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CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation survey on November 13, 2024 through November 15, 2024.	D 000		
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 A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure residents received appropriate care for 1 of 5 sampled residents (#4) related to a resident who was not seen by a physician when she had a swollen hand and arm. The findings are: Review of the facility's Change in Resident Status policy dated 05/11/22 revealed: -Staff had the responsibility to provide care to each resident and summon medical attention when the resident had a change in status. -When there was an actual change in status or ability to function the resident's physician should be immediately notified. -A significant change included a change in the ability to use one's hands to grasp small objects. Review of Resident #4's current FL-2 dated 01/11/24 revealed diagnoses included dementia, hypertension, and anxiety. Review of Resident #4's Resident Register	D 273		

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D 273	Continued From page 1 revealed Resident #4 was admitted on 05/19/21. Review of Resident #4's hospital admission notes revealed: -She was hospitalized from 09/23/24 to 09/26/24. -She presented to the emergency room with a swollen right hand/arm. -Her right arm was visibly swollen, red and hot to the touch. -There was documentation her right hand and arm was edematous (swollen), erythema (redness), warm and tenderness to palpation. -On 09/23/24, an X-ray of the right hand revealed diffuse edema of the superficial soft tissue. -Resident #4 was admitted to the hospital due to a diagnosis of cellulitis, erysipelas (a bacterial infection of the skin), trauma, gout/inflammatory arthritis, physical examination revealed significant erythema, pain and elevated C-Reactive Protein (CRP, a blood test which measures inflammation in he body) . -She received intravenous (IV) antibiotics, IV steroids, and oral antibiotics. a. Review of Resident #4's progress note dated 09/24/24 revealed: -A late entry for 09/18/24, the Resident Care Director (RCD) documented Resident #4's hand was slightly swollen. -A late entry for 09/19/24, the RCD documented Resident #4's hand was very swollen and Emergency Medical Services removed the rings from Resident #4's fingers. -A late entry for 09/20/24, the RCD documented Resident #4's hand was still swollen, notified Resident #4's PCP and a Xray was ordered. Review of Resident #4's record revealed there were no Accident/Incident reports completed on 09/18/24 and 09/19/24.	D 273		

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D 273	Continued From page 2 Review of an email to Resident #4's PCP from the RCD dated 09/21/24 at 12:11pm revealed: -The subject line titled was Resident #4's name. -The body of the email included, "hey, this is her hand this morning". -The was no attachment. Review of three photos of Resident #4's right hand provided by Resident #4's Power of Attorney (POA) dated 09/21/24 at 12:14pm revealed: -Resident #4's right hand swollen at least twice the size of the left hand. -The swelling extended up into the forearm area. -The color of the right hand was red and shiny. -The right pointer finger revealed an indention from where the ring had been and a small abrasion above the ring indentation. Review of three photos of Resident #4's right hand provided by Resident #4's POA dated 09/22/24 at 12:00pm revealed: -Resident #4's right hand was swollen more than it had been in the picture dated 09/21/24. -Swelling extended up into the forearm area more than it had been in the picture dated 09/21/24. -The right sleeve of the sweater Resident #4 was wearing was tighter around her hand than the sleeve of the left hand. -Resident #4's right hand and wrist area was red. -The right pointer finger revealed an indention from where the ring had been and a small abrasion above the ring indentation. -The right middle finger revealed a small skin abrasion on the section between the base of the finger and the middle joint. Review of an email to the RCD from Resident #4's PCP dated 09/23/24 at 8:10am revealed: -The subject line was titled Resident #4's name.	D 273		

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-The body of the email included, "oh goodness", "that may need to be sent out", and "how is it today?".

Review of an email to Resident #4's PCP from the RCD dated 09/23/24 at 8:26am revealed:
-There were two photos of Resident #4's right hand.
-The body of the email included, "this is her hand this morning??".

Review of a photo of Resident #4's right hand provided by Resident #4's POA dated 09/23/24 at 7:04pm revealed:
-Resident #4's right hand was still swollen.
-The swelling extended up into the forearm area
-The color of the right hand and wrist area was red.
-The right pointer finger revealed an indention from where the ring had been and a small abrasion above the ring indentation.
-The right middle finger revealed a small skin abrasion on the section between the base of the finger and the middle joint.

Review of a telephone call transcript from Resident #4's POA to Resident #4's PCP office dated 09/23/24 at 7:21pm revealed:
-Another provider received a call from Resident #4's POA.
-Resident #4's POA informed the provider that Resident #4's right hand had been swollen for a week.
-On 09/18/24, Resident #4's rings were cut off by the local fire department.
-Staff at the facility told the POA that X-rays were ordered and should be back by today (09/23/24).
-The provider reviewed Resident #4's office record and there was no documentation of having any workup related to Resident #4's hand.

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-The POA was told the PCP would be seeing Resident #4 on Tuesday, 09/24/24.

Review of Resident #4's history and physical dated 09/23/24 at 8:37pm revealed:
-An assessment and plan was completed by Resident #4's PCP.
-The PCP spoke with Resident #4's POA
-A picture of a left hand was received by email and reviewed on 09/23/24.
-The POA stated Resident #4 was sent to the emergency room for evaluation.
-The POA was under the impression that an X-ray was ordered, however, it was not as of 09/23/24.

