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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow up and complaint survey on 07/09/18 through 07/13/18 and 07/16/18 with exit conference via telephone on 07/19/18.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure laundry detergents, laundry boosters, laundry softeners, and laundry de-stainers were stored in a locked area resulting in hazardous chemicals being unattended and accessible to residents. The findings are: Observation of the laundry room on the assisted living (AL) side of the facility on 07/09/18 at 1:39pm revealed: -There were two doors that entered into the laundry room from the hallway. -There were at least 28 five gallon buckets of liquid laundry chemicals stored in the laundry room. -The chemicals included de-stainer (chlorine	D 056		

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bleach), concentrated laundry break (laundry builder/booster), concentrated laundry detergent, and concentrated laundry softener.
-Four of the five gallon buckets of liquid laundry chemicals had tubing attached to the commercial laundry machines.
-The labels on the laundry chemicals had various warnings including: keep out of reach of children; danger - avoid contact with skin, eyes or mucus membranes; causes severe skin burns and eye damage.

Interview with a housekeeper on 07/09/18 at 1:44pm revealed:
-She had worked at the facility about 3 months.
-She was not sure if the laundry room doors were supposed to be locked.
-The doors to the laundry room were usually unlocked.

Interview with a second housekeeper on 07/16/18 at 12:25pm revealed:
-The laundry room doors were usually unlocked so staff could go in and out to take soiled linens and to get clean linens.
-She was not aware the laundry room needed to be locked due to the laundry chemicals that were stored in there.

Interview with the Administrator on 07/16/18 at 12:40pm revealed:
-She was aware laundry chemicals were stored in the laundry room.
-She was not aware the chemicals need to be in a locked area.
-The laundry room was not usually locked because staff were going in and out for linens.
-She would check on the status of the keys to the laundry room and they would get it locked.

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D 056	Continued From page 2 Interview with the laundry aide on 07/16/18 at 12:58pm revealed: -The laundry room doors were not usually kept locked. -The laundry chemicals were usually stored in the laundry room. -She was not aware the chemical needed to be in a locked area. Interview with the Resident Care Manager (RCM) on 07/16/18 at 2:30pm revealed: -The doors to the laundry room should be closed at all times. -She was aware the laundry chemicals were stored in the laundry room. -She was not aware the chemicals needed to be stored in a locked area. -There were at least two residents on the assisted living side of the facility who were confused. -One of the confused residents was ambulatory and walked up and down the halls. Observation of the laundry room on the AL side of the facility on 07/16/18 at 4:22pm revealed: -Both doors to the laundry room were unlocked and no staff were in the laundry room. -There were at least 29 five gallon buckets of liquid laundry chemicals stored in the laundry room. -The chemicals included de-stainer (chlorine bleach), concentrated laundry break (laundry builder/booster), concentrated laundry detergent, and concentrated laundry softener. -Four of the five gallon buckets of liquid laundry chemicals had tubing attached to the commercial laundry machines. Observation of the hallway with the laundry room on the assisted living side of the facility on 07/16/18 from 5:58pm - 5:59pm revealed:	D 056		

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D 056	Continued From page 3 -A resident (identified as confused by staff) walked from the nurses' station to the other end of the hall and stopped at the first laundry room door. -The resident stood in front of the laundry room door staring at the door for a few seconds. -There were no staff in the hallway or in sight of the resident. -The resident turned around and walked back toward the nurses' station. -Both laundry room doors were unlocked with no staff inside the laundry room.	D 056		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure there were no chronic odors of urine and feces in the special care unit. The findings are: Confidential interview with a family member revealed: -There were always strange odors like urine and maybe body odor in the resident's room when the family member visited almost daily. -On one occasion, there was feces on the grab bar by the toilet; the family member cleaned the grab bar with a wash cloth and placed the soiled	D 075		

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wash cloth in the shower where it stayed for a week.

Observations on 07/09/18 from 11:20am until 1:00pm revealed:
-There was a urine odor in resident rooms #205, #209, #314, #319, the hallway of the 200 hall and the television room in the special care unit (SCU).
-There were five brown smears on the recliner in resident room #205; two of the smears had raised thickness and resembled dried feces; there was a feces odor in the room.
-There were thick, brown smears on the towel bar and a feces odor in the bathroom of resident room #205.
-There were large brown smears on the garbage can in the bathroom of resident room #317.
-There were brown smears on the light switch in the bathroom of resident room #318.
-Resident #2 (at 12:29pm) and Resident #6 (at 12:14pm) entered the television room and had a urine odor detectable from approximately three feet away.

Interview with a personal care aide (PCA) on 07/09/18 at 5:15pm revealed:
-She was not aware of the brown smears on the chair and on the towel bar in resident room #205.
-The housekeeping staff were supposed to have cleaned the chair and towel bar.

Interview with the Memory Care Manager (MCM) on 07/09/18 at 5:26pm revealed:
-She was not aware there was what appeared to be feces smeared on the chair and the towel bar in resident room #205 from 12:48pm until 5:26pm.
-Housekeeping staff should have cleaned those areas and she would follow up with the housekeepers.

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D 075	Continued From page 5 Observations on 07/09/18 at 5:03pm, 07/10/18 at 11:27am and 07/13/18 at 2:31pm revealed there was a urine odor in the hallway upon entrance to the SCU and in the hallway of the 200 hall. Observation on 07/11/18 at 5:20am revealed there was a strong urine odor in resident room #205. Observation on 07/11/18 at 6:20am revealed there was a strong urine odor in resident room #319. Observation of a resident room #314 on 07/11/18 at 6:16am revealed: -There was a strong urine odor in the room. -The sheets on each bed were dry. -There were clothes in baskets and bags on the right side of the bed at the door. Interview with a PCA on 07/11/18 at 6:35am revealed: -She was not sure where the smell of urine was in resident room #314. -She thought it could have been from all the clothes at the door since the resident would sometimes put dirty and clean clothes in a pile. -She wasn't sure the last time the clothes on the side of the bed had been washed. Observation of room #314 on 7/11/18 at 12:17pm revealed there was a 2 foot by 1 foot spot on the chair seat under the cushion that smelled like urine. Interview with the housekeeping staff on 07/11/18 at 12:17pm revealed: -She had known that room #314 had a strong urine odor.	D 075		

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-She cleaned the room daily but could not get the urine odor out.
-She had wanted to do a deep cleaning of the room for a while and had reported it to her supervisor.
-The housekeeping staff were not allowed to move a resident's clothing in the room.
-She was not aware that the chair had the urine stain on it.

Interview with the Memory Care Manager (MCM) on 07/11/18 at 12:25pm revealed:
-She was not aware of the chair saturated with urine or the strong urine odor in room #314.
-She would call the family regarding the chair and ask if they wanted to send in a replacement.
-She would make sure all laundry on the side of the first bed was laundered.

Observation on 07/11/18 at 1:05pm revealed the chair in room #314 was being removed by staff and the clothing beside the first bed had been taken out of the room.

Observation on 07/13/18 at 9:50am of room #319 revealed:
-The room had a strong urine odor.
-The sheets and blankets on each bed were clean and dry.

Interview with the housekeeping staff on 07/13/18 at 9:55am revealed:
-She had known that room #319 had a strong urine odor.
-She cleaned the room daily but could not get the urine odor out.
-She wanted to do a deep cleaning of the room.

Observation on 07/16/18 at 12:00pm of room #319 revealed:

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D 075	Continued From page 7 -The room had a strong odor of urine. -The recliner in the room had dark black spots in various shapes on the seat cushion. -The recliner seat cushion had a strong odor of urine. Interview with the MCM on 07/16/18 at 12:30pm revealed: -She was not aware of the recliner saturated with urine or the strong urine odor in room #314. -She would call the family regarding the chair and ask if they wanted send in a replacement.	D 075		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 6 staff sampled (F) was tested for Tuberculosis (TB) disease upon hire according to control measures for the Commission for Health Services. The findings are: Review of Staff F's personnel record revealed: -Staff F was hired on 09/27/13 as a resident	D 131		

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assistant / medication aide.
-Staff F had a tuberculosis (TB) skin test placed on 07/15/10 and read as negative on 07/17/10.
-Staff F had a TB skin test placed on 08/14/10 and read as negative on 08/16/10.
-There was no documentation of any TB skin tests for Staff F upon hire in 09/2013.

Telephone interview with Staff F on 07/17/18 at 2:31pm revealed:
-She had worked with this corporation for about 18 years but she had only worked at this particular facility for about 6 years.
-She thought she had a TB skin tests when she started working at the facility about 6 years ago but she was not sure.
-She was not sure if she had a second TB skin test.

Interview with the Administrator on 07/16/18 at 5:45pm revealed:
-She was not sure if Staff F had TB skin tests completed upon hire in 09/2013.
-Staff F was employed at a sister facility prior to being hired in 09/2013.
-The business office manager (BOM) was responsible for the personnel files.

Interview with the BOM on 07/16/18 at 5:50pm revealed:
-She was not sure if TB skin tests were done for Staff F upon hire in in 09/2013.
-She would check on it.
-She was responsible for the personnel files.
-She usually checked the personnel files quarterly to make sure the required documentation for staff qualifications was on file.

Interview with the Administrator on 07/17/18 at 3:43pm revealed:

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D 131	Continued From page 9 -They were unable to locate any documentation of TB skin tests since Staff F was hired at the facility in 2013. -The TB skin tests on file were from a sister facility Staff F worked at prior to being hired at this facility in 09/2013.	D 131		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 6 staff sampled (F) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. The findings are: Review of Staff F's personnel record revealed: -Staff F was hired on 09/27/13 as a resident assistant / medication aide. -Staff F had a criminal background check completed on 07/13/10. -There was no documentation of a criminal background check or consent upon hire on 09/27/13. Telephone interview with Staff F on 07/17/18 at 2:31pm revealed: -She had worked with this corporation for about 18 years but she had only worked at this particular facility for about 6 years. -She thought a criminal background check was done but she was not sure when it would have	D 139		

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D 139	Continued From page 10 been done. Interview with the Administrator on 07/16/18 at 5:45pm revealed: -She was not sure if Staff F had TB skin tests completed upon hire. -The business office manager (BOM) was responsible for the personnel files. Interview with the BOM on 07/16/18 at 5:50pm revealed: -She was not sure if a criminal background check was done for Staff F upon hire in 09/2013. -She would check on it. -She was responsible for the personnel files. -She usually checked the personnel files quarterly to make sure the required documentation for staff qualifications was on file. Interview with the Administrator on 07/17/18 at 3:43pm revealed: -They were unable to locate any documentation of a criminal background check since Staff F was hired at the facility in 2013. -The criminal background check on file was from a sister facility Staff F worked at prior to being hired at this facility in 09/2013.	D 139		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet	D 188		

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the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:
(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)
(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure aide hours met the minimum requirements on 14 of 36 shifts

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sampled for 12 days from March 2018 - July 2018 on the assisted living side of the facility.

The findings are:

Confidential interview with staff revealed "we are very short staffed."

Interview with a medication aide (MA) on 07/09/18 at 1:10pm revealed:
-First shift staff hours were from 7:00 a.m. to 3:00 p.m.
-Second shift staff hours were from 3:00 p.m. to 11:00 p.m.
-Third shift staff hours were from 11:00 p.m. to 7:00 a.m.

Interview with the Administrator on 07/16/18 at 6:10pm revealed:
-There was no record of a staffing schedule that specified which staff worked on the assisted living (AL) side and which staff worked on the special care unit (SCU) each shift.
-When staff reported to work on each shift, a dry erase board was used to note which staff were working on each side of the facility.
-Staff who were training were not counted in the required aide hours.
-The Resident Care Manager (RCM) was usually available Monday through Friday from 8:30am - 5:00pm to work as an aide if needed.
-The Administrator would assist the RCM or Memory Care Manager (MCM) with their duties if the CMs were filling in and providing care to residents.

Upon request, census reports for 03/02/18, 03/03/18, 03/04/18, 04/08/18, 04/09/18, 05/23/18, 05/24/18, 06/26/18, 06/27/18, 06/28/18, 07/07/18 and 07/08/18 were not available for review.

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D 188	Continued From page 13 Review of the "Punch Detail" timecard report dated 03/03/18 revealed: -There was a handwritten entry at the top of the page which noted the census on the AL side was 25 which required 16 hours of staff time for first shift. -There were 6.95 staff hours provided on first shift leaving the AL side short 9.05 aide hours. Review of the "Punch Detail" timecard report dated 03/04/18 revealed: -There was a handwritten entry at the top of the page which noted the census on the AL side was 25 which required 16 hours of staff time for first and second shift. -There were 6.97 staff hours provided on first shift leaving the AL side short 9.03 aide hours. -There were 9.5 staff hours provided on second shift leaving the AL side short 6.5 aide hours. Review of the "Punch Detail" timecard report dated 04/08/18 revealed: -There was a hand written entry at the top of the page that noted the census for the AL side of the facility was 23 residents which required 16 hours of aide duty for first and second shift, and 8 hours of aide duty for third shift. -There were 14.85 aide hours provided on first shift leaving the AL side 1.15 aide hours short. -There were 13.07 aide hours provided on second shift leaving the AL side 2.93 aide hours short. -There were 7.28 aide hours provided on third shift leaving the AL side short 0.72 aide hours. Review of the "Punch Detail" timecard report dated 05/23/18 revealed: -There was a hand written entry at the top of the page that noted the census for the AL side of the	D 188		

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facility was 25 residents which required 16 hours of aide duty for second shift.
-There were 8.08 aide hours provided on second shift leaving the AL side 7.92 aide hours short.

Review of the "Punch Detail" timecard reports dated 06/26/18 revealed:
-There was a handwritten entry at the top of the page that noted the census on the AL was 25 which required 16 hours of staff time for the first shift and 8 hours of staff time for the third shift.
-There were 11.38 staff hours provided on second shift but leaving the AL side short 4.62 hours.
-There were 1.07 staff hours provided on third shift leaving the AL side short 6.93 hours.

Review of the "Punch Detail" timecard reports dated 06/27/18 revealed:
-There was a handwritten entry at the top of the page that noted the census on the AL was 25 which required 16 hours of staff time for the second shift.
-There were 12.27 staff hours provided on second shift leaving the AL side short 3.73 hours.

Review of the "Punch Detail" timecard reports dated 06/28/18 revealed:
-There was a handwritten entry at the top of the page that noted the census on the AL was 25 which required 16 hours of staff time for the second shift.
-There were 12.56 staff hours provided on second shift leaving the AL side short 3.44 hours.

Review of the "Punch Detail" timecard reports dated 07/07/18 revealed:
-There was a handwritten entry at the top of the page that noted the census in the AL was 24 which required 16 hours of staff time for the second shift.

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D 188	Continued From page 15 -There were 12.5 aide hours provided on second shift leaving the AL short 3.5 aide hours Review of the "Punch Detail" timecard reports dated 07/08/18 revealed: -There was a handwritten entry at the top of the page that noted the census in the AL was 24 which required 16 hours of staff time for the first and second shifts. -There were 7.27 aide hours provided on the first shift leaving the AL short 8.73 aide hours. -There were 5.77 aide hours provided on the second shift leaving the AL short 10.23 aide hours. Interview with the MCM on 07/19/18 at 11:31am revealed: -She made the schedule for the nursing staff (MAs and PCAs) for the whole facility, SCU and AL every two weeks. -There were usually changes in the schedule at least once or twice in a two week period. -A staff person from the SCU usually covered the 1 hour break for the third shift staff on the AL if there was only 1 staff assigned to the AL. -Staff on break do not leave the premises while on their 1 hour break. -If staff called out, she tried to find coverage. -If she was unable to find coverage, someone was supposed to stay until a relief staff person came to the facility. -If no staff volunteered to stay to cover a shift, they would draw a name out of a hat. -Management staff also stayed to cover shifts "a lot" from week to week. -It was routine for staff to work double shifts at times to cover the shortages. -There was a lot of staff turnover and it was difficult to find new employees in their location. -She thought staffing had gotten better recently.	D 188		

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D 188	Continued From page 16 Interview with the Administrator on 07/19/18 at 12:07pm revealed: -Staff got a 1 hour break during their shift but they were not allowed to leave the building while on break. -If a resident needed something while staff was on break, the expectation was that staff would clock back in and help. -Sometimes staff may work part of their shift on the AL side and part of the shift in the SCU.	D 188		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance (toileting, mouth care, dressing and nail care) in accordance with the care plan and the needs of the residents for 3 of 7 sampled residents (Resident #1, #11, and #12). The findings are: 1. Review of Resident #12's current FL-2 dated 02/09/18 revealed:	D 269		

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D 269	Continued From page 17 -Diagnoses included dementia, type II diabetes mellitus, hypothyroidism, atrial fibrillation and back pain. -Resident #12 was continent of bladder and bowel and used a hearing aid. Review of Resident #12's current care plan dated 07/17/18 revealed: -Resident #12 was ambulatory with a wheeled walker and used a hearing aid. -Resident #12 had occasional bladder and bowel incontinence and required limited assistance with toileting. -There was a notation under toileting that Resident #12 was assisted to the bathroom every two hours and as needed for incontinence. Review of a telephone/verbal order dated 06/06/18 for Resident #12 revealed: -There was an order documented by the hospice nurse to get Resident #12 up 30 minutes before meals and lay down 30 minutes after meals. -There was a notation that Resident #12 did not have to get up if she did not want to. Review of a licensed health professional support (LHPS) evaluation dated 06/21/18 for Resident #12 revealed: -Resident #12 had significant confusion, was oriented to self only and was non-ambulatory. -Resident #12 required one to two staff maximum assistance and verbal cues with transfers out of bed. -Resident #12 did not bear weight on her right leg and did not tolerate transfers well. -Staff reported Resident #12 was up in her recliner for meals, but otherwise spent most of the day in bed. Interview with a personal care aide (PCA) on	D 269		

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D 269	Continued From page 18 07/09/18 at 5:15pm revealed: -The hospice aide assisted Resident #12 with bathing and dressing and got her up to her chair every day. -PCAs brought Resident #12 a plate to her room for each meal. -Resident #12 ate her meals sitting up in bed. -Resident #12 was very hard of hearing and talked sometimes, but not as much as she used to. Interview with the hospice PCA on 07/10/18 at 9:20am revealed: -She was at the facility every day for Resident #12 and gave the resident a bed bath or a shower. -She would get Resident #12 up to bathroom every day; Resident #12 had been up to the bathroom on 07/10/18 and had a large bowel movement. -She had also helped Resident #12 with her breakfast on 07/10/18 which was brought in by a family member. -Resident #12 "was probably more with it than most," she was oriented and knew what happened and when. Interview with the hospice PCA on 07/11/18 at 6:38am revealed: -Resident #12 used to get up and go to the assisted living side for all of her meals before she fell and broke her hip (04/16/18). -Resident #12 did not get out of bed for a while, but "now she gets up" and was "fairly continent". -Resident #12 would call staff using the call bell and ask to get up and use the toilet. -Resident #12 told the hospice PCA that staff did not take the resident to the bathroom. Interview with a second PCA on 07/11/18 at	D 269		

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8:42am revealed if a resident asked to use the toilet, the PCAs were supposed to take the resident to the bathroom.

Observations on 07/12/18 from 12:02pm until 12:19pm revealed:
-Resident #12's bedroom door was open and the resident was lying on her left side with the head of the bed elevated.
-Resident #12 stated, "I need to pee and I can't get anybody to help me."
-Resident #12's call light inside the room was red indicating the string had been pulled.
-There was a computer screen facing the hall in the window of the medication room which showed call lights that had been activated; Resident #12's room (#213), was listed on the screen.
-At 12:19, the call light went off the screen and indicated it had been on for a total of 38 minutes.
-At 12:19pm, a PCA was seated next to Resident #12's bed assisting the resident with eating the lunch meal.

