Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Landings of Oak Island
Address: 2910 Pine Plantation Parkway, Oak Island, NC
County: Brunswick
License Number: HAL-010-013

II. Date(s) of Visit(s): 05/28/24, 05/29/24, 06/06/24
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 07/15/24

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .1004	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: 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.		
Level of Non-Compliance: Type A1 Violation		
Findings: This rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents, (#3), related to two medications used to manage and treat symptoms of a neurological disorder. The findings are: Review of the facility's Medication Administration policy dated November 2018 revealed:		

-Medications were to be administered as prescribed.
-Medication Aides (MA's) were to follow "five rights" when administering medication which included ensuring the right resident, right drug, right dose, right route, and right time were applied for each medication being administered.
-Staff were to "triple check" three areas of medication administration which included the selection of medication, preparing the dose, and completion of the preparation.
-The medication selection included checking the medication label, container, and contents and comparing it to the electronic medication administration record (eMAR).
-Preparation of the medication was to include removal of the dose from the container and verifying against the label and the MAR following the "five rights".
-Completion of the preparation of medication included re-verifying the label against the MAR by reviewing the "five rights" when putting the medication away.

Review of Resident #3's current FL-2 dated 07/19/23 revealed:
-Diagnoses included Parkinson's disease (a degenerative neurological disorder), anxiety disorder, essential hypertension, and hyperlipidemia.
-The recommended level of care was Assisted Living.

a. Review of Resident #3's physician's orders dated 07/19/23 revealed there was an order for Nuplazid (used to treat hallucinations and delusions associated with Parkinson's disease) 34mg one capsule to be given by mouth one time daily.

Telephone interview with Resident #3's Power of Attorney (POA) on 5/29/24 at 11:47am revealed:
-Resident #3 was admitted to the facility in September 2021 and was discharged in April 2024 after repeated falls which ultimately led to a hospitalization for a head injury, after which the resident was admitted to a Skilled Nursing Facility (SNF).
-While residing at the facility, Resident #3 was being treated by a Neurologist for Parkinson's disease and was prescribed Nuplazid to treat hallucinations associated with the disease.
-Nuplazid was an expensive medication and had to be purchased from a specialty pharmacy, so she took on the responsibility of getting the medication each month and delivering it to the facility.
-Each month, the specialty pharmacy would call and alert her they were about to ship the thirty-day supply of

Nuplazid to her, and upon receipt, the she would promptly deliver the medication to the facility.
-There were no time gaps when the facility did not have the Nuplazid available to administer to Resident #3.
-Based on previous conversations with Resident #3's Neurologist, she knew the importance of the resident taking Nuplazid as prescribed, to help control hallucinations caused by Parkinson's disease.
-Around November 2023, Resident #3 began to show signs of a progressive decline.
-Resident #3 had begun to experience frequent hallucinations, which caused her to be more prone to falling,
-Resident #3 began to fall "almost every day".
-In December 2023 she took Resident #3 to her Neurologist to discuss the resident's decline.
-She informed the Neurologist that Resident #3 was reporting she did not always get her medications as ordered.
-During the visit, the Neurologist stressed the importance of Resident #3 taking her medications prescribed for Parkinson's disease, including her Nuplazid, as ordered, and he added information about this to Resident #3's electronic "My Chart" record.
-After the Neurology visit, the POA printed information from Resident #3's Neurology "My Chart", which stressed the importance of Resident #3 taking her PD medications as ordered and the POA provided a copy of this information to Resident #3's MAs.
-Resident #3 continued to have falls and was admitted to the hospital after her last fall in April 2024, due to a brain bleed.
-While Resident #3 was still hospitalized, she picked up Resident #3's belongings from the facility, including all remaining medications.
-After a conversation with the hospital Registered Nurse (RN) about the resident needing her medications for her Parkinson's disease, she informed the hospital RN she had picked up the resident's medications from the facility and would go out to her car to see what was given to her by the facility.
-She planned to give any remaining Nuplazid to the hospital RN so that Resident #3 could continue to take the medication as ordered while she was hospitalized.
-When she began to look through Resident #3's medications given to her by the facility, she saw there was a bottle of Nuplazid from October 2023 with 12 pills remaining in the bottle and a bottle of Nuplazid from December 2023 that had not been opened, as evidenced by the unbroken seal on the bottle.
-She "was shocked" Resident #3 had not received the

Nuplazid, and immediately thought the resident's increased hallucinations and sudden and rapid decline were likely related to the facility failing to administer the Nuplazid as ordered.
-She requested a copy of Resident #3's eMAR's from the facility.
-When she received and reviewed Resident #3's eMAR's, the October 2023 and December 2023 eMAR's had daily entries showing Nuplazid was administered.
-There was no way the Nuplazid was administered to Resident #3 if the medication was still in the bottles after her discharge.
-The Nuplazid was not included in Resident #3's multi-dose bubble pack and staff had to pull that medication separately, so she suspected staff had checked off the medication as given, without going into the medication cart to get the Nuplazid so it could be administered with the medications included in the multi-dose pack.
-The facility had a new Executive Director (ED) who began working at the facility after Resident #3 was discharged, and she emailed the new ED asking if he could explain how Resident #3's Nuplazid was documented as administered on the eMAR's but was still in the bottles from October 2023 and December 2023.
-She received an email response from the ED who stated he was working with his team to get answers which would be provided to her within the coming days, but she did not hear from the ED again.

Telephone interview with a local hospital Registered Nurse (RN) on 06/26/24 at 10:56am revealed:
-She was one of Resident #3's nurses when the resident was admitted to the local hospital in April 2024.
-Resident #3's POA informed her she had picked up Resident #3's medications from the facility where Resident #3 had just been discharged.
-The POA brought the bottles of medication to her and they were both surprised to see the October 2023 fill of 30 tablets of Nuplazid had about half the tablets remaining in the bottle and the December 2023 fill of 30 tablets had an unbroken seal.
-The RN saw the pills and said, "Oh my gosh! None of this Nuplazid was given."
-There was not a hospital log of the medication with the exact count that was given to her, but she knew there was close to half of the Nuplazid October 2023 fill and the whole bottle for December 2023.

Review of Resident #3's Primary Care Physician (PCP) after visit summary dated 12/13/23 revealed:
-On 12/01/23, Resident #3 was sent to the Emergency Room (ER) after a fall and was diagnosed with left two rib fractures.
-Additional falls occurred on 12/04/23 and 12/07/23.
-Resident #3's Neurology appointment was "moved up" to December 18th, 2023 due to "worsening symptoms" including increased falls, increased tremors, and generalized weakness.
-The PCP would continue to collaborate with Resident #3's Neurologist to manage her Parkinson's disease.

Review of a second PCP after visit summary dated 12/14/23 revealed Resident #3 reported she was feeling depressed the day before (12/13/23) because she could not pull up her pants.

Review of Resident #3's Neurology after visit summary dated 12/18/23 revealed:
-Resident #3 was steadily declining.
-Resident #3 had 5 falls at the facility in the last two weeks.
-Resident #3 was more unsteady on her feet and was having uncontrolled involuntary muscle movement.
-Resident #3 was having hallucinations and had stated she was not always given her medications as ordered by facility staff, which caused Resident #3 to have increased anxiety.
-Among the instructions given for Resident #3 by the Neurologist, Resident #3 was to continue with her prescribed daily dose of Nuplazid 34mg daily.