Interview with a representative from the local fire department on 11/13/24 at 5:15pm revealed on 09/18/24 at 5:18pm fire fighters responded to a call from the facility to assist cutting rings off of Resident #4's fingers of her right hand.

Interview with the RCD on 11/14/24 at 9:52am revealed:
-On 09/17/24, staff informed her that Resident #4's right hand was swollen.
-She found Resident #4's right hand to be slightly swollen so she told the staff to keep it elevated.
-On 09/18/24, Resident #4's hand was very swollen and after speaking to the Special Care Coordinator (SCC), they concluded the rings on Resident #4's right fingers were possibly causing the fingers and hand to swell.
-Resident #4's entire hand and fingers were so swollen, the rings looked like the were cutting off the circulation of the fingers due to their slight blue tinged color.
-She called the local fire department to come and cut the rings off of Resident #4's fingers.
-She did not contact Resident #4's PCP because she thought the rings were causing the fingers

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and hands to swell.
-On 09/19/24, the swelling had gone down some in Resident #4's hand and fingers.
-On 09/20/24, Resident #4's hand and fingers were swollen more so she called the PCP.
-When she called the PCP, she informed the PCP about another resident needing an xray of the hand and then she told the PCP about Resident #4 and the PCP said she would order the X-ray.
-She was under the understanding an X-ray was ordered for two resident's hands which included Resident #4.

Telephone interview with Resident #4's POA on 11/14/24 at 10:06am revealed:
-On 09/18/24, a family member called him and told him Resident #4's hand was swollen and the staff needed permission to cut rings off.
-On 09/18/24, he went to the facility to check on Resident #4 and the RCD asked for permission to cut the rings off of Resident #4's fingers.
-On 09/18/24, Resident #4 was not sent out to the emergency room because the RCD thought the swelling was because of the rings and the fire department could cut them off.
-On 09/20/24, he was shocked to find Resident #4's hand and forearm were swollen more than on 09/18/24, even after the rings were cut off.
-The RCD stated the PCP was aware and an X-ray was ordered and they were waiting on the results.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/14/24 at 12:01pm revealed:
-On Friday 09/20/24, the RCD called her about another resident with a hand and foot injury from a fall.
-During the telephone conversation on 09/20/24,

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Resident #4 was mentioned but at that time it was not clear as to why Resident #4 was mentioned.
-She did not an X-ray for Resident #4.
-She was not notified that Resident #4's hand was swollen on 09/18/24 and required Resident #4's rings to be cut off by the local fire department.
-She did not find out Resident #4 needed an X-ray until 09/23/24 because of a misunderstanding with the RCD on 09/20/24.
-There was no documentation in Resident #4's office records related to an X-ray of Resident #4's right hand due to swelling until 09/23/23 when Resident #4's POA called to inquire about the results of a hand X-ray.
-If she was notified on 09/18/24, when staff noticed Resident #4's hand was swollen and they called the fire department to cut rings off because of the swelling then she could have seen Resident #4 via virtual visit or had Resident #4 sent out to be evaluated.
-The X-ray and possible antibiotics could have been ordered on the 09/18/24.

Refer to telephone interview with the Administrator on 11/15/24 at 3:25pm.

b. Review of Resident #4's progress note dated 09/24/24 revealed a late entry for 09/20/24, the RCD documented Resident #4's hand was still swollen, notified Resident #4's PCP and an X-ray was ordered.

Review of Resident #4's record revealed there were no physician's order dated 09/20/24 for an X-ray of the hand.

Review of Resident #4's progress note dated 09/24/24 revealed:
-A late entry for 09/21/24, the RCD documented

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she received a call from the staff regarding Resident #4's POA's concern of Resident #4's hand.
-She spoke with Resident #4's POA and told him that an X-ray was ordered but no results were received from the PCP office.
-On 09/21/24 she called the PCP's office about the X-ray and a nurse told her that there was no X-ray ordered or found in Resident #4's office record.
-She emailed a picture of Resident #4's hand and would follow-up with PCP on Monday, 09/23/24.
-Resident #4 showed signs of pain with movement of the right hand.

Interview with the RCD on 11/14/24 at 9:52am revealed:
-On 09/20/24, she was under the understanding an X-ray was ordered for two resident's hands which included Resident #4 and they were completed.
-On 09/21/24, She called to the PCP's office and inquired about the X-ray for Resident #4's hand because staff notified her Resident #4's POA was inquiring about the results of the X-ray and Resident #4's hand was still swollen.
-She called the PCP's office and was told by a nurse there was not an order in for an X-ray for Resident #4 in Resident #4 office record.
-She did not ask to speak to the on-call provider to inform them about the swelling in Resident #4's hand and arm or to ask what needed to be done.
-She sent an email to Resident #4's PCP earlier that day and would just wait to follow-up with the PCP on Monday morning (09/23/24).

Interview with a medication aide (MA) on 11/14/24 at 9:21am revealed:
-Around 09/16/24, Resident #4's hand was swollen and she informed the Special Care

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Coordinator (SCC).
-She was directed by the RCD to keep Resident #4's hand elevated.
-About two days later, someone outside of the facility cut the rings off of Resident #4's fingers.
-Over the next few days Resident #4 hand continued to swell.
-On 09/21/24, Resident #4's POA was upset over how much Resident #4's hand and forearm had swollen since the rings were cut off instead of getting better.
-She called the RCD and was told that the PCP ordered an X-ray which was not resulted yet.
-She did not call the PCP because the RCD was taking care of it.