Interview with a third PCA on 07/16/18 at 2:24pm revealed:
-The call light had been turned off before she came to assist Resident #12 with lunch on 07/12/18.
-Resident #12 used a "pamper" and not the toilet; Resident #12 had never requested to get up and go to the toilet.
-Resident #12 needed two staff to get out of bed and if she had another staff to assist, she would get Resident #12 up to the toilet if the resident asked.

Telephone interview with Resident #12's Power of Attorney (POA) on 07/19/18 at 7:04am revealed:
-Getting Resident #12 up for 30 minutes before and after meals was an order she requested

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because there was so many problems with the aides getting Resident #12 up.
-When Resident #12 returned to the facility from the hospital after breaking her hip, the doctors had said not to get Resident #12 up out of bed.
-There was a staff who was insistent that Resident #12 got up so she would heal faster.
-The POA had to have many conversations with the Memory Care Manager (MCM) and Administrator about not getting Resident #12 up before she healed from the hip fracture; this might have been where the confusion came with getting Resident #12 up or not.
-Since then, there was an order to get Resident #12 up out of the bed for meals; if Resident #12 was allowed to get up for meals, she was certainly allowed to get up to use the bathroom.
-She was concerned that staff did not provide incontinence care for Resident #12 and ignored her call light; she had written down a few occasions when this happened.
-On 05/06/18 at 7:15pm, she found Resident #12 uncovered in her bed with nothing on except a shirt; she did not have an incontinence brief on and the bed linens were all askew.
-On 05/22/18 at 8:20am, Resident #12 had not been served breakfast which was supposed to have been served at 7:30am; the POA had to go and request staff assistance with getting breakfast and for incontinence care for Resident #12 because staff did not respond to the call light.
-There were many times when the aides would just slap down Resident #12's meal tray which did not have eating utensils or a napkin and the staff did not offer any assistance.
-There was also a time in May 2018 when the POA came to visit and the power cord to the bed was unplugged and the call light string was not attached to Resident #12's bed; "if (Resident #12) needed help, she could not have gotten it".

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-On 06/06/18, she had told a medication aide (MA), a personal care aide (PCA) and the MCM, that if Resident #12 wanted to get up to get her up.

Telephone interview with the Memory Care Manager (MCM) on 07/18/18 at 12:25pm revealed:
-Resident #12's POA did not want Resident #12 to be moved after the resident broke her hip (04/16/18).
-The order written to get Resident #12 up, only stated to get the resident up for meals so staff would get Resident #12 up then.
-The facility had to be cautious and respect the POA's concerns related to Resident #12's care.
-The MCM and the Administrator have had conversations with staff about getting Resident #12 up if the resident asked because that was her right.
-Staff needed to first make sure it was safe because the facility did not want any more falls; safe meant sitting Resident #12 at the edge of the bed first to make sure she was not dizzy and had the strength to get up.
-Resident #12 needed one to two staff to assist her out of bed depending on her condition at the time.

2. Review of Resident #11's current FL-2 dated 03/15/18 revealed:
-Diagnoses included: osteoarthritis, hypothyroidism, post-traumatic stress syndrome, aphasia, hyperlipidemia, traumatic brain injury, history of thyroid cancer, bradycardia, chronic cognitive disorders, renal tubular dysgenesis and dementia with behavioral disturbances.

Review of Resident #11's care plan dated 3/20/18 revealed:

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D 269	Continued From page 22 -The resident required extensive assistance with bathing, dressing and toileting. -The instructions listed under bathing were that staff assists resident with nail care and oral care 7 days per week. Review of Resident #11's quarterly profile dated 03/21/18 revealed: -Residen #11 required extensive help with grooming/ hygiene. -Resident #11 required staff to brush his teeth. -Resident #11 required staff to clip his nails. a). Observation of Resident #11 in the TV room on 07/09/18 at 12:39pm revealed long, thick, discolored toe nails. Interview with a personal care aide (PCA) on 07/09/18 at 12:33pm revealed: -The medication aide (MA) told the PCA when to cut a resident's finger nails. -She was unsure who cut any resident's toe nails. -The podiatrist came to the facility. -One podiatrist saw all the residents living in the Special Care Unit every two to three months. -She was unaware of what the podiatrist said about Resident #11's toes. -Resident #11 could be hard to take care of because he got "a little violent". Interview with a second PCA on 07/10/18 at 8:53am revealed: -The podiatrist came every two to three months. -Finger and toe nails were filed at each shower and residents usually got showers twice per week. -The PCA cut the resident's toe nails if the resident allowed it. "Toe nails are rough. No resident likes their toe nails cut". -If there is an issue with cutting finger or toe nails,	D 269		

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she reported it to the MA.
-Resident #11's feet "looked that way (long and discolored toe nails) when he came in".
-"Resident #11 doesn't like us to look at his toes. He won't let us touch them".
-"It's been awhile", but she mentioned the condition of Resident #11's toe nails to the MA.

Interview with a third PCA on 07/10/18 at 9:16am revealed:
-Resident's nails were cut and filed every shower.
-Nail care "can be the biggest challenge in the building".
-A PCA can file toe nails for the residents if the resident is not a diabetic.
-Resident #11 won't let us cut his toe nails.

A second interview with the third PCA on 07/10/18 at 10:15am revealed:
-There was no set time for nail care but she did it "mostly at shower time".
-Most residents showered twice per week.
-She cut finger and toe nails when "she noticed them".
-She would cut toe nails "as long as she didn't get sick looking at feet".
-She did not cut diabetic nails.
-Resident #11 would not sit still for the podiatrist visits.
-"The podiatrist can barely see him".
-I've tried to cut his nails but he will eat the nails".
-She had reported this behavior to the MA.

Interview with a fourth PCA on 07/10/18 at 11:15 am revealed:
-She did nail care after resident showers.
-She did not cut diabetic resident's toe nails.
-Nail care included clipping and filing finger and toe nails.
-Nail care was done on first and second shift.

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D 269	Continued From page 24 -She did not give nail care for Resident #11. Interview with a fifth PCA on 07/11/18 at 5:40am revealed: -All shifts did nail care as needed. -Nail care included trimming, filing and cleaning nails. -PCAs look at toe nails as well as finger nails. -The podiatrist came to the facility but she was not sure of the schedule. -She was not sure if the podiatrist saw all of the residents but "he visits quite a few". Interview with a sixth PCA on 07/11/18 at 7:00am revealed: -She "was under the impression we (PCAs) don't do (cut) toes (nails)". -The podiatrist "did the feet". -She reported "odd looking toe nails" to the MA. -She did not think that the Resident 11's toe nails "looked good to her". -Resident 11's toe nails have been that way for a long time. -She reported Resident #11's toe nails to a MA "that no longer works here". -The MAs had seen Resident #11 toe nails. -She reported the condition of Resident #2's toe nails to the MA. Interview with a medication aide (MA) on 07/09/18 at 12:33pm revealed Resident #11's toe nails looked like that when he came here three months ago. Interview with a second (MA) on 07/10/18 at 9:48am revealed: -She was not sure if the PCAs did nail care. -The MAs gave nail care as needed after passing medications.	D 269		

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D 269	Continued From page 25 Interview with a third MA on 07/10/18 at 9:57am revealed: -The PCAs "have to do everything for (Resident #11). -The PCAs are "required to cut finger and toe nails on shower days". -The podiatrist had to "mess with the toe nails". -She was unaware of the podiatrist schedule. -The MAs could call the podiatrist and request resident appointments between regularly scheduled doctor visits. -The regular doctor saw (Resident #11's) feet before. -The manager said there was not too much we can do for his toe nail care. Interview with a fourth MA on 07/11/18 at 6:30am revealed nail care, including toe nail care, was done at every shower. Interview with the podiatrist on 07/11/18 at 8:00am revealed Resident #11 had never been seen as a patient. Interview with the memory care manager (MCM) on 07/11/18 at 12:15pm revealed: -The nail care policy was "to clip nails as needed, fingers or toes except for diabetics and residents on a blood thinner". -She preferred the PCA did not cut toe nails due to infection control. -The podiatrist came to the facility every three months to see all residents with "long nails or infections". -When a resident was admitted he/she agreed to have the house podiatrist to treat. b). Observation of Resident #11 in the TV room on 07/09/18 at 12:39am revealed thick, white build up on his teeth.	D 269		

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D 269	Continued From page 26 Interview with a PCA on 07/12/18 at 5:30pm revealed: -Mouth care meant brushing teeth twice per day. -"That's their right if they don't want to (brush their teeth)". -She reported to the MA when a resident refused mouth care. -Resident #11 received mouth care. -"(Resident #11) don't give me a hard time. He gets aggressive and I get another helper". Interview with a second PCA on 07/16/18 at 12:40pm revealed: -Resident #11 refused mouth care. -Resident #11 "refuses everything". -She reported Resident #11's refusals to the MA. Interview with a third PCA on 07/11/18 at 7:00am revealed Resident #11 was combative with personal care. Interview with a fourth PCA on 07/16/18 at 12:45pm revealed: -She was assigned to work with Resident #11 today. -Sometimes the resident did not let her give mouth care. -She reported his refusals to the MA. A confidential interview with a staff member revealed: -Resident #11 was "the most difficult resident in the facility". -Resident #11 could be combative with care. -"Sometimes he will allow help with brushing his teeth". Interview with a MA on 07/11/18 at 6:30am revealed:	D 269		

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-"[Resident #11] is [Resident #11]".
-"Resident #11 is very, very, very hard to care for".
-The resident was unable to speak and "doesn't communicate at all".
-At times, it took three or four people to give care to Resident #11.

Interview with a second MA on 07/16/18 at 11am revealed:
-If a resident refused mouth care, the PCA told the MA.
-Both the PCA and MA talked to the resident three different times to see if the resident would accept care.
-The MA reported the refusal to the memory care manager.
-The MA would not call the doctor.
-"I don't think he (Resident #11) will allow us to brush his teeth".

Interview with the third MA on 07/17/18 at 10:12am revealed:
-"I feel so bad" for Resident #11.
-It was difficult to brush the resident's teeth.
-Resident #11 would not let her do mouth care.
-"If I can get mouthwash in him he'd swallow it. He don't never let me brush his teeth".

Interview with the memory care manager (MRC) on 07/11/18 at 12:15pm revealed:
-Resident #11 was "somewhat challenging to redirect".
-Resident #11 was "hard to care for because of communication".

A second interview with the MCM on 07/16/18 at 1:40pm revealed:
-There was no policy on mouth care.
-She expected third shift to brush resident's teeth

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in the morning.
-She expected the PCA to tell the MA of any mouth care refusal.
-"I don't work on the floor. I expect them to let me know".
-There was no process to ensure the MCM was notified of personal care refusals.

An interview with the physician's assistant (PA) on 07/17/18 at 11:05am revealed:
-She started seeing Resident #11 in March.
-Resident #11 had "trouble communicating his needs".
-"No one can understand what he says".
-Resident #11 had "cooperative behavior".
-She was unaware that Resident #11 would not allow for daily mouthcare.
-If resident #11 had an issue, it would be with communication because "that's the main problem".
-If a resident refused mouth care she would expect the facility to give the ordered PRN (as needed) medication for agitation and attempt to give care.
-"It would be important for them to give it" so care can be given.

3. Review of Resident #1's current FL-2 dated 06/17/18 revealed diagnoses included Alzheimer's type dementia, unspecified anxiety disorder, moderate opiate disorder, major depressive disorder, and unspecified schizophrenia spectrum disorder.

Review of Resident #1's Resident Register revealed an admission date of 03/12/18.

Review of Resident #1's Behavioral Health History & Physical dated 02/16/18 revealed he had a past medical history of Diabetes and was

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D 269	Continued From page 29 currently taking Metformin 850 mg twice a day. Review of Resident #1's most current care plan dated 05/09/18 revealed he required staff assistance 7 days per week with sponge bath, skin care, nail care, and oral care. Review of Resident #1's care notes on 07/09/18 revealed there was no documentation of the condition of the resident's fingernails prior to 07/09/2018. Observation of Resident #1 on 07/09/18 at 12:00pm revealed: -He was lying in bed and was alert and oriented. -All 10 of the resident #1's fingernails were thicker than normal, yellow in color and extended approximately ½ inch beyond the end of each nail bed. Interview with Resident #1 on 07/09/18 at 12:00pm revealed: -Since he was admitted to the facility, no one had ever offered to cut his fingernails. -He would like his fingernails cut. -He had not asked anyone to cut his fingernails. Interview with a personal care aide (PCA) on 07/09/18 at 12:15pm revealed: -She had taken care of Resident #1 for a few months. -She had seen his long fingernails last week and told a medication aide (MA). -Resident #1 did not want his fingernails cut. -Their process was to evaluate each resident for nail care during their bath and if needed, clean and cut them. Interview with the Memory Care Manager (MCM) on 07/09/18 at 12:20pm revealed she was not	D 269		

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aware of Resident #1's long fingernails and no one had reported it to her.

Interview with the MA on 07/09/18 at 12:55pm revealed:
-No one had reported to her that Resident #1's fingernails were long.
-She tried to cut Resident #1's fingernails and toenails on 07/07/18 but he refused.
-She did not report to the physician that Resident #1 would not allow his nails to be cut.
-She would go and attempt to cut Resident #1's fingernails again.

Interview with Resident #1 on 07/09/18 at 5:05pm revealed:
-The MA had cut his fingernails earlier that day.
-The MA had not offered to cut his nails on 07/07/18.
-He was thankful that his fingernails were cut.

Interview with a second MA on 07/09/18 at 5:15pm revealed:
-She knew Resident #1's fingernails were long but he didn't want anyone to cut them.
-The process for nail care was the PCAs perform nail care on the residents' shower days.

Interview with the Administrator on 07/09/18 at 5:20pm revealed:
-She was not aware of Resident #1's long fingernails.
-The process was if the personal care aide (PCA) cannot cut the resident's nails, then it should be reported to the MA.
-If the MA cannot cut them, then the family should be notified as well as the physician.
-She was not aware if there had been any reporting on Resident #1's nails to his physician.

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D 269	Continued From page 31 Interview with a third MA on 07/10/18 at 1:05pm revealed she had cut Resident #1's fingernails on 07/09/18. Interview on 07/12/18 at 1:25pm with a second PCA revealed: -Resident #1 had a history of refusing baths, shaving and nail care. -She had reported it to the MA on duty and was not sure if the physician had been notified if Resident #1 continued to refuse care. Interview with a fourth MA on 07/12/18 at 1:35pm revealed: -No one had ever reported to her that Resident #1 refused anything except once the previous week he had refused to have his fingernails cut. -They had not called the physician last week to report Resident #1's refusal. Interview the Administrator on 07/13/18 at 10:22am revealed: -She was not aware that Resident #1 was a diabetic. -The protocol for diabetic nail care is they use "best practices, meaning diabetics are referred to the Podiatrist". Interview with Resident #1's physician on 07/13/18 at 11:45am revealed: -She was not aware that Resident #1 was a diabetic and did not see that he had a history of diabetes on his behavioral health notes. -She had never been informed that he refused any care or that he had any issues with his toenails or fingernails. -She would expect that she would be informed if Resident #1 denied nail care and if his nails were over grown or had any issues.	D 269		

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D 269	Continued From page 32 The facility failed to provide personal care assistance for 3 of 7 sampled residents, with two of the residents residing on the special care unit. The faility's failure resulted in incontinence for Resident #12 when staff delayed and denied the residents request to go to the bathroom which was detrimental to Resident #12's health and welfare and constitues a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/08/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 2, 2018.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 6 sampled residents (#2, #4, and #8) as evidenced by not performing 15 and 30 minute checks in acordance with the resident's care plan and the facility's falls management team protocol; and failing to assure safety devices such as bed	D 270		

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and chair alarms, fall mats and side rails, as ordered, were in place for three residents (#2, #4, #8) at high risk to fall with histories of falls with injuries such as head traumas, bruises and skin tears (#2, #4, #8).

Confidential interview with a family member revealed:
-The family member had visited the special care unit (SCU) daily and would frequently see staff hang out in the television room off of the dining room braiding each other's hair and on cell phones during 2nd shift.
-There were residents that were kept in wheelchairs near the front of the SCU to keep staff from having to "run down (to the resident's room) every time an alarm went off".
-Family members had reported concerns to the Memory Care Manager (MCM) and the Administrator.

Confidential interview with a second family member revealed:
-The family member visited the SCU weekly and it seemed from the number of falls for a named resident, residents wearing other resident's clothes, residents missing personal items, that staff did not pay attention when they should have been paying attention.
-There was a little room in the SCU where the personal care aides went and stayed.
-It seemed like the staff put the residents to bed and then went and stayed in that little room instead of being out in the halls watching the residents.

Confidential interview with a third family member revealed:
-Supervision and oversight of staff was a very poor.

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D 270	Continued From page 34 -Staff on the SCU frequently congregated in that little room with the windows while residents wandered up and down the halls with their pants falling down and no socks on, and rooms that were dirty. -There were four to five staff in the little room at a time "a lot" and as recently as June 2018, when the family came to the SCU. -The Administrator was made aware, but nothing changed. Telephone interview with the MCM on 07/19/18 at 11:33am revealed: -She was aware that 2nd and 3rd shift staff had been congregating in the medication room which had been the activity room with tables and chairs, and the television room. -The Administrator talked to all of the nursing staff in a mandatory meeting about a month and half ago (late May/early June 2018). -Staff were told not to congregate in those areas and to perform resident safety checks. -There was no situation under which staff take breaks together; staff may have used those areas for their break time, but only one staff at a time. -The Supervisor for each shift was responsible for making sure each staff was doing what they were supposed to do. -She "would be next in line," and observed staff performance every Monday through Friday from 8:30am until 5:00pm. -There was nothing in place to monitor staff performance on 2nd and 3rd shifts and the weekends. Telephone interview with the Administrator on 07/19/18 at 12:09pm revealed: -There had been family members that reported concerns about staff being gathered in the medication room.	D 270		

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D 270	Continued From page 35 -The change of shift "stand up" was conducted at 3:30pm each day with all staff in the medication room on the SCU. -She had explained to staff that the medication room was for working with charts and medications. -Any staff seen just sitting in the medication room would be written up. -The Supervisors were responsible for monitoring staff when the MCM and Administrator were not in the facility. Interview with the Resident Care Manager (RCM) on 07/16/18 at 1:25pm revealed: -At one time the facility staff was doing 30 minute checks on all residents because they thought it was required. -They realized in June 2018 that 30 minute checks were not required so they started doing routine 1 hour checks on all residents. -Some residents were on 15 minute or 30 minute checks for safety. -She could not say how many falls would trigger a resident to be put on 30 minute or 15 minute checks. -Their falls protocol was to monitor residents' vital signs and check them for changes in condition on each shift for 72 after a fall. 1. Review of Resident #8's current FL-2 dated 09/19/17 revealed: -Diagnoses included dementia without behavioral disorder, altered mental status, chronic atrial fibrillation, type II diabetes mellitus, history of falls, muscle weakness, unsteady on feet and anxiety. -Resident #8 was intermittently disoriented, had wandering behaviors and was semi-ambulatory with the use of a wheelchair.	D 270		

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Review of Resident #8's care plan dated 09/25/17 revealed:
-Resident #8 was always disoriented, had wandering behaviors and was ambulatory with a wheelchair.
-Under the section for risk management provisions and safety measures to be implemented, there was an entry for "resident checks every 30 minutes for safety".