Review of a typewritten letter from Resident #3's Neurologist dated 05/30/24 revealed:
-The letter was addressed "To whom it may concern".
-Resident #3 had Parkinson's disease, which was a chronic and incurable neurological disorder for which she was prescribed Nuplazid and had "good effect" from taking the medication and was doing well at her April 2024 Neurology visit.
-Resident #3 had been seen by Neurology "urgently" on 12/18/23 due to multiple falls, worsening confusion, and recurrent hallucinations.
-Medications were addressed and instructions were given for Resident #3 to continue taking the prescribed Nuplazid daily.
-In May 2024, the physician was notified by Resident #3's POA that after the resident was discharged from the facility in April 2024, the POA received a bottle of Nuplazid from the facility that had been filled in October 2023 that still had several pills in it and a second bottle of Nuplazid filled in

December 2023 that was still sealed and unopened.
-The Neurologist included a statement of warning that Nuplazid was an atypical antipsychotic medication with a high affinity for the 5HT-2A receptor and that abrupt discontinuation of this medication could lead to dose-related extrapyramidal (uncontrollable motor system movement) symptoms, akathisia (a neuropsychiatric movement disorder that causes uncontrollable urge to move, often accompanied by mental distress and the inability to sit still), and psychosis (symptoms that affect the mind and cause a person to lose touch with reality).
-In summary, the letter stated "In my medical opinion, it is at least as likely that the apparent discontinuation of this medication (Nuplazid) (In October 2023 and December 2023) contributed to worsening mobility and cognitive status" for Resident #3.

Review of Resident #3's eMAR's for October 2023 through December 2023 revealed:
-In October 2023, there was an entry for Nuplazid 34mg to be given every morning at 9:00am, and beside the entry was notification in parenthesis that read, (Gets from outside pharmacy).
-Nuplazid 34mg was documented as administered daily from 10/01/23 to 10/31/23 and there were no exceptions.
-In November 2023, there was an entry for Nuplazid 34mg to be given every morning at 9:00am, and beside the entry there was a notification in parenthesis that read, (Gets from outside pharmacy).
-Nuplazid 34mg was documented as administered daily from 11/01/23 to 11/30/23 and there were no exceptions.
-In December 2023, there was an entry for Nuplazid 34mg to be given every morning at 9:00am, and beside the entry was a notification in parenthesis that read, (Gets from outside pharmacy).
-Nuplazid 34mg was documented as administered daily from 12/01/23 to 12/31/23 and there were no exceptions.

Review of Resident #3's medication dispense dates for November 2023 through March 2024 revealed Nuplazid 34mg, a thirty-day supply (30 tablets), was filled on 11/14/23, 12/13/23, 01/11/24, 02/13/24, and 03/11/24.

Review of Resident #3's electronic progress notes for October 2023 and December 2023 revealed:

-On 10/17/23 there was an entry by Resident #3's PCP that the resident had an onset of hallucinations and worsening tremors that started five days earlier, that the resident was already prescribed Nuplazid for hallucinations, but she was actively hallucinating and aware of what she was seeing.
-On 11/30/24 at 12:08pm there was an entry Resident #3 had an unwitnessed fall and hit her head.
-On 12/01/23 at 4:23pm there was entry Resident #3 had an unwitnessed fall and hit her head.
-On 12/01/23 at 11:50pm there was a second entry Resident #3 had an unwitnessed fall with head and leg injury and was sent to the emergency room (ER), where she was diagnosed with two rib fractures.
-On 12/04/23 at 8:20pm there was an entry Resident #3 had an unwitnessed fall with a head injury and was sent to the ER.
-On 12/07/23 at 9:47pm there was an entry Resident #3 had a witnessed fall.
-On 12/18/23 at 7:11am there was an entry Resident #3 had an unwitnessed fall with a head injury and went to her Neurology appointment with her POA.
-On 12/29/23 at 7:35pm there was an entry Resident #3 had an unwitnessed fall documented as a "ground level fall" with injury to both knees.

Review of Resident #3's accident report dated 12/01/23 at 11:30am revealed Resident #3 was transported to the hospital after a fall and returned to the facility the same day with a fractured rib.

Attempted review of additional accident reports for Resident #3 for December 2023 was unsuccessful.

Review of Resident #3's Emergency Room (ED) visited dated 12/04/23 revealed:
-Resident #3 was seen at the ED due to head trauma.
-Resident #3 had multiple head scans completed to rule out an intracranial hemorrhage or extra-axial fluid collections that could have resulted from her falling and hitting her head.
-Intracranial injury was ruled out and Resident #3 returned to the facility.

Attempted review of additional ED visit reports for Resident #3 in December 2023 was unsuccessful.

Review of Resident #3's electronic Fall Risk Intervention

Care Plan 2 eFRICP) dated December 2023 revealed:
-The eFRICP was completed post falls to help evaluate the possible causes for the fall so that appropriate interventions could be implemented.
-The Resident Care Coordinator's (RCC) name was entered as completing Resident #3's eFRICP's.
-One of the post-fall evaluation sections on the eFRICP included a check box selection confirming completion of evaluating medications as possible causal factors and checking yes or no if a medication appeared to be a factor.
-The check box selection entitled "Evaluate medication as possible causal factors" and the check box selection entitled "Does it appear to be medication related?" had no entries for fall evaluations completed on 12/12/23 for a fall that occurred on 12/01/23 and on 12/12/23 for a fall that occurred on 12/04/23.
-The check box selection entitled "Evaluate medication as possible causal factors" had no entry and the section "Does it appear to be medication related" was checked as "No" for falls evaluations completed on 12/10/23 for a fall that occurred on 12/07/23, on 01/05/24 for a fall that occurred on 12/18/23, and 01/05/24 for a fall that occurred on 12/29/23.

Telephone interview with a third shift Medication Aide (MA) on 06/10/24 at 10:42am revealed:
-She worked with Resident #3 regularly.
-Resident #3 was very familiar with her medications, could recognize them, and knew what different medications were given for.
-Resident #3 was given Nuplazid for hallucinations for her Parkinson's disease.
-She usually worked 7:00pm to 7:00am, but she had worked over on some mornings to administer morning medications to residents, including Resident #3, and that was the time the resident's Nuplazid was administered.
-There had been times when she went to administer medications to Resident #3, and the resident would recognize there was a medication missing and would tell her to go and find it.
-She did not remember which medications Resident #3 recognized as missing, but it was probably something that was not included in the multi-dose pill packs.
-The process for administering medications to Resident #3 was to review the eMAR and then to locate the medication in the medication cart.
-She would confirm the correct name and resident by viewing the resident's photo and calling the resident by name if she

did not know them, but she knew Resident #3.
-The next step was to scan the medication pack before administering.
-The facility primarily had multi-dose medication packs, but sometimes a medication would be packaged separately.
-There was usually notification on the eMAR if a medication was packaged separately, but not always.
-If there was a medication that was separate from the multi-dose pack, there was supposed to be a sticker on the pack to alert MAs there was a separate medication "card" that needed to be pulled from the medication cart.
-She did not know if the stickers had not been added to some multi-dose packs or if the stickers fell off, but there were times that MAs would think they were administering all prescribed medications to a resident and then one of the resident's medications would be delivered from the pharmacy "maybe a couple of days later" that was not in the multi-dose pack, so "obviously the medication had already been checked off as given" because the MAs did not know it was not in the multidose pack.
-MAs sometimes "click off" the medication as given "just to find out after the fact, that it was never in the pill pack".
-Some of the multi-dose packs had photos and names of each pill on the back of the pack, but not all of them.
-Sometimes the name on the back of the multi-dose pack may be a generic name that did not always match the name on the eMAR, which was confusing.
-If staff looked at the eMAR and there was no notification a pill was not included in the multi-dose pack, it created a situation where residents might miss getting prescribed medication.
-There were times she had looked up pills online to see if the image online matched the image on the back of the multi-dose pack, to ensure all of the medications were in the multi-dose pack, but this was time-consuming and often confusing.
-If Resident #3's eMAR provided highlighted notification that Nuplazid was "obtained from an outside pharmacy" MAs should have known it was packaged separately.
-She did not know why the medication was not given as ordered.