Telephone interview with Resident #4's POA on 11/14/24 at 10:06am revealed:
-On 09/21/24, Resident #4's right hand was swollen more since 09/18/24, even after the rings were cut off.
-The hand and forearm area were swollen.
-Resident #4's right hand was red and shiny.
-Resident #4 had indention's from where the rings were and an abrasion on her pointer finger.
-He asked the MA about the X-ray and was told that the RCD said the X-ray which was not resulted yet.
-On 09/22/24, Resident #4's swelling was the same and he was concerned that nothing was being done so he asked the MA on duty.
-The MA told him that the RCD said they were waiting on the X-ray results.
-He considered taking Resident #4 to the ER but the MA said the X-ray result should be back in the morning (09/23/24).
-On 09/23/24 about 7:30pm, he called Resident #8's PCP's office and spoke to another provider.
-The other provider told him no X-ray order or any other information concerning Resident #4's

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swollen right hand had been documented in the past week.
-On 09/23/24, he had already requested the facility to send Resident #4 to the ER when he received a call from the PCP, who explained there was a misunderstanding with the RCD related to the X-ray order for Resident #4's hand.
-She said she did not know about the condition of Resident #4's hand and did not order an X-ray until 09/23/24.
-The PCP did not receive any calls about the increased swelling or the X-ray not being done for over a six day span.
-"Everyone" assumed the PCP knew about the swelling, rings cut off and the redness, but none of the staff actually checked with the PCP.

Telephone interview with a second MA on 11/15/24 at 10:27 revealed:
-On 09/22/24, Resident #4's POA was visiting when Resident #4 complained of pain.
-She saw the swelling and redness in Resident #4's hand and forearm.
-She was not given a report about Resident #4's hand and arm so she asked a personal care aide (PCA).
-After speaking to the PCA she called the RCD and reported her findings.
-The RCD stated there was an X-ray completed and they were just waiting for the results.
-She told the POA that there were no results yet.
-The POA was concerned because the swelling was worse but she told him that the PCP was aware and they were just waiting on the results but if he thought he should take Resident #4 to his physician then he should but she did not have a reason to send Resident #4 out because Resident #4 was seen by the PCP and tests were ordered.
-She did not call the PCP because she was told

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to notify the RCD and the RCD would call the physician or tell her to call 911.
-She was directed to call 911.

Telephone interview with the SCC on 11/15/24 at 1:31pm revealed:
-On 09/18/24, about 5:00pm, a PCA informed her about Resident #4's swollen hand.
-After she saw Resident #4's swollen hand she called the RCD.
-After the RCD assessed Resident #4's hand, she told the RCD that the fire department could cut the ring off and the fire department was called.
-A fire fighter cut the 2 or 3 rings off of Resident #4's right hand fingers.
-The policy was to send out if an emergency, if not notify RCD, then RCD would assess the concern and determine if the physician was to be notified or send the resident out.
-Resident #4's swelling decreased a little bit after the rings were cut off but began to swell more on Thursday evening 09/19/24.
-She informed the RCD on Friday morning 09/20/24.
-On 09/20/24 the RCD told her the PCP ordered an X-ray and would be completed today.
-On 09/20/24, she did not see the mobile X-ray technician in the building before she left around 6:30pm.
-She did not call the PCP because the RCD said the PCP was aware and waiting on the X-ray results.

Telephone interview with Resident #4's PCP on 11/14/24 at 12:01pm revealed:
-She did not find out Resident #4 needed an X-ray of her right hand until 09/23/24 because of a misunderstanding with the RCD on 09/20/24.
-There was no documentation in Resident #4's office records related to an X-ray of Resident #4's

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right hand due to swelling until 09/23/23 when Resident #4's POA called inquiring about the results of a hand X-ray.
-Staff should have called the on-call service over the weekend because there was not an X-ray completed.

Refer to telephone interview with the Administrator on 11/15/24 at 3:25pm.

c. Review of Resident #4's Hospital Discharge Summary dated 09/26/24 at 4:17pm revealed:
-An order for prednisone (used to treat inflammation) 20mg every day for 10 days, to begin on 09/26/24.
-An order for tramadol (used to treat pain) 50mg, two times a day for 30 days, to begin on 09/26/24.
-An order to continue allopurinol (used to treat gout) 100mg every morning.
-An order to continue amlodipine besylate (used to treat blood pressure) 10mg every day.
-An order to continue divalproex (used to treat dementia) 125mg two times a day.
-An order to continue donepezil (used to treat dementia) 10mg at bedtime.
-An order to continue memantine (used to treat dementia) 10mg at bedtime.

