STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R-C 12/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

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{D 000}	Initial Comments The Adult Care Licensure Section and the Franklin County Department of Social Services conducted a follow up survey and a complaint investigation on 12/8/15 through 12/11/15, and 12/14/15. The complaint investigation was initiated by the Franklin County Department of Social Services on 10/29/15.	{D 000}		
D 209	10A NCAC 13F .0604 (2-e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care Other Staffing The following describes the nature of the aide's duties, including allowances and limitations (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to ensure personal care aides (PCA) and medication aides (MA) were not assigned food service duties, which interfered with residents' activities of daily living and medication needs being met. The findings are: Observation on 12/9/15 at 11:45am revealed: -Three personal care aides set up the dining room for meal service. -The PCAs served the 27 residents their meal. -At some tables, 2 or 3 residents would be served, while the other 1 or 2 residents at the	D 209		

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table were awaiting their meal.
-Some of the residents at the table would be finished eating and leaving the dining room while others at the table were awaiting their meal.
-There were 3 visiting family members assisting their family member with eating, two cutting up and setting up and one feeding the resident.
-The residents that required feeding were served last.
-There was a resident that did not come to the dining room for meal service and she was taken her tray after all of the other residents were served and fed.
-The staff serving in the dining room were unaware of which residents were not in the dining room during the meal.
-The two medication aides were working on their medication carts.

Observation of the lunch meal on 12/10/15 at 12:00pm through 12:45pm revealed:
-Meal plate service in the dining room began at 12:10pm.
-At 12:20pm one full table was served, there were multiple tables with 1 or 2 residents eating.
-At one table where 3 residents were served, a resident asked the staff when another resident at her table would receive her meal. The resident said to staff "please hurry up with her food".
-One of the other residents at the table, where the 3 residents were served, left the table and refused to eat. He did not want to eat, while other residents at the table did not have their food.
-At 12:20pm a resident was trying to feed another resident.
-At 12:32pm the maintenance man informed one of the PCAs that one of the residents (a feeder on hospice) in the dining room had not been served a plate. The PCA went and got the resident a plate and sat it in front of him at 12:35pm. The

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PCA finished assisting other residents. The resident sat with the food in front of him unable to eat. The PCA started feeding the resident at 12:43pm.

Confidential interviews with 4 staff revealed:
-The facility did not employ dietary aides.
-The PCAs and MAs were required to set up the dining room, serve the residents in the dining room, break down the tables after the meals, and wipe down and sweep the dining room after each meal.
-The first shift staff reported to work at 7:00am and the first thing they had to do was start getting the residents served.
-The MA usually started their 8:00am medications between 8:30am and 9:00am due to serving the breakfast meal.
-The medications that were due at 8:00am usually were finished between 10:30am and 10:45am.
-The PCAs and MA were required to launder and fold the cloth napkins after each meal.
-The facility did not have a laundry person.
-The night staff usually did the laundry at night, but during 1st or 2nd shift if a resident soiled their clothing, they were responsible for laundering their clothes.
-The residents are scheduled to have a bath twice a week, but that did not always happen because there was not enough time.

Confidential interviews with family members revealed:
-They had to come to the facility regularly to ensure their family member received a shower and got their hair washed and teeth brushed, they used to wait for staff to do it but it was not happening regularly.
-She came to the facility to feed her family

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member whenever she could.
-There were residents seated at the tables during meals that needed assistance, but there was not enough staff to assist them with eating.
-There was a resident that was new to the facility and she would yell out at the table during meals, she did not eat because she needed assistance. After a while, staff would return her to her room, where she would continue yelling out. This happened each day at the lunch meal.
-There had been a lot of falls at the facility, she had seen multiple bruised-up residents during visits to the facility.
-They had seen residents soil themselves because they could not get into their rooms to use the bathroom.

Observation on 12/10/15 at 10:30am revealed the medication aide was administering medication that were scheduled for 8:00am.

Observation on 12/11/15 at 1200pm revealed the medication aide was just finishing administering medications that were scheduled to be given at 8:00am.

Observation on 12/14/15 at 10:45am revealed both medication aides were administering medications that were scheduled to be given at 8:00am.

Observation on 12/14/15 at 10:40 am through 11:00am revealed:
-A female resident walked around the common area of the facility with her underpants on the outside of her pants, housecoat tied around her waist and her hair uncombed.
-No one approached the resident or offered to assist with dressing or grooming.

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D 209	Continued From page 4 Interview with Administrator on 12/14/15 at 4:00pm revealed: -The facility employs one cook and one dietary manager, we do not have dietary aides. -This staffing had been in effect since February of 2015. -The PCAs and MAs fill in as dietary aides. -The PCAs and MAs set the tables in the dining room, serve the 37 residents in the dining room, buss the tables after the meal, and clean up the dining room after each meal. -The PCAs and MAs serve the residents in the dining area for each meal. -The residents were seated by the medication aides assigned to those residents. -The patient care aides (PCA) and medication aides (MA) fold the scheduled and unscheduled laundry, between patient care and medication administration at all times of day. -The Housekeepers rarely did laundry because they were occupied with the general facility and resident room cleaning throughout the day. -The PCA and MAs served snacks at 10am, 2pm and 7pm. -The Activities Coordinator assisted with snack delivery in the evening hours. -The PCAs and MAs would begin seating residents for breakfast around 7:15am, serve at 7:30am and assist residents with eating between 7:30am to 8:30am. -Residents would leave the dining room between 8:30am and 8:45am. -The PCAs and MAs would set up lunch between 11:30am to 11:45pm, serve the meal between 11:45am and 12:00pm and assist residents with eating between 12:00pm and 12:45pm. -The medication aides would set up dinner beginning at 4:00pm, serve the residents between 4:30pm, and assist residents with their meals between 5:30pm to 5:45pm.	D 209		

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D 209	Continued From page 5 -There were 2 to 3 PCAs and MAs that performed approximately 2 hours of dietary aide work for each meal which included set up of meal, meal service, break down of meal, cleaning the dining room, and transporting the residents to and from their rooms and the dining room. -There was no medication administration at 7:00am, so one medication aide would begin "rounding up the residents." -The medication aides process all the physician's orders. -The facility did not currently have a Resident Care Coordinator to assist with the orders, there is an acting RCC that was helping out from a sister facility during this week. -There was no backup staff to ensure all residents reported to the dining room for each meal. -She was unaware that the showers and bathing needs of the residents were not being performed as listed in each resident's daily care task sheets. She would ensure there were enough staff to serve the resident meals, provide care to the resident and ensure they got their medications on time. _____ Review of the Plan of Protection received from the facility on 12/14/15 revealed: -The dining services will set up the dining room prior to meals and clean the dining room after meals. -Care staff will only assist with serving residents and assist residents with feeding. -To ensure residents are protected from further risk or additional harm, the executive Director, Food Service Director, or designee will monitor at least 2 meals per day, while onsite to ensure compliance.	D 209		

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D 209	Continued From page 6 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2016	D 209		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: UNABATED TYPE A1 VIOLATION Based on observation, record review and interview, the facility failed to ensure personal care was provided to two of five Residents (# 2, and #7) based on their assessed needs, resulting in excoriation of the skin (Resident #2), and rib and hip fractures (Resident #7). The findings are: 1. Review of Resident #7's current FL2 dated 10/28/15 revealed: -Diagnoses included Dementia w/ behavioral disturbance, anxiety, hypothyroid, HTN, fractured patella, tear of Achilles tendon, carotid artery stenosis, arthritis, and macular degeneration. -An order for Resident #7 to ambulate with a walker and documented as a fall risk -Resident #7 was admitted to the facility on 10/28/2015 Review of Resident #7's preadmission	{D 269}		