Telephone interview with a first shift MA on 06/10/24 at 2:19pm revealed:
-She worked with Resident #3.
-She did not know Resident #3's family was given a full bottle of Nuplazid from December 2023 and part of a bottle from October 2023 after her discharge, but, if that was the

case, obviously it was not administered to the resident.
-If Nuplazid was documented as administered on Resident #3's eMAR, but she did not receive the medication, it must have been an oversight by the MAs.
-There had been times when she administered medication to a resident and all medication would be included in the multi-dose medication pack on the first day of the week, and then during the rest of the week, the same medication was packaged separately.
-She did not know why this occurred, but the MAs needed to watch very closely to ensure all medication on the eMAR were being administered.
-It might be easy for an MA to miss administering Resident #3's Nuplazid if they were less experienced and were not checking and rechecking what was included in the multi-dose pack.
-The MAs were supposed to follow the five rights for medication administration, which were the right resident, the right drug, the right dose, the right route, and the right time so that things like what happened with Resident #3's Nuplazid, did not happen.
-MAs should have counted Resident #3's medications on the eMAR and the tablets in the multi-dose packs before administering the medications.
-There was "no way" Nuplazid was administered as ordered if Resident #3's family received pills in bottles dated October 2023 and December 2023, and she did not know how this happened.

Interview with the Director of Resident Care Registered Nurse (DRC) on 05/18/24 at 2:15pm revealed:
-Resident #3 left before she began working at the facility.
-Staff were responsible for ensuring the medications were administered as ordered.
-There were some medications that the family members provided but most came from the facility pharmacy.
-When a family member brought in a medication, they would usually give it to the MA on duty and the MA was responsible for ensuring the medication was added to the medication cart.
-She did not know anything about Resident #3's medications or if there was a medication that was not administered.
-When a resident was discharged from the facility, medication that was not administered was given to the resident or their responsible party.

Interview with the Executive Director (ED) on 05/29/24 at 3:00pm revealed:
-He began working at the facility as ED in April 2024, after Resident #3 was discharged.
-He had been contacted by Resident #3's POA who requested eMARs.
-The POA had contacted him asking why Resident #3 did not get Nuplazid as ordered.
-He had asked his leadership staff to look into the matter, and no one had been able to determine how there could be an unsealed bottle of the medication from December 2023 and part of a bottle from October 2023, if the Nuplazid was administered as ordered.
-His "best guess" was that the medication was overlooked because it was not included in the multi-dose pack of Resident #3's medication.

Telephone interview with the DRC on 07/01/24 at 11:46 revealed:
-If a medication was packaged separately from the multi-dose medication pack, there was an alert on the bubble pack, highlighted lime green, to notify the MA of the separate packaging and this had been in place since she began working at the facility in April 2024.
-Even though a medication might not be included in the multi-dose pack, it was usually still listed on the multi-dose packs along with all the medications and she did not feel this was adequate just to have it highlighted green.
-Since she started, she had advocated for the medication name to be "completely marked out" on the multi-dose pack if it was packaged separately, so staff were now doing that on the pill packs.

Telephone interview with the ED on 07/01/24 at 1:16pm revealed:
-He did not have any additional information related to why Resident #3 Nuplazid was left over after Resident #3's discharge and continued to believe the medication was overlooked by the MA's because it was packaged separately from the resident's other medications.
-He had requested that his RCC implement measures to ensure the issue did not happen again.
-He did not know how the error was not identified during cart audits for the months the Nuplazid was not given, but all he could do was start fresh to ensure accuracy something like that did not happen again.

Telephone interview with the RCC on 07/01/24 at 1:34pm revealed:
-She did not know why there would be an unsealed bottle of Resident #3's Nuplazid from December 2023 and a half bottle from October 2023.
-Nuplazid was prescribed to Resident #3 to treat symptoms related to Parkinson's disease.
-If Resident #3's Nuplazid was being checked off as administered on the eMARs during those months (October 2023 and December 2023), she found it hard to believe that Resident #3 was not getting it.
-She did not have an explanation and did not understand it.
-Nuplazid was an expensive medication so it was "quite a waste" if it was not being administered to Resident #3.
-She would check on the issue and would provide more information if she was able to locate anything regarding the administration of the Nuplazid in October 2023 and December 2023.
-It was the responsibility of the MAs to complete cart audits regularly.
-The RCC or the DRC RN conducted cart audits monthly.
-If Resident #3 had Nuplazid that was not being administered, it should have been caught when staff did cart audits, so she did not know why it was not found.
-She was not working at the RCC during the months of October 2023 and December 2023, so she did not know who was completing the cart audits during that time or why an issue with Resident #3's Nuplazid was not identified and corrected.

Telephone interview with Resident #3's Neurologist on 07/09/24 at 10:15am revealed:
-Resident #3 had been a patient at the practice since April 2021 and was prescribed Nuplazid to help control hallucinations that could occur with Parkinson's disease.
-It was extremely important that Resident #3 received medications prescribed to treat the Parkinson's disease as they were ordered.
-When Resident #3 was seen at the physician's office in April 2023, she was stable, doing well, engaged in different activities at the facility, which was an indication of good response from taking her prescribed Nuplazid.
-When Resident #3 was seen by one of the physician's colleagues in December 2023, she was seen urgently due to a sudden onset of worsening confusion, recurrent hallucinations, and frequent falls.
-Decisions made for Resident #3's treatment were based on

the assumption that Resident #3 was being given Nuplazid as ordered, and it was not until the resident was discharged from the facility that she learned Nuplazid was returned to the family that was not administered to the resident in October 2023 or December 2023.
-It was during this time that Resident #3 had sudden impaired mobility and hallucinations that were at times quite scary, so this scenario contributed significantly to her frequent falls.
-In addition to Resident #3 not receiving her Nuplazid, if it was stopped abruptly, this could have also contributed to her decline.
-When Resident #3 did not receive her Nuplazid as ordered, it most likely caused the onset of her hallucinations, increased confusion, and repeated falls, which in Resident #3's case resulted in the serious injury of a brain bleed.

Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 06/28/24 at 2:00pm and 07/08/24 at 8:53am was unsuccessful.

Refer to telephone interview with a third shift MA on 06/10/24 at 10:42am.

Refer to interview with the DRC on 05/18/24 at 2:15pm.

Refer to interview with a first shift MA on 06/10/24 at 2:19pm.

Refer to confidential telephone interview with an MA.

Refer to telephone interview with the RCC on 07/01/24 at 1:34pm.

Refer to telephone interview with the DRC on 07/01/24 at 11:46am.

Refer to telephone interview with the ED on 07/01/24 at 1:16pm.

b. Review of Resident #3's physicians orders dated 07/19/23 revealed there was an order for Rivastigmine (used to improve mental changes and cognitive loss associated with Parkinson's disease) 9.5mg patch to be applied to the resident's skin 1 time daily and worn for 24-hours.

Review of the Rivastigmine drug warning label revealed a

warning in bold print that read, "Do not stop taking this medication without consulting with your doctor first because stopping this medication suddenly may cause mental or behavioral changes."