Review of Resident #4's September 2024 electronic Medication Administration Record (eMAR) revealed:
-An entry for prednisone 20mg every day, with a start date of 09/29/24, and there was no documentation the prednisone was administered on 09/27/24 and 09/28/24 at 9:00am.
-An entry for tramadol 50mg two times a day, with a start date of 03/01/24, and there was no documentation the tramadol was administered on 09/26/24 at 9:00pm and 09/27/24 at 9:00am.
-An entry for allopurinol 100mg every day, with a

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CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

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start dated of 03/01/24, and there was no documentation the allopurinol was administered on 09/27/24 at 9:00am.
-An entry for amlodipine besylate 10mg every day, with a start date of 03/01/24 and there was no documentation the amlodipine was administered on 09/27/24 at 9:00am.
-An entry for divalproex 125mg, two times a day with a start date of 03/01/24 and there was no documentation the divalproex was administered on 09/26/24 at 9:00pm and 09/28/24 at 9:00am.
-An entry for donepezil 10mg at bedtime with a start date of 03/01/24 and there was no documentation the donepezil was administered on 09/26/24 at 9:00pm.
-An entry for memantine 10mg at bedtime with a start date of 03/01/24 and there was no documentation the memantine was administered on 09/26/24 at 9:00pm.

Interview with the RCD on 11/14/24 at 9:52am revealed:
-On 09/26/24, Resident #4 returned from the hospital but the family did not bring the discharge paperwork with her.
-Since there was no discharge paperwork she could not make the necessary changes to Resident #4's medications in the eMAR or fax the changes/additions to the pharmacy.
-Resident #4's status remained as "LOA", leave of absence on the eMAR until 09/28/24 when the family brought in the discharge paperwork.
-She did not call the hospital for a copy of the discharge paperwork because in the past "that never worked" and she did not call the PCP for recommendations or to see if their office could get a copy or if they received a copy.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/14/24 at 12:01pm

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revealed:
-She did not know the facility did not receive Resident #4's discharge instructions dated 09/26/24.
-The facility staff were responsible for getting the discharge instructions at the time of discharge.
-The facility staff should have called the hospital for a copy of the discharge instructions once Resident #4 returned to the facility and did not have the instructions.
-The facility staff could have called her office for assistance in getting the discharge instructions because they may have had it in their system.
-The purpose of the discharge instructions were to provide a plan of care for Resident #4 once she returned to the facility and without those instructions, staff would not know what to do and were responsible for notifying her if they could not get those instructions by the next morning.

Refer to a telephone interview with the Administrator on 11/15/24 at 3:25pm.

d. Review of Resident #4's Hospital Discharge Summary dated 09/26/24 at 4:17pm revealed:
-An order for prednisone 20mg every day for 10 days, to begin on 09/26/24.
-An order for tramadol 50mg, two times a day for 30 days, to begin on 09/26/24.
-An order to continue allopurinol 100mg every morning.
-An order to continue amlodipine besylate 10mg every day.
-An order to continue divalproex 125mg two times a day.
-An order to continue donepezil 10mg at bedtime.
-An order to continue memantine 10mg at bedtime.

Review of Resident #4's September 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 14 electronic Medication Administration Record (eMAR) revealed: -An entry for prednisone 20mg every day, with a start date of 09/29/24, and there was no documentation the prednisone was administered on 09/27/24 and 09/28/24 at 9:00am. -An entry for tramadol 50mg two times a day, with a start date of 03/01/24, and there was no documentation the tramadol was administered on 09/26/24 at 9:00pm and 09/27/24 at 9:00am. -An entry for allopurinol 100mg every day, with a start dated of 03/01/24, and there was no documentation the allopurinol was administered on 09/27/24 at 9:00am. -An entry for amlodipine besylate 10mg every day, with a start date of 03/01/24 and there was no documentation the amlodipine was administered on 09/27/24 at 9:00am. -An entry for divalproex 125mg, two times a day with a start date of 03/01/24 and there was no documentation the divalproex was administered on 09/26/24 at 9:00pm and 09/28/24 at 9:00am. -An entry for donepezil 10mg at bedtime with a start date of 03/01/24 and there was no documentation the donepezil was administered on 09/26/24 at 9:00pm. -An entry for memantine 10mg at bedtime with a start date of 03/01/24 and there was no documentation the memantine was administered on 09/26/24 at 9:00pm. Interview with the RCD on 11/14/24 at 9:52am revealed she did not call the Resident #4's PCP to notify about the missed medications for 2 days, especially missing the prednisone and tramadol. Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/14/24 at 12:01pm revealed: -She did not know Resident #4 did not receive	D 273		

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discharge medications on 09/26/24 to 09/28/24.
-She expected the staff to call her and notify her that they did not have the discharge instructions dated 09/26/24 because she could have assisted in getting the instructions or given orders to cover Resident #4 in the mean time.
-Her concerns with not getting the prednisone was, Resident #4 could have an increase in inflammation and that was apart of her hospitalization diagnoses.
-Her concerns with not getting the tramadol was, Resident #4 could have an increase in pain and that was apart of her hospitalization diagnoses.
-Her concerns with not getting the allopurinol was, Resident #4 could have an exacerbation of gout.
-Her concerns with not getting the amlodipine was, Resident #4 could have an increase in her blood pressure.
-Her concerns with not getting the divalproex was, Resident #4 could have an increase in behaviors.
-Her concerns with not getting the donepezil was, Resident #4's dementia could get worse.
-Her concerns with not getting the memantine was, Resident #4's dementia could get worse.
-When medication were missed, it caused a delay in the treatment process.