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{D 269}	Continued From page 7 assessment dated 10/14/15 revealed physical assistance was required for ambulation. Review of Resident #7's facility record revealed no care plan. Review of incident reports for Resident #7 revealed: -On 11/4/15, she was found on the dining room floor by a NA. -On 11/6/15, a MA found her on the floor with a knot on her forehead, complaining of side pain. She was sent to ER. Resident #7 was diagnosed with a hematoma on the forehead and 2 left rib fractures. No walker or assistive device was noted. -On 11/13/15, she was found on the dining room floor lying on her left side by a MA. She was sent to ER. No walker or assistive device was noted. -On 11/19/15, a NA found Resident #7 on the floor in a hallway, she was sent to ER. The fall resulted in a hip fracture. Review of a fall review for resident #7 completed on 11/4/15 revealed: -Resident #3 had a fall within the last 3 months. -She was confused or had an altered level of consciousness. -Resident #7 did not ambulate with an assistive device. Review of a document labelled Post Fall Investigation for Resident #7 dated 11/4/15 revealed: -She had been at risk for falls. She had a previous history of falls. -She had been last checked on at 1:15pm and she was ambulating independently. -Resident #7 had an unwitnessed fall on 11/4/15	{D 269}		

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{D 269}	Continued From page 8 at 1:30pm in the dining room. -There was no documentation of resident having or using an assistive device. Interview with family member power of attorney (POA) of Resident #7 on 11/4/15 at 3:45pm revealed: -The relative reported many concerns regarding resident #7's supervision and care. -Within one month of Resident #7's admission to the facility, the resident had multiple falls that resulted in a downward spiral of her health. -He was concerned there was not enough staff, nurses or supervision. - Resident #7 was prescribed a walker for ambulation and the staff would not remind her or assist her in using it. -The staff could not even locate the walker at the time of discharge. -Resident #7 is currently in Intensive Care at the hospital with multiple health issues that have arisen in the 3 1/2 weeks spent at the facility. -The last fall resulted in a broken hip and when she was put in the hospital, she was diagnosed with hip fracture, dehydration, euro sepsis and test results indicating a recent heart attack. - POA reported that the resident is now bedridden. -Interview with a Nursing Assistant (NA) on 12/9/15 at 11:30am revealed: -The NA did provide care for Resident #7 on first and second shift. - Resident #7 did not have a walker, but did have trouble walking and fell a lot. - It is very hard to keep up with all the residents, especially the ones that are mobile and fast. - Resident #7 walked a lot in the facility. She could not recall ever seeing her with a walker.	{D 269}		

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{D 269}	Continued From page 9 Interview with a medication aide (MA) on 12/9/15 at 2:10pm revealed: -She provided care for Resident #7 during her stay usually on first shift. - Resident #7 did not use a walker. - Resident #7 had multiple falls, mostly unwitnessed. -The MA could not remember the falls exactly, but does recall that Resident #7 had some stitches on her face after one fall. -Resident #7 had multiple behavioral problems and providing care was difficult. Interview with a Nursing Assistant (NA) on 12/at 1:30am revealed: -A couple of residents have been found on the floor after a fall since she was employed. -The staff have a hard time checking on and monitoring each resident regularly, along with their other required duties. -Resident #7 on first and second shift. -She reports that resident #7 did have a walker, but did not want to use it. -A resident is assessed and the MD is contacted after any fall. Interview with Resident #7's POA on 11/30/15 at 2:28pm revealed: Resident #7 was still hospitalized. The POA did not feel the resident would make it out of the hospital. 2. Review of Resident #2's current FL2 dated 1/23/15 revealed that resident had a diagnosis of dementia, hypertension, hypothyroidism and atrial fibrillation. Observation of Resident #2 inside Resident #2's bedroom on 12/8/15 at 11:15am revealed:	{D 269}		

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{D 269}	Continued From page 10 -The resident was in a reclined position with foot rest extended. -The resident was wearing a burgundy robe with food stains. -The resident had not been showered, -There were ted hose hanging on the bathroom towel bar. -There there were several stryrofoam breakfast dishes and cups in her room on the chairside table and dresser. -There was a dry erase board on the wall behind the resident which read "write the times after every Depends (adult diaper) change every 2-3 hours" with no written times or dates. Observation of Resident #2 with home health nurse on 12/9/15 at 1:10pm revealed: -The resident's incontinent brief was soiled with runny stool. -The resident's inner thighs were red and excoriated. -The resident was unable to stand up to get to her walker -The resident asked the home health nurse for assistance to stand. -The resident's robe was wet in the buttocks area. -She was eating turkey, scalloped potatoes and a vegetable from a Styrofoam plate. -She had one metal fork and a plastic spoon for utensils. -Resident was wearing the same burgundy robe from 12/8/15. -Resident's television remote was on the floor under her recliner. -Resident's brown-tinged nails had fecal matter underneath each of her 2-centimeter long nails on both hands. -The resident's toenails were in need of being cut, as evidenced by approximately 2 centimeres of overgrowth on each toe.	{D 269}		

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{D 269}	Continued From page 11 -The resident had brown sticky residue on her abdomen from previous adult brief adhesive tabs. -The resident was not wearing ted hose as ordered. -A dry erase board on the wall behind the resident's recliner reflected: "Change Depends every 2-3 hours between wake-up and bedtime and record times below." -Only one time was recorded reflecting 10:40pm with no date or initials of the adult brief change. Observation of resident's bathroom on 12/9/15 at 1:15pm revealed ted hose hanging from the resident ' s bathroom towel bar. Confidential interview with staff revealed: -Resident #2 has worn the same burgundy robe for 3 days. -Resident #2 does not eat in the dining area with the rest of the residents. -Resident #2 has her food brought to her room on a regular basis. -The staff does not check on Resident #2 except when bringing food or medications. Interview with a medication aide on 12/9/15 at 1:30pm revealed: -Resident #2 could get up and toilet herself with aide of her walker. -The resident bathing schedule was during first shift every Wednesday and Saturday. -Resident #2 was supposed to be checked every two hours for toileting needs and "trash pick up." -There was a book for the resident's daily care task sheets for logging resident showers and room checks. -The daily care task sheet was to be signed at the end of each shift. -Resident #2 usually stayed in her room. -Resident #2 received medications by the	{D 269}		

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medication aides in her room.
-She could not remember the last time she changed her.
-She could not remember the last time another aide changed her.
-There was an order for staff to "check the trash can every two hours" in Resident #2's room.

Review of Resident #2's daily care task sheet log book revealed:
-There were blank copies for Resident #2's daily care tasks for staff to sign at the end of each day.
-There was one unsigned sheet available dated 12/7/15.
-There were missing sheets for 12/8/15 and 12/9/15.
-The tasks listed included an entry for trash to be collected from Resident #2's room every 2 hours and for the resident to be showered every Wednesday and Saturday.
-Ted hose application and removal was not listed on the task sheet.