Review of a licensed health professional support (LHPS) evaluation dated 01/18/18 for Resident #8 revealed:
-There was documentation in the assessment narrative that Resident #8 was oriented to self only and easily agitated at times.
-Resident #8 had a bed and chair alarm in use and a mesh side rail was in place "due to numerous falls from bed resulting in head injuries".
-Resident #8 was checked every 30 minutes and released every two hours and as needed.
-Resident #8 required one to two staff "contact guard" assistance with transfers and one staff assistance with her wheelchair "at times".

Review of a restraint order dated 04/18/18 for Resident #8 revealed:
-There was an order for a geriatric chair with a tray to be used at all times unless the resident was sleeping in the bed for the prevention of falls that may result in injury.
-There was an order for the restraint to be checked every 30 minutes and released every two hours for range of motion and bathroom privileges.

Review of a restraint order dated 04/18/18 for Resident #8 revealed:
-There was an order for a half side rail to be used

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when the resident was in the bed because of numerous head injuries and a diagnoses of dementia.
-There was an order for the restraint to be checked every 30 minutes and released every two hours and as needed for resident care.

Review of an incident report dated 11/03/17 for Resident #8 revealed:
-A personal care aide (PCA) found bruising on Resident #8's left side while toileting the resident at 1:45am.
-Resident #8 was sent to the emergency department (ED) and diagnosed with bruising of the left side and hypertension.

Telephone interview with the PCA on 07/18/18 at 9:56am revealed she did not remember the specific incident of Resident #8 having bruises on her side on 11/03/17 or what was done for Resident #8 after the bruises were found.

Telephone interview with Resident #8's Power of Attorney (POA) on 07/17/18 at 7:58pm revealed:
-He did not recall seeing a bruise on her left side from November 2017 because it may have been covered by clothing.
-Resident #8 had "pretty ugly bruises on her arm and leg," that he did see in November 2017.
but .
-Staff were not able to say what happened to cause the bruises to Resident #8 from November 2017.

Review of an incident report dated 11/25/17 for Resident #8 revealed:
-A medication aide (MA) observed Resident #8 on the floor, sitting on her buttocks against the night stand with a nickel sized knot on the right side of her head at 11:50pm.

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D 270	Continued From page 38 -Resident #8 was sent to the ED and diagnosed with a fall and cough. Telephone interview with the MA on 07/18/18 at 11:30am revealed: -She did not remember Resident #8 falling on 11/25/17. -Resident #8 would walk around the SCU and someone bumped into her causing her to hit her head. -She did not remember who bumped into Resident #8. -She could not remember when a resident bumped into Resident #8, but that maybe that's what happened on 11/25/17. Review of an incident report dated 11/27/17 for Resident #8 revealed: -A MA observed Resident #8 lying on the floor with a baseball sized knot on the right side of her head at 10:05pm. -Resident #8 was sent to the ED and diagnosed with a fall, closed head injury. Attempted interview with the MA on 07/18/18 at 11:35am was unsuccessful. Review of an incident report dated 12/03/17 for Resident #8 revealed: -A PCA reported Resident #8 fell and hit her head on the rail at 2:30am. -A MA observed a knot the size of a golf ball on the back of Resident #8's head. -Resident #8 was sent to the ED and diagnosed with a fall from standing and a hematoma on the occipital surface of the head. Telephone interview with the PCA on 07/18/18 at 11:46am revealed: -On 12/03/17, Resident #8 was walking in the hall	D 270		

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with "fuzzy socks" on and the resident tried to grab the hand rail and turn around; as she turned, she slipped and hit the back of her head on the hand rail.
-Resident #8 was sent to the ED, but she could not remember what else was done to prevent further injuries for Resident #8.

Telephone interview with Resident #8's POA on 07/17/18 at 7:58pm revealed he knew about the knot on the back of Resident #8's head on 12/03/17, but the staff did not say how it happened.

Review of an incident report dated 01/14/18 for Resident #8 revealed:
-A MA observed Resident #8 on the floor beside her bed with a golf ball sized knot on the right side of her head at 1:02am.
-Resident #8 was sent to the ED and diagnosed with a fall.

Telephone interview with the PCA on 07/18/18 at 11:46am revealed:
-She could not remember what happened on 01/14/18 because it was between 1:00am and 3:00am on 3rd shift.
-She could only remember what happened on 12/03/17 because it happened on 2nd shift.

Attempted interview with the MA on 07/18/18 at 11:30am was unsuccessful.

Review of an incident report dated 01/30/18 for Resident #8 revealed:
-A MA observed a bruise and swelling on the right side of Resident #8's back at 3:30pm.
-Resident #8 was sent to the ED and diagnosed with a fall and a back contusion.

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D 270	Continued From page 40 Telephone interview with the PCA on 07/18/18 at 11:46am revealed: -She did remember finding the bruise on Resident #8's back on 01/20/18; she was giving Resident #8 a shower and found the bruise on Resident #8's back which was purple and looked like it was a "fresh" bruise. -She reported the bruise the MA and did not know what happened after that. Telephone interview with the MA on 07/18/18 at 10:56am revealed she remembered Resident #8 having a bruise on her back on 01/30/18, but she could not recall which side, if the bruise came from a fall or what was done to protect Resident #8 from future injuries. Telephone interview with Resident #8's POA on 07/17/18 at 7:58pm revealed the bruise was on Resident #8's back in January 2018, near the kidney area which was "a very peculiar place to come from a fall;" the staff were not able to say what happened to Resident #8. Review of a care note dated 02/28/18 at 4:36pm for Resident #8 revealed: -A staff member was in the room and Resident #8 "slipped to the floor". -Vital signs were documented for Resident #8. -There was no documentation of any injury or safety interventions for Resident #8. Review of a care note dated 03/09/18 at 3:45pm for Resident #8 revealed: -A MA observed Resident #8 sitting on the floor on her "bottom" in front of her wheelchair. -Resident #8 did not have any bruises or bumps and vital signs were documented. -There was no documentation of safety interventions for Resident #8.	D 270		

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D 270	Continued From page 41 Review of a fax notification to Resident #8's primary care provider (PCP) dated 03/09/18 revealed the MA documented Resident #8 was observed sitting on the floor on her "bottom" in front of her wheelchair. Review of a care note dated 03/13/18 at 8:50pm for Resident #8 revealed: -A MA documented a "late insert" that Resident #8 was found on the floor in front of her wheelchair with a cut above her left eye. -The date and time of the fall was not documented. -Vital signs were documented for Resident #8. -There was no documentation of any injury or safety interventions for Resident #8. Review of a fax notification to Resident #8's primary care provider (PCP) dated 03/13/18 revealed the MA documented Resident #8 was observed in the hallway on the floor in front of the wheelchair with a cut above her left eye. Review of an electronic progress note dated 04/10/18 at 3:46am revealed: -A MA observed Resident #8 "standing at the end of the 300 hall with another resident holding her arm, (the MA) observed a very large knot on the right side above the eye." -There was no documentation of safety interventions for Resident #8. Attempted interview with the MA on 07/19/18 at 8:49am was unsuccessful. Review of a fax notification dated 04/10/18 for Resident #8 revealed: -There was documentation to Resident #8's primary care provider (PCP) that Resident #8 was	D 270		

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sent to the ED for a large knot over the right eye and complaints of right leg pain.
-The form was signed by the Physician's Assistant (PA).

Upon request 07/18/18 and 07/19/18, there was no incident report dated 04/10/18 for Resident #8 available for review.

Review of a 24 hour initial report dated 04/10/18 for Resident #8 revealed:
-A MA observed Resident #8 with a knot above the right eye at 3:35am.
-Resident #8 returned from the ED with a diagnosis of a fracture of the greater trochanter of the right femur.

Review of an electronic progress note dated 04/10/18 at 2:35am for Resident #8 revealed:
-A MA documented Resident #8 returned from the ED with diagnoses of a traumatic hematoma of the forehead, a fracture of the greater trochanter of the right femur (hip) and a urinary tract infection.
-There was no documentation of safety interventions for Resident #8.

Review of the ED discharge summary dated 04/10/18 for Resident #8 revealed:
-The first vital signs documented in the ED were on 04/10/18 at 3:50am and the discharge summary was printed on 04/10/18 at 12:52pm.
-Resident #8 was seen for a fall with right hip and right leg pain and a large hematoma to the right forehead above the eye.
-Resident #8 was diagnoses with a traumatic hematoma of the forehead, a fracture of the greater trochanter of the right femur which was non-operable and an acute urinary tract infection.

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Interview with the hospice PCA on 07/11/18 at 6:38am revealed:
-Resident #8 had a bed alarm after she came back from the hospital (04/10/18).
-Resident #8 had a fall and had a knot above her eye, she went to the hospital and they found she had broken her leg.
-Whenever a resident on hospice fell, hospice will put safety measures in place; hospice ordered the bed alarm for Resident #8.

Telephone interview with Resident #8's POA on 07/17/18 at 7:58pm revealed:
-Resident #8 had lived with the POA for four years prior to admission at the facility in September 2017 and had not had a history of falling.
-"All of a sudden, I (POA) started getting calls in the middle of the night, always in the middle of the night, that she (Resident #8) fell."
-Resident #8 was supposed to have a side rail, a floor mat and some kind of alarm on the bed.
-The POA did not see the side rail up and the floor mat was not beside the bed when he visited.
-Resident #8 fell approximately three weeks to a month before she died (07/02/18), where she had broken her leg and got a large knot on her head that stayed on her head until she died.
-The POA did not understand how Resident #8 fell out of the bed on her face if the side rail was up, the mat was on the floor and there was some kind of alarm that was supposed to go off if Resident #8 tried to get out of the bed.

Telephone interview with a hospice Licensed Practical Nurse (LPN) on 07/18/18 at 10:13am revealed:
-Resident #8 was admitted to hospice on 02/09/18 and she was familiar with Resident #8.
-Resident #8 had a bed alarm, side rail and floor

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mat in place prior to her fall on 04/10/18.
-She was not able to find the original order dates for the side rail, geriatric chair, floor mat and bed alarm.

Review of PA visit note dated 04/18/18 revealed:
-Resident #8 was seen on 04/18/18 for a follow up visit to the ED treatment for a fall on 04/10/18.
-Resident #8 was "recently admitted to hospice services for Alzheimer's decline."
-There was documentation of the history of Resident #8's falls and injuries including 11/03/17, 01/30/18 and 04/10/18.

Review of an electronic progress note dated 04/21/18 at 10:15pm revealed:
-A MA observed Resident #8 lying on her left side beside the bed with no noted injury or complaint of pain.
-There was no documentation of safety interventions for Resident #8.

Review of a fax notification dated 05/18/18 for Resident #8 revealed:
-There was documentation to Resident #8's PCP that a MA "witnessed" Resident #8 on the floor on her "bottom" beside the bed.
-There was no documentation on whether or not Resident #8 had any injury and staff did not sign the form.
-The form was signed by the Physician's Assistant (PA).

Review of an electronic progress note dated 05/18/18 at 7:42pm revealed:
-A MA observed Resident #8 sitting on her "bottom" on the floor in front of her bed with no noted injury.
-There was no documentation of safety interventions for Resident #8.

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D 270	Continued From page 45 Review of an electronic progress note dated 06/23/18 at 5:42pm revealed: -A MA observed a quarter sized skin tear on Resident #8's right elbow. -There was documentation the MA cleaned the wound, applied triple antibiotic ointment and covered the wound with gauze. -There was no documentation of safety interventions for Resident #8. Telephone interview with the MA on 07/18/18 at 10:03am revealed she could not remember anything more than whatever she wrote in the note for Resident #8. Review of an incident report dated 07/18/18 for Resident #8 revealed: -A MA observed Resident #8 face down on the floor in her room with no injury noted on 06/30/18 at 4:06pm. -There was no documentation of any intervention. -The form documented the report was completed on 07/18/18 at 4:09pm. Telephone interview with a hospice LPN on 07/18/18 at 10:13am revealed: -The facility staff notified hospice that Resident #8 was found on the floor on 06/30/18. -The facility staff reported Resident #8 was found on the floor at the end of her bed and had apparently tried to get up and walk. -The facility staff reported Resident #8 did not have any injuries from the fall. Interview with a medication aide (MA) on 07/11/18 at 5:52am revealed: -Resident #8 died at the facility (07/02/18). -Resident #8 fell just before she died, but the MA could not remember the details.	D 270		

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D 270	Continued From page 46 Telephone interview with a MA on 07/17/18 at 10:10am revealed: -Resident #8 required staff assistance for transfers in and out of bed, toileting and bathing. -Resident #8 would get combative with staff when staff would try to transfer the resident to and from the bed because Resident #8 was afraid she was going to fall. -Resident #8 did try to get up from the bed or the geriatric chair on her own. -Resident #8 had a bed alarm, side rail and a fall mat that was in use right up until the resident died (07/02/18). -Resident #8 was not able to put the side rail down by herself, but she was able to scoot down and get around the bed rail. -The PCAs were responsible for checking on residents with restraints every 15 to 30 minutes by going in the room and looking at the resident. -The MAs were responsible for checking and releasing the restraints every two hours for incontinence care. Interview with the PA on 07/13/18 at 12:10pm revealed: -Resident #8 had recently died at the facility; she had been declining from Alzheimer's and frequent falls, especially a fall in April 2018 where she fractured her hip. -Resident #8 had a geriatric chair in place for the falls and had been evaluated by physical therapy. Telephone interview with the Memory Care Manager (MCM) on 07/18/18 at 12:25pm revealed: -She could not recall the specifics of each of Resident #8's falls and injuries. -If she signed the incident report, then she was made aware at the time of the incident.	D 270		

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D 270	Continued From page 47 -She was not aware that Resident #8 fell on 06/30/18. -For fall prevention measures, Resident #8 had been referred to physical therapy several times, had a "lap buddy," a geriatric chair and a half side rail. -She was not sure of the timeline for each intervention. -The side rail and the geriatric tray were both in place to help prevent falls prior to 04/10/18. -She was not sure if Resident #8 had a bed and/or chair alarm. Review of a care note dated 12/14/17 at 12:45pm for Resident #8 revealed: -Resident #8 was evaluated for physical therapy due to falls. -Resident #8 had "severe cognitive deficits and endangered herself from impulsive movements that was unlikely to change with skilled intervention." Telephone interview with the PA on 07/18/18 at 5:57pm revealed: -She vaguely remembered Resident #8 having bruising and she thought it came from a fall in November 2017. -She did not recall the bruising in January 2018, but did think the right flank was a peculiar place to get a bruise from a fall. -She could not recall if she had been notified of Resident #8's fall on 06/30/18. -Resident #8 had a lot of falls; physical therapy had been tried, but did not work so Resident #8 was referred to hospice. -Resident #8 had a side rail, floor mat and geriatric chair; she did not recall the exact dates of the orders, but she believed the fall mat was in the room when Resident #8 was seen after the hip fracture (04/18/18).	D 270		

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D 270	Continued From page 48 -She was not exactly sure, but she thought Resident #8 had a bed and chair alarm in use also. Telephone interview with the PA on 07/19/18 at 10:40am revealed: -The bed and chair alarm was ordered in December 2017 for Resident #8 because she had fallen out of bed and out of her chair several times. -She was not notified of Resident #8 falling on 06/30/18 because Resident #8 was managed by hospice, so staff would have notified hospice. Telephone interview with the MCM on 07/19/18 at 11:33am revealed: -She was aware that 2nd and 3rd shift staff had been congregating in the medication room which had been the activity room with tables and chairs, and the television room. -The Administrator talked to all of the nursing staff in a mandatory meeting about a month and half ago (late May/early June 2018). -Staff were told not to congregate in those areas and to perform resident safety checks. -There was no situation under which staff take breaks together; staff may have used those areas for their break time, but only one staff at a time. -The Supervisor for each shift was responsible for making sure each staff was doing what they were supposed to do. -She "would be next in line," and observed staff performance every Monday through Friday from 8:30am until 5:00pm. -There was nothing in place to monitor staff performance on 2nd and 3rd shifts and the weekends. Telephone interview with the Administrator on 07/19/18 at 12:09pm revealed:	D 270		

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D 270	Continued From page 49 -There had been family members that reported concerns about staff being gathered in the medication room. -The change of shift "stand up" was conducted at 3:30pm each day with all staff in the medication room on the SCU. -She had explained to staff that the medication room was for working with charts and medications. -Any staff seen just sitting in the medication room would be written up. -The Supervisors were responsible for monitoring staff when the MCM and Administrator were not in the facility. 2. Review of Resident #4's current FL-2 dated 01/31/18 revealed: -Diagnoses included diabetes mellitus type II (uncontrolled), atrial fibrillation, iron deficiency anemia, osteoarthritis, senile dementia, hypertension, urine incontinence, and Vitamin D deficiency. -The resident was semi-ambulatory with a walker. -The resident required assistance with bathing and dressing. Review of Resident #4's Resident Register revealed: -The resident as admitted to the facility on 02/02/18. -The resident required assistance with dressing, bathing, nail care, ambulation, toileting, hair/grooming, and skin care. -The resident was forgetful and needed reminders. -The resident used a walker. Review of Resident #4's current assessment and care plan dated 02/20/18 revealed: -The resident was sometimes disoriented.	D 270		

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D 270	Continued From page 50 -The resident's memory was adequate. -The resident was ambulatory and used a rollator walker. -The resident required limited assistance with ambulation, transferring, toileting, bathing, grooming, and eating. -The resident required extensive assistance with dressing. -The resident required checks every 30 minutes for safety. -The resident was supervised for falls, staff cleared pathways/minimized clutter and retrieved/returned equipment. -Resident was assisted to bathroom every 2 hours and as needed for incontinence. Interview with Resident #4 on 07/09/18 at 12:23pm revealed: -She was admitted to the facility in February 2018. -She had some falls since being admitted. -She fell off the bed one time and her head hit the corner of the nightstand. -She had a "hole" in her head and had to get 4 staples in her head. -She fell another time when she tripped over her feet. -She had weakness in her arms and legs. -They had not done anything about her falls. -She fell again last week but could not recall the date. Review of Resident #4's progress notes and incident/accident reports revealed Resident #4 had six falls from 05/19/18 - 07/09/18. Review of Resident #4's progress notes and incident/accident reports for May 2018 revealed: -On 05/19/18 (2:47am): The resident was observed laying on right side on the floor beside	D 270		

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her bed with blood coming from the right side of her head above the ear. The resident complained of head pain and had a laceration on her head. The resident was transported to the emergency room (ER).
-On 05/19/18 (8:55pm): The resident returned to the facility with diagnoses of scalp laceration, contusion of right leg, and ankle sprain. Staples in the resident's head were to be removed in 7 days.
-Monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall.
-On 05/31/18 (12:04pm): The resident was observed lying on the floor with half of her body in the hallway and the other half of her body in another resident's room. No injuries at this time and the resident was not complaining of pain.

Review of Resident #4's May 2018 medication administration record (MAR) revealed:
-There was a computer printed entry for "resident checks every shift, staff to visualize resident every 30 minutes for safety".
-There was a row for each shift (7:00am - 3:00pm, 3:00pm - 11:00pm, and 11:00pm - 7:00am).
-Staff had initialed once per shift each day from 05/01/18 - 05/31/18.
-There was an entry for "fall: initiate fall prevention program, monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall".
-Staff initialed and documented the resident's vital signs on all 3 shifts from 05/21/18 - 05/24/18 and on 05/31/18.
-Documentation for third shift on 05/23/18 was blank.