Telephone interview with Resident #3's POA on 05/29/24 at 11:47am revealed:
-At the end of January 2024, she received a telephone call from an Medication Aide (MA) who worked at the facility who informed her she
had requested a refill on Resident #3's Rivastigmine patch.
-She asked the MA "Are you saying she has run out of it?", and she was shocked when the MA said she had been out of it for at least two weeks.
-She asked why she had not been informed sooner and the MA told her she did not know but the Primary Care Physician (PCP) had been notified.
-The MA said she did not know why the Rivastigmine patch had not been refilled but said the facility had recently changed from one state to another for their pharmacy provider, which may have caused a billing issue.
-This did not make sense since all of Resident #3's medications had been filled by the new pharmacy.
-All of Resident #3's medication bills were set up for automatic draft from her bank account and
the new pharmacy had deducted payment for Resident #3's other medications.
-Resident #3's neurologist had emphasized to her the importance of Resident #3 getting her Parkinson's medication as scheduled.
-After getting the call from the MA, she called the person who was ED at the time, and told her she could not believe Resident #3 had not been getting her Rivastigmine patch and the main focus for the former ED was what staff member had given her the information.
-The ED told her she would check on what had occurred with the Rivastigmine not being available for administration and would get back to her, but the ED never called her back to provide any additional information.
-A few days later she was able to confirm with an MA at the facility that the medication was filled by the pharmacy and Resident #3 was being given the Rivastigmine.
-She requested a copy of Resident #3's electronic Medicatoin Administration Record (eMAR's_ from the facility.
-When she received and reviewed Resident #3's eMAR's, there were several days in January 2024 when staff documented Rivastigmine was not administered.

-According to the MA that called her, Resident #3 had been out of her patch for at least two weeks, so she did not know if the resident was out of the medication longer than was reflected on the eMAR.

Review of Resident #3's October 2023 through February 2024 eMAR revealed:
-In October 2023, there was an entry for Rivastigmine 9.5mg patch to be given every evening at bedtime.
-Rivastigmine 9.5mg patch was documented as administered daily from 10/01/23 to 10/31/23 and there were no exceptions.
-In November 2023, there was an entry for Rivastigmine 9.5mg patch to be given every evening at bedtime.
-Rivastigmine 9.5mg patch was documented as administered daily from 11/01/23 to 11/30/23 and there were no exceptions.
-In December 2023, there was an entry for Rivastigmine 9.5mg patch to be given every evening at bedtime.
-Rivastigmine 9.5mg patch was documented as administered daily from 12/01/23 to 12/31/23 and there were no exceptions.
-In January 2024, there was an entry for Rivastigmine 9.5mg patch to be given every evening at bedtime.
-There was an exception documented on 01/24/24 as not administered due to waiting on medication, on 01/25/24 as not administered due to waiting on medication, on 01/26/24 due to the medication being on hold, on 01/27/24 due to medication on hold, on 01/28/24 due to the medication on hold, and on 01/29/24 due to medication on hold.
-On 01/30/24, documentation of administration of Resident #3's Rivastigmine 9.5mg patches resumed.
-The January 2024 documented exceptions for Rivastigmine totaled 6 days.

Review of Resident #3's pharmacy dispensing record for October 2023 through January 2024 revealed:
-On 10/13/23, Rivastigmine 9.5mg patch was filled for a thirty-day supply (30 patches).
-On 11/13/23, Rivastigmine 9.5mg patch was filled for a thirty-day supply (30 patches).
-In December 2023, Rivastigmine 9.5mg patch was not filled by the pharmacy.
-On 01/29/24, Rivastigmine 9.5mg patch was filled for a thirty-day supply (30 patches).
-From the November 2023 fill date of 11/13/23 through the January fill date of 01/29/24, Rivastigmine was not filled.

Review of Resident #3's electronic progress notes for January

2024 revealed:
-On 01/09/24 at 7:30pm there was an entry Resident #3 had an unwitnessed fall which resulted in skin tears to her left hand and both knees.
-On 01/23/24 at 1:44pm there was an entry by Resident #3's PCP stating concern about her increased tremors and falls on 01/09/24 and 01/10/24.

Interview with the Director of Resident Care (DRC) on 05/18/24 at 2:15pm revealed:
-If a medication was getting low, staff would get an alert in the eMAR system, and reordering medications was usually just the click of a button.
-There was occasionally a delay in getting a refill and MAs were required to follow up with the pharmacy by fax or phone to get an update.
-The MAs were responsible for contacting the pharmacy for updates about medication, but if the pharmacy was "really spinning their wheels", staff were to ask for assistance from her or the Resident Care Coordinator (RCC).
-Staff did not always notify her or the RCC if there was a problem with a medication not being on hand, but they were supposed to.
-All efforts related to medication fills and refills were supposed to be documented in the resident's progress notes.

Telephone interview with the DRC on 07/01/24 revealed:
-She was not working at the facility during the time Resident #3's Rivastigmine patch ran out, so she did not know what efforts were made by staff.
-All efforts made by staff to get the medication, should have been documented in Resident #3's progress notes.
-It was not enough for a MA to just notify the pharmacy and their supervisor if a medication was not on hand for administration, they were to notify the PCP so that an alternative plan could be made until the medication arrived.

Telephone interview with a third shift Medication Aide (MA) on 06/10/24 at 10:42am revealed:
-She remembered Resident #3 running out of her Rivastigmine patch.
-She was planning to take a few leave days off work (dates not known) but sent an electronic request for a refill of Rivastigmine patches before taking her leave days.
-When she returned to work and went to administer Resident #3's Rivastigmine patch, Resident #3 only had about two

patches left.
-There was "no good reason a resident should run out of medication"
-On that same day she called the pharmacy and the pharmacy representative said the Rivastigmine patch had not been refilled because there was some type of billing issue and they needed to contact the family before refilling the medication.
-The issue probably had something to do with when the facility pharmacy switching from one state to another state but she did not know what happened.
-She documented her effort to get the medication refilled in Resident #3's progress notes.
-She did not know how long Resident #3 was out of her Rivastigmine patch, or what month it was, but the resident was out for a while.
-A hold order was probably obtained since the Rivastigmine was not available for administration.
-She did not know if any other staff had contacted the pharmacy about Resident #3's Rivastigmine patch, but if they did, it would be noted in the residents progress notes.

Attempted review of a physicians hold order for Rivastigmine 9.5mg patch from 01/26/24 through 01/29/24 revealed an order was not available for review.

Review of Resident #3's electronic progress notes for January 2024 revealed on 01/14/24 at 1:33pm there was one entry indicating a third shift MA attempted to reorder Rivastigmine patches and was informed by the pharmacy they needed authorization from the POA before refilling.

Telephone interview with a first shift MA on 06/10/24 at 2:19pm revealed:
-All MAs were responsible for reordering medication and following up to ensure the medication was refilled before it ran out.
-If there was a problem getting a medication filled, it should always be reported to the RCD and RCC.
-She always "checked and double-checked" if she could not find a medication on hand and she would also have another MA come and check the cart with her.
-There had been times when she went to administer a medication and it could not be found, and she would realize the medication had not been reordered and had run out.
-She always documented well when this occurred, to show evidence of trying to administer the medication but it not being on hand and to show that she reordered the

medication when she identified it was out.
-MAs were required to do cart audits to ensure all medications were on hand but she was not aware of supervisors doing them.
-There had been times when she reordered a medication from the pharmacy, either through the electronic system or by fax, and when the medication did not get refilled, the pharmacy would say they did not get the request.
-There had been other times when she realized at the change of shift that a medication needed to be reordered, and she would request that first shift MAs reorder the medication, but the first shift MAs did not reorder the medication because they "just did not want to do any extra work."
-When she came back into work at the next shift change she would ask the MAs why the medication did not get ordered and they would say they just did not have time, but when she arrived at work, they were just sitting around doing nothing.
-The MA did not remember Resident #3's Rivastigmine patch running out and did not know why there was a gap of several weeks between her fill dates.