Interview with the Acting Resident Care Coordinator (ARCC) on 12/10/15 at 1:45pm revealed:
-The staff were supposed to sign the resident task sheets every day.
-She could not provide the care sheets for the past week.
-She did not know where the missing sheets were located.
-She did not check the task log book to ensure that staff were completing the tasks.
-Resident #2 was checked every 2 hours.
-She personally had not checked on Resident #2.
-She could not explain how she knew that staff check on Resident #2, only that she knew they did.
-There was no system in place to initial every two

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{D 269}	Continued From page 13 hours after each check. -She did not know who put the dry erase board in Resident #2's room. -She did not know if staff were signing the board. -The staff knew they had to apply the ted hose in the morning and remove them at night. -The staff knew that they had to reposition her "every so often." -Staff applied the ted hose every day but they forgot today. -She could not determine who was responsible for bathing and toileting Resident #2 each day "because it varies." Interview with the home health nurse on 12/9/15 at 1:10pm revealed: -Resident #2 had regular scheduled visits to address a sacral wound. -Resident #2 had a history of frequent diarrhea and excoriated skin. -Resident #2 had a history of C-Diff. -The facility had orders to reposition the patient every two hours. A confidential interview revealed: -The administrator and a medication aide were informed of the need to follow the written orders to reposition the patient every two hours. -Resident #2's frequent reinfections were caused by the resident sitting in her own stool and urine for extended period. -Resident #2 was wearing the same burgundy robe with food stains since 12/6/15. -Resident #2 had not been showered or bathed since 12/6/15 after having informed the administrator and a medication aide on 12/10/15. -The facility was not toileting, bathing or performing checks every two hours. Record review of Resident #2's home health	{D 269}		

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{D 269}	Continued From page 14 progress notes revealed: -The home health nurse documented a conversation with Administrator and Medication Aide about the importance of adherence to the two-hour toileting checks, showering schedule and hand hygiene. -There was an order for ted hose to be applied in the morning. -There was an order for ted hose to be removed at bedtime. -There was an order for toileting checks every two hours. -There was an order for handwashing for both the resident and staff before and after treatments and toileting. -There were home health nurse progress notes which described the need for assistance from the staff to toilet the resident. -There was a current order for ted hose application in the morning and removal at bedtime. Interview with Resident #2 on 12/9/15 at 1:15pm revealed: -Staff did not check on her. -Staff do not put zinc oxide cream on her red areas per physician order. -The home health nurse is the one who facilitated her adult diaper changes. -The staff always brought in paper plates for her meals. -She always stayed in her room and watched television. -She did not make requests to staff because "they don't come when called." -She did not participate in any facility activities because they were not offered to her. Interview with another Medication Aide on 12/9/15 at 1:20pm in Resident #2's room revealed:	{D 269}		

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{D 269}	Continued From page 15 -She knew of the ted hose order for morning application and removal at night. -She forgot that the ted hose were drying on the towel bar and were not applied this morning. -She could not remember when she last toileted Resident #2. Observation of Resident #2 and Resident #2's room on 12/10/15 at 8:13am revealed. -The resident was currently wearing the same food-stained burgundy robe observed on 12/8/15 and 12/9/15. -The resident's recliner side table had 2 empty medicine cups and 2 empty water cups. -There were 2 empty styrofoam cups and 1 empty plastic cup on top of the dresser. -The resident's walker was 5 feet from her recliner. -The resident's ted hose were hanging from the resident's bathroom towel bar. Interview with Resident #2 on 12/10/15 at 8:13am revealed: -Resident was not showered today nor in the last 3 days. -Staff did not check on her this morning. -Staff did not put on her ted hose. -The med aide came earlier to give her medication and left the water cups and med cup in the room on the table. -Staff did not toilet her or check her adult brief when they came in this morning with her medication. -Resident was hungry and wanted water. -Resident requires no feeding assistance. -Staff never offer to take her to the dining room to eat. -Resident watched television all day in her room. Observation of Resident #2 on 12/10/15 at	{D 269}		

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{D 269}	Continued From page 16 8:45am revealed she was eating in her room after all other residents were finished with their breakfast in the dining room. Observation of Resident #2 and the Resident #2's room on 12/10/15 at 11:00am revealed: -Resident was wearing the same burgundy robe. -Resident was in the same seated position despite the reposition every 2 hours order. -A dry erase board on the wall behind the resident reflected: "Change Depends every 2-3 hours between wake-up and bedtime and record times below" with still no new time entries or dates written. -Only one time was recorded reflecting 10:40pm with no date or initials of the adult brief change for the last 3 days. Interview with another medication aide on 12/10/15 at 12:30pm revealed: -All residents had daily scheduled care sheet for daily care. -Resident #2's care sheets included toileting every 2 hours, "emptying trash every two hours" and Wednesday/Saturday weekly showers. -Medication aide was unable to find Resident #2's care sheets for 12/9/15 (Wednesday). -She could not determine if Resident #2 was given a shower. -She did not know who was responsible for giving her a shower. -Two hour checks are performed but they do not initial each check. -The care sheet is only signed at the end of the day. Interview with Administrator on 12/10/15 at 1:55pm revealed: -She had expectations that all staff perform the scheduled care tasks for each resident.	{D 269}		

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{D 269}	Continued From page 17 -She was aware of Resident #2's recent health history and toileting needs. -She had not seen Resident #2 today. -She was unaware that Resident #2 was not being toileted and bathed per the scheduled care sheet. -She was unaware that Resident #2 was wearing the same burgundy robe since 12/6/15. -She was unaware that Resident #2's nails were dirty and handwashing orders were not being adhered to. -She was unaware that Resident #2 was currently soiled and wet. -The facility had just hired Resident #2's home health nurse to do all future staff training in the facility. Observation of Resident #2 on 12/10/15 at 3:00pm revealed: -The resident was clean and wearing fresh clothes. -The resident had a fresh pad in her recliner. -The resident had a fresh disposable brief. -The room was free of clutter. -The resident was wearing ted hose. -The residents nails were clean. _____ Review of the plan of protection received from the facility on 12/10/15 revealed: -Effective 12/10/15 The executive director or designee, nurse or resident care director will monitor the direct care staff to ensure proper care such as incontinent care, bathing, feeding is being performed on each resident in a timely manner each shift. -There will be patient care sheets in place for care staff to document when care has been completed, to be monitored daily by the resident care director, nurse, and administrator or	{D 269}		

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{D 269}	Continued From page 18 designee. CORRECTION DATE FOR THE UNABATED TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 13, 2016.	{D 269}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure referral and follow up for one of five sampled residents (#4) related to contacting emergency medical services for a fractured hip and knee. The findings are: Review of the current FL-2 for Resident #4 dated 4/20/15 revealed: -Diagnoses included dementia, osteoarthritis, esophageal reflux, hearing loss and myalgia. -The resident was described as intermittently disoriented. -She was admitted to the facility on 4/20/15. Review of Resident #4's Progress Notes revealed: -The first of 2 entries, dated 4/24/15 had no time noted and was documented as a late entry described Resident #4's admission to the facility. -The second entry was dated 7/20/15 and timed 7:10am.	D 273		

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D 273	Continued From page 19 -Resident #4 left her room and was ambulating fast. -The medication aide (MA) called out to her to tell her to slow down. -She tripped over her feet, causing her to fall in the hallway. -The resident complained of hip pain, no other visible injuries. -The emergency medical systems were called and Resident #4 was taken to the local emergency room (ER). -Resident #4 was admitted to the hospital with a fractured hip. Interview with Resident #4's responsible party on 12/11/15 at 9:45 revealed: -She reported to the facility at 11:45am on 7/20/15. -Resident #4 was sitting at a table in the dining room upon her arrival. -Resident #4 appeared to be in pain. -Resident #4 was sitting with both of her arms on the table to hold her up, leaning more on her right hip, trying to keep her weight off of her left hip. -The responsible party asked the MA what was wrong with the resident. -The MA responded nothing was wrong with Resident #4 and said the resident had been sitting at that table since the MA had reported to work at 7:00am. -The responsible party approached the resident and confirmed she was in extreme pain. -The responsible party asked Resident #4 if she could sit up in her chair, the resident cried out in pain when the responsible party tried to move the resident. -The responsible party went to the Resident Care Director ' s (RCD) office to ask if she knew what happened to Resident #4. -The RCD replied nothing had happened to	D 273		