Refer to a telephone interview with the Administrator on 11/15/24 at 3:25pm.

_____

Telephone interview with the Administrator on 11/15/24 at 3:35pm revealed:
-On 09/18/24 she knew that Resident #4's hand was swollen and the facility had to contact the local fire department to come cut the rings cut off.
-She was under the impression that the RCD was in communication with Resident #4's PCP by sending pictures but she could not recall the dates.

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D 273	Continued From page 16 -The RCD should have notified Resident #4's PCP about the swollen hand which required the rings to be cut off because there were to be no clinical decisions without the PCP's orders. -The RCD was responsible for making sure an order was received from the PCP related to the hand X-ray by calling the mobile X-ray department and verifying the order was received within a couple of hours. -The RCD was responsible to call the PCP back if the order for the X-ray did not go through. -The RCD was responsible to follow-up with the PCP after Resident #4's hand continued to swell and when the X-ray was not completed on 09/20/24 when the other resident received their X-ray. -The RCD was responsible for contacting the PCP's office and speaking to an on call provider when it was the weekend or after hours. -The RCD was responsible for processing the discharge paperwork on 09/26/24 when Resident #4 returned from the hospital within the same day. -The MAs were responsible for obtaining the discharge paperwork from the transport within the same day. -The RCD was responsible to call the hospital and family to obtain the discharge paperwork if it was not delivered when a resident returned from the hospital within the same day. -The RCD was responsible for notifying the PCP when there was a delay in receiving the medications were missed medications due to no discharge paperwork after the resident returned to the facility. _____ The facility failed to notify Resident #4's primary care provider for six days after the staff noticed her right hand and arm was red and swollen	D 273		

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D 273	Continued From page 17 resulting in the resident being hospitalized for three days for cellulitis, requiring intravenous antibiotics, intravenous steroids and oral antibiotics. The failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/24 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 15, 2024.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#4)) related to medications used to treat inflammation, pain, gout, blood pressure, behaviors and dementia. The findings are: Review of Resident #4's FL-2 dated 01/11/24	D 358		

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revealed diagnoses included dementia, hypertension, and anxiety.

Review of Resident #4's Hospital Admission notes revealed:
-Her hospitalization was from 09/23/24 to 09/26/24.
-She presented to the emergency room with a swollen right hand/arm.
-Her right arm was visibly swollen, red and hot to the touch.
-There was documentation her right hand and arm noted edema, erythema, warm and tenderness to palpation.
-Due to a diagnosis of cellulitis, erysipelas (a bacterial infection of the skin), trauma, gout/inflammatory arthritis, physical examination revealed significant erythema, pain and elevated C-Reactive Protein, Resident #4 was admitted to the hospital.
-She received intravenous (IV) antibiotics, IV steroids, and oral antibiotics.
-A discharge time of 4:17pm on 09/26/24.
-An order for prednisone 20mg every day for 10 days, to begin on 09/26/24.
-An order for tramadol 50mg, two times a day for 30 days, to begin on 09/26/24.
-An order to continue allopurinol 100mg every morning.
-An order to continue amlodipine besylate 10mg every day.
-An order to continue divalproex 125mg two times a day.
-An order to continue donepezil 10mg at bedtime.
-An order to continue memantine 10mg at bedtime.

Review of Resident #4's September 2024 electronic Medication Administration Record (eMAR) revealed:

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D 358	Continued From page 19 -An entry for prednisone 20mg every day, with a start date of 09/29/24, and there was no documentation the prednisone was administered on 09/27/24 and 09/28/24 at 9:00am. -An entry for tramadol 50mg two times a day, with a start date of 03/01/24, and there was no documentation the tramadol was administered on 09/26/24 at 9:00pm and 09/27/24 at 9:00am. -An entry for allopurinol 100mg every day, with a start dated of 03/01/24, and there was no documentation the allopurinol was administered on 09/27/24 at 9:00am. -An entry for amlodipine besylate 10mg every day, with a start date of 03/01/24 and there was no documentation the amlodipine was administered on 09/27/24 at 9:00am. -An entry for divalproex 125mg, two times a day with a start date of 03/01/24 and there was no documentation the divalproex was administered on 09/26/24 at 9:00pm and 09/28/24 at 9:00am. -An entry for donepezil 10mg at bedtime with a start date of 03/01/24 and there was no documentation the donepezil was administered on 09/26/24 at 9:00pm. -An entry for memantine 10mg at bedtime with a start date of 03/01/24 and there was no documentation the memantine was administered on 09/26/24 at 9:00pm. Interview with the Resident Care Director (RCD) on 11/14/24 at 9:52am revealed: -On 09/26/24, Resident #4 returned from the hospital and the family did not bring the discharge paperwork with her. -Since there was no discharge paperwork she could not make the necessary changes to Resident #4's medications in the eMAR or fax the changes/additions to the pharmacy. -Resident #4 remained as "LOA", leave of absence on the eMAR until 09/28/24 when the	D 358		

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family brought in the discharge paperwork.
-Since Resident #4 remained as "LOA" the eMAR would not have prompted the MAs to administer the medications.