Review of Resident #4's progress notes and

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incident/accident reports for June 2018 revealed:
-On 06/24/18 (2:23pm): The resident fell and was on her knees on the floor beside the dining room table at 12:20pm. The resident was "shaky and dizzy". The resident had redness and complained of pain in both knees. The resident was sent to the ER.
-06/24/18 (4:42pm): Resident was seen for knee pain and swelling due to a fall. Discharge diagnoses were fall and knee pain.
-It was noted on the incident report to initiate fall prevention program.
-Monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall.
-Chart progress notes daily.
-On 06/26/18 (12:04pm): The resident was observed sitting on the floor at the foot of the bed on her bottom. The resident had no complaints of pain.
-On 06/28/18 (2:19pm): The resident was observed sitting on her bottom on the dining room floor. The resident had no complaints of pain and no visible injuries.

Review of Resident #4's June 2018 MAR revealed:
-There was a computer printed entry for "resident checks every shift, staff to visualize resident every 30 minutes for safety".
-There was a row for each shift (7:00am - 3:00pm, 3:00pm - 11:00pm, and 11:00pm - 7:00am).
-Staff had initialed once per shift each day from 06/01/18 - 06/06/18 (first shift).
-There was a discontinue date of 06/06/18 and no documentation of any checks after first shift on 06/06/18.
-There was an entry for "fall: initiate fall prevention program, monitor status for 72 hours

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for bruising, change in mental status/condition, pain, or other injuries related to fall".
-Staff initialed and documented the resident's vital signs on all 3 shifts from 06/01/18 - 06/03/18 and from 06/24/18 - 06/28/18.
-Documentation for first shift on 06/27/18 was not done because "assisting other resident".

Review of Resident #4's progress notes and incident/accident reports for July 2018 revealed:
-On 07/09/18 (8:46pm): The resident was observed on the bathroom floor with no injuries.
-The resident did not want to be sent to the hospital.

Review of Resident #4's July 2018 MAR on 07/10/18 revealed:
-There was an entry for "fall: initiate fall prevention program every shift".
-Staff initialed and documented the resident's vital signs on all 3 shifts from second shift on 07/09/18 through first shift on 07/10/18.

Review of 30 minute check logs for Resident #4 revealed:
-Thirty minutes checks were initialed by staff starting on 12:00am on 07/01/18 through the present time of 07/16/18 at 1:00pm.
-Staff initialed and documented the resident's location at 30 minute increment on each of these days.
-Thirty minute checks were not documented on 07/08/18 at 6:30am and 07/09/18 at 6:30pm.
-The location of the resident was not documented on 07/15/18 at 7:00am, 7:30am, 10:30am, 11:00am, and 11:30am.
-There were no 30 minute check logs for Resident #4 prior to 07/01/18.

Interview with Resident #4 on 07/16/18 at 5:53pm

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revealed:
-Staff usually checked on her about every 2 hours.
-She did not ever recall staff checking on her every 15 minutes or every 30 minutes since she was admitted to the facility in February 2018.

Interview with a personal care aide (PCA) on 07/13/18 at 11:30am revealed:
-Resident #4's legs were weak and the resident pushed the walker too far in front of her when she walked.
-Resident #4 had fallen in the dining room, the hallway, and in the resident's room.
-Resident #4 was on 30 minute checks because of falls but she was not sure if the resident was still being checked every 30 minutes.
-Staff were supposed to physically observe the residents during the checks and document what the residents were doing.

Interview with a medication aide (MA) on 07/13/18 at 12:45pm revealed:
-Residents on the assisted living side of the facility were supposed to be checked every 30 minutes.
-The 30 minute checks were usually documented each shift on the MARs.
-When a resident had a fall, staff would do vital signs and check the resident every shift for a change in condition for 72 hours after the fall.
-Resident #4 had not been feeling well for the last few weeks.
-The resident was not herself; she had become weak.
-The resident needed more assistance with transfers and she pushed the rollator walker too far in front of her.
-Resident #4 was on routine 30 minute checks prior to her falls and that did not change after the

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falls to her knowledge.

Interview with a second MA on 07/13/18 at 2:10pm revealed:
-All residents were on 30 minute routine checks including Resident #4.
-Residents vital signs were checked each shift for 72 hours after a fall.

Interview with a second PCA on 07/16/18 at 1:29pm revealed:
-When the staff do 30 minute checks, they were supposed to physically check the resident and document the location of the resident using the key on the bottom of the log sheet.
-Resident #4 was currently on 30 minute checks but she was not sure how long the resident had been on 30 minute checks.

Interview with the Resident Care Manager (RCM) on 07/16/18 at 1:25pm revealed:
-The 30 minute checks for Resident #4 were discontinued from the MAR on 06/06/18 because they realized 30 minute checks were not required for all residents.
-Some residents were on 15 minute or 30 minute checks for safety.
-Resident #4 had routine 1 hour checks after 06/06/18 until 07/01/18 when she was started on 30 minute checks due to falls.
-Thirty minute checks were not done for Resident #4 from 06/07/18 - 07/01/18.

Interview with the Administrator on 07/17/18 at 11:20am revealed:
-Residents on the assisted living side of the facility were usually checked routinely every hour or if a call bell was activated.
-If a resident started having problems like falls or behavior concerns, they would increase their

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supervision to 30 minute checks.
-They discussed and revised the 30 minute check logs effective 07/01/18.
-A resident's first fall would prompt a referral for PT/OT.
-After PT/OT was completed, if a resident continued to fall, they would increase their supervision from hourly checks to 30 minute checks.

Interview with the nurse at the PCP's office for Resident #4 on 07/13/18 at 10:10am revealed:
-The PCP was unavailable for interview.
-They were aware of Resident #4's falls on 05/19/18 and 06/24/18 because they received reports from the local hospital.
-They saw the resident at their office on 05/29/18 to remove the staples from her head caused by the fall on 05/19/18.
-They expect the facility to notify them of any falls or changes in the resident's condition.
-Prior to 05/29/18, the resident was last seen at their office on 04/04/18 for a routine checkup.
-The facility requested a referral for physical therapy on 07/10/18 due to "multiple falls".

3. Review of Resident #2's current FL-2 dated 04/04/18 revealed:
-Diagnoses included: dementia of the Alzheimer's type, unspecified depressive disorder, hypertension, hypothyroid, osteoarthritis and atrial fibrillation.
-Physician orders included Resident #2 to be on 30 minute checks by staff.

Review of Resident #2's care plan dated 05/04/18 revealed the resident was on 30 minute checks for safety.

Review of Resident #2 progress notes dated

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D 270	Continued From page 57 04/09/18 to 7/12/18 revealed: -The resident fell out of a chair and hit her head resulting in being treated at the hospital emergency room for a fall on 04/09/18. -The resident had an accident/incident report on 06/10/18 where she was found crying on her knees beside a chair. -The resident had an accident/ incident report on 06/14/18 where she was found in a laundry basket with redness on her arm and chest. -The resident had an accident/incident report on 06/23/18 where she was found sitting in the hallway. -The resident had an accident/incident report on 06/27/18 with noted bruised coloration and swelling of the lip. -The resident had an accident/incident report on 06/28/18 with facial contusion and fracture of the distal radius (wrist). Review of the fall management team meeting notes for July 2018 revealed: -Staff will continue to monitor Resident #2 every 15 minutes. -Staff will continue to monitor Resident #2 every 30 minutes. -The memory care manager and the executive director were the team members present for the meeting. Review of the 15/30 minute check log posted in the medication room 07/11/18 at 6:27am revealed Resident #2 was on 15 minute checks. Review of the hospital discharge summary for Resident #2 dated 06/28/18 revealed: -Resident #2 was treated for a fall on 06/28/18. -The resident arrived to the emergency room at 12:59pm.	D 270		

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D 270	Continued From page 58 Review of resident progress notes for Resident #2 revealed the resident returned from the hospital at 3:15pm. Review of 15 minute check log for Resident #2 dated 06/28/18 revealed: -The resident was listed as sitting from 9:15am to 10:30am. -The resident was listed as bathroom at 10:45am. -The resident was listed as sitting from 11:00am to 11:15am. -The resident was listed as eating from 11:30am to 11:45am. -The resident was listed as sitting from 12:00pm 12:45pm. -The resident was listed as bathroom at 1:00pm. -The resident was listed as sitting from 1:15pm to 2:45pm. -The resident was listed as bathroom at 3:00pm. -The resident was listed as walking from 3:15pm to 5:30pm. Interview with the memory care manager (MCM) on 07/19/18 at 2:21 pm revealed: -She expected her staff to "lay eyes on the resident" for the fifteen minute checks. -The resident was sent to the emergency department at 12:46pm on 06/28/18. -She was not sure why the fifteen minute check logs were completed to show the resident was in the building. -"I can't answer that question". Interview with a PCA on 07/10/18 at 9:57am revealed: -"We do everything for (resident #2). -Resident #2 had been on 15 or 30 minutes checks for at least two months. -Resident #2 fell a lot. -"We try to watch her".	D 270		

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D 270	Continued From page 59 -Resident #2 used to fall a lot but now she fell about once per month. Interview with a second PCA on 07/10/18 at 10:15am revealed: -The resident was on fifteen minute checks. -The resident "wanders and walks around". -Resident #2 used to fall a lot but she "doesn't hardly even fall now". Interview with a third PCA on 07/10/18 at 11:15 am revealed Resident# 2 was on 30 minute checks. Interview with a fourth PCA on 07/11/18 at 5:40am revealed Resident #2 did not have "multiple falls but she falls". Interview with a fifth PCA on 07/12/18 at 5:30pm revealed: -Fifteen minute checks meant keeping a close eye on residents "at all times". -"I locate them (the resident on 15 minute checks) and redirect them." Interview with a MA on 07/10/18 at 9:57am revealed: -Resident #2 had been on either 15 or 30 minute checks for about two months. -"We try to watch her". Interview with a second MA on 07/11/18 at 6:30am revealed Resident #2's "head propels her forward so she is off balance". A second interview with MCM on 07/11/18 at 12:15pm revealed: -She was unsure if Resident #2 was on 15 or 30 minute checks. -Everyone in the special care unit was on one	D 270		

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hour checks "for safety."
-Resident #2's "falls come in spells".
-The Resident's daughter said "the falls would be normal".
-The resident used to have a wheelchair.
-"It looked as if she (Resident #2) fell and caught herself when she fractured her wrist on 06/28/18.
-Resident #2 was "very mobile"

Interview with a third MA on 07/16/18 at 1:03pm revealed Resident had a "tender spot in her head so she was a falls risk".

Interview with the Hospice nurse on 07/16/18 at 2:30pm revealed Resident #2 was a falls risk when she was receiving Hospice care.

Interview with the physician's assistant (PA) on 07/17/18 at 11:05am revealed:
-Resident #2 "tends to have a lot of falls'.
-Resident #2 did not want to stay in a wheelchair.
-Resident #2 preferred to walk around the facility.
-Resident #2 had been on and off Hospice.
-Resident #2 would fall after being discharged from Hospice.
-Resident #2 had a brain bleed after a fall on 04/09/18.
-"I would think that (the facility) had a standard falls precaution".
-She expected the facility to follow orders as written.

The facility failed to supervise 3 of 6 sampled residents (#2, #4 and #8) who required increased supervision based on histories of falls and serious injuries such as head trauma (#2, #4, and #8). The facility's failure to supervise residents #2, #4 and #8 resulted in serious neglect of each resident; and a fractured wrist for Resident #2; a head injury requiring staples, a sprained ankle,

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D 270	Continued From page 61 and knee injuries for Resident #4; and a fractured hip with a traumatic hematoma on the head for Resident #8 which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/19/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 18, 2018.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the routine and acute healthcare needs were met for 4 of 6 residents sampled (#1, #3, #4, #11) as related to failing to notify the physician of Resident #4's weakness and difficulty standing and walking and to follow up on a request for physical therapy and obtain a knee x-ray for Resident #4; failing to schedule podiatry care for Resident #1, a diabetic, who had long, ingrown, and thickened toenails; failing to notify the physician of chest bruises of unknown origin and combative behavior for Resident #3; and for behaviors	D 273		

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involving eating and smearing feces for Resident #11.

The findings are:

1. Review of Resident #4's current FL-2 dated 01/31/18 revealed:
-Diagnoses included diabetes mellitus type II (uncontrolled), atrial fibrillation, iron deficiency anemia, osteoarthritis, senile dementia, hypertension, urine incontinence, and Vitamin D deficiency.
-The resident was semi-ambulatory with a walker.

Review of Resident #4's Resident Register revealed:
-The resident as admitted to the facility on 02/02/18.
-The resident required assistance with dressing, bathing, nail care, ambulation, toileting, hair/grooming, and skin care.
-The resident was forgetful and needed reminders.
-The resident used a walker.

Review of Resident #4's current assessment and care plan dated 02/20/18 revealed:
-The resident was sometimes disoriented.
-The resident's memory was adequate.
-The resident was ambulatory and used a rollator walker.
-The resident required limited assistance with ambulation, transferring, toileting, bathing, grooming, and eating.
-The resident required extensive assistance with dressing.
-The resident required checks every 30 minutes for safety.
-The resident was supervised for falls, staff cleared pathways/minimized clutter and

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retrieved/returned equipment.
-Resident was assisted to the bathroom every 2 hours and as needed for incontinence.

Interview with a personal care aide (PCA) on 07/13/18 at 11:30am revealed :
-Resident #4's legs were weak and the resident pushed the walker too far in front of her when she walked.
-Resident #4 had fallen in the dining room, the hallway, and in the bedroom.
-She observed Resident #4 when she fell in the dining room (06/24/18).
-Resident #4 was at the table trying to turn with the rollator walker and lost her balance.

a. Review of a fax communication note addressed to Resident #4's primary care provider (PCP) dated 04/19/18 revealed:
-Resident #4 was having trouble standing.
-When walking, the resident was pushing the walker away from her.
-The resident stated her legs were weak and it was hard to walk.
-Staff requested an order for physical therapy/occupational therapy (PT/OT).
-There was no response from the PCP documented on the form.
-The fax stamp at the top of the page noted the line was busy and the fax was not sent.

Review of Resident #4's progress notes and provider visit notes revealed no documentation of the resident receiving any PT/OT services.

Interview with Resident #4 on 07/09/18 at 12:23pm revealed:
-She was admitted to the facility in February 2018.
-She had some falls since being admitted.

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-She fell off the bed one time and her head hit the corner of the nightstand.
-She had a "hole" in her head and had to get 4 staples in her head.
-She fell another time when she tripped over her feet.
-She could not recall the dates of the falls.
-She had weakness in her arms and legs.
-She had not received any PT while at this facility.
-They had not done anything about her falls.
-She fell again last week but could not recall the date.

Interview with a personal care aide (PCA) on 07/13/18 at 11:30am revealed she was aware of the resident's falls, weakness, and difficulty walking with the walker but she did not know if the resident had received any PT/OT services.

Review of Resident #4's progress notes, incident/accident reports, and hospital visit forms revealed:
-Resident #4 had 7 falls from 05/19/18 - 07/09/18.
-One fall on 05/19/18 resulted in an emergency room visit for a scalp laceration with staples, a contusion of the right leg, and an ankle sprain.
-Another fall on 06/24/18 resulted in an emergency room visit for pain and swelling in both knees.

Interview with a medication aide (MA) on 07/13/18 at 12:45pm revealed:
-Resident #4 had not been feeling well for the last few weeks.
-The resident was not herself; she had become weak.
-The resident needed more assistance with transfers and she pushed the rollator walker too far in front of her.
-The PCP was faxed about the resident's

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weakness and difficulty ambulating "a while ago, at least a few weeks ago".
-They requested an order for PT.
-She did not recall if the PCP responded to the fax.
-She never heard back from the PCP about the resident's difficulty with ambulating or the request for a PT order.

Interview with the Resident Care Manager (RCM) on 07/16/18 at 4:29pm revealed:
-She was aware Resident #4 had some falls and she had noticed the resident "stumbling".
-She was not aware there was a request for a PT referral in April 2018 for Resident #4.
-When a fax was sent to a provider, staff were supposed to get a fax confirmation and attach it.

Interview with a MA/supervisor (MA/S) on 07/13/18 at 10:43am revealed:
-When she went on medical leave in April 2018, Resident #4 was getting "wobbly" and holding her rollator walker way out in front of her.
-A fax was sent to the PCP on 04/19/18 to notify him that the resident was weak and having trouble walking.
-She thought the fax to the PCP on 04/19/18 was resent but there should be a confirmation if it was re-faxed.
-Resident #4 had not received any PT services since she was admitted to the facility to her knowledge.
-When she returned to work on 07/03/18, she noticed Resident #4 had an unsteady gait and had been experiencing some falls.
-She faxed Resident #4's PCP one day this week (07/10/18) to get an order for physical therapy.

Interview with the nurse at the PCP's office for Resident #4 on 07/13/18 at 10:10am revealed:

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-The PCP was unavailable for interview.
-They were aware of Resident #4's falls on 05/19/18 and 06/24/18 because they received reports from the local hospital.
-They saw the resident on 05/29/18 to remove the staples from her head caused by the fall on 05/19/18.
-They expected the facility to notify them of any falls or changes in the resident's condition.
-Prior to the 05/29/18 visit, the resident was last seen at their office on 04/04/18 for a routine checkup.
-They did not receive a fax from the facility about the resident's weakness and difficulty walking with a request for physical therapy on 04/19/18.
-The facility requested a referral for physical therapy on 07/10/18 due to "multiple falls."
-They faxed an order for PT to the facility on 07/11/18.

Review of a physician's order dated 07/11/18 for Resident #4 revealed an order by the PCP for a PT referral for multiple falls.

Interview with a physical therapist on 07/13/18 at 11:10am revealed:
-He had just arrived to the facility to do an evaluation on Resident #4.
-They received the order for PT this week.
-There were no previous orders for PT from the facility for this resident to his knowledge.
-After reviewing Resident #4's record, he was concerned about her falls.

Review of Resident #4's care notes for physical therapy (PT) revealed:
-07/13/18: PT evaluation was completed. The resident complained of a lot of leg weakness and instability on feet. The resident will be seen for PT to increase lower extremity strength, gait safety,

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and reduce falls.
07/16/18: PT visit included gait training with rollator walker.

Interview with Resident #4 on 07/13/18 at 2:55pm revealed:
-She was feeling weak and sleepy.
-She had physical therapy for the first time today (07/13/18) since being admitted to the facility (in 02/2018).
-The physical therapist said the handles on her rollator walker were too high so he moved the handles to a lower position.
-She felt like lowering the handles on her walker helped a lot and made it easier for her to use the walker.

b. Review of Resident #4's progress notes, incident/accident reports, and hospital visit forms revealed:
-On 06/24/18 (2:23pm): Resident was observed in the dining room on her knees. The resident was "shaky and dizzy" and complained of pain in both knees. The resident was sent to the emergency room (ER).
-On 06/24/18 (4:42pm): Resident was seen at ER for knee pain and swelling due to a fall.

Interview with a personal care aide (PCA) on 07/13/18 at 11:30am revealed Resident #4 complained of knee pain when she fell on 06/24/18 and she continued to complain of knee pain currently.

Review of a fax communication form dated 06/24/18 to Resident #4's PCP revealed:
-The resident was observed on the floor on her knees.
-The resident complained of knee pain and her knees were red.

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-The resident was shaking a lot and complaining of being dizzy.
-The PCP noted on the form to "consider" knee x-ray of both knees.

Review of a verbal order dated 06/26/18 for Resident #4 revealed an order from the PCP for mobile x-ray of both knees to rule out fracture.

Review of Resident #4's progress notes revealed:
-06/26/18 (12:04pm): Resident was observed sitting on the floor at the foot of the bed on her bottom. The resident had no complaints of pain.
-06/26/18 (2:43pm): Medication aide received a verbal order from resident's primary care provider for a mobile x-ray of both knees to rule out fracture.