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Resident #4.
-The responsible party made the RCD aware of what she had just observed in the dining room and requested the RCD called the physician and EMS and have the resident sent out.
-The RCD told the responsible party it would be an extra charge if Resident #4 was seen for an emergency visit.
-The responsible party told her she understood.
-The RCD handed the responsible party the physician's business card.
-The responsible party placed a call to the physician.
-When the responsible party returned to the dining room she (responsible party) told the MA to call EMS, and they were then called at about 12:00pm.
-When EMS arrived the paramedic said Resident #4's "hip was fractured".
-As resident was being loaded onto the gurney, the responsible party overheard a staff member say Resident #4 had fallen that morning, she heard that statement made twice.
-Resident #4 was transported to the local emergency room.
-Resident #4 was admitted to the hospital and after x-rays it was determined she had a fractured left hip and a fractured left knee.
-Resident #4 had surgery on both the knee and the left hip on the 7/21/15.
-The RCD called the resident's family member listed as a contact on 7/21/15 at 6:00am to inform her that Resident #4 had no longer been at the facility.
-The family member was already at the resident's bedside when the RCD called her.
-The RCD read the family member an incident report.
-The responsible party wasn't as upset that Resident #4 had fallen, it was what was done or

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not done after the fall that she was concerned about.
-She was upset there was staff at the facility that was aware that Resident #4 had fallen, helped her up, sat her at the table and let her sit there from 7:00am until she arrived at 11:45am and had not alerted EMS.
-Resident #4 had been sitting there in pain all that time.
-Resident #4 was now living at home with 24 hour care from a home health agency and unable to walk since the surgery.

Review of an incident report for Resident #4 sent to the County DSS on 7/26/15 revealed:
-On 7/20/15 at 7:10am Resident #4 left out of her room in a fast pace and tripped over her feet causing her to fall.
-Staff called 911 and she was sent to the emergency room for evaluation.
-Resident #4 had a fractured hip and knee.
-Family was notified on 7/20/15 (7/21/15) at 6:00am.
-The physician was notified no date or time noted.

Interview with EMS on 12/11/15 at 11:00am revealed:
-The EMS responded to a call at the facility on the afternoon of 7/20/15.
-Resident #4 was transported from the facility to a local ER on 7/20/15 at 12:55pm.

Interview with the Administrator on 12/11/15 at 12:10pm revealed:
-In July when Resident #4 fell she was not working in the role of administrator, but she was working at the facility.
-Resident used to walk really fast and staff consistently reminded her to slow down.
-She did not witness the fall.

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D 273	Continued From page 22 -She had heard a report of the fall during the daily stand up meeting, however she could not recall many of the details. -A staff member said Resident #4 was found on the floor the day before she was sent out. -The MA who documented the incident was no longer employed at the facility. -The RCD who was working at the facility and completed the incident report was no longer employed at the facility. -There had been a lot of staff turn-over at the facility It would be difficult to find anyone who would have been around during that time. -There was a MA who had been working at the facility during that time period. Interview with a MA on 12/11/15 at 12:50pm revealed: -When a resident has a fall, the resident is to be assessed for injuries and pain. -If they are injured, hit their head or are in a lot of pain, the physician was to be called and the residents were to be sent out. -She was not working on the day Resident #4 fell, but when she returned to work she heard about it. -She was told Resident #4 fell and she was not sent out that day. -She had been told at first that Resident #4 wasn't limping, but later that day, she was. -The next day Resident #4's family came to the facility and wanted her sent out. -The next thing she heard was they sent her out and Resident #4 ended up with a hip fracture. -"None of the staff that was working the day [Resident #4 fell] or the day she got sent out, were still around." Interviews with 2 MAs and 3 personal care aides (PCA) on 12/14/15 revealed they were not employed at the facility in July of 2015.	D 273		

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D 273	Continued From page 23 Review of the plan of protection received from the facility on 12/14/15 revealed: -Starting 12/14/15, all residents having incidents resulting in injury of the need of emergency medical attention will be sent to the hospital immediately. -All medication aides will be trained on the incident reporting protocol. -The Executive Director or designee will review incident reports daily to ensure protocols are followed. -Dependent upon the type of incident, follow up charting will occur as outlined in the policy. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 13, 2016.	D 273		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility delayed physician orders for a urine screen and antibiotics for a resident (#6); and	{D 276}		

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{D 276}	Continued From page 24 failed to implement physician orders for 2 of 5 residents (#6 and #7) that required the use of a walker for ambulation, resulting in both residents having multiple falls with injuries. The findings are: 1. Review of Resident #6's current FL2 revealed: -Diagnosis included Dementia/ Alzheimer ' s disease, acquired Hypothyroidism, depression, Glaucoma, and alteration of sodium. -An order for Resident #6 to ambulate with a walker. Resident #6 was admitted to the facility on January 10, 2014. Review of the care plan dated January 7, 2014 for Resident #6 revealed she was ambulatory with a walker. A. Review of incident reports for Resident #6 revealed: -She had 5 documented falls in which her walker was not in use. -On 01-10-15 she had an unwitnessed fall resulted in eye and facial bruising. -On 01-17-15 there was a fall reported. -On 01-24-15 an unwitnessed fall was reported. -On 01-31-15 she had a fall and was sent to the hospital. -On 03-26-15 she had a fall reported. Interview with a Medication Aide On November 4, 2015 AT 3:45PM revealed: -She provided care and assistance to Resident #6. -She worked 1st and 2nd shifts. -The MA did not recall resident #6 using a walker during the time she was at the facility. -The MA reported Resident #6 may have had a	{D 276}		

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{D 276}	Continued From page 25 walker, but did not use it. -The residents are monitored closely, but they do sometimes miss residents falling and find them on the floor. -When walkers are ordered for a resident the staff would usually verbally reminded the resident to use the device, but there was no assurance that it was being used. -There was no documentation of whether or not the resident used their walker. -There was no documentation the physician was notified when residents did not use their walker as ordered. Interview with Resident #6 ' s physician on November 4, 2014 AT 4:50PM revealed: -Resident #6 did had orders for a walker for ambulation. -It was his expectation for staff to remind and assist the resident using the assistive devices to prevent falls. -Resident #6 had multiple falls that were reported to him. -He was not informed if a walker was being used or not during any of the falls. Interview with a 2nd MA on November 30, 2014 at 4:00PM revealed: -She recalled assisting Resident #6 while she was at the facility. -Resident #6 was very resistant to care most of the time. -She did not remember a walker being used with Resident #6, or reminding her to use a walker. -She did not remember if a walker was on the resident's care plan or not. -Residents were usually reminded to use a walker if they had one, some of the residents just don't remember, or are resistant to the walkers. -She did not remember a specific fall with this	{D 276}		

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{D 276}	Continued From page 26 resident. -She reports that they did find residents who have fallen in the facility and a lot of the time, they do not know what happened. Interview on October 29, 2015 with power of attorney (POA) of the Resident #6 revealed: - The POA felt that a lot of the problem was not enough staff and supervision of the residents. - This relative said that the staff was attentive, when you could find them, there was just not enough staff for this facility. -The POA reports that the resident had just had too many unwitnessed falls and injuries. B. Review of physician order dated January 19, 2015 revealed an order to obtain a urine specimen from Resident #6 to test for a possible urinary tract infection. Review of the progress notes revealed the specimen was obtained on 1/20/15. Review of the physician ' s order revealed on 1/25/15 an order was written for Ampicillin and Macrodantin for acute urinary tract infection. Review of Pharmacy records revealed, both medications were received by the facility on 1/27/15. Review of the January 2015 MAR revealed: -Ampicillin was started on 01-27-15. -Macrodantin was started on 01-28-15. 2. Review of Resident #7's current FL2 revealed: - Diagnoses included Dementia w/ behavioral disturbance, anxiety, hypothyroid, HTN, fractured patella, tear of Achilles tendon, carotid artery	{D 276}		