Telephone with a Pharmacist from the facility's contracted pharmacy on 11/14/24 at 3:31pm revealed:
-On 09/27/24, the facility faxed over hospital discharge summary dated 09/26/24.
-On 09/27/24, there was an order for prednisone 20mg every day for 10 days.
-The pharmacy dispensed prednisone 20mg, 10 tablets, a 10 day supply on 09/27/24.
-On 09/27/24, there was an order for tramadol 50mg two times a day, for 30 days.
-The pharmacy dispensed tramadol 50mg, 60 tablets, a 30 day supply on 11/05/24.
-The allopurinol 100mg every day, amlodipine besylate 10mg every day, divalproex 125mg, two times a day, donepezil 10mg at bedtime, and memantine 10mg at bedtime were orders that were to be continued and the facility did not need a fill yet.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/14/24 at 12:01pm revealed:
-She was concerned about Resident #4 not getting the prednisone because she could have an increase in inflammation and swelling, and that was apart of her hospitalization diagnoses.
-She was concerned about Resident #4 not getting the tramadol because she could have an increase in pain and that was apart of her hospitalization diagnoses.
-She was concerned about Resident #4 not getting the allopurinol because she could have an exacerbation of gout.
-She was concerned about Resident #4 not

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D 358	Continued From page 21 getting the amlodipine because she could have an increase in her blood pressure. -She was concerned about Resident #4 not getting the divalproex because she could have an increase in behaviors. -She was concerned about Resident #4 not getting the donepezil because her dementia could get worse. -She was concerned about Resident #4 not getting the memantine because her dementia could get worse. -When medication were missed, it caused a delay in the treatment process. Telephone interview with the Administrator on 11/15/24 at 3:35pm revealed: -The RCD was responsible for processing the discharge paperwork on 09/26/24 when Resident #4 returned from the hospital within the same day. -The MAs were responsible for obtaining the discharge paperwork from the transport within the same day. -The RCD was responsible to make sure the medications were available for administration. -On 09/27/24, the RCD reported that Resident #8 did not have discharge instructions and that the RCD had notified the family to bring back the instructions.	D 358		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services:	D 433		

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D 433	Continued From page 22 (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure resident records were maintained in an orderly manner for	D 433		

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D 433	Continued From page 23 3 of 5 sampled residents (#2, #3 and #4) related to accurate documentation of falls on the resident's care plans. The findings are: 1. Review of Resident #2's current FL2 dated 02/01/24 revealed: -Diagnosis included dementia. -Resident #2 was constantly disoriented. -Resident #2 was ambulatory. -Resident's level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register revealed an admission date of 05/10/21. Review of Resident #2's Accident and Incident report dated 06/23/24 revealed documentation that the resident had an unwitnessed fall. Review of Resident #2's staff progress report dated 07/05/24 revealed documentation that the resident had fallen out of her bed. Review of Resident #2's Care Plan dated 07/09/24 revealed: -Under the assessment section for fall potential, no was documented for known history of fall within the past three months. -Resident #2's fall risk score was documented as low risk. Telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm revealed: -She had completed Resident #2's care plan. -She knew Resident #2 had a history of falls. -She did not know there was a section on the care plan for fall assessment.	D 433		

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D 433	Continued From page 24 Interview with the Resident Care Director (RCD) on 11/15/24 at 3:07pm revealed: -She know Resident #2 had a history of falls. -She did not know Resident #2 had documentation of no fall history within the previous three months. Telephone interview with the Administrator on 11/15/24 at 3:28pm revealed: -She knew Resident #2 had a history of falls. -She did not know Resident #2 had documentation of no fall history within the previous three months. Refer to a telephone interview with the SCC on 11/15/24 at 1:32pm. Refer to interview with the RCD on 11/15/24 at 3:07pm. Refer to a telephone interview with the Administrator on 11/15/24 at 3:28pm. 2. Review of Resident #3's current FL2 dated 07/08/24 revealed: -Diagnosis included cerebral infarction, cognitive communication deficit, atrial fibrillation and hypertension. -Resident #3 was constantly disoriented. -Resident #3 was ambulatory. -Resident's level of care was for Special Care Unit (SCU). Review of Resident #3's Resident Register revealed an admission date of 09/22/21. Review of Resident #3's Accident and Incident report dated 11/09/24 revealed documentation that the resident had a fall.	D 433		

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	HAL060160	A. BUILDING: _____ B. WING _____	C 11/15/2024

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D 433	Continued From page 25 Review of Resident #3's staff progress report dated 11/09/24 revealed documentation that the resident had a fall and transported to the ER. Review of Resident #3's Care Plan dated 11/15/24 revealed: -Under the assessment section for fall potential, no was documented for known history of fall within the past three months. -Resident #3's fall risk score was documented as low risk. Telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm revealed: -She completed Resident #3's care plan. -She knew Resident #3 had a history of falls. -She did not know there was a section on the care plan for fall assessment. Telephone interview with the Administrator on 11/15/24 at 3:28pm revealed: -She knew Resident #3 had a history of falls. -She did not know Resident #3 had documentation of no fall history within the previous three months. Refer to a telephone interview with the SCC on 11/15/24 at 1:32pm. Refer to interview with the RCD on 11/15/24 at 3:07pm. Refer to a telephone interview with the Administrator on 11/15/24 at 3:28pm. 3. Review of Resident #4's current FL2 dated 01/11/24 revealed: -Diagnosis included dementia.	D 433		