Interview with Resident #4 on 07/13/18 at 2:55pm revealed:
-When she fell on her knees in the dining room (06/24/18), the skin was broken on both knees.
-Her knees hurt after the fall and they were still sore.
-There had been no x-rays taken of her knees since she fell on them on 06/24/18.
-She had another fall in the bathroom on 07/09/18 because she lost her balance and her legs were weak and sore.

Review of Resident #4's progress notes and provider notes revealed no documentation that the resident's knees had been x-rayed as ordered on 06/26/18.

Interview with a medication aide (MA) on 07/13/18 at 12:45pm revealed:
-When they received an order for an x-ray, they would call the mobile x-ray provider to schedule an appointment and document it in the progress

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notes.
-The mobile x-ray provider would come to the facility to do x-rays.
-She thought she called the mobile x-ray provider about Resident #4's knee x-rays but she was not sure if the x-rays were done.
-She was in the dining room when Resident #4 fell on her knees (on 06/24/18).
-The resident's knees were red and the resident complained of pain in her knees.

Interview with a medication aide/supervisor (MA/S) on 07/13/18 at 10:43am revealed:
-She did not know if Resident #4's knee x-rays were done because she was on medical leave at the time the order was received.
-When they received an order for x-rays, the MAs were supposed to call the mobile x-ray provider to come to the facility to do the x-ray.
-The mobile x-ray provider would usually come that same day and the MAs would give a copy of the order to the x-ray technician when they got to the facility.
-The facility usually received a faxed copy of the x-ray results from the mobile x-ray provider.
-The MAs were supposed to fax a copy of the results to the resident's PCP and file a copy in the resident's record under the lab/special reports section.
-She could not find any documentation that the mobile x-ray provider was notified of the verbal order for Resident #4's knee x-rays.
-She would contact the mobile x-ray provider about it.

Interview with a representative from the mobile x-ray provider on 07/13/18 at 10:49am revealed:
-As of the current date and time, they had not received an order for Resident #4's knee x-rays.
-They would come today, 07/13/18, to do the

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D 273	Continued From page 70 knee x-rays. Interview with the Resident Care Manager (RCM) on 07/16/18 at 4:29pm revealed: -When an order for an x-ray was received by the facility, the MAs were supposed to give her a copy of the order. -The MAs were supposed to call the mobile x-ray provider to notify them of the order. -The facility used a "bucket system" meaning she was supposed to get copies of orders so she could check to make sure the orders were implemented. -She usually checked the orders daily. -She was not aware of the order for Resident #4 to have knee x-rays. -She did not receive a copy of the order for Resident #4's knee x-rays in June 2018. -She was aware Resident #4 had some falls and she had noticed the resident "stumbling". Interview with the nurse at the PCP's office for Resident #4 on 07/13/18 at 10:10am revealed: -There was a verbal order on 06/26/18 for the resident's knees to be x-rayed. -They had not received an x-ray report or any record indicating the x-rays were done. -They had received no calls from the facility about the knee x-rays. -She did know if the x-rays had been completed as ordered. 2. Review of Resident #1's current FL-2 dated 06/17/18 revealed diagnoses included Alzheimer's type dementia, unspecified anxiety disorder, moderate opiate disorder, major depressive disorder, and unspecified schizophrenia spectrum disorder. . Review of Resident #1's Resident Register	D 273		

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revealed an admission date of 03/12/18.

Review of Resident #1's Behavioral Health History & Physical dated 02/16/18 revealed a past medical history of diabetes and the resident was currently prescribed Metformin 850 mg twice a day.

Review of Resident #1's most current care plan dated 05/09/18 revealed he required limited staff assistance 7 days per week with sponge bath, skin care, nail care, and oral care.

Observation of Resident #1 on 07/09/18 at 12:00pm revealed:
-He was lying in bed and was alert and oriented.
-The resident's toenails were thicker than normal, yellow in color, and very long extending over the end of each nail bed onto the bottom side of each toe.
-The 3rd left toe was reddened around the toenail and had crusty material on the outside of the 3rd toenail and the outside of 4th left toenail where the two toes were touching.
-There was no right great toe.

Interview with Resident #1 on 07/09/18 at 12:00pm revealed:
-Since he was admitted to the facility, no one had ever offered to cut his toenails.
-He would like his toenails cut.
-He had not asked anyone to cut his toenails.
-He had his right large toe amputated in 2001 due to an infection.
-He had pain in his left great toe and 3rd toe but he had not told anyone.
-He was concerned that he'd have to have more toes amputated.

Review of Resident #1's care notes on 07/09/18

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revealed:
-There was no documentation of the condition of the resident's toenails prior to 07/09/18.
-There was no documentation of podiatry evaluation or podiatry care, or any documentation of any pending or scheduled podiatry appointments prior to 07/09/18.
-There was an authorization that was not dated, but signed by Resident #1's responsible party authorizing Resident #1 to receive foot care services by the Podiatrist.

Interview with the Memory Care Manager (MCM) on 07/09/18 at 12:20pm revealed she was not aware of Resident #1's long toenails and no one had reported it to her.

Interview with a Medication Aide (MA) on 07/09/18 at 12:55pm revealed:
-She had been working at the facility for two and a half months, but returned to work a week ago.
-No one had reported to her that Resident #1's toenails were long or that he had pain.
-She tried to cut Resident #1's toenails on 07/07/18 but he refused.
-She did not report to the physician that Resident #1 would not allow his nails to be cut.
-She was not aware of the reddened area on his 3rd left toe.
-She would look at his toes immediately.

Interview with the MA on 07/09/18 at 1:07pm revealed she had observed Resident #1's toes and would tell the physician immediately that his 3rd left toe was reddened and his toenails need to be cut.

Review of a faxed note sent by the facility to Resident #1's physician on 070/9/18 at 1:32pm revealed the resident's toes on his left foot were

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swollen and red, and the facility requested an antibiotic.

Interview with a second MA on 07/09/18 at 5:15pm revealed:
-She had not seen Resident #1's toes because he always had on socks.
-The 1st shift MA told her that a note had been sent to Resident #1's physician regarding his infected toe on his left foot to see if they could get an antibiotic for him.

Interview with the Administrator on 07/09/18 at 5:20pm revealed:
-She was not aware of Resident #1's long toenails and did not know that one of his toes was reddened.
-The process was if the personal care aide (PCA) could not cut the resident's toenails, then it should be reported to the MA.
-If the MA could not cut them, then the family should be notified as well as the physician.
-She did not know if there had been any reporting on Resident #1's toenails to his physician.
-They had residents who saw a podiatrist every other month but did not know if Resident #1 was on the podiatrist's schedule.

A second interview with the Administrator on 07/09/18 at 5:30pm revealed:
-She had just observed Resident #1's toenails.
-She was not aware they were "that bad".
-She would make sure the Podiatrist was called immediately to schedule an appointment for Resident #1.

Interview with Resident #1 on 07/09/18 at 5:40pm with the Administrator present revealed:
-His toes hurt very badly, especially the toes on his left foot.

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D 273	Continued From page 74 -When the staff helped him shower, they stood outside the shower and ask him if he needed help. -No staff member had looked at his toes that he remembered. Interview with the MA on 07/10/18 at 1:05pm revealed: -She tried to cut Resident #1's toenails on 07/09/18 but could not because it was too painful for him. -She just got documentation from the Podiatrist that Resident #1 refused podiatry visits on 05/11/18 and 05/25/18. -She made an appointment for Resident #1 to see the Podiatrist on 07/11/18 at 9:45am. Review of Resident #1's notes from the podiatry visit dated 07/11/18 revealed: -The resident was seen for thick toenails, unable to care for himself, and pain. -The resident had diabetes. -The resident's toenails 1-5 left and toenails 2-5 right were excessively long. -The resident's left great toenail, left 5th toenail and left 3rd toenail were crumbly and discolored yellow, thickened, and had debris under the nails. -The left 3rd toenail and left great toenail were painful to palpation. -The 3rd left toenail had started growing into the tip of the 3rd left toe. -The great right toe was previously amputated. -The nails were debrided bilaterally with nail clippers as possible and then ground with an electric grinder, cleaned with a curette and benzalkonium chloride applied. -A betadine ointment bandage was applied to the 3rd left toe and was ordered to be removed in 3 days.	D 273		

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D 273	Continued From page 75 Interview with the Podiatrist on 07/11/18 at 4:30pm revealed: -A week prior to his scheduled visit to the facility, he would send a list of those residents who were seen on his last visit, so the facility could see if they needed to be seen on the upcoming visit. -He came to the facility quarterly and would see any residents the facility put on the list. -He saw Resident #1 for the first time that day on 07/11/18. -Resident #1 had never been referred to him for care until today (07/11/18). -He was told by his office staff today that Resident #1 refused to see him the last time he came to the facility. -Resident #1's toenails may have taken 3-9 months to get in the condition they were in that day. -He had put betadine and a bandage on Resident #1's 3rd left toe that had probably taken 9 months to get in the condition it was at the time he saw him. -Staff would refer residents to him to be seen between the quarterly visits, but he had never had a referral for Resident #1. Interview with the MA on 07/13/18 at 10:15am revealed: -She was not aware that Resident #1 was a diabetic. -The protocol for diabetic nail care is they could file the nails but the resident should be referred to a podiatrist. Interview the Administrator on 07/13/18 at 10:22am revealed: -She was not aware that Resident #1 was a diabetic. -The protocol for diabetic nail care was they used "best practices, meaning diabetics are referred to	D 273		

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D 273	Continued From page 76 the Podiatrist". Interview with Resident #1's physician on 07/13/18 at 11:45am revealed: -She was not aware that Resident #1 was a diabetic and did not see that he had a history of diabetes on his behavioral health notes. -She did not look at his toes on his last visit on 04/25/18; she typically looked for pedal edema. -She had never been informed that he refused any care or that he had any issues with his toenails. -She would expect that she would be informed if Resident #1 denied nail care and if his nails were over grown or had any issues. 3. Review of Resident #11 current FL-2 dated 03/15/18 revealed: -Diagnoses included: dementia, osteoarthritis, hypothyroidism, post-traumatic stress syndrome, aphasia, hyperlipidemia, traumatic brain injury, history of thyroid cancer, bradycardia, chronic cognitive disorders, renal tubular dysgenesis and dementia with behavioral disturbances. -The resident was constantly disoriented. Review of Resident #11's care plan dated 3/20/18 revealed: -The resident required extensive assistance with bathing, dressing and toileting. -Resident #11 required limited assistance with mobility and eating. Review of Resident #11 quarterly profile dated 03/21/18 revealed Resident #11 required "extensive orientation" due to dementia. Observation of Resident #11 on 07/09/18 at 11:57 am revealed the resident ate off of the dining room floor.	D 273		

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D 273	Continued From page 77 Observation of Resident #11 on 07/09/18 at 5:00pm revealed the resident ate off of the floor in the hall. Observation of Resident #11 on 07/10/18 at 12:12 pm revealed the resident picked an unknown substance off the couch in the TV room and ate it. Interview with a personal care assistant (PCA) on 07/11/18 at 5:40am revealed: -Resident #11 could not communicate well. -Resident #11 ate items off of the floor including feces, ants and trash. -Resident #11 was hard to redirect. -"Everyone is aware of his behaviors." Interview with a seond PCA on 07/11/18 at 7:00am revealed: -Resident #11 ate items off the floor. -She told the medication aide (MA) when the resident ate off the floor. Interview with a third PCA on 07/16/18 at 12:23pm revealed: -She had seen Resident #11 eat items from the floor. -"I think that he just don't [sic] know no [sic] better" than to eat off of the floor due to his dementia. -"I try to avoid that assignment (to Resident #11) as much as I can." -She heard that Resident #11 ate feces from other staff, but she did not see him do that. Interview with a fourth PCA on 07/16/18 at 12:40pm revealed: -She had seen Resident #11 eat items off of the floor.	D 273		

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D 273	Continued From page 78 -She reported him eating items off of the floor to the MA. Interview with a fifth PCA on 07/16/18 at 4:36pm revealed: -She had seen Resident #11 eat feces. -She reported Resident #11 eating feces to the MA. -She was told that "we always have to report it" (unusual behaviors). Interview with a sixth PCA on 07/19/18 at 4:40pm revealed: -Resident #11 ate feces. -He reported Resident #11 eating feces to the MA. Interview with a MA on 07/11/18 at 6:30am revealed: -"[Resident #11's name] was [Resident #11's name]." -"[Resident #11's name] was very, very, very hard to care for." -The resident was unable to speak, and "did not communicate at all." -Resident #11 ate and played in feces. -Resident #11 ate off the floor. -She reported his behaviors to the Memory Care Manager (MCM). -She did not know if the doctor knew of Resident #11's behaviors (eating feces and eating off of the floor). Interview with a second MA on 07/11/18 at 3:51pm revealed she saw Resident #11 with feces in his hands. Interview with a third MA on 07/12/18 at 5:35pm revealed: -"It was complicated to keep an eye on him	D 273		

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(Resident #11) with everyone running around."
-She did not know if the doctor knew about Resident #11's behaviors of eating feces.

Interview with a fourth MA on 07/16/18 at 11am revealed:
-A PCA told her Resident #11 was eating off the floor.
-A PCA told her Resident #11 was eating feces.
-She saw Resident #11 eating feces.
-She told the MCM what Resident #11 was eating.
-The MA did not discuss this with the doctor.
-The MA could call the doctor directly "depending on the situation."

Interview with a fifth MA on 07/16/18 at 1:03pm revealed:
-Resident #11 ate off of the floor
-Resident #11 urinated in the hallway.
-Resident #11 played with feces.
-Resident #11 ate feces.
-She did not report these behaviors to the doctor.
-She did not report these behaviors to the MCM because she assumed "the MCM was aware".

Interview with a sixth MA on 07/16/18 at 1:17pm revealed:
-She had seen Resident #11 eat off of the floor.
-She had seen Resident #11 "smear feces then put his hands in his mouth."
-She did not report Resident #11 eating off of the floor because "I just saw it last week for the first time."
-She did not report Resident #11 playing or eating feces.
-"I should have reported that (playing or eating feces). I'm still learning a lot."
-"My supervisor instructed me to chart any unusual behavior."

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D 273	Continued From page 80 -She was instructed by the supervisor to chart unusual behavior after 07/09/18. A second interview with a MA on 07/17/18 at 10:12am revealed: -"I feel so bad" for Resident #11. -Resident #11 put feces on the wall. -The resident "did that a lot, not every day but every other day." -The resident ate feces. -She reported Resident #11 eating feces to the MCM. Interview with the MCM on 07/11/18 at 12:15pm revealed: -Resident #11 was "somewhat challenging to redirect." -Resident #11 was "hard to care for because of communication." Interview with the MCM on 07/16/18 at 1:40pm revealed: -She was told about Resident #11's unusual behaviors such as eating feces and unknown substances off of the floor last week after 07/09/18. -The PCA and MA should redirect the resident to help with his behaviors. -The PCA reported issues to the MA. -The MA documented in the resident's progress notes and also reported to the MCM. -The MA would communicate to the MCM in "some sort of communication like the shift report book." -She did not review the shift report book. -The MA should tell the MCM "in her face or by a piece of paper under her door" if there were issues she needed to know about. -It was not reported to her that Resident #11 ate off the floor.	D 273		

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D 273	Continued From page 81 -'I'm not on the floor." Interview with the physician's assistant (PA) on 07/17/18 at 11:05am revealed: -She worked in the facility about two years. -She started seeing Resident #11 in March 2018. -Resident #11 had "trouble communicating his needs." -"No one could understand what he said." -Resident #11 had "cooperative behavior." -She was not told that Resident #11 ate feces. -There were no care notes regarding Resident #11 eating feces or other non-edible items. -She would expect the facility to tell her when a resident has unusual behaviors like eating feces. 4. Review of Resident #3's current FL-2 dated 03/08/18 revealed diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease and hypotension. a. Telephone interview with Resident #3's Power of Attorney (POA) on 07/13/18 at 9:41am revealed: -There had been "some mishaps" with Resident #3 at the facility. -One of the mishaps was an incident where she found bruises which were purple and yellow and went all the way across Resident #3's chest. -She reported the bruises to the staff at the facility. -Staff were never able to say what happened to Resident #3. -Another family member had taken pictures of the bruises and would know the date the POA found the bruises. Telephone interview with Resident #3's family member on 07/13/18 at 10:00am revealed: -She was concerned about finding bruises that	D 273		

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were already yellow on Resident #3's chest.
-She had taken a picture of the bruises which was date stamped 06/30/18.
-If the staff was changing Resident #3's shirt every day they would have noticed bruises that went from his "collar bones down to his pecs [sic]."

Review of a photo of Resident #3's chest revealed:
-The photo was date and time stamped for 06/30/18 at 11:49am.
-There were yellow bruises on both sides of Resident #3's chest with scattered small areas of purple and red at the center of the right sided chest bruise.
-Both bruises extended from approximately the breast line to the neck area of the collar bones.
-The bruise on the right side was darker in color and larger in size.

Review of a telephone/verbal order form dated 06/29/18 at 10:24am revealed there was an order from the physician's assistant (PA) for a chest x-ray for evaluation of bruising.

Review of an electronic progress note dated 06/29/18 at 10:00am revealed:
-The Resident Care Manager (RCM) documented Resident #3's family member reported Resident #3 had bruising on his chest.
-The RCM documented that she assessed Resident #3 and the resident did not complain of pain.
-The RCM documented the PCP was notified and an order for an x-ray was obtained.
-There was no documentation of the size, color or character of the bruises on Resident #3's chest.

Interview with the Resident Care Manager (RCM)

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on 07/13/18 at 4:40pm revealed:
-There was no bruising of any nature when she saw Resident #3's chest on the day the family reported the bruises (06/29/18).
-When she saw Resident #3's chest the area was red, not bruised; she did not know what happened to Resident #3.
-She notified the doctor and completed an incident report.

Interview with the Physician's Assistant (PA) on 07/13/18 at 12:10pm revealed:
-She could not recall being notified of bruises on Resident #3's chest on 06/29/18.
-She would have wanted to see Resident #3 and evaluate the bruises if she had known about the bruises.
-From a medical stand point, there would have been concern for rib fractures and a pneumothorax with bruises like the ones on Resident #3's chest (observed in the photo).
-Resident #3 had not been added to the list of Residents to be seen after 06/30/18.
-The bruises in the photo taken 06/30/18, looked to be about a week old.
-The bruises would have been noticeable with dressing, undressing and bathing Resident #3 before 06/29/18.
-The facility had requested an x-ray, she was not aware the x-ray was for bruising on Resident #3's chest.
-It was common for the facility to request an x-ray if a resident was having symptoms of a respiratory infection.

Interview with the Administrator in 07/13/18 at 1:19pm revealed:
-She expected that staff would have noticed the chest bruises with dressing and bathing Resident #3 and reported the bruises to the MA and the MA

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should have reported to the PA.
-She had not seen the bruises on Resident #3's chest.
-She thought that if staff had gotten a verbal order for a chest x-ray, that the doctor would have been notified of the bruising on Resident #3's chest.

Observation of Resident #3's chest area on 07/11/18 at 3:55pm revealed there was no visible bruising from under the breast to the shoulder bilaterally.

b. Interview with a MA on 07/11/18 at 5:34am revealed:
-It was difficult to provide care for Resident #3 because he was probably going to want to fight with staff and "what not;" fight and what not meant, Resident #3 would ball up his fists, punch staff, hit staff; Resident #3 was "very combative" with staff.
-Resident #3 was only aggressive and combative with staff trying to provide care, not with other residents.
-Resident #3 required two staff for assistance with all activities of daily living such as dressing, toileting and bathing.
-Resident #3 only had medication to help him sleep, he did not have anything ordered for agitation.