Telephone interview with the ED on 07/01/24 at 1:16pm revealed:
-Resident #3 was discharged from the facility when he began working as ED and he did not know why Resident #3's Rivastigmine patch ran out.
-He expected the MAs to follow the instructions of the DRC RN and the RCC regarding medication refills.
-The facility was responsible for ensuring residents had their medications on hand for administration.
-He would have thought the staff would have tried to get Resident #3's Rivastigmine from the backup pharmacy until whatever issues there were could be resolved, but if the staff attempted to do that, it would be documented in Resident #3's progress notes.

Telephone interview with the RCC on 07/01/24 at 1:34pm revealed:
-She expected MAs to reorder medications electronically before medications ran out.
-If a medication was ordered and did not arrive, it was the responsibility of the MAs to call the pharmacy to ask why the medication had not been sent.
-The next step would be for the MA to notify the physician if a resident missed a dose of medication, to tell the physician why it was not given, and to get a hold order for the

medication.
-She would try to locate the physician's hold order for Resident #3's Rivastigmine and would provide it if it was found.
-She knew when medications were not on hand for administration because she received a medication activity report every morning that notified her if a medication was not there.
-She did not remember anything about Resident #3's Rivastigmine patch running out.
-She did not know Resident #3's Rivastigmine had not been administered as ordered.
-Upon review of the eMAR, she could see that Resident #3's Rivastigmine patch was documented as not administered from 01/24/24 through 01/29/24, but she did not know why.
-If Resident #3's Rivastigmine patch was reordered and the MAs were unsuccessful in getting it from the pharmacy, it would have been the responsibility of the RCC to assist in getting it, but she was not the RCC during January 2024 and she did not think the facility had one during that time.

Telephone interview with Resident #3's Neurologist on 07/09/24 at 10:15am revealed:
-Resident #3 was prescribed Rivastigmine patch to help control the mental changes and cognitive loss associated with Parkinson's disease.
-It was extremely important that Resident #3 received medications prescribed for Parkinson's disease as ordered, including her Rivastigmine patch.
-If pharmacy dispensing orders and eMARs indicated Resident #3 did not received her Rivastigmine as ordered, which was supposed to be daily, it was likely a contributor to her sudden cognitive decline and increased confusion which led to frequent falls, the last of which resulted in her head injury with a brain bleed.

Attempted interview with Resident #3's Primary Care Provider on 06/28/24 at 2:00pm and 07/08/24 at 8:53am was unsuccessful.

Refer to telephone interview with a third shift MA on 06/10/24 at 10:42am.

Refer to interview with the DRC on 05/18/24 at 2:15am.

Refer to interview with a first-shift MA on 06/10/24 at 2:19pm.

Refer to confidential telephone interview with a MA.

Refer to telephone interview with the RCC on 07/01/24 at 1:34pm.

Refer to telephone interview with the DRC on 07/01/24 at 11:46am.

Refer to telephone interview with the ED on 07/01/24 at 1:16pm.

Telephone interview with a third shift Medication Aide (MA) on 06/10/24 at 10:42am revealed:
-The MAs reported to the Resident Care Director and Resident Care Coordinator.
-The MAs were supposed to attempt to resolve medication issues themselves but could request assistance from the DRC or RCC if needed.
-She had observed there were some staff did a much better job with ensuring medications were administered as ordered, and then there were some staff who did not go out of their way to ensure all medications were available, accounted for, and administered as ordered.
-Some of the MAs had a habit of "kind of doing whatever they wanted" and waiting for someone else to try to solve problems with medications.

Interview with the DRC on 05/18/24 at 2:15am revealed:
-She, the RCC, and the MAs were all responsible for ensuring medications were administered as ordered.
-She began working at the facility on 04/22/24.
-It was the responsibility of the DRC RN and the RCC to supervise medication administration for all residents.
-Since coming to work at the facility, she had significant concerns regarding medication administration, and she was working hard to ensure things were being done properly.
-Process training and retraining of MAs was imperative and she believed that was beginning to happen, and this needed to include reeducating all MAs on the intended flow for all areas related to medication administration.

Telephone interview with a first shift MA on 06/10/24 at 2:19pm revealed:
-There needed to be a "major overhaul" of the whole process of medication administration for the facility which should

include retraining and close supervision of MAs.
-MAs should be held to a high-level of accountability.

Confidential telephone interview with a MA revealed:
-The MA had worked as an MA in other facilities for years before coming to work at the facility but had never worked in any facility with as many problems with medication administration.
-The MA, as well as other MAs, had instances when they would to go to administer medication to a resident, she did not remember who, the previous medication pass was checked off as completed on the eMAR, but the previous dose of medication's in the multi-dose pack were in the medication cart with an unbroken seal.
-The MA had reported this to the RCC but had continued to see issues with medication administration.
-It was common knowledge among all staff that there were many medication administration issues.

Telephone interview with the RCC on 07/01/24 at 1:34pm revealed:
-She and the DRC were responsible for oversight of medication administration.
-If she knew about a problem with medication administration, she always addressed it, but if she did not know, there was not anything she could do.
-She expected the MAs to address medication administration issues on their own as much as possible but would assist when needed.
-She completed cart audits monthly and expected the MA's to do them at least weekly, and hopefully this would help catch errors.

Telephone interview with the DRC RN on 07/01/24 at 11:46am revealed:
-She had identified many issues with medication administration since she began working at the facility and was in the process of implementing measures to ensure medications were being administered as ordered.
-She had seen some improvements with medication administration since she started but there was still a lot of work to be done.
-There needed to be a strong focus on process training and the intended flow for medication administration.
-MAs were conducting cart audits weekly and the RCC was completing cart audits monthly.

Telephone interview with the Executive Director (ED) on 07/01/24 at 1:16pm
revealed:
-Soon after he began working at the facility in April 2024, Resident #3's Power of Attorney (POA) had requested eMARs from the facility and that was the first indication he had that there may have been some problems with Resident #3's medications.
-He had not been able to get the answers needed for the family about what occurred with Resident #3's.
-He understood there could be serious outcomes if medications were not administered as ordered to residents.
-The facility had many issues related to medication administration, and he was working to implement measures to correct the problems.
-He had asked the RCC to implement a more in-depth and more frequent cart audit process.
-He expected the DRC and the RCC to provide supervision for all areas of medication administration.
-He was still learning all the processed for medication administration and he expected the policies for medication administration to be followed.
-He was working with his "team" to ensure everyone had a clear understanding of what their responsibilities were.

The facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#3), who had Parkinson's disease and did not receive medications to treat symptoms associated with the disease, including Nuplazid, prescribed to treat hallucinations and Rivastigmine, prescribed to improve mental changes and cognitive loss. During this time, Resident #3 had a sudden decline which included unsteadiness, weakness, uncontrolled muscle movement, anxiety, hallucinations, akathisia, and frequent falls. The falls, resulted the resident hitting her head five times in December 2023 requiring two visits to the ED for head trauma, rib fractures, as well as leg and knee contusions. The facility's failure to administer medications as ordered resulted in physical harm and neglect which constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 received on 06/07/24.