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D 433	Continued From page 26 -Resident #4 was constantly disoriented. -Resident #4 was non-ambulatory. -Resident's level of care was for Special Care Unit (SCU). Review of Resident #4's Resident Register revealed an admission date of 05/09/21. Review of Resident #4's Accident and Incident report dated 08/17/24 revealed documentation that the resident had an unwitnessed fall. Review of Resident #4's staff progress report dated 08/17/24 revealed documentation that the resident had an unwitnessed fall. Review of Resident #4's Care Plan dated 09/30/24 revealed: -Under the assessment section for fall potential, no was documented for known history of fall within the past three months. -Resident #4's fall risk score was documented as low risk. Telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm revealed: -She completed Resident #4's care plan. -She knew Resident #4 had a history of falls. -She did not know there was a section on the care plan for fall assessment. Telephone interview with the Administrator on 11/15/24 at 3:28pm revealed: -She knew Resident #4 had a history of falls. -She did not know Resident #4 had documentation of no fall history within the previous three months. Refer to a telephone interview with the SCC on	D 433		

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D 433	Continued From page 27 11/15/24 at 1:32pm. Refer to interview with the RCD on 11/15/24 at 3:07pm. Refer to a telephone interview with the Administrator on 11/15/24 at 3:28pm. _____ Telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm revealed: -The Resident Care Director (RCD) normally completed all resident care plans, but she completed care plans if the RCD was out. -The RCD would review all care plans prior to sending the care plan to the Primary Care Provider (PCP) for signature. Interview with the RCD on 11/15/24 at 3:07pm revealed: -She and the SCC were responsible for completing resident care plans. -She reviews all care plans that are completed by the SCC prior to sending the care plan to the PCP for signature. Telephone interview with the Administrator on 11/15/24 at 3:28pm revealed: -The RCD and SCC were responsible for completed resident care plans. -If the SCC completes a resident care plan, the care plan is reviewed by the RCD prior to sending the care plan to the PCP for signature. -She expected the care plans to be accurate. -She only reviews resident care plans when there was a scheduled care plan meeting with resident families.	D 433		

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D 451	Continued From page 28	D 451		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the County Department of Social Services (DSS) of accident/incidents that required emergency medical evaluation for 5 of 5 sampled residents (#1, #2, #3, #4 and #5). The findings are: Review of facility's Incident Report and State Report Policy with an effective date of 06/08/21 revealed: -An internal incident report is completed by staff for all unusual occurrences, injury and incidents. -The Resident Care Director (RCD) or designated staff completes the incident report. -Incidents are reported immediately to family/responsible party and physician with documentation of the date and time the report was made to the family/responsible party and physician in the narrative charting section. -An adult care home shall notify the county department of social services of any accident or incident resulting in death or any accident or	D 451		

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incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization or medical treatment other than first aide.
-The report shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident.

1. Review of Resident #1's current FL2 dated 01/11/24 revealed:
-Diagnosis included anxiety, Alzheimer's Disease, and dementia.
-Resident #1 was constantly disoriented.
-Resident's level of care was Special Care Unit (SCU).

Review of Resident #1's emergency department (ED) report dated 10/24/24 revealed Resident #1 was evaluated after a fall with head injury.

Review of Resident #1's Incident Report dated 10/24/24 revealed:
-Resident #1 had a fall while pushing her walker into another walker.
-Resident #1 hit her head when she fell and was sent to the ED.
-The accident/incident report did not have an area on the form for staff to document notification to the local department of social services.

Telephone interview with the Department of Social Services (DSS) Adult Home Specialist (AHS) Supervisor on 11/15/24 at 2:05pm revealed DSS did not receive notification of Resident #1's ED visit on 10/24/24.

Refer to the telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm.

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D 451	Continued From page 30 Refer to the telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm. Refer to the interview with the Resident Care Director (RCD) on 11/15/24 at 3:07pm. Refer to the telephone interview with the Administrator on 11/15/24 at 3:28pm. 2. Review of Resident #5's current FL2 dated 09/26/24 revealed: -Diagnoses included cognitive impairment deficit, muscle weakness and depression. -Resident #5 was constantly disoriented. -Resident's level of care was Assisted Living (AL). Review of Resident 5's hospital discharge report dated 09/06/24 revealed Resident #5 was admitted to the hospital on 08/31/24 for altered mental status. Review of Resident #5's late entry progress note dated 09/05/24 revealed the resident was sent to the emergency department (ED) on 08/31/24 for evaluation due to being lethargic (fatigue). Review of Resident #5's record revealed there was no incident report for the resident's hospitalization from 08/31/24 to 09/06/24. Telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm revealed DSS did not receive notification of Resident #5's hospitalization from 08/31/24 to 09/06/24. Refer to the telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm. Refer to the telephone interview with the Special	D 451		

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Care Coordinator (SCC) on 11/15/24 at 1:32pm.

Refer to the interview with the Resident Care Director (RCD) on 11/15/24 at 3:07pm.

Refer to the telephone interview with the Administrator on 11/15/24 at 3:28pm.