Interview with a PCA on 07/11/18 at 6:10am revealed:
-Resident #3 was "very combative" whenever she tried to help him go to the bathroom or change his clothes.
-There was an incident where Resident #3 had grabbed her shirt and pinned her against the wall, another PCA intervened, Resident #3 swung at that PCA and then Resident #3 just stopped and it was over.

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D 273	Continued From page 85 -There had been prior incidents where Resident #3 was combative, but she did not report Resident #3 behaviors to anyone. Interview with a second PCA on 07/12/18 at 11:13am revealed: -Resident #3 was aggressive and combative towards staff. -Resident #3 would try to fight staff by punching staff when staff tried to take Resident #3 to the bathroom. -Resident #3 was most often combative in the morning because he did not like to get up. -Having a second staff was helpful, but it was best to just let Resident #3 be and come back later and try again. Review of Resident #3's electronic progress notes dated 04/07/18 through 07/07/18 revealed there was no documentation of Resident #3 having aggressive and combative behaviors with staff. Review of fax notifications to Resident #3's primary care provider (PCP) dated 04/03/18 through 6/18/18 revealed there was no documentation of Resident #3 having aggressive and combative behaviors with staff. Interview with the Administrator on 07/12/18 at 10:40am revealed: -Resident #3's behaviors were specific with bathing, dressing and toileting. -Staff were expected to give step by step instructions to resident #3 when providing care. -There was supposed to be two staff present to provide care for Resident #3; one staff was to provide care and the other staff was to hold Resident #3's hands or else he would try to swing at staff.	D 273		

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D 273	Continued From page 86 Interview with the Physician's Assistant (PA) on 07/13/18 at 12:10pm revealed: -Resident #3 was combative and agitated at times, but he was easily redirected. -Routine agitation should probably have been managed with scheduled medications. -She was not aware that Resident #3 was consistently agitated and combative with personal care. -She had been told of "episodes here and there" and had she known Resident #3's combative behavior was consistent, she could have prescribed something to give before personal care. Interview with the Memory Care Manager (MCM) on 07/16/18 at 1:47pm revealed: -The PCAs were expected to notify the MA of any concerns or behaviors, the MA was expected to write a note in the electronic record and send a note to the MCM or verbally notify the MCM. -The MAs documented shift events and concerns in a shift report book, but she did not regularly check the shift report book. -The MAs were expected to notify the doctor by fax so the doctor was aware. -There was no process in place to monitor staff observing, reporting and notifying the MCM and doctor about resident concerns and/or behavior. Interview with the Administrator on 07/12/18 at 10:10am revealed: -She had addressed management of resident behaviors with staff on 07/11/18 and several times before. -Staff were expected to report any behavior concerns to the management and management would then work with the family and the doctor to see what could be done to improve behaviors.	D 273		

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D 273	Continued From page 87 -Staff were expected to report anything out of the normal, increased agitation and/or aggression to the MA; the MA reported to the MCM. -If the MCM could not handle the situation "according to her care plan", then she would consult the Administrator. _____ The facility failed to assure referral and follow up for the acute health care needs of 4 of 6 sampled residents. The facility failed to notify the primary care provider for a physical therapy referral for Resident #4 who was experiencing weakness with difficulty walking and standing, which resulted in seven falls for Resident #4 between 05/19/18 and 07/09/18, with Resident #4 sustaining a head laceration which required staples, right leg contusion, right ankle sprain and knee injuries; failed to obtain podiatry care for Resident #1, who was diabetic, and resulted in long, ingrown, and thickened toenails with a high risk of infection; and failed to notify the primary care provider for behaviors involving eating and smearing feces for Resident #11 which resulted in a high risk for illness. The facility's failure resulted in serious injury and serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/13/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 18, 2018.	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	D 276		

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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 observations, interviews and record reviews, the facility failed to assure the implementation of physician's orders for 2 of 5 sampled residents (#2 and #3) by not implementing a fall mat and bed alarm to prevent falls and injuries for Resident #2, who had a history of falls with head injuries; and an order to record meal intake after each meal for Resident #3 for three months.

The findings are:

1. Review of Resident #2's current FL-2 dated 04/04/18 revealed:
-Diagnoses included: dementia of the Alzheimers type, unspecified depressive disorder, hypertension, hypothyroid, osteoarthritis and atrial fibrillation.
-There was an order for a bed/chair alarm to be on the Resident's wheelchair or on bed at all times.
-There was an order for a fall mat to be placed beside resident's bed when resident is in bed.

Review of physician's orders from 05/07/18-06/07/18 for Resident #2 revealed:
-Physician orders included bed/chair alarm to be

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on Resident #2's wheelchair or on the bed at all times.
-Physician orders included a fall mat to be placed beside Resident #2's bed when the resident was in bed.
-There was no order to discontinue either the bed/chair alarm or the fall mat.

Review of Resident #2 quarterly assessment dated 02/03/18 revealed:
-Resident #2 required supervision with ambulation.
-Resident #2 was a falls risk.
-Resident #2 had dementia.

Review of Resident #2's Medication Administration Records (MARs) for May 2018, June 2018 and July 2018 revealed:
-There was an entry for bed/chair alarm to be on the Resident's wheelchair or on the Resident's bed at all times.
-The staff documented the presence of the bed/chair alarm check 209 of 219 opportunities as of 07/02/18.
-There was an entry for the fall mat to be beside the Resident's bed when the Resident was in bed.
-The staff documented the presence of the fall mat check 209 of 219 opportunities as of 07/02/18.

Observations of Resident #2's room on 07/12/18 at 12:22pm revealed:
-There was no chair or bed alarm in the room.
-There was no fall mat in the room.
-Two medication aides (MA) and the housekeeper could not find the fall mat under the bed or in either closet.
-Two MAs and the housekeeper could not find the bed/chair alarm under the bed, on Resident #2's

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D 276	Continued From page 90 chair or in either closet. Interview with a personal care aide (PCA) on 07/11/12 at 4:47pm revealed: -Resident #2 did not have orders for a floor mat. -Resident #2 did not have orders for a bed/chair alarm. Interview with a second PCA on 07/16/18 at 12:23pm revealed: -Resident #2 did not need a bed/chair alarm because the resident walked by herself. -Residents only have floor mats when they are receiving Hospice. -Resident #2 was not on Hospice now. Interview with a third PCA on 07/16/18 at 12:40pm revealed: -Resident #2 did not have a chair/bed alarm. -Resident #2 did not have a fall mat. Interview with a fourth PCA on 07/16/18 at 12:45pm revealed: -She was assigned to Resident #2 every other day. -Resident #2 did not have a chair/bed alarm. -Resident #2 did not have a fall mat. Interview with a fifth PCA on 07/16/18 at 4:36pm revealed: -She worked in the facility for two weeks. -She helped put Resident #2 to bed on her shift. -She had never seen a fall mat for Resident #2. -She saw a bed/chair alarm for Resident #2 on her first day of work but had not seen one since then. Interview with an sixth PCA on 07/16/18 at 4:40pm revealed: -He worked with Resident #2 on all three shifts.	D 276		

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D 276	Continued From page 91 -He had never seen a floor mat for Resident #2. -He had never seen a bed/chair alarm for Resident #2. Interview with a MA on 07/12/18 at 12:18pm revealed: -She was unsure if the resident had a fall mat in her room. -The chair alarm was ordered for one week only. Interview with a second MA on 07/12/18 at 5:35pm revealed: -She was not aware of an order for a fall mat for Resident #2. -She was not aware of an order for a bed/chair alarm for Resident #2. Interview with a third MA on 07/16/18 at 11:00am revealed: -"The fall mat for Resident #2 "was in place when I started (5 months ago)". -"The bed/chair alarm for Resident #2 "was in place when I started (5 months ago)". -The fall mat and bed/chair alarm "should be in place to prevent a fall". -She had seen the fall mat for Resident #2 in the past. -She was unaware of an order for a fall mat. -She thought Resident #2 "always had it (a fall mat). Interview with a fourth MA on 07/16/18 at 1:03pm revealed: -She had not seen a floor mat for Resident #2 . -Since Resident #2 was not in a wheelchair, she must not have needed a bed/chair alarm. -Floor mats were used when a resident was in bed overnight or during naps. -Bed/chair alarms would start to ring when the resident got up.	D 276		

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-Resident #2 had "a tender spot in her head so she was a fall risk".
-Being a fall risk might be the reason for having an order for a fall mat.
-Maintenance brought the PCA or MA the fall mat if there was an order.
-The PCA was responsible for getting the fall mat when the residents were in bed.

Interview with a fifth MA on 07/16/18 at 1:17pm revealed:
-Resident #2's floor mat should not have been removed.
-"Nobody knew what happened to it (the floor mat)."
-Resident #2 was declining and had a fall.
-Resident #2 did not have a bed/chair alarm.
-She thought the bed/chair alarm was used when the resident was on Hospice and in a wheelchair.

Interview with an sixth MA on 07/17/18 at 10:12am revealed:
- If a resident is on fifteen or thirty minute checks, the facility staff should check if the fall mat or bed/chair alarm are in place.
-When Resident #2 went to bed, the MA checked that the bed/ chair alarm worked.
-"I've seen that alarm. It's got a clip on it. I turn it off whenever (Resident #2) isn't in bed."
-She saw a fall mat in Resident #2's room. "Where did the mat and alarm go?"
-The mat had been in place for "a few weeks".

Interview with the Memory Care Manager (MCM) on 07/16/18 at 1:40pm revealed:
-If there was an order for a chair/bed alarm on the MAR, the MA was responsible for making sure it was in place.
-If there was an order for a fall mat on the MAR, the MA was responsible for making sure it was in

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place when the resident was in bed.
-She was not notified Resident #2 did not have a fall mat available.
-A fall mat would be ordered after a resident had several falls.
-The chair/bed alarm was for Resident #2's wheelchair.
-Resident #2 did not use a wheelchair.
-She thought a fall resulted in the mat and alarm being ordered for Resident #2.
-Resident #2 had been on and off of Hospice several times.
-Most floor mats were ordered through Hospice, "not all but most".
-When a resident was discharged from Hospice, the resident's orders do not get discontinued.

Review of Resident #2's progress notes dated 04/09/18 to 07/12/18 revealed she had three unwitnessed falls with one fall occuring in her room resulting in a wrist fracture on 06/28/18.

Interview with a family member on 07/12/18 at 10:50am revealed:
-She came to the facility four to seven times per week.
-She varied the times she came to the facility.
-Resident #2 was unstable when she walked.
-One to three months ago, Resident #2 had a fall mat, but it was taken away because the resident was doing so well.
-She was called by the Resident Care Manager (RCM) after breakfast on 06/28/18 when Resident #2 fractured her wrist; she was told that Resident #2 "fell out of bed last night".
-The RCM told her Resident #2 "fell out of bed and then got back in bed".
-The RCM said Resident #2 had a bruise and a swollen wrist.

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D 276	Continued From page 94 The RCM was unavailable for interview 07/09/18 through 07/13/18. Interview with a personal care aide (PCA) on 07/09/18 at 8:45am revealed: -She was unsure how Resident #2 got hurt on 06/28/18. -"She probably fell off of her bed. She wouldn't tell you if she did that. Sometimes she was in and out." Interview with the MCM on 07/11/18 at 12:15pm revealed: -The staff found Resident #2 with a swollen wrist on 06/28/18 and informed the physician's assistant. -She was on vacation when Resident #2 fractured her wrist on 06/28/18. -Resident #2's falls "come in spells". -The resident had been on and off Hospice about three or four times. -The wrist fracture happened because "it looked as if she (Resident #2) fell and caught herself". Interview with a hospice aide on 07/16/18 at 2:30pm revealed: -She worked with Resident #2 when the resident was on Hospice. -The resident was a falls risk when she was on Hospice. -Hospice protocol would be to order a falls mat and chair/ bed alarm. -She was unsure if hospice removed the falls mat or bed/ chair alarm when services discontinued. -She was not sure if the fall mat was rented by Hospice. -"We don't take the alarms (bed/chair) back." Interview with a representaive of the medical equipment on 07/16/18 at 2:45pm revealed:	D 276		

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D 276	Continued From page 95 -Resident #2 was listed as a current Hospice patient in the computer system. -On 12/04/17 a hospital bed, concave mattress, fall mat and bed/chair alarm was delivered to the facility for Resident #2. -On 03/19/18 a hospital bed, concave mattress, fall mat and bed/ chair alarm were picked up at the facility from Resident #2. -He was not sure why the items were picked up. Review of Resident #2's current FL-2 dated 04/04/18 revealed there was a current order for the bed/ chair alarm and the falls mat written after the bed/ chair alarm was picked up by the medical equipement company. Interview with a Hospice nurse on 07/17/18 at 2:26pm revealed: -Resident #2 started Hospice services on 11/21/17. -Resident #2 was discharged from Hospice services on 3/16/18. -Once a resident was discharged from Hospice the medical equipment company would pick up the equipment that was ordered. Interview with the physician's assistant (PA) on 07/17/18 at 11:05am revealed: -Resident #2 was on and off of Hospice several times. -Resident #2 had a brain bleed from a past fall. -Most recently resident #2 had a wrist fracture from an unwitnessed fall on 06/28/18. -Resident #2 fell a lot because she did not want to stay in a wheelchair. -The resident was not currently in a wheelchair. -Resident #2 liked to walk a lot. -"I would think that (the facility) had a standard "falls precaution". -She did not remember ordering a fall mat for	D 276		

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Resident #2.
-She did not remember ordering a chair/ bed alarm for Resident #2.
-She was unsure if a resident's treatment orders discontinue when a resident discontinues Hospice services.
-She expected the facility to follow orders as written.

Interview with the Administrator on 07/16/18 at 4:27pm revealed:
-The facility would continue with physician orders after a resident was discharged from Hospice unless the physician discontinued the order.
-The facility would "try to utilize (bed alarms and fall mats) what we have here".

2. Review of Resident #3's current FL-2 dated 03/08/18 revealed:
-Diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease and hypotension.
-Resident #3 weighed 170 pounds.

Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 04/02/18.

Review of a physician's order dated 04/18/18 for Resident #3 revealed an order to record meal intake after each meal.

Observations of Resident #3 during the lunch meal on 07/10/18 from at 12:05pm revealed:
-Resident #3 was served coffee, tea, water, pulled pork sandwich, pinto beans, collard greens and a brownie.
-Resident #3 ate half of the pulled pork sandwich, half of the collard greens and the whole brownie.

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D 276	Continued From page 97 Observations of Resident #3 during the breakfast meal on 07/11/18 from 7:41am until 9:02am revealed Resident #3 was sleeping in his recliner in his room, he did not eat the breakfast meal and a plate was not set aside. Interview with a dietary aide on 07/11/18 at 9:11am revealed the breakfast meal was over and there were no plates being held for any residents. Observation on 07/12/18 at 11:13am revealed Resident #3 weighed 169 pounds on the electronic scale on the assisted living side. Interview with a personal care aide (PCA) on 07/12/18 at 11:13am revealed: -She had not been writing down how much Resident #3 ate after each meal. -Resident #3 was not a "morning person," he did not usually wake up for breakfast. -Staff usually did not wake Resident #3 because he was combative with staff if they tried to help him and he did not want to get up. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Telephone interview with Resident #3's Power of Attorney (POA) on 07/13/18 at 9:41am revealed: -She brought snacks for Resident #3 to have in his room because she was concerned that he was not eating enough. -She was concerned Resident #3 did not eat enough because the resident usually slept through breakfast. -Resident #3's clothing seemed to fit the same, the POA just did not want to see him lose any weight.	D 276		

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D 276	Continued From page 98 Telephone interview with the Physician's Assistant (PA) on 07/18/18 at 5:57pm revealed: -She did not have Resident #3's chart readily available, but she thought the order to record meal intake was probably because there was a concern the resident might not have been eating well. -Resident #3 had not been at the facility long enough to notice any significant weight loss concerns. Telephone interview with the Memory Care Manager (MCM) on 07/18/18 at 12:25pm revealed: -She was not aware of the order dated 04/18/18 to record meal intake for Resident #3. -The order should have been faxed to the pharmacy, the pharmacy would have entered the order onto the electronic medication administration record (eMAR) and she would have seen the order for approval. -She was responsible for approving medication orders for the eMAR. -The order probably came from the POA's concern that Resident #3 was not eating enough. -The POA knew Resident #3 did not like to get up for breakfast so the staff put the order to record meal intake in place to be able to show the POA what Resident #3 ate. Interview with the Administrator on 07/13/18 at 6:15pm revealed she was not able to find any documentation on the meal intake being recorded for Resident #3. _____ The facility failed to implement a fall mat and bed alarm for Resident #2, who had a history of previous falls and head injury resulting in Resident #2 having an unwitnessed fall and	D 276		

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D 276	Continued From page 99 sustaining a wrist fracture. The non-compliance placed Resident #2 at substantial risk of serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/16/18 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 18, 2018.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure foods were free from contamination related to a build-up substance in two ice machines, rusty shelves in the cooler and surrounding areas, dusty air vents, black build up under the storage racks and storage room shelving units that were cracked and peeling. The findings are: Observations of the kitchen on 07/09/18 at 1:25pm revealed:	D 282		

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D 282	Continued From page 100 -There was a rust spot in the front left corner inside of the cooler approximately 3 inches wide. -The cooler racks and legs had rust and were flaking. -The cooler racks were covered in a thick, wet white and black mold like substance. -There was an area of dried rust and wet, black residue under the left side cooler shelving unit that was approximately one foot long. -The shelf in the back of the cooler had no legs and was being held up by seven rusted #10 cans. -There were areas of black mold like substance under the right side cooler shelving unit. -The threshold to the cooler was rusted along the entire bottom strip of the door and in the area between the cooler and freezer. -The pan lids on the shelving unit outside of the freezer had burned on debris along the edges and sides on one pan. -The shelving unit outside of the freezer had the plastic coated shelf worn down to expose the metal underneath. -The area of plastic wallcovering above the metal wall of the freezer had black residue and dried food stuck in several areas. -The right side of the door jamb for the storage room was rusty along the bottom third with metal flaking off at the bottom in the area closest to the floor. -The shelving unit racks and legs in the dry storage room were rusty and the metal was flaking off. -There was areas of a sticky, black substance and food debris under the shelving units. -The air vent above the dish washer was rusty over most of the vent. -The ceiling area surrounding the vent was dusty. -The air vent over the oven area was dusty on the vent and the surrounding ceiling. -There was a heavy build-up of a dried, brown	D 282		

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and black mold like substance and dried rust on the upper portion of the white shield that separated the ice bin from the upper vaulted section of the ice machine.
-Food items were stored on the shelves that had the mold like substance.

Observations of the special care unit kitchen ice machine on 07/10/18 at 11:25am revealed:
-There was a heavy build-up of a wet, thick brown, pink and black mold like substance on the upper portion of the white shield that separated the ice bin from the upper vaulted section of the ice machine and on the upper portion the area where ice was dispensed.
-There was a thin layer of pink mold like substance on the plastic shield directly above the ice bin.
-There was water dripping from the shield into the bin that contained the ice.

Observation of the special care unit ice machine on 07/11/18 at 6:24am revealed:
-The ice bin was full of ice.
-There was a note taped to the front of the ice machine that read "out of service!! Thanks, Management 7/10/18.