THE CORRECTIVE DATE FOR THIS VIOLATION SHALL NOT EXCEED 08/14/24.

Rule/Statute Number: 10A NCAC 13F .0901

Rule/Statutory Reference: 10A NCAC 13F .0901 Personal Care and Supervision

(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan, and symptoms.

Level of Non-Compliance: Type A1 Violation

Findings:

This Rule is not met as evidenced by:

Based on interviews and record reviews, the facility failed to provide supervision in accordance with the resident's current symptoms for 1 of 5 sampled residents (#3), who was having frequent unwitnessed falls resulting in multiple injuries.

Review of the facility's current falls management policy (not dated) revealed:

-On the day a resident had a fall, the Medication Aides (MAs) were to answer the first three questions on the electronic Fall Risk Intervention Care Plan 2 (eFRICP) to indicate the time and nature of the fall.

-No later than the day after the fall, the Resident Care Coordinator (RCC) or the Executive Director (ED) were to review the information related to the fall and to complete the eFRICP including selecting the planned fall interventions, and then add the fall interventions to the resident's orders to be added to the electronic Medication Administration Record (eMAR).

-There was to be a monthly falls staff meeting to include a review of all falls, the current interventions in place, and to determine if the current interventions were successful in preventing falls or needed to be changed.

-If new interventions needed to be implemented, the resident, the responsible party, and the Primary Care Physician (PCP) were to be notified.

-All information related to the falls meeting and the outcome was to be added to the resident's progress notes and new fall intervention orders were to be generated and added to the eMAR.

Review of Resident #3's current FL-2 dated 07/19/23 revealed:
-Diagnoses of Parkinson's disease (a degenerative neurological disorder), anxiety disorder, essential hypertension, and hyperlipidemia.
-The recommended level of care was Assisted Living.

Review of Resident #3's current Care Plan dated 03/18/24 revealed:
-Resident #3 required supervision for ambulating.
-Resident #3 required limited assistance for transferring.

Review of Resident #3's Primary Care Physician (PCP) after visit summary dated 12/13/23 revealed:
-On 12/01/23 Resident #3 was sent to the ER after a fall and was diagnosed with left side two rib fractures.
-Additional falls occurred on 12/04/23 and 12/07/23.
-Resident #3's had "worsening symptoms" including increased falls, increased tremors, and generalized weakness.

Review of Resident #3's PCP after visit summary dated 01/09/24 revealed Resident #3 continued to have falls and had a ground-level fall on 12/29/23.

Review of Resident #3's Neurology after visit summary dated 12/18/23 revealed:
-Resident #3 was steadily declining.
-Resident #3 had 5 falls at the facility in the last two weeks.
-Resident #3 was more unsteady on her feet and was having uncontrolled involuntary muscle movement.
-Resident #3 was having hallucinations.

Review of Resident #3's accident report dated 12/01/23 at 11:30am revealed Resident #3 was transported to the hospital after a fall and returned to the facility the same day with a fractured rib.

Review of Resident #3's accident report dated 04/02/24 revealed
-Resident #3 had an unwitnessed fall in her room and was found on the floor with a puddle of blood near her head.
-Resident #3 had injuries to her head and arms and was transported to the hospital where she was admitted.
-The hospital admitting diagnosis was not documented on the report.

Review of Resident #3's electronic progress notes from December 2023 through April 2024 revealed:
-On 12/01/23 at 4:23pm there was entry Resident #3 had an unwitnessed fall and hit her head.
-On 12/01/23 at 11:50pm there was a second entry Resident #3 had an unwitnessed fall with head and leg injury and was sent to the emergency room (ER) where she was diagnosed with two rib fractures.
-On 12/04/23 at 8:20pm there was an entry Resident #3 had an unwitnessed fall with a head injury and was sent to the ER.
-On 12/07/23 at 9:47pm there was an entry Resident #3 had an assisted fall by staff.
-On 12/18/23 at 7:11am there was an entry Resident #3 had an unwitnessed fall with a head injury and went to her Neurology appointment that day with her Power of Attorney (POA).
-On 12/29/23 at 7:35pm there was an entry Resident #3 had an unwitnessed fall documented as a "ground level fall" with injury to both knees.
-On 01/09/24 at 7:30pm there was an entry Resident #3 had an unwitnessed fall with injuries to head and knees.
-On 01/10/24 at 8:50pm there was an entry Resident #3 had an unwitnessed fall.
-On 02/04/24 at 1:44pm there was an entry Resident #3 had an unwitnessed fall with an elbow injury.
-On 02/15/24 at 10:57am there was an entry Resident #3 had an unwitnessed fall with an elbow injury and a hip injury for which a mobile x-ray was completed on the resident's pelvis, both hips, and the right knee.
-On 02/25/24 at 10:30am there was an entry Resident #3 had an unwitnessed fall and had a telehealth visit with the PCP.
-On 02/26/24 at 1:00am there was an entry Resident #3 had an unwitnessed fall with injury, but no details were noted.
-On 02/27/24 at 11:11pm there was an entry Resident #3 had an unwitnessed fall.
-On 03/16/24 at 10:00am there was an entry Resident #3 had an unwitnessed fall.
-On 03/16/24 at 2:45pm there was a second entry Resident #3 had an unwitnessed fall.
-On 03/18/24 at 2:20pm there was an entry Resident #3 had an unwitnessed fall.
-On 03/19/24 at 3:10pm there was an entry Resident #3 had an unwitnessed fall and had a telehealth visit with the PCP.
-On 03/22/24 at 7:35pm there was an entry Resident #3 had an unwitnessed fall.
-On 03/24/24 at 11:13pm there was an entry Resident #3 had an unwitnessed fall.
-On 03/26/24 at 7:20am there was an entry Resident #3 had an

unwitnessed fall.
-On 04/02/24 at 8:20pm there was an entry Resident #3 had an unwitnessed fall with head and arm injuries and was sent to the hospital where the resident was admitted.
-On 04/04/24 at 10:56am there was an entry Resident #3 remained hospitalized and was diagnosed with a subdural hematoma (brain bleed) resulting from her fall on 04/02/24.
-On 04/20/24 at 1:06pm there was an entry Resident #3 would not be returning to the facility and was going to a Skilled Nursing Care facility.
-Resident #3 had 21 documented falls from 12/01/23 through 04/02/24.

Telephone interview with Resident #3's Power of Attorney (POA) on 5/29/24 at 11:47am revealed:
-Resident #3 had "fall after fall" at the facility.
-Even though she asked, staff never provided any information about what they were doing to address the falls, they would just call her to notify her Resident #3 had another fall.
-In January 2024 she asked the Executive Director (ED) who was at the facility during that time but was no longer there if she could meet with her to discuss concerns about Resident #3, which included her falls.
-She wanted to find out what the facility was doing to address Resident #3's falls.
-The ED told her she would get back with her to schedule a time to meet, but she never did.
-The facility had a Licensed Practical Nurse (LPN) who was working during that time but was no longer there, and the POA expressed concerns to the LPN about the resident's falls.
-She told the LPN Resident #3 was "falling almost every day" and she really needed to meet with someone so they could work together to try to figure out what was going on with Resident #3 and what to do to ensure she did not continue to fall.
-She told the LPN she was really afraid Resident #3 was going to keep falling until it ended in a very serious injury.
-The LPN told her she would get back with her to schedule a time to meet, but she never did.
-When she did not hear back from the ED or the LPN, she called the facility and told the ED she had spoken with the LPN about her concerns about Resident #3's falls but had not heard back from her, at which time the ED said the LPN was in a meeting and would call her back.
-The LPN did not call her and she soon learned the LPN had resigned and was no longer at the facility.