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{D 276}	Continued From page 27 stenosis, arthritis, macular- degeneration. -An order for Resident #7 to ambulate with a walker and documented as a fall risk. -Resident #7 was admitted to the facility on October 28, 2015. Review of Resident #7's preadmission assessment dated October 14, 2015 revealed: -Resident #7 required physical assistance for ambulation.-Review of resident #7 facility record did not reveal a care plan. Review of incident reports for Resident #7 revealed: -On 11-04-15 - unwitnessed fall reported, facility completed fall investigation and reported no walker or assistive device. -On 11-04-15 - unwitnessed fall reported resulting in a hematoma on forehead and 2 left ribs fractured, resident sent to ER. -On 11-13-15 - fall reported, unwitnessed, resident sent to ER. -On 11-19-15 -unwitnessed fall, resulting in a left hip fracture. Interview with family member (POA) of resident #7 on November 4, 2015 at 3:45pm revealed: -The relative reported many concerns regarding resident #7s supervision and care. -Within one month of Resident #7's admission to the facility, the resident had multiple falls that resulted in a downward spiral of her health. -He was concerned there was not enough staff, nurses or supervision. - Resident #7 was prescribed a walker for ambulation and the staff would not remind her or assist her in using it. -The staff could not even locate the walker at the time of discharge. -Resident #7 is currently in Intensive Care at the	{D 276}		

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{D 276}	Continued From page 28 hospital with multiple health issues that have arisen in the 3 1/2 weeks spent at the facility. -The last fall resulted in a broken hip and when she was put in the hospital, she was diagnosed with hip fracture, dehydration, euro sepsis and test results indicating a recent heart attack. - POA reported that the resident is now bedridden and he is concerned for other residents at the facility. An interview with Certified Nursing Assistant (NA) on December 9, 2015 at 11:30am revealed: -She provided care for Resident #7 on 1st and 2nd shift. - Resident #7 did not have a walker, but did have trouble walking and fell a lot. - She reports that resident #7 walked a lot in the facility. She could not recall ever seeing her with a walker. An interview with a medication aide (MA) on December 9, 2015 at 2:10pm revealed: -She worked with the Resident #7 during her stay, usually on 1st shift. - She reports that Resident #7 did not use a walker. -She did not remember Resident #7's falls exactly, but does recall that she had some stitches on her face after one fall. -She reported that Resident #7 had multiple behavioral problems and care was difficult. An interview with a Certified Nursing Assistant (NA) on December 14, 2015 at 1:30am revealed: - She provided care for Resident #7 on 1st and 2nd shift. -Resident #7 did have a walker, but did not want to use it. -Resident #7 would be reminded to use walker or staff would give resident the walker.	{D 276}		

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{D 276}	Continued From page 29 - Resident #7 would refuse the walker. _____ Review of the plan of protection received from the facility on 12/14/15 revealed: -Starting 12/14/15 staff will e trained on new order taking and alert charting. -The Executive Director or Designee will review reports daily and alert charting to ensure protocols are followed. alert charting is a method which brings designated care managers and the resident care director in as part of the process of required documentation in the progress notes; including an initial entry followed by daily notes for a least 72 hours following a resident incident. depending on the type of incident, follow up charting will occur as outlined in the policy. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 13, 2016.	{D 276}		
{D 299}	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by:	{D 299}		

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{D 299}	Continued From page 30 Based on observation and interview and record reviews, the facility failed to serve milk to residents in the special care unit twice daily. The findings are: Observation of the lunch meal on 12/9/15 at 12:00 pm revealed: -Twenty eight residents were in the dining room. -A glass of milk was placed on the table for one resident before he sat at the dining room table. -A personal care aide walked around with a tray of milk and offered milk to all of the residents. -Eight residents accepted the offered milk. Observation of the lunch meal on 12/10/15 12:00pm through 12:30pm revealed: - A glass of milk was placed on the table for one resident before he sat at the dining room table. -The personal care aide poured a tray with 6 glasses of milk and set them on the counter in the dining room. -No other residents were offered milk with their meal, except the one glass that was placed on the table for one resident, before he entered the dining room. -The glasses of milk remained on the counter as residents finished eating their meal and left the table. Interview with the dietary manager on 12/11/15 at 9:30am revealed: -She did not know why the PCAs did not offer milk to all of the residents. -There was a list of six residents that liked milk at all three meals every day. -The list also has a reminder for staff to offer all residents milk at all meals. Interview with a resident on 12/11/15 at 10:30am revealed:	{D 299}		

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{D 299}	Continued From page 31 -She liked to drink milk sometimes, not every day, but once in a while. -She was not always offered milk. -Staff did not always go around with a tray of milk for everyone like they did the other day. Review of the Regular, Low Concentrated Sweets, and No Added Salt Diet Menus for 12/9/15 and 12/10/15 revealed a 4 fl. Oz. cup of milk should be served at lunch and dinner and 8 fl. Oz. cup of milk should be served at breakfast. Interview with a personal care aide on 12/10/15 at 2:00pm revealed: -There was one resident they knew liked milk and the staff placed it on the table in front of him every day at every meal. -The other resident should be offered milk at every day at every meal also. Interview with the Administrator in charge on 12/11/15 at 12:10pm revealed every residents should be offered milk at each meal. Observation of the lunch meal on 12/11/15 at 12:20pm revealed milk was offered to all of the 30 residents in the dining room.	{D 299}		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION	D 338		

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D 338	Continued From page 32 Based on observation, interview, the facility failed to ensure all residents were treated with respect, consideration, and dignity, relating to their bedroom doors being unlocked and accessible to the residents, without the need to ask for staff assistance when entering or exiting their rooms. The findings are: Observations on 12/8/15 at 10:30am during the tour revealed: -Eight resident room doors were locked and staff was needed to open the doors as residents did not have keys. -Five of the eight residents were in their rooms when the door was unlocked by staff. -There was masking tape on the handle of the eight doors taped across the lock of the door. -Residents were observed walking up to their doors trying the door handles and looking for staff to let them in their rooms. Observation of Resident #2's room door on 12/10/15 at 8:11am revealed; -The door was locked with resident inside room. -Resident was unable to open the door and stated "I can't get up to let you in, why is the door locked? " -A medication aide was immediately called to open door. -The inside handle lock button was depressed using masking tape to hold it in the locked position Interview with the medication aide on 12/10/15 at 8:12am revealed: -We have wanderers in the building and Resident #2's door is kept locked to keep out any stray residents who may wander in her room. -Some of the staff had room keys to open the	D 338		

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door but not all of them.
-The residents knew to ask the staff to unlock their own rooms if they wanted entry.
-Resident #2 could unlock her door from the inside if she wanted to.

Interview with Resident #2 on 12/10/15 at 8:13am revealed:
-The resident never asked for her door to be locked.
-The resident wanted her door always unlocked in case of a fire.
-She required assistance to stand up and could not get to the door.
-The resident could not previously enter her room when she was ambulatory unless she asked staff.
-The resident did not understand why the room's inside door handle lock was taped down.
-No one had ever wandered into her room.
-The resident did not have her room key.

Interview with the Maintenance man on 12/10/15 at 9:45am revealed:
-He has been employed for 5 weeks at the facility.
-The doors were taped locked when he started his employment at the facility.
-The facility has ordered new locks for all doors.
-One resident had his own key to his room and no one in the facility has a master key to enter his room.
-Most of the facility's bedroom doors were taped from the inside.
-He just received an order to remove all the tape from the inside locks.
-The facility has ordered new "special care locks" with one master key for all of the doors.