An observation of a medication aide (MA) on 07/11/18 at 6:22am revealed:
-She filled two pitchers with ice from the special care unit ice machine.
-She added water to the pitchers.
-She walked out of the special care unit kitchen and walked down the hallway toward the medication cart with the full pitchers in her hands.
-She poured the pitchers out when ask about the ice machine status by the surveyor.

Interview with a MA on 07/11/18 at 6:30am

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revealed:
-She was filling the pitchers to use the water for her medication pass for the day.
- She was told in the shift change meeting that "they said they were throwing the ice out."
-She thought they (the kitchen staff) was "just defrosting the machine".

Interview with a dietary aide on 07/10/18 at 10:50am revealed:
-"If everyone would do their part, it (the kitchen) would be in good shape".
-"I'm not supposed to be the only one (that cleans) but no one else will do it".
-Part of the dietary aide's responsibility was to wipe down containers and shelves.
-There was no work schedule.
-The kitchen was supposed to be getting new shelves.
-She "tried to clean (the shelves) once per week but "she was pressed for time" and "could not always get to it".

Interview with the dietary manager on 07/09/17 at 2:35pm revealed:
-She was unaware that there was rust in the ice machine.
-She did not look inside the ice machine to check for rust or mold.
-She "never knew there was a hole up there".
-She did not know when the ice machine was last cleaned.
-The cooler racks were cleaned once per month.
-She was instructed to clean the cooler racks by the prior administration.
-The storage room racks were cleaned "pretty much weekly".
-"(One of the dietary aides) takes everything down (off the shelves) and wipes them weekly" before the delivery truck came.

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D 282	Continued From page 103 -She did not talk to maintenance about the rust in the cooler, shelves or kitchen. -She did not think the shelves were in good condition. -She did not ask the administration for new shelving units because she "just got new floors and was getting a new microwave". -She thought the Administrator checked behind her because "she was the boss". -There was no cleaning schedule but "everyone just knows what to do". -There was no one assigned to clean the inside of ice machine. An interview with the maintenance technician on 07/11/18 at 9:20am revealed: -He was the technician for three buildings. -He started working in this building about six or seven months ago. -He reported to the district facilities manager. -He was in the building one to two times per week. -He was not aware there was rust in the ice machine in the main kitchen. -He was not aware there was a mold like substance in the ice machine in the special care unit kitchen. -The work orders come through the Administrator and BOM into the computer system called Impulse. -There was a log book for staff to write in work orders. -He was not sure which staff members were able to write in the log book but only used the Impulse system to get work orders. -"I've been doing maintenance for so long it's just built in. You just know what to do". -The preventative maintenance for the ice machine was deep cleaning the ice machine. -He did not remember seeing a work order for	D 282		

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either of the building's ice machines.
-Cleaning the ice machine was a shared responsibility with the dietary department.
-He "cleaned the ice machine to another level" when he did preventative maintenance on an ice machine which included taking the machine apart and looking for mold, grime or rust.
-Preventative maintenance for an ice machine should be done twice per year.
-"I would think that the kitchen (staff) should check the ice machine once per month."
-The last preventative maintenance may have been done by the previous maintenance technician.

Interview with the district manager for facilities on 07/10/18 at 10:20am revealed:
-He had been with this building about nine months.
-He came to the building twice per month.
-Part of his monthly rounds included checking the kitchen equipment to ensure everything was working well.
-Kitchen inspections included making sure the stove burners worked, the oven worked, the cooler and freezer temperatures were within acceptable ranges, the toaster and dishwasher were working properly.
-The kitchen inspections also included checking the ceiling and floors for cracks.
-During the inspections he asked the dietary staff if "there was anything they needed".
-He was not aware there was rust in the ice machine in the main kitchen.
-He was not aware there was a mold like substance in the ice machine in the special care unit kitchen.
-He was unaware that there was rust in the cooler, on the shelves or on the door frame.
-Cleaning the air vents was part of the

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housekeeping responsibilities.
-The Administrator and business office manager (BOM) can put in work orders.
-The on site technician did weekly rounds and was able to put in work orders.
-Work orders were marked complete by the technicians after the work was done but was not closed out in the computer system until he closed it.
-The technician worked in the facility two to three days per week.
-Rust in the kitchen would have been a medium priority in the computer system.
-Medium priority work orders were usually completed within two weeks.
-There was no log book for work orders.
-If there was no work order in the computer system "then there is not a work order".
-There were no work orders for rusty parts in the kitchen.
-There was no order for a crack in the kitchen ceiling.
-"These shelves could have been painted".

A second interview with the district manager for facilities on 07/10/18 at 11:20am revealed:
-Preventative maintenance was done for the ice machine every six months.
-Preventative maintenance included cleaning the ice bin and changing the vent filters.
-Cleaning the ice bin meant cleaning the interior and the ice shield.
-He "encouraged the kitchen staff to clean in there" (the ice machine bin).
-He was unsure if the dietary staff was trained on cleaning the ice machines.
-The executive director set up training for the facility.

An interview with the memory care manager

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D 282	Continued From page 106 (MCM) on 07/11/18 at 12:15pm revealed: -There was a maintenance book in the BOM office. -The maintenance technician checked the book every other day. -Anyone can write a maintenance request in the log book. An interview with the Administrator on 07/10/18 at 1:10 revealed: -She supervised the dietary manager. -She was in the kitchen at least twice per week at different times of the day. -She "sort of peeked at things" when she was in the kitchens. -The kitchen staff "made her aware of things so she could put in a work order". -She was not aware of the conditions of the shelving units. -She was not aware there was rust in the kitchen or in the ice machine. -If there was a problem in the kitchen she expected the staff to tell her about it. The failure of the facility to protect foods from contamination that were being stored and served to residents as evidenced by rust and a black, brown and pink mold like substance in the two ice machines, cracked and peeling shelving units in the cooler and storage room, rusty areas in the cooler and surrounding areas, dusty air vents and black build up under the storage room shelving units was detrimental to the (health, safety and/or welfare) of Resident #** and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/18 for this violation.	D 282		

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D 282	Continued From page 107 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 09/03/18.	D 282		
D 288	10A NCAC 13F .0904(b)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (3) Hot foods shall be served hot and cold foods shall be served cold. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure that foods were served at the appropriate temperatures for 2 meals observed as evidenced by the hot food served below the appropriate limit and milk served above the appropriate limit. Observation of the Special Care Unit dining room on 07/09/18 at 11:28am revealed the milk that was preset for meal service was 61°Farenheit (°F). Interview with a PCA on 07/09/18 at 11:29am revealed lunch started at 11:30am. Observation of the Special Care Unit kitchen on 07/09/18 at 11:30am revealed: -The pans of lunch food were sitting on top of the lids for the serving line or on top of the delivery cart and not in the wells. -The temperature gauges were not set to the highest setting on the serving line. -There was no thermometer in the refrigerator. -The hamburgers were 93°F on the serving line -The green beans were 113°F on the serving line	D 288		

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D 288	Continued From page 108 -The sweet potatoes were 109°F on the serving line. -The chopped sweet potatoes were 83°F on top of the transport cart. -The chopped green beans were 85°F on top of the transport cart. -The chopped beef was 73°F on top of the transport cart. -The puree plate was 84°F inside of the transport cart. Observation of the Special Care Unit kitchen on 07/10/18 at 12:00am revealed: -The chopped BBQ sandwich was 107°F in the serving line. -The chopped beans were 96°F in the transport cart. -The chopped meat was 97°F in the transport cart. -The chopped greens were 100°F in the transport cart. -The puree plate was 93°F in the transport cart. According to the US Department of Agriculture guidelines hot foods should be served 135°F or higher and cold foods should be served 41°F or lower. Interview with a resident on 07/11/18 at 7:44am revealed the food was cold. Interview with a second resident on 07/11/18 at 7:44am revealed: -The food was cold. -"If you send the food back (to the kitchen) you don't get to eat. I've seen that before". Interview with a third resident on 07/11/18 at 7:44am revealed: -The food was cold.	D 288		

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D 288	Continued From page 109 -"I just eat it cold". Interview with a fourth resident on 07/11/18 at 7:45am revealed: -The food was cold. -"I just eat it cold and don't say anything." Interview with a fifth resident on 07/11/18 at 7:45am revealed the food was cold. Interview with a sixth resident on 07/11/18 at 7:45am revealed the food was cold. Interview with a PCA on 07/11/18 at 7:00am revealed: -Residents have reported having cold food when she worked second shift. -She reported the cold food to the MA -The medication aide (MA) would ask for another plate from the server or report it to the memory care manager (MCM). Interview with a MA on 07/11/18 at 6:30am revealed: -"Oh...yes, the food is cold" -There are complaints about the cold food "all the time" when she worked first and second shifts. -She would take the plate of cold food to the kitchen and ask the server for warmer food. -She told "the big kitchen" that the food was served cold. Interview with a server on 07/09/18 at 11:30 am revealed: -She was trained on food temperatures "a long time ago". -She was not aware of what temperature the foods should be served. -She was not aware that the well on the right side was not hot.	D 288		

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D 288	Continued From page 110 -She did not think she had to put the food in the wells. -There was no thermometer for the refrigerator so she did not know if the milk was being kept cold. An interview with the maintenance technician on 07/11/18 at 9:20am revealed: -He was not aware one of the serving line wells was not getting hot. -The work orders come through the computer system called Impulse. -The executive director and business office manager put the work orders into the Impulse system. Interview with the dietary manager on 07/09/17 at 2:35pm revealed: -The temperature of the equipment in the main kitchen was recorded but the refrigerator temperature in the Special Care kitchen was not. -Food temperatures were not recorded in the main kitchen. -Food temperatures were not recorded in the special care unit kitchen. -All the chopped, ground and puree foods were processed in the main kitchen and brought to the Special Care Unit. -She "kept tables on the food because we don't want it too hot". -She was not aware one of the serving wells was not getting hot. An interview with the memory care manager (MCM) on 07/11/18 at 12:15pm revealed she was unaware that the food was cold. Interview with the Administrator on 07/16/18 at 4:27pm revealed: -She expected "good temperatures". -"Good temperatures" were within regulations	D 288		

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D 288	Continued From page 111 -She expected the food pans to be in the hot wells of the serving line.	D 288		
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 Based on observations, interviews and record reviews, the facility failed to assure residents were free of abuse as evidenced by allegations of at least four staff (Staff C, Staff G, Staff H and Staff I) handling residents roughly (#20) with three residents known to have bruises of an unknown origin (Resident #3, Resident #5 and Resident #20). The findings are: Confidential interviews with a staff revealed: -The Administrator says "don't handle people that way, but these people (residents) are hard to deal with;" meaning for staff not to be rough or speak stearnly when residents were combative towards staff. -Staff would come in and see bruises and skin tears on residents, ask what happened and did not get any answers.	D 338		

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D 338	Continued From page 112 Confidential interview with a family member revealed: -Any concerns brought to the management about how residents were treated or cared for were negated to cover up the mismanagement of the facility. -The family member had witnessed personal care aides (PCAs) being "overly rough" with residents. -The family member did not know the name of the staff or the resident, but had witnessed a PCA "pry a residents hand open to take a tissue from a resident". -The family member could not remember when that happened. -The family member became afraid of reporting concerns out of fear of retaliation, that staff would mistreat the residents by ignoring and/or mistreating the residents by handling residents roughly. Confidential interview with a resident revealed: -Staff C, Staff G, Staff H, and Staff I were "aggressive and rough" with the residents when providing incontinence care to residents. 1. Review of Resident #20's current FL-2 dated 08/24/17 revealed: -Diagnoses included dementia of the Alzheimer's type with behavioral disturbance and major depressive disorder (single episode - severe). -The resident was intermittently disoriented. Confidential interview with a resident revealed: -Staff were sometimes rough when they changed Resident #20's incontinence briefs and the resident would "holler". -Resident #20 had bruises on her arms. -Staff would pull on the resident's arms. -If Resident #20 did not turn over during	D 338		

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incontinence care, staff would push the resident over and the resident would yell.
-Resident #20 could not walk.
-Two staff hold Resident #20 under the arms, with her feet "dangling", and "drag" her to the bathroom.

Interview with Staff H on 07/13/18 at 10:57am revealed she had never mistreated or been overly rough with a resident and she had never seen any other staff mistreat a resident.

Based on observations, interviews, and record reviews it was determined Resident #20 was not interviewable.

Refer to interview with the Administrator on 07/11/18 at 12:05pm.

2. Telephone interview with Resident #5's Power of Attorney (POA) on 07/10/18 at 12:20pm revealed:
-It had been reported to the POA by an aide, that other staff handled Resident #5 "roughly".
-Resident #5 had bruises on his arms that looked like someone had grabbed his arms.
-Resident #5 was frequently left sitting in a transport type wheelchair near the front of the Special Care Unit (SCU).
-Staff would tell the POA, Resident #5 was in the transport chair so the staff would not have to "keep running down the hall every time (Resident #5's) (chair) alarm went off".

Telephone interview with a hospice Licensed Practical Nurse (LPN) on 07/18/18 at 10:43am revealed when Resident #5 came home from the facility (03/05/18), the resident had bruises on the back of his upper arms which "looked like someone grabbed him from up under his arm"

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because the bruises were on the back of his arm where you grab someone by the arm.

Telephone interview with the Administrator on 07/19/18 at 12:09pm revealed she was not aware of Resident #5 having bruises on his upper arms at the time of his discharge from the facility (03/05/18).

Refer to interview with the Administrator on 07/11/18 at 12:05pm.

3. Review of Resident #3's current FL-2 dated 03/08/18 revealed diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease and hypotension.

Telephone interview with Resident #3's Power of Attorney (POA) on 07/13/18 at 9:41am revealed:
-Resident #3 had been hurt "so many times" at the facility since his admission in April 2018 and the staff were not able to say happened to Resident #3.
-She could not remember when it was, but she had found bruises on Resident #3's arms that "were exactly the same on both arms, like somebody grabbed him".

Confidential interview with a staff revealed:
-Last week (week of 07/01/18), Staff C yelled at Resident #3, "You're not stronger than me."
-Staff C was "very aggressive" with Resident #3 and there were places on Resident #3's arms that were bleeding.
-Resident #3 was a "picker," so it was difficult to say whether Staff C caused the bleeding on the resident's arms.
-The incident was reported by a staff to the MA, but nothing was done about it.
-The management (Administrator and Memory

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Care Manager) had since told staff to stop talking about the incident because the facility was short staffed enough.

Interview with a medication aide (MA) on 07/11/18 at 5:52am revealed:
-There was an incident one day last week (week of 07/01/18) where Staff C, a personal care aide (PCA), was "not yelling, but being stern with" Resident #3.
-She heard Staff C on the 300 hall with Resident #3; she didn't recall the exact details, but Resident #3 had Staff C's shirt twisted up in the front and then let Staff C go.
-Staff C told the MA "this was hard" meaning working with residents who had dementia.
-She told Staff C to ask for help if she needed help with a resident.
-She had never seen or heard of a staff putting their hands on a resident.
-There were several residents that were hard to take care of because they were combative or resistant when staff tried to help them.
-Resident #3 was one of those residents.

Interview with Staff C, PCA, on 07/11/18 at 6:10am revealed:
-Resident #3 was "very combative" whenever she tried to help him go to the bathroom or change his clothes.
-There was an incident where Resident #3 had grabbed her shirt and pinned her against the wall.
-Another PCA intervened, Resident #3 swung at that PCA and then Resident #3 just stopped and it was over.
-There had prior incidents where Resident #3 was combative, but she did not report Resident #3 behaviors to anyone.

Interview with the Administrator on 07/11/18 at

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D 338	Continued From page 116 12:05pm revealed: -She was aware an incident involving Staff C and Resident #3; the hospice PCA reported Staff C said to Resident #3, "calm down, you're not stronger than me". -The hospice PCA then helped Staff C with Resident #3. -She spoke with the MA and Staff C and both reported the same story as the hospice PCA. -She told Staff C the statement she made about Resident #3 not being stronger than her, was inappropriate. -She instructed Staff C to "take a second staff whenever she might feel a resident was combative, for her protection and the safety of the residents." -She went over reporting resident concerns with staff "all the time". -She "randomly went up and down the halls" on all three shifts to observe staff interactions with residents. Refer to interview with the Administrator on 07/11/18 at 12:05pm. _____ Interview with the Administrator on 07/11/18 at 12:05pm revealed: -She was not aware of any instance of staff handling residents roughly or being disrespectful while communicating with residents. -She went over reporting resident concerns with staff "all the time". -She "randomly went up and down the halls" on all three shifts to observe staff interactions with residents. _____ The facility failed to assure residents on the special care unit were free from abuse. The failure of the facility to protect three residents (#3, #5 and #20) resulted in Resident #20 hollering	D 338		

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D 338	Continued From page 117 when staff pushed her over and treated her roughly when providing incontinence care; Resident #5 having bruises on his upper arms upon discharge from the facility; and Resident #3 being treated aggressively when interacting with staff. This failure was detrimental to the residents' safety and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/11/18, 07/12/18 and 07/13/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 2, 2018.	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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 5 of 6 residents (#13, #14, #15, #16, #17) observed during the medication passes including errors with insulin (#13), a calcium supplement (#14), a potassium	D 358		

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supplement, medications for acid reflux (#15, #16), a blood pressure medication (#16), and an eye drop for glaucoma (#17); and for 1 of 5 residents (#4) sampled who did not receive a vaginal cream due to the medication being unavailable.

The findings are:

1. The medication error rate was 22% as evidenced by the observation of 7 errors out of 31 opportunities during the 7:30am - 9:00am medication passes on 07/10/18 and the 8:00 a.m. medication pass on 07/12/18.

a. Review of Resident #16's current FL-2 dated 08/18/17 revealed diagnoses included Alzheimer's dementia, type II diabetes mellitus, hyperlipidemia, bipolar depression, and dependent edema.

Review of a primary care provider (PCP) visit note dated 05/31/18 for Resident #16 revealed:
-The resident's blood pressure (BP) was 138/70 and was managed with Hydrochlorothiazide (used to lower BP).
-The resident's blood pressure was checked daily and had ranged from 128/60 to 150/80.
-There was an order to start taking Diltiazem ER 24hr 120mg once daily on 06/02/18. (Diltiazem ER is used to lower blood pressure.)

Observation of the 8:00am medication pass on 07/10/18 revealed:
-The medication aide (MA) prepared and administered medications scheduled for 8:00am to Resident #16.
-Diltiazem ER 24hr 120mg was not administered to the resident.