3. Review of Resident #2's current FL2 dated 02/01/24 revealed:
-Diagnosis included dementia.
-Resident #2 was constantly disoriented.
-Resident #2 was ambulatory.
-Resident's level of care was Special Care Unit (SCU).

Review of Resident #2's emergency department (ED) report dated 06/05/24 revealed:
-Resident #2 was evaluated due to altered mental status and Alzheimer's dementia with agitation.
-Resident #2 became agitated and pushed another resident.

Review of Resident #2's record revealed there was no documentation that a Accident or Incident Report had been completed.

Review of Resident #2's accident/incident report dated 08/14/24 revealed:
-Resident #2 fell in the spa bathroom on her face and was bleeding.
-There was no documentation of Resident #2 being sent to the hospital.
-There was no documentation of family or responsible party notification.
-Under Treatment, no medical treatment was documented.
-The accident/incident report did not have an area on the form for staff to document notification to DSS.

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D 451	Continued From page 32 Review of Resident #2's ED report dated 08/14/24 revealed: -Resident #2 had an unwitnessed fall where she landed on the hard floor. -Resident #2 had a small laceration to her upper inner lip with mild swelling with a mild irregularity to front tooth but not loose. -Resident #2 had an abrasion and contusion to her left arm. -Resident #2 had four separate contusions and deep purple, almost greenish bruising to her right leg. -Resident #2 to be admitted to the hospital due to fall, contusion of face, urinary tract infection and hyponatremia. Refer to the telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm. Refer to the telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm. Refer to the interview with the Resident Care Director (RCD) on 11/15/24 at 3:07pm. Refer to the telephone interview with the Administrator on 11/15/24 at 3:28pm. 4. Review of Resident #3's current FL2 dated 07/08/24 revealed: -Diagnosis included cerebral infarction, cognitive communication deficit, atrial fibrillation and hypertension. -Resident #3 was constantly disoriented. -Resident #3 was ambulatory. -Resident's level of care was for Special Care Unit (SCU).	D 451		

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D 451	Continued From page 33 Review of Resident #3's hospital discharge summary dated 10/16/24 revealed Resident #3 was admitted for six days due to obstructive uropathy (obstruction to urine flow), placement of a suprapubic catheter and discharged to a skilled nursing facility. Review of Resident #3's record revealed there was no Incident Report dated 10/16/24. Telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm revealed DSS did not receive notification of Resident #3's hospital visit on 10/16/24. Refer to the telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm. Refer to the telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm. Refer to the interview with the Resident Care Director (RCD) on 11/15/24 at 3:07pm. Refer to the telephone interview with the Administrator on 11/15/24 at 3:28pm. 5. Review of Resident #4's current FL2 dated 01/11/24 revealed: -Diagnosis included dementia. -Resident #4 was constantly disoriented. -Resident #4 was non-ambulatory. -Resident's level of care was for Special Care Unit (SCU). Review of Resident 4's hospital discharge report dated 09/26/24 revealed Resident #4 was admitted to the hospital on 09/23/24 for cellulitis of the right hand and arm.	D 451		

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D 451	Continued From page 34 Review of Resident #4's late entry progress note dated 09/24/24 revealed the resident was sent to the emergency department (ED) on 09/23/24 for evaluation due to swelling to the right hand and arm. Review of Resident #4's record revealed there was no Incident Report dated 09/23/24. Telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm revealed DSS did not receive notification of Resident #4's hospitalization from 09/23/24 to 09/26/24. Refer to the telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm. Refer to the telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm. Refer to the interview with the Resident Care Director (RCD) on 11/15/24 at 3:07pm. Refer to the telephone interview with the Administrator on 11/15/24 at 3:28pm. _____ Telephone interview with the DSS AHS Supervisor on 11/15/24 at 2:05pm revealed: -The facility was responsible for faxing incident reports to the Department of Social Services for any incidents that happened which required more than first aid. -She received one accident/incident report for one of the five sampled residents since January 2024. Telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm revealed: -Medication Aides (MA) were responsible for	D 451		

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completing accident/incident reports for residents who displayed behaviors and/or falls.
-Accident/incident reports were to be turned into the RCD as soon as completed.
-The Administrator was responsible for sending accident/incident reports to the Department of Social Services.
-She did not know when an accident/incident report should be sent to the Department of Social Services.

Interview with the RCD on 11/15/24 at 3:07pm revealed:
-MAs completed accident/incident reports and she reviewed them.
-She was notified by the MA if there was an accident/incident.
-MAs were only required to document an accident/incident in a staff progress note, in an accident/incident report or on a physician communication form.
-She expected the MA to always fax a physician communication form to the Primary Care Provider (PCP) when there was an accident/incident.
-She, the SCC and the Administrator were responsible for sending accident/incident reports to the Department of Social Services.
-She sent accident/incident reports to the Department of Social Services when a resident needed more than first aide.

Telephone interview with the Administrator on 11/15/24 at 3:28pm revealed:
-An accident/incident report should be sent to the Department of Social Services within 24 hours of a resident being sent to the hospital.
-She did not know the Department of Social Services had not been receiving accident/incident reports.
-She expected the RCD to complete

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D 451	Continued From page 36 accident/incident reports and send to the Department of Social Services. -The facility had not completed audits of accident/incident reports.	D 451		