Confidential Interviews with facility staff revealed:
-The tape is on the doors to residents' rooms

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keep the doors locked.
-The tape had been on the doors since they were hired so they never questioned it.
-Some of the resident doors are locked to keep other residents from entering their rooms and taking things.
-Some of the resident doors are locked to keep the resident out of their own room.
-"I would tell the medication aide" one of the residents [named resident they were trying to keep out of the room] wanted to go in their room and she would just shake her head no, to let me know they were locking him out on purpose.
-Some residents go in their rooms and get into things and staff don't know where they are, so they are unable keep an eye on them.

Confidential Interviews with 3 family members revealed:
-All of the residents' room doors at the facility were locked for safety.
-Some of the higher functioning residents had keys and were able to unlock their own doors, whenever they wanted.
-Some of the residents had to find a staff member to get in their room to use the bathroom.
-There had been several times where she had seen a resident unable to find staff to let them in their room to use the bathroom and the resident had soiled their clothes.
-There are several residents that wander and they go into other residents' rooms and take things.

Interview with Administrator on 12/10/15 at 1:55pm revealed:
-She had ordered all the tape on the inside bedroom door locks to be removed immediately.
-The facility had ordered new special care unit locks for all doors in the facility for use with one

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D 338	Continued From page 35 master key. _____ Review of the Plan of Protection received from the Interim Executive Director on 12/14/15 revealed: -All Resident door locks have been inspected and unlocked to allow residents to enter and exit their rooms when they would like. -staff will be inserviced on residents' rights on 12/14/15. the maintanence director or designee will inspect the door locks on an ongoing basis to ensure the residents have immediate access to enter or exit their rooms. the execuive Director or Designee will perform daily routine checks to ensure resident rooms are accessilble to each resident. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2016	D 338		
{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: UNABATED TYPE B VIOLATION	{D 358}		

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{D 358}	Continued From page 36 Based on observation, record review and interview, the facility failed to assure that staff administered Vitamin D, Zyprexa, Sertraline, Namenda and Tylenol as ordered for 1 of 8 residents (#8). The findings are: 1. Review of Resident #8's current FL2 dated 1/6/15 revealed: -The resident's diagnoses included right parietal gyrus hemmorhagic, contusion left zymomatic arch, gerd, hypertension, irritable bowel syndrome, spinal stenosis, prostate cancer and multi-facial fractures. -The resident was admitted on 1/5/15. Observation of med pass on 12/10/15 at 10:45am revealed: -Medication aide checked the MAR to determine which medications to give Resident #8. -There were 5 medications which were not available on the medication cart for Resident #8: Vitamin D (for bone strength), Sertraline (for depression), Namenda (treats dementia), Zyprexa (treats mood conditions) and Tylenol (for generalized pain). Review of Resident #8's December 2015 Medication Administration Record revealed: -The resident was ordered Vitamin D (for bone strength), Sertraline (for depression), Namenda (treats dementia), Zyprexa (treats mood conditions) and Tylenol (for generalized pain). -All medications were listed as administered the day before on 12/9/15. -There were no notations on the MAR sheet indicating the meds were not available on the previous shifts. -There were no notations on the MAR sheet	{D 358}		

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{D 358}	Continued From page 37 indicating that the meds had been ordered. Interview with medication aide on 12/10/15 at 10:45am revealed: -The Vitamin D, Sertraline, Namenda, Zyprexa and Tylenol were not available. -She could not determine if they had been ordered. -She could not determine when they would be available. -She had to call the pharmacy when they were out of medications. -The facility kept track of all medications reorders to the pharmacy in the back office. -All medication reorders were faxed to the pharmacy and fax transmission sheets of those faxes were kept in a file box. -When there are no more pills left in the medication cards, they can call the backup pharmacy. -The primary pharmacy delivers same day when ordered in the morning. -Medications aides are supposed to write on the back of the MARs to let the other staff know that the medications have been ordered. -She could not explain why the back of the MARs where reordered medication notations should have been written were blank. -The previous shift using the last pill should have called the backup pharmacy immediately. -She could not determing the initials of the name of the person who gave the last dose. Observation of medication reordering file box on 12/10/15 at 10:55am revealed: -Vitamin D was reordered at 4:35am on 12/10/15at 4:45am from the primary pharmacy. -Sertraline was reordered on 12/6/15 from the primary pharmacy. -Namenda was reordered at 4:35am on 12/10/15	{D 358}		

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from the primary pharmacy.
-Zyprexa 2.5mg was reordered at 4:35am on 12/10/15 from the primary pharmacy.
-Tylenol was reordered on 12/6/15 from the primary pharmacy.

Interview with the Acting Resident Care Coordinator on 12/10/15 at 11:05am revealed:
-The medications were reordered.
-She did not have an explanation why they had not arrived.
-She had permission to use the backup pharmacy when medications were out of stock.
-She was anticipating that Resident #8's medcations would arrive shortly.
-She did not call the backup pharmacy to obtain the medications.
-She confirmed the dates for reordered meds from the file box.
-She could not explain why the medications from 12/6/15 had not arrived yet.

Interivew with the facility's nurse consultant on 12/14/15 at 3:45pm revealed:
-The facility had a tracking system for ensuring medications were available for all residents at all times.
-She could not explain why Resident #8 was out of 5 different medcations.
-All medication tracking is assured by a "hotbox" system they have in place.
-She did not know why the system failed.
-Resident #8's Vitamin D was currently available on the medication cart.
-Resident #8's Namenda was currently available on the medication cart.
-Resident #8's Zyprexa 2.5mg was currently available on the medication cart.
-Resident #8's Tylenol reordered on 12-6-15 was currently available on the medication cart.

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{D 358}	Continued From page 39 -Resident #8's Sertraline was still not available due to the pharmacy's inability to read the reorder fax on 12/6/15. -The facility would have to make arrangements to obtain the Sertraline using the backup pharmacy. -Facility policy was to record times of medication reordering on the back of the paper MAR for each resident. -She could not explain why there were no notations on the back of Resident #8's MARs indicating the date and time the meds were reordered. -All staff needed to be reeducated on policy related to medication reordering. -There was no assigned staff member to oversee that medications were received. Observation of medication cart on 12/14/15 at 4:00pm revealed that all of Resident #8's medications were available except Sertraline. _____ Review of the Plan of Protection received from the facility on 12/14/15 revealed: The Executive Director or Designee would review staffing each day to ensure adequate coverage. The shifts have been evaluated and additional medication aides would be added to ensure a timely med pass, by 12/15/15. All medication aides would receive medication administration training on 12/15/15 provided by their consulting pharmacy. The medication training would include documentation and ordering of medications from pharmacy and utilizing the back- up pharmacy when medications are not available. To ensure all medications are given to every resident as ordered. The Executive Director or Designee will have biweekly medication aide meetings for 4 months and then monthly thereafter.	{D 358}		

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{D 358}	Continued From page 40 From 7:00am through 11:00pm daily there will be two medication aides while the census remains at 39 or greater. The Executive Director or Designee will review the medication pass daily when on site to ensure timeliness and adjust the medication hours as needed. The Executive Director or Designee will audit a sample of medication administration records daily to ensure medications are given per physician orders. CORRECTION DATE FOR THE UNABATED TYPE B VIOLATION SHALL NOT EXCEED JANUARY 13, 2016	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a	D 367		

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signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to assure the medication administration records (MARs) were accurate for sampled residents (#1, #8, #9) whose medication was administered beyond the one hour widow alotted for medication administration. The documentation on MARs did not match the time of documented medicatin administration. The findings are:

1. Review of Resident #1's current FL2 dated 10/14/15 revealed:
-Diagnoses included Alzheimer's, dementia, hypothyroidism, osteoporosis, osteoarthritis, overactive bladder and anxiety disorder.