-The signs were there that Resident #3 was not being properly supervised and she wished she had discharged Resident #3 before her last fall at the facility when she hit her head on 04/02/24, which resulted in her being hospitalized with a brain hemorrhage.
-When Resident #3 was discharged from the hospital in April 2024, she was admitted to long-term care and never returned to the facility.

Review of Resident #3's hospital discharge summary dated 04/23/24 revealed:
-Resident #3 was admitted to the hospital on 04/02/24.
-Resident #3 was reported by her POA to have been having frequent falls at the facility.
-During the fall on 04/02/24, Resident #3 sustained a "right subdural hematoma/traumatic brain injury with a left forehead periorbital hematoma".
-During her hospital stay, it was suspected that Resident #3's subdural hematoma accelerated her Parkinson's disease.
-Upon discharge from the hospital, Resident #3 was admitted to a skilled nursing facility with hospice care.

Interview with the Director of Resident Care (DRC) on 05/18/24 at 2:15am revealed:
-For residents that had frequent falls, the intervention was to add the resident to the "hotbox" which meant they had increased supervision for 72-hours.
-Staff were required to document the increased supervision on the eMAR and in the progress notes.
-Increased supervision varied and could mean checking on a resident every hour or in extreme cases, every 15 minutes.
-Extreme cases would be residents who were having frequent falls.
-Resident #3 did have frequent falls.
-When a resident had a fall, the MA's documented the fall in the electronic documentation system, the system automatically triggered an eFRICP to open, and a manager was responsible for completing it.
-A manager would be considered the RCC or the Memory Care Coordinator (MCC).
-The eFRICP contained multiple areas to be evaluated for possible reasons contributing to a fall after which the selected fall interventions were "checked off" on the plan.
-When the planned interventions were selected on the eFRICP, an order was created and added to the eMAR where staff would document the completion of the fall intervention

task.
-An example of a fall intervention would be increased supervision.
-Resident #3 lived at the facility before she started working there so she did not know what interventions had been implemented related to her falls, but she was pretty sure increased supervision would have been one of them.

Interview with the MCC on 05/18/24 at 3:00pm revealed:
-If the RCC was not available to complete the eFRICP after resident falls, she would complete them for both Special Care Unit residents as well as Assisted Living Residents.
-She did not remember if she had completed any eFRICPs for Resident #3.
-For residents having frequent falls, staff were to increase supervision for 72-hours, so that if she completed an eFRICP for Resident #3, it probably had increased supervision as an intervention.
-Increased supervision meant the staff was to "lay eyes on" the resident more frequently, usually about every hour.
-The electronic documentation system would automatically populate an eFRICP after falls and she or the RCC would complete the eFRICP.
-The answers to the questions on the eFRICP would help determine if the resident needed increased supervision or what was needed as a fall intervention.
-She did not remember what other interventions were listed on the eFRICP as fall prevention options, but any planned interventions would have been added to the eMAR for staff to document completion.

Review of Resident #3's eFRICP reports dated December 2023 through April 2024 revealed:
-The eFRICP was completed post falls to help evaluate the possible causes for the fall so that appropriate interventions would be implemented.
-The areas on the eFRICP to be assessed for possible causal factors for falls including medical conditions, medications, and environmental conditions.
-The eFRICP contained over 90 fall intervention check box selection options including but not limited to addressing medical and medication needs, appropriate footwear, checking bed locks and call bells, fall mats, assisted activities during identified high-risk times, speaking with the family about a private sitter, bed and chair alarms, and increased supervision.
-On 12/01/23 an eFRICP was started by the RCC that

contained a typewritten entry "fall with injury", the check box selection was marked "Yes" for admitted to hospital, and "Stop and complete a readmission fall risk evaluation when the resident returns."
-On 12/04/23 an eFRICP was started by the RCC that contained a typewritten entry "fall with injury", the check box selection was marked "Yes" for admitted to hospital and "Stop and complete a readmission fall risk evaluation when the resident returns."
-On 12/07/23 an eFRICP was started by the RCC that contained a typewritten entry "Fall without injury"; there were no fall intervention plan check box selections marked and the intervention report was closed on 12/10/24.
-On 12/18/23 an eFRICP was started by the RCC that contained a typewritten entry "Fall without injury"; there were no fall intervention plan check box selections marked and the intervention report was closed on 01/05/24.
-On 12/29/23 an eFRICP was started by the RCC that contained a typewritten entry "Fall with injury"; there were no fall intervention plan check box selections marked and the intervention report was closed on 01/05/24.
-On 01/09/24 an eFRICP was started by the RCC that contained a typewritten entry "Fall with injury"; there were no fall intervention plan check box selections marked and the intervention report was closed on 01/10/24.
-On 01/10/24 an eFRICP was started by the RCC that contained a typewritten entry "Fall without injury"; there were no fall intervention plan check box selections marked and the intervention report was closed on 01/19/24.
-On 02/09/24 an eFRICP was started by a MCC that contained a typewritten entry "Fall with injury on 02/04/24"; there were no fall intervention plan check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 02/09/24.
-On 02/19/24 an eFRICP was started by the MCC that contained a typewritten entry "Fall with injury on 02/15/24"; there were no fall intervention check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 02/19/24.
-On 02/26/24 an eFRICP was started by the MCC that contained a typewritten entry "Fall without injury on

02/25/24"; there were no fall intervention plan check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 02/26/24. -On 02/27/24 an eFRICP was started by the MCC that contained a typewritten entry "Fall with injury on 02/26/24"; there were no fall intervention plan check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 02/27/24. -On 03/18/24 an eFRICP was started by the MCC that contained a typewritten entry "Fall without injury on 03/16/24"; there were no fall intervention plan check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 03/18/24. -On 03/20/24 an eFRICP was started by the MCC that contained a typewritten entry "Fall without injury on 03/19/24"; there were no fall intervention plan check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 03/20/24. -On 03/25/24 an eFRICP was started by the MCC that contained a typewritten entry "Fall without injury on 03/22/24"; there were no fall intervention plan check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 03/25/24. -On 03/25/24 an eFRICP was started by the MCC that contained a typewritten entry "Fall without injury on 03/24/24"; there were no fall intervention plan check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 03/25/24.		

-On 03/27/24 an eFRICP was started by the MCC that contained a typewritten entry "Fall without injury on 03/26/24"; there were no fall intervention plan check box selections marked; there was a typewritten date indicating on 09/08/21 a safety awareness emblem was placed on Resident #3's door and on 09/08/21 a fall risk banner was added to the electronic documentation system; the intervention report was closed on 03/27/24.
-On 04/02/24 an eFRICP was started by the RCC that contained a typewritten entry "fall with injury", the check box selection was marked "Yes" for admitted to hospital, and "Stop and complete a readmission fall risk evaluation when the resident returns."