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D 358	Continued From page 119 Interview with the MA on 07/10/18 at 9:17am revealed: -She could not locate any Diltiazem ER 120mg in the medication cart or the overstock storage area. -Diltiazem was a new medication for the resident and she had not been taking it very long. -The last dose documented as administered on the MAR was 07/09/18 at 8:41am. -She was not sure if the medication was administered on 07/09/18 because it was documented as unavailable on 07/08/18. -She was not sure if the Diltiazem had been ordered from the pharmacy. -She would contact the pharmacy and the Diltiazem should come in the pharmacy tote that night. Review of Resident #16's May 2018 medication administration record (MAR) revealed: -There was no entry for Diltiazem ER 24hr 120mg once daily. -The resident's daily BP ranged from 108/64 - 156/60 from 05/01/18 - 05/31/18. Review of Resident #16's June 2018 MAR revealed: -There was an entry for Diltiazem ER 24hr 120mg 1 capsule daily and it was scheduled to be administered at 8:00am. -Diltiazem was documented as administered on 27 out of 30 days starting on 06/01/18. -Diltiazem was not administered on 06/06/18 due to refusal, on 06/10/18 due to resident unavailable, and on 06/24/18 due to "on hold" (withheld per doctor's order). -The resident's daily BP ranged from 91/54 - 145/78 from 06/01/18 - 06/30/18. Review of Resident #16's physician's orders revealed there was no order to hold the Diltiazem.	D 358		

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D 358	Continued From page 120 Review of Resident #16's July 2018 MAR revealed: -There was an entry for Diltiazem ER 24hr 120mg 1 capsule daily and it was scheduled to be administered at 8:00am. -Diltiazem was not administered through 07/05/18 and on 07/08/18 due to the medication being unavailable, "waiting on pharmacy". -Diltiazem was initialed as administered on 07/06/18, 07/07/18, and 07/09/18. -The resident's daily BP ranged from 112/60 - 142/80 through 07/09/18. Interview with the MA on 07/10/18 at 10:40am revealed: -She spoke with the memory care manager (MCM) and the pharmacy about the Diltiazem. -The MCM said the Diltiazem needed a refill. -The MA was supposed to take care of the refill order yesterday, 07/09/18. -The pharmacy received a refill order for the Diltiazem yesterday, 07/09/18. -The pharmacy was supposed to send the Diltiazem either this afternoon or tonight (07/10/18). Review of a pharmacy shipment form for Resident #16 revealed 19 Diltiazem ER 120mg capsules were delivered to the facility on 05/31/18 at 10:24pm. Interviews with the pharmacist at the facility's primary pharmacy on 07/11/18 at 8:38am and 10:07am revealed: -The pharmacy received the order for Diltiazem on 05/31/18. -The facility was on monthly cycle fills on the 19th of each month. -The pharmacy dispensed 19 Diltiazem ER 24hr	D 358		

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120mg capsules on 05/31/18 to last until the facility's next cycle was due on 06/19/18.
-There were no refills on the Diltiazem so they would need a refill authorization to fill the Diltiazem again.
-When refills were needed the pharmacy would put a note in the pharmacy tote that was delivered to the facility.
-The facility would usually get a refill authorization from the prescribing practitioner and forward to the pharmacy.
-The pharmacy sent a request to the prescribing practitioner (not sure of date) but did not receive a response.
-The facility did not contact the pharmacy to request a refill of the Diltiazem until 07/08/18.
-The pharmacy received a refill authorization for the Diltiazem on 07/09/18 and the order was processed and dispensed on 07/10/18.
-There were no requests by the facility to refill the Diltiazem prior to 07/08/18.
-They dispensed 9 Diltiazem ER 24hr 120mg capsules on 07/10/18 and they would have been delivered to the facility that night on 07/10/18.

Interview with the memory care manager (MCM) on 07/10/18 at 2:25pm revealed:
-Most of the medications were delivered by the pharmacy in cycle batches every month.
-If a medication did not come in the cycle fill, the MAs were responsible for ordering medications when they were getting low which meant when there were "less than 10" pills remaining.
-If the medication did not come in from the pharmacy after it was ordered, the MAs were supposed to call the pharmacy.
-If they still could not get the medication from the pharmacy, the MAs were supposed to notify her.
-She was not aware Resident #16's Diltiazem was unavailable and no one had reported it to

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her.
-The MAs should have contacted the pharmacy to find out why the Diltiazem had not been refilled.
-If refills were needed, the MAs should contact the physician to get refills.
-The MAs were not supposed to initial a medication as administered if it was unavailable.

Interview with Resident #16's primary care provider (PCP) on 07/13/18 at 11:45am revealed:
-Resident #16's Diltiazem had not been discontinued.
-There was an order to start Diltiazem on 06/2/18.
-She was not notified the resident was out of the Diltiazem.
-She did not see any documentation of her office being contacted regarding refills for the Diltiazem.
-The facility should have contacted her for a refill request.
-She was concerned that the resident's blood pressure could get too high if she was not receiving the Diltiazem.

Interview with Resident #16 on 07/10/18 at 1:52pm revealed:
-She did not know what kind of medications she received.
-She denied any symptoms of high blood pressure such as headache or dizziness.

b. Review of Resident #16's current FL-2 dated 08/18/17 revealed there was an order for Omeprazole 20mg 1 capsule twice daily. (Omeprazole is for acid reflux and heartburn. The brand name of Omeprazole is Prilosec.)

Review of Resident #16's July 2018 medication administration record (MAR) revealed there was an entry for Omeprazole 20mg 1 capsule twice daily scheduled to be administered at 8:00am and

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D 358	Continued From page 123 8:00pm. Observation of the morning medication pass on 07/10/18 revealed: -Resident #16 was administered one Esomeprazole 20mg capsule instead of Omeprazole 20mg at 9:13am. -The Esomeprazole was in the original manufacturer container with the resident's name written on it. Review of Resident #16's physician's orders revealed no documentation the order for Omeprazole had been changed to Esomeprazole. Interview with the medication aide (MA) on 07/10/18 at 2:12pm revealed: -She thought Esomeprazole was a generic version of Omeprazole. -Resident #16's family provided the supply of Esomeprazole 20mg tablets. -The MAs were supposed to compare the labels and the MARs when administering medications. -If something did not match, the MAs were supposed to call the pharmacy to verify or let the memory care manager (MCM) know about the discrepancy. -She was not aware Esomeprazole was not the same medication as Omeprazole. -It did not occur to her that the names did not match because she assumed one was the generic brand of the other. Interview with the MCM on 07/10/18 at 2:25pm revealed: -The MA on duty was responsible for checking any medications brought by family to make sure it matched the order on the MAR. -The MAs were supposed to compare the medication labels with the MARs when	D 358		

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administering medications.
-If the medication label did not match the MARs, the MAs were supposed to stop and notify either the MCM or the resident care manager (RCM).
-No one had notified her of any concerns with the medication brought in by Resident #16's family.

Interview with Resident #16 on 07/10/18 at 1:52pm revealed:
-She did not know what kind of medications she received.
-She did not currently have any issues with heartburn or indigestion.

c. Review of Resident #13's current FL-2 dated 10/17/17 revealed diagnoses included diabetes mellitus, mild mental retardation, hypertension, hyperlipidemia, and chronic venous insufficiency.

Review of physician's orders for Resident #13 revealed:
-There was an order dated 02/28/18 for Tresiba 200units/ml inject 45 units twice daily at 8:00am and 8:00pm. (Tresiba is a long-acting insulin used to lower blood sugar. According to the manufacturer, the Tresiba FlexTouch pen should be primed with a 2 unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. Press and hold the dose button for at least 6 seconds after the counter returns to zero. If a needle is removed before the 6 second count is completed after the dose counter returns to zero, then under-dosing may occur by as much as 20 %.)
-There was a verbal order dated 04/10/18 to decrease Tresiba to 44 units twice daily at 8:00am and 8:00pm.

Review of Resident #13's July 2018 medication administration record (MAR) revealed:

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D 358	Continued From page 125 -There was an entry for Tresiba FlexTouch U-200 pen inject 44 units twice daily at 8:00am and 8:00pm. -The resident's blood sugar ranged from 99 - 348 from 07/01/18 - 07/10/18. Observation of the 8:00am medication pass on 07/10/18 revealed: -The medication aide (MA) dialed up 44 units on Resident #13's Tresiba FlexTouch pen. -The MA did not dial and perform a 2 unit air shot prior to dialing the scheduled 44 units of Tresiba. -The MA administered the Tresiba into the resident's left abdomen at 8:24am. -The MA pressed the dose button until the counter clicked and returned to zero and then immediately pulled the insulin pen from the resident's abdomen. -The MA did not hold the insulin pen dose button for 6 seconds as required to ensure the complete dosage of insulin was administered. Interview with the MA on 07/10/18 at 1:28pm revealed: -She had training on diabetes including insulin pens upon hire and annually. -She usually did a 2 unit air shot prior to dialing the scheduled dose but she forgot to do it that morning with Resident #13. -She usually held the pen in the skin for about 2 seconds. -She was not aware she needed to hold it in for 6 seconds. Interview with the memory care manager (MCM) on 07/10/18 at 2:25pm revealed: -The facility's nurse had trained the MAs on how to use insulin pens. -They were trained to do a 2 unit air shot prior to dialing the scheduled dose.	D 358		

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D 358	Continued From page 126 -She was not aware the insulin pen should be held in the skin for 6 seconds after the dial clicked back to zero. -She could not recall if they were trained to hold the pen in the skin to ensure the complete dose was administered. -She would make sure the MAs were re-trained on the use of the insulin pens. d. Review of Resident #15's current FL-2 dated 04/04/18 revealed: -Diagnoses included vascular dementia, coronary artery disease, chronic renal failure, dependent edema, hypertension, dyslipidemia, and bilateral deafness. -There was an order for Potassium Chloride ER 10mEq 1 tablet daily. (Potassium Chloride ER is an extended released potassium supplement and should not be crushed. Too much of the medication can be released at one time if it is crushed and it can irritate the mouth and throat.) -There was an order that medications may be crushed if not enteric coated or time released and placed in applesauce, yogurt, or juice if desired. Review of Resident #15's July 2018 medication administration record (MAR) revealed there was an entry for Potassium Chloride ER 1 tablet daily scheduled to be administered at 8:00am. Observation of the morning medication pass on 07/10/18 revealed: -The medication aide (MA) crushed Resident #15's oral tablets, including the Potassium Chloride ER 10mEq tablet and administered the crushed medications in yogurt at 8:50am. -The Potassium Chloride was extended released and should not be crushed. -The resident cringed when he swallowed the crushed medications.	D 358		

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D 358	Continued From page 127 Review of Resident #15's medications on hand on 07/10/18 revealed there was a computer printed note on the Potassium Chloride ER 10mEq label that read, "No not chew or crush prior to swallowing". Interview with MA on 07/10/18 at 1:56pm revealed: -She usually crushed Resident #15's oral tablets, including the Potassium Chloride tablet. -They had a Do Not Crush (DNC) medication list in the shift notebook. -It was usually noted on the MAR or on the medication label if a medication could be not be crushed. -She did not check the DNC medication list and she did not notice the warning on the label to not crush the Potassium Chloride ER tablet. -She should have read the label. Review of the facility's DNC medication list revealed Potassium Chloride was included on the list as medication that should not be crushed because it was a time released formulation. Interview with the memory care manager (MCM) on 07/10/18 at 2:25pm revealed: -There was a DNC medication list in a notebook on the medication carts. -The MAs were supposed to use the DNC list to determine if a medication could be crushed. -It was also usually noted on the MAR or the mediation label if a medication could be crushed. -She was not aware the MAs were crushing Resident #15's Potassium Chloride ER tablets. -The Potassium Chloride ER tablet should not be crushed. Based on observations, interviews, and record	D 358		

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reviews it was determined Resident #15 was not interviewable.

e. Review of Resident #15's current FL-2 dated 04/04/18 revealed there was an order for Omeprazole 20mg 1 capsule daily in the morning. (Omeprazole is used to treat acid reflux and heartburn.)

Review of Resident #15's July 2018 medication administration record (MAR) revealed there was an entry for Omeprazole 20mg 1 capsule twice daily before breakfast and before dinner scheduled to be administered at 7:30am and 5:30pm.

Observation of the morning medication pass on 07/10/18 revealed:
-Resident #15 was in the dining room and had already finished eating breakfast at 8:50am.
-The medication aide (MA) administered Omeprazole 20mg to the resident at 8:50am after breakfast instead of before breakfast as ordered.

Interview with the MA on 07/10/18 at 1:56pm revealed:
-She usually tried to start with blood sugars and medications ordered before meals in the mornings.
-It had been a "hectic' morning and she was running behind with the medication pass.
-Resident #15 usually got the Omeprazole before breakfast but it was late that morning.

Interview with the memory care manager (MCM) on 07/10/18 at 2:25pm revealed:
-The MAs should read the MARs and administer the medications as ordered.
-A medication ordered before breakfast should be given before the meal instead of after the meal.

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D 358	Continued From page 129 Based on observations, interviews, and record reviews it was determined Resident #15 was not interviewable. f. Review of Resident #17's current FL-2 dated 08/01/17 revealed: -Diagnoses included Alzheimer's dementia, glaucoma, hypertension, osteoarthritis, and left lower extremity abscess. -There was an order for Cosopt 1 drop in each eye twice daily. (Cosopt eye drops are used to treat glaucoma.) Review of Resident #17's July 2018 medication administration record (MAR) revealed there was an entry for Cosopt instill 1 drop into both eyes twice daily scheduled to be administered at 8:00am and 8:00pm. Observation of the 8:00am medication pass on 07/12/18 revealed: -Resident #17's Cosopt eye drops were supplied in individual unit dose vials. -The MA took to unit dose vials from the Cosopt box labeled with the resident's name. -The MA used one unit dose vial of Cosopt for each eye. -The MA administered 4 drops in Resident #17's left eye and 7 drops in the right eye at 8:58am. -The eye drops ran down the resident's face. Interview with the MA on 07/12/18 at 10:04am revealed: -She was aware the order for Cosopt was for 1 drop in each eye. -She was trained by another MA to use the whole vial when it was a unit dose vial of eye drops. Interview with the memory care manager (MCM)	D 358		

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on 07/12/18 at 11:17am revealed:
-The MAs were trained to administer medications as ordered.
-The MA should administer 1 drop of Cosopt in each eye for Resident #17 and discard the remaining solution in the individual unit dose vial.

Interview with Resident #17 on 07/12/18 at 10:27am revealed:
-She received eye drops every day.
-She thought they put 1 drop in each eye but she was not sure.
-The eye drops felt good to her eyes.

g. Review of Resident #14's current FL-2 dated 11/16/17 revealed:
-Diagnoses included osteoporosis, frontotemporal dementia, hypertension, hyperlipidemia, hypothyroidism, gastroesophageal reflux disease, depression, anxiety, and ataxic gait.
-There was an order for Calcium Carbonate 600mg 1 tablet daily. (Calcium Carbonate is a calcium supplement.)
-There was an order for Vitamin D3, 2000 units 1 tablet daily. (Vitamin D is a supplement.)

Review of Resident #14's July 2018 medication administration record (MAR) revealed:
-There was an entry for Calcium Carbonate 600mg 1 tablet daily and it was scheduled to be administered at 9:00am.
-There was an entry for Vitamin D3, 2000 units 1 capsule daily and it was scheduled to be administered at 9:00am.

Observation of the 9:00am medication pass on 07/10/18 revealed:
-Resident #14 was administered one Calcium with Vitamin D 600mg/400unit tablet at 8:32am instead of one Calcium 600mg tablet as ordered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 131 -The Calcium with Vitamin D tablet was in the original manufacturer container with the resident's name written on the bottle. -The resident was also administered one Vitamin D3, 2000unit tablet. -The resident was administered more Vitamin D than ordered. Interview with the medication aide (MA) on 07/10/18 at 1:17pm revealed: -Resident #14's family provided the supply of Calcium 600mg tablets. -The MAs do not document when a family brought in medications for residents. -They just put the medication in the cart. -The MAs were supposed to read the label on the medication container and make sure it matched the MARs when the family brought in the medications. -The MAs were supposed to compare the labels and the MARs when administering medications. -She had not noticed the supply of Calcium for Resident #14 also contained 400 units of Vitamin D in each tablet. -She would notify the resident's primary care provider and contact the family. Interview with the memory care manager (MCM) on 07/10/18 at 2:25pm revealed: -The MA on duty was responsible for checking any medications brought by family to make sure it matched the order on the MAR. -They did not document medications brought in by families. -The MAs were supposed to compare the medication labels with the MARs when administering medications. -If the medication label did not match the MARs, the MAs were supposed to stop and notify either the MCM or the resident care manager (RCM).	D 358		

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D 358	Continued From page 132 -No one had notified her the supply of Calcium tablets brought by Resident #14's family did not match the MARs. Review of Resident #14's lab reports revealed: -The resident's Vitamin D level was 30.0 (reference range 30.0 - 100.0) on 11/16/17. -There were no Vitamin D levels after 11/16/17. 2. Review of Resident #4's current FL-2 dated 01/31/18 revealed: -Diagnoses included diabetes mellitus type II (uncontrolled), atrial fibrillation, iron deficiency anemia, osteoarthritis, senile dementia, hypertension, urine incontinence, and Vitamin D deficiency. Review of Resident #4's physician's orders revealed an order dated 02/05/18 for Premarin vaginal cream, insert 0.5g vaginally twice a week on Tuesdays and Fridays. (Premarin vaginal cream is used to treat vaginal dryness and irritation.) Review of Resident #4's May 2018 medication administration record (MAR) revealed: -There was an entry for Premarin vaginal cream insert 0.5g vaginally twice weekly on Tuesday and Friday at 8:00pm. -Premarin was documented as refused on Tuesday, 05/01/18. -Premarin was documented as administered on 8 occasions from 05/04/18 - 05/29/18. Review of Resident #4's June 2018 MAR revealed: -There was an entry for Premarin vaginal cream insert 0.5g vaginally twice weekly on Tuesday and Friday at 8:00pm. -Premarin was documented as administered on 7	D 358		

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D 358	Continued From page 133	D 358		

occasions from 06/01/18 - 06/22/18.
-Premarin was documented as unavailable on 06/26/18 and blank on 06/29/18 with no reason for the omission documented.

Review of Resident #4's July 2018 MAR revealed:
-There was an entry for Premarin vaginal cream insert 0.5g vaginally twice weekly on Tuesday and Friday at 8:00pm.
-Premarin was documented as administered on 2 occasions from 07/03/18 - 07/09/18.
-Doses were due to be administered on 07/10/18 and 07/13/18.

Review of medications on hand for Resident #4 on 07/13/18 (Friday) at 2:10pm revealed there was no Premarin vaginal cream available in the facility.

Interview with two medication aides (MAs) on 07/13/8 at 2:10pm revealed:
-They did not know why there was no Premarin vaginal cream on hand for Resident #4.
-It did not appear the Premarin had been ordered.
-They were unsure how long the resident had been out of the Premarin.
-They would contact the pharmacy about the Premarin.

Interview with the MA/Supervisor on 07/16/18 at 1:12pm revealed:
-She could not locate any Premarin vaginal cream in the medication cart for Resident #4.
-She was not sure if it had been ordered but she would check.
-The MAs were responsible for ordering medications before the medications ran out.
-She would order the Premarin for Resident #4.

Interview with pharmacist at the facility's primary

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D 358	Continued From page 134 pharmacy on 07/17/18 at 10:32am revealed: -The last refill request by the facility for Resident #4's Premarin vaginal cream was on 07/16/18 at 2:44pm. -The Premarin vaginal cream was last filled on 07/16/18 with 30 gram tube. -The supply dispensed on 07/16/18 was documented as received by the facility at 1:00am on 07/17/18. -There was 30g of Premarin vaginal cream dispensed on one other occasion on 02/06/18. Review of pharmacy dispensing records for Resident #4 revealed: -One 30g tube of Premarin vaginal cream was dispensed on 02/06/18. -One 30g tube of Premarin vaginal cream was dispensed on 02/06/18. -At 0.5g twice a week, 1 gram of Premarin would be needed weekly, so a 30 gram tube should last 30 weeks (approximately 4 and ½ months.) Interview with Resident #4 on 07/13/18 at 2:55pm revealed: -She had been to a gynecologist in the past for issues with vaginal bleeding. -The MAs would prepare and bring the vaginal cream to her and she would insert it herself. -She could not recall how often she used the cream but it was not every day. -She denied any current vaginal bleeding.	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:	D 367		

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D 367	Continued From page 135 (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 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 observations, interviews, and record reviews, the facility failed to assure medication administration records were accurate and complete for 2 of 6 residents sampled (#3, #4) including documentation of a medication for agitation (#3) and documentation for 9 scheduled medications for a resident from 06/29/18 - 07/02/18 (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 01/31/18 revealed: -