Review of Resident #1's provider orders revealed:
-There was a medication order for calcium/vitamin D 600/400mg (for bone maintenance) twice daily.
-There was a medication order for magnesium oxide 400mg (for maintenance of muscles and nerves) twice daily written on 10/14/15.
-There was a medication order for Tylenol 500mg (for generalized pain) twice daily written on 10/14/15.
-There was a medication order for Colace 100mg (for stool softening) daily written on 10/14/15.
-There was a medication order for Bactrim DS 800-160mg (for urinary tract infection) twice daily written on 12/8/15.

Review of Resident #1's pharmacy-printed MARs revealed:
-Calcium/vitamin D 600/400mg was scheduled to

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be administered at 9am and 9pm.
-Magnesium oxide 400mg was scheduled to be administered at 9am and 9pm.
-Tylenol 500mg was scheduled to be administered at 9am and 9pm.
-Colace 100mg was scheduled to be administered at 8am.
-Bactrim DS was scheduled to be administered at 8am and 4pm.
-Olanzapine was scheduled to be administered at 8:00am and 8:00pm.

Observation of Resident #1's medication administration on 12/11/15 at 11:30 revealed:
-Calcium/vitamin D 600/400mg, Magnesium oxide 400mg, Tylenol 500mg, Colace 100mg, and Bactrim DS 800-160mg were administered.
-Resident #1's family member asked the medication aide (MA) if the 8:00am medication time had been changed for Resident #1's medication administration or if it was still scheduled for 8:00am.
-The MA replied "Resident #1's medication times had not been changed, they were still scheduled to be given at 8:00am but [she] was running behind".

Interview with the medication aide on 12/11/15 at 11:35 revealed:
-She was administering medications that were scheduled to be given at 8:00m, because she had been running behind, due to a staff call out.
-She still had 2 other residents to administer medications to that were due to be given at 8:00am.

Review of the MAR for Resident #1 revealed:
-All of her medications had been documented as administered for the printed times they were scheduled to be given.

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D 367	Continued From page 43 -Colace 100mg was documented as administered at 8am. -Bactrim DS was documented administered as at 8am. -Olanzapine was scheduled documented as administered at 8:00am. -Tylenol 500mg was scheduled documented as administered at 9am. -Calcium/vitamin D 600/400mg was documented as administered at 9am. -Magnesium oxide 400mg was documented as administered at 9am. -The medication administration record did not have any notation of late administration. 2. Review of Resident #9's current FL2 dated 3/18/15 revealed: -Diagnoses included CHF, hypertension, dementia, BPH and depressive disorder. Observation of Resident #9's medication administration on 12/11/15 at 12:00pm revealed: -The MA administered 10 medications. -Senokot S-6mg-50mg (for relief of constipation), Vitamin D-3 5000 units (for dietary supplement), Vitamin B-12 500mcg (for memory loss in Alzheimer's patients), Finasteride 5mg (for the treatment of benign prostatic hyperplasia), Flomax 0.4mg (for treatment of the symptoms of an enlarged prostate), Zoloft 50mg (for treatment of depression), Furosemide 20mg (prevents your body from absorbing too much salt), Coreg 3.25mg (for treatment of high blood pressure and heart failure), Tylenol 325mg (for generalized pain), Pepcid 10mg (used to treat ulcers in the stomach and for conditions where the stomach produces too much acid) were administered. Review of Resident #9's physician orders revealed:	D 367		

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D 367	Continued From page 44 -There was an order dated 3/18/15 for Pepcid 10mg two times a day. -There was an order dated 9/14/15 for Senokot -S 6mg-50mg daily, vitamin D-3 5000 units daily, and vitamin B-12 500 mcg daily. -There was an order dated 10/1/15 for Finasteride 5mg daily, Flomax 0.4mg daily, and Coreg 3.25mg two times a day. -There was an order dated 10/9/15 for Tylenol 325mg (2) three times daily. -There was an order dated 10/16/15 for Zoloft 50mg daily. - There was an order dated 11/17/15 for Furosemide 20mg daily. Review of Resident #9's medication administration record (MAR) for December 2015 revealed the listed medications were scheduled to be given at 8:00am daily: -Senokot S-6mg-50mg. -Vitamin D-3 5000 units. -Vitamin B-12 500mcg. -Finasteride 5mg. -Flomax 0.4mg. -Zoloft 50mg. -Furosemide 20mg. Review of Resident #9's MAR of December 2015 revealed: -Coreg 3.25mg two times a day was scheduled to be given at 8:00am and 4:00pm. -Tylenol 325mg (2) three times daily was scheduled to be given at 8:00am, 12:00pm and 4:00pm. - Pepcid 10mg was scheduled to be given at 8:00am and 8:00pm daily. -All of the medications were documented as administered at 8:00am each day. -The medication administration record did not have any notation of late administration.	D 367		

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D 367	Continued From page 45 Interview with the medication aide (MA) on 12/11/15 at 12:00pm revealed: -She had just completed her 8:00am medication pass. -She was administering medications that were scheduled to be given at 8:00am for Resident #9. -She was the only medication aide working on 12/11/15. -There had been a staff call out and she was administering medications on both medications carts that day. -There was often one medication aide working due to staff call outs. -She was not usually still administering 8:00am medications at 12:00pm. -Normally she would begin her 8:00am med pass at 7:00am. -She had been dealing with skin tear issues with a couple of residents and was not able to start administering medications until 8:30. -She would usually complete her 8:00am medication pass around 10:00am. -She had not been in the habit of calling the physician to alert her aware the 8:00am medications were administered late. -She was aware there was a dose of Tylenol scheduled for Resident #9 for 8:00am and 12:00pm. -She did not administer both doses to Resident #9, she administered one dose of Tylenol 350mg (2) tabs. -She signed off all of the medications on the MAR for 8:00am and 12:00pm although she administered them at 12:00pm. -She would contact the physician and see if the 4:00pm dose of Coreg 3.125mg should be withheld. -The acting RCC did not administer any resident medications on the morning of 12/11/15.	D 367		

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D 367	Continued From page 46 3. Review of Resident #8's current FL2 dated 1/6/15 revealed: -The resident's diagnoses included right parietal gyrus hemorrhagic, contusion, left zygomatic arch fracture, multiple facial fractures, Alzheimer ' s, hypertension, GERD, irritable bowel syndrome, spinal stenosis and prostate cancer. -The resident was admitted on 1/5/15. Review of Resident #8's physician orders revealed: -There was a medication order for Tylenol 650mg (for generalized pain) three times daily. -There was a medication order for olanzepine 5mg (for mood disorder) at bedtime. -There was a medication order for olanzepine 2.5mg (for mood disorder) at 8am and 4pm. -There was a medication order for alprazolam 0.5mg (for anxiety) four times daily as needed. -There was a medication order for omeprazole 40mg (for acid reflux) in the morning. -There was a medication order for fluorocortisone acetate 0.1% (for sodium maintenance in the body) daily. -There was a medication order for Namenda 10mg (treats dementia) twice daily. -There was a medication order for Vitamin D-3 5000 units (for bone health) daily. -There was a medication order for Sertraline 100mg (for depression) twice daily. -There was a medication order for Senna 8.6mg daily as needed for constipation. Review of Resident #8's pharmacy-printed MARs for the month of December 2015 revealed: -Tylenol 650mg was scheduled to be given at 8am, 1pm and 8pm. -Olanzepine 5mg was scheduled to be given at	D 367		