A second telephone interview with the RCC on 07/01/24 at 1:34pm revealed:
-Since the MCC had recently resigned, she was now the person primarily responsible for completing eFRICPs.
-Depending on the fall interventions selected on the eFRICP, orders were opened up on the eMAR, and staff were required to document the intervention as completed on each shift.
-If there were no fall intervention selections marked on

Resident #3's eFRICPs she did not know why.
-If there were no fall intervention selections completed on Resident #3's eFRICP's, she must have just added fall intervention orders to the eMAR.
-For residents needing increased supervision, staff were expected to lay eyes on them more often, maybe every 1 to 2 hours.
-If a resident like Resident #3 were under increased supervision and continued to have falls, staff were to try to determine what might be causing the falls and to correct it.
-She would try to locate evidence of measures implemented to help prevent Resident #3 from falling, including plans made at falls meetings, and would provide this information by tomorrow (07/02/24).
-No additional information was provided related to measures implemented related to Resident #3's falls.

Review of Resident #'3s eMAR's for December 2023 through April 2024 revealed:
-From 12/10/23 through 04/02/24 there was an entry each month to "Increase supervision to prevent falls" to be completed every hour and documented one time from 7:00am

to 7:00pm and one time from 7:00pm to 7:00am.
-Increased hourly supervision was documented one time each shift as completed on 12/01/23 through 12/31/23, 01/01/24 through 01/31/24, 02/01/24 through 02/29/24, 03/01/24 through 03/31/24, and 04/01/24 through 04/02/24.
-From 01/01/24 through 04/02/24 there was an entry each month to "ensure the call bell and pendent was within reach of the resident" and that "fall risk sign was posted in the room".
-The call bell, resident pendent, and signage was documented one time on each shift as completed on 01/01/24 through 01/31/24, 02/01/24 through 02/29/24, 03/01/24 through 03/31/24, and 04/01/24 through 04/02/24.
-From 02/26/24 through 04/02/24 there was an entry each month to "ensure the correct footwear was on the resident".
-Checking footwear was documented as completed on 02/26/24 through 02/29/24, 03/01/24 through 03/31/24, and 04/01/24 through 04/02/24

Telephone interview with a third shift Medication Aide (MA) on 07/01/24 at 10:43am revealed:
-The staff did very little to supervise residents, and this was one of the reasons the MA recently resigned.
-The response to residents who needed increased supervision was "really not much of anything."
-Even if a resident was having falls and was supposed to be monitored closely, staff might say they were checking on the resident regularly, but it did not mean they were actually doing it.
-There had been multiple incidents of night-shift Personal Care Aide's (PCA) sleeping while on duty.
-"Obviously, if the staff were sleeping, they could not supervise the residents".
-The MA had photos taken recently of two different third-shift PCAs sleeping while on duty.
-He reported this to "upper management" but did not know if anything was done.

Review of two photos dated 06/12/24 revealed:
-A photo timestamped for 3:01am showed a male wearing uniform scrubs who appeared to be sleeping with his head face down in his arm lying on a tabletop in a facility day room.
-A second photo timestamped for 5:02am showed a female wearing uniform scrubs who appeared to be sleeping with her head face down on her hands and lying on a tabletop in a facility day room.

Interview with a first shift PCA on 06/06/24 at 9:15am revealed:
-She did not know what "increased supervision" meant.
-If a resident was having a lot of falls and staff were to watch them closer, she would usually check on them first thing in the morning and then again around lunchtime.
-She did not think the PCAs were always informed when a resident was supposed to be on increased supervision by staff.
-If a resident was having frequent falls, other than checking on them more often, she did not know of anything else the staff did.
-Resident #3 had a lot of falls and checking on her more often did not seem to help.

Interview with a first shift MA on 06/06/24 at 9:30am revealed:
-Increased supervision meant if a resident was prone to falling and she saw the resident walking down the hall without their assistive device, like a walker or wheelchair, she would go to them and would bring the resident their device.
-When an incident report was completed after a fall and was placed on increased supervision, staff were to check on the resident more frequently, but she did not know if there was a set number of times staff were to see the resident within a shift.
-She did not remember if the eMAR stated the exact intervals for supervision.
-If a resident was placed on increased supervision and continued to have falls, she did not know what else the staff was to do.

Telephone interview with a first shift MA on 06/10/24 at 10:42am revealed:
-If a resident was having frequent falls, she believed the resident was put on a "fall plan" but she was "not a hundred percent sure."
-She did not know what was included in a fall plan or if Resident #3 had one.
-Increased supervision was probably part of fall plans.
-Increased supervision meant checking on the resident more often but she was not sure how often it was supposed to be.
-Supervisors were always informed when a resident had increased falls because the MAs were responsible for notification to the DRC or RCC when a resident fell.
-If falls occurred during the third shift or on weekends, either the DRC or the RCC was on call and staff notified whoever was assigned to on-call duty.

-After a fall, MAs were also required to complete an "event" form in the electronic documentation system on which they were to document the details related to the fall, so one "would think" the DRC or RCC would put the resident on a fall plan.
-The MA was pretty sure the fall response protocol included checking on the resident every hour.
-If a resident was on increased supervision for falls, and continued to have falls, she did not know what other interventions were tried, maybe asking the family to hire a private sitter, but she was not sure.
-She did not know how frequently staff were supposed to complete a "safety check" for Resident #3 but she did remember Resident #3 had a lot of falls.

Telephone interview with a first shift MA on 06/10/24 at 2:19pm revealed:
-Resident #3 had "really bad" Parkinson's disease.
-Resident #3 was very independent so that increased her chances of falling more because she ambulated frequently.
-Resident #3 was placed on increased supervision.
-Increased supervision meant staff checked on her every "one to two hours."
-She did not know if any additional interventions that the facility implemented in response to Resident #3's falls.
-Checking Resident #3 every hour or two did not work and she was still falling constantly.
-As far as she knew, no other plans were put into place when checking on Resident #3 every hour or two did not work and she continued to fall.

Telephone interview with the ED on 07/01/24 at 1:16pm revealed:
-Resident #3 was already discharged from the facility when he began working as ED, so he did not know what efforts were made by staff in relation to supervision.
-If a resident was having frequent falls, it was his expectation that staff increase the supervision to whatever frequency it would take to decrease or prevent the falls.
-He was working with his staff to come of with ideas as to how to best address situations with residents who need more supervision.
-All staff efforts related to supervision were to be documented in the electronic documentation system.
-If staff have exhausted all efforts and a resident continued to fall, there were things such as referrals to hospice for those that are appropriate, home health, or speaking to family

members about private sitters.
-If a resident had frequent falls, there needed to be thorough evidence staff were doing everything possible to help prevent this from happening.
-Staff should keep "hypervigilant eyes" on residents experiencing falls.

Attempted interview with Resident #3's Primary Care Provider on 06/28/24 at 2:00pm and 07/08/24 at 8:53am was unsuccessful.

The facility failed to ensure adequate supervision for 1 of 5 sampled residents (#3), who had Parkinson's disease with symptoms of weakness, confusion, hallucinations, akathisia, and had 21 falls in three months resulting in injuries that included leg, knee, and hip contusions, rib fractures and six head injuries, the last of which resulted in a hospitalization for a subdural hematoma. Medical records indicated it was suspected that the subdural hematoma accelerated the residents Parkinson's disease, and she was discharged from the hospital to a skilled nursing facility with hospice care. The facility's failure to provide supervision resulted in serious physical harm and neglect which constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 received on 06/07/24 for this violation.

THE CORRECTIVE DATE FOR THIS VIOLATION SHALL NOT EXCEED 08/14/24.

IV. Delivered Via:	Hand Delivered	Date: 07/15/24
DSS Signature:	Jamie Robins	Return to DSS By: 08/05/24

V. CAR Received by:	Administrator/Designee (print name): X Justin Lovin	
	Signature: X Justin	Date: X 7/15/2
	Title: X Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name):

Facility Name:

	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		