disease (disorder of the central nervous system that affects movement), and anxiety. Review of Resident #1's Care Plan dated 11/30/22 revealed Resident #1 required the assistance of 1 person for transfers.	D 438		

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D 438	Continued From page 29 Interview with a MA on 09/12/23 at 1:55pm revealed: -She worked on third shift when Resident #1 was in her room and called for staff to assist her. -Staff A went to Resident #1's room to assist the resident. -Staff A finished in Resident #1's room and said she wasn't going to enable Resident #1 because she could do some things herself. -The MA went into Resident #1's room and the resident was crying and said Staff A yelled at her because she needed assistance to the bathroom. -She reported this event to the supervisor. -She could not recall the date of the event or when she reported it. Interview with the Supervisor on 09/13/23 at 8:56am revealed: -She was informed by the MA that there was an allegation that Staff A yelled at Resident #1. -She witnessed an event when Staff A came out of Resident #1's room, stood in the open doorway, and used a curse word to describe the resident. -She knew Resident #1 could hear that because she was in her room within hearing distance. -She informed the Administrator of both these events but could not recall the dates. Interview with Resident #1 on 09/12/23 at 9:40am revealed: -She required staff to assist her with showers and transfers. -Sometimes staff were rude, disrespectful and yelled at her. -She could not recall specific events or dates. Interview with the Health and Wellness Director (HWD) on 09/13/23 at 12:53pm revealed:	D 438		

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D 438	Continued From page 30 -She became aware on 07/12/23 there was an allegation of verbal abuse by Staff A when Resident #1 told her Staff A was rude and yelled at her because she required assistance with transferring from the chair to wheelchair and toilet. -She asked Resident #1 on subsequent days if Staff A stopped yelling at her and being rude and Resident #1 said it had not stopped. -She reported it to the Administrator on 07/12/23. Interview with the Administrator on 09/13/23 at 9:10am revealed: -She could not recall staff informing her Staff A was verbally abusive to Resident #1. -Staff A came to her office on 07/13/23 and informed her she was frustrated with Resident #1 because the resident should do more to help herself. -She was concerned with the tone Staff A used in speaking and how she stated she spoke to Resident #1. -Staff A was given a written disciplinary form for abusive and/or disrespectful conduct to the resident on 07/19/23 and instructed she could no longer work on the floor where Resident #1 resided. -She did not suspend Staff A. -She had a meeting with the HWD and the RCC on 07/24/23 and the decision was made to terminate Staff A if she was being disrespectful and rude to residents. -She did not report Staff A to the HCPR.	D 438		