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D 367	Continued From page 47 8pm. -Olanzepine 2.5mg was scheduled to be given at 8am and 4pm. -Omeprazole 40mg was scheduled to be given at 8am. -Alprazolam 0.5mg was scheduled to be given as needed. -Namenda 10mg was scheduled to be given at 9am and 9pm. -Vitamin D-3 5000 units was scheduled to be given at 9am. -Fluorocortisone acetate 0.1% was scheduled to be given at 9am. -Sertraline 100mg was scheduled to be given at 9am and 9pm. -Senna 8.6mg was scheduled to be given as needed. Observation of Resident #8's medication administration on 12/14/15 at 10:45 revealed: -The 8am and 9am medications were administered late at 10:45am. -The medication aide did not record make a notation or reasoning for any of the six medications administered late on the MAR. -5 of the 6 medications were unavailable (Vitamin D-3, sertraline, Namenda, onlanzepine and Tylenol). Interview on 12/14/15 at 10:45am with the medication aide revealed: -Resident #8's available medications were in the medication aide's hands. -She had not given the medications. -The medications were scheduled to be given at 8:00am per the MAR. -The medications were already documented as given. -The medication aide had predocumented on the MAR but not yet given the medications.	D 367		

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D 367	Continued From page 48 -She should not have precharted the med administration under the 8:00am block it until after it was given. -If a medication was given late, it should be documented on the back of the MAR with an explanation of why it is late. -None of the staff adhere to that policy because there are too many medications that are late, so "we do the best we can." -She did not have an explanation why the medications were late. -She knew they were 8am medications but she was the one who just signed the MAR moments ago and Resident #8 had not yet received his medications. -It is frequently difficult to adhere to the administration times listed on the MAR so "we give them as soon as we can." -Five medications were not available on the medication cart. -All medications for Resident #8 were documented as administered the day before on 12/9/15. -There were no notations on the MAR sheet indicating that the meds had been ordered. -The medication aide did not document on the back of the MAR that 5 of Resident #8's medications were not available. Interivew with the facility's nurse consultant on 12/14/15 at 3:45pm revealed: -The staff were taught to sign the back of the MARs with an explanation of why the medication was given late. -The RCC should have helped if the medication aides were unable to give their medications at the appropriate times. -She was unaware of multiple residents recieving their medications outside their scheduled	D 367		

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D 367	Continued From page 49 administration times. -The facility had to have more staff to fix the issue with late medications. Interivew with the Administrator on 12/14/15 at 3:55pm revealed: -The facility needs more staff. -She was unaware of the frequent late medication adminstration for multiple residents. -She acknowledged the need for more staff. -Medication aides performing dietary aide duties, personal care duties and laundry duties "may have caused their occasional delays in their [medication aides] med passes."	D 367		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure minimum staffing requirements were met to meet the needs of the 37 residents residing in the Memory Care Facility from 10/20/15 through 10/29/15. The findings are: Interview with the Interim Administrator on	D 465		

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D 465	Continued From page 50 12/8/15 at 10:15am revealed: -There were 37 residents currently residing at the facility. -The staffing matrix for the facility to function at full staff required 5 staff persons on first and second shift, and 4 staff to work third shift. -Two medication aides (MA) to work daily 7:00am - 11:00pm, with three personal care aides (PCA) to work daily 7:00am - 11:00pm, and one MA and three PCAs to work 11:00pm -7:00am daily. -There had been a lot of staff turnover at the facility. -There was not a current Memory Care Director working at the facility, they were in the process of hiring someone. -There was not a full time nurse currently employed at the facility. -There was a nurse consultant on Mondays and Wednesdays that did assessments at the facility. -There was a Regional Clinical Director of Nursing that would be working at the facility until a Nurse was hired. Review of staff timecards 10/20/15 through 10/29/15 revealed: -There were 18 shifts between 10/20/15 and 10/29/15 where the required staffing matrix was not met. -The first shift was I person short for five shifts on 10/16/15, 10/18/15, 10/19/15, 10/27/15 and 10/29/15. -The second shift was 1 person short for 5 shifts on 10/19/15, 10/24/15, 10/21/15, 10/26/15 and 10/28/15. -The third shift was 1 person short on 7 shifts 10/17/15, 10/21/15, 10/23/15, 10/24/15, 10/25/15, 10/27/15, and on 10/28/15 -one person worked 2 hours, making the facility short 1 person for 6 hours. -On 10/18/15 and 10/20/15 the facility was 2	D 465		

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D 465	Continued From page 51 persons short on third shift. Confidential interviews with family members revealed: -Family members had to come to the facility regularly to ensure their family member received a shower and got their hair washed and teeth brushed, they used to wait for staff to do it but it was not happening regularly. -A family member came to the facility to feed her family member whenever she could. -There were residents seated at the tables during meals that needed assistance, but there was not enough staff to assist them with eating. -There was a resident who would yell out at the table during meals, she did not eat because she needed assistance. After a while, staff would return her to her room, where she would continue yelling out; this happened each day at the lunch meal. -There had been a lot of falls at the facility, a family member had seen multiple bruised-up residents during visits to the facility. -Family members had seen residents soil themselves because they could not get into their rooms to use the bathroom. Interview with the interim administrator on 10/29/15 at 2:20pm revealed: -Each staff was assigned an area and a number of residents to monitor and provide care for each shift. -Some of the residents are busy and fast and are difficult to supervise. -Most residents were in the common areas most of the day and there were several staff in the area. -She does not feel that the facility has had more falls than usual with this population. -Most recently, she had fired 4 staff for sleeping	D 465		

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D 465	Continued From page 52 during 3rd shift. -She has had a number of staff changes and was still working on being fully staffed. Interview with the interim administrator on 11/30/15 at 4:00pm revealed: -The facility has started (2) 12 hour shifts, due to staff shortages. -At this point she does not know if this will be permanent. -The facility now has a nurse consultant 2 or 3 days per week to focus on new orders and chart reviews. -She feels that they are doing better, staying on top of things.	D 465		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration, residents' rights and providing adeqaute staffing. The findings are: Based on observation, interview and record	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R-C 12/14/2015

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{D912}	Continued From page 53 review, the facility failed to ensure personal care aides (PCA) and medication aides (MA) were not assigned food service duties, which interfered with residents' activities of daily living and medication needs being met. [Refer to tag 209, 10A NCAC 13F. 0604(2)(e) Personal Care and Other Staffing Type B Violation]. Based on observation, interview, the facility failed to ensure all residents were treated with respect, consideration, and dignity, relating to their bedroom doors being unlocked and accessible to the residents, without the need to ask for staff assistance when entering or exiting their rooms. [Refer to tag 338 10A NCAC 13F. 0909 Residents' Rights Type B Violation]. Based on observation, record review and interview, the facility failed to assure that staff administered Vitamin D, Zyprexa, Sertraline, Namenda and Tylenol as ordered for 1 of 8 residents (#8). [Refer to tag 358, 10A NCAC 13F. 1004(a) Medication Administration Unabated Type B Violation].	{D912}		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents were free of neglect related to a resident receiving emergency attention for an acute injury resulting in a knee and hip fracture; personal care, and failure to implent physician order resulting in	{D914}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D914}	Continued From page 54 residents having multiple falls and one resident sustaining rib and hip fractures. The findings are: Based on observation, record review and interview, the facility failed to ensure personal care was provided to two of five Residents (# 2, and #7) based on their assessed needs, resulting in excoriation of the skin (Resident #2), and rib and hip fractures (Resident #7). [Refer to tag 269, 10A NCAC 13F.0901(a) Personal Care and Supervision Uabated Type A1 Violation]. Based on observation, interview, and record review, the facility failed to assure referral and follow up for one of five sampled residents (#4) related to contacting emergency medical services for a fractured hip and knee. [Refer to tag D 273, 10A NCAC 13F .0902(b) Health Care Type A2 Violation]. Based on interviews and record reviews, the facility delayed physician orders for a urine screen and antibiotics for a resident (#6); and failed to implement physician orders for 2 of 5 residents (#6 and #7) that required the use of a walker for ambulation, resulting in both residents having multiple falls with injuries. [Refer to tag D276, 10A NCAC 13F .0902(c)(4) Health Care Type A2 Violation].	{D914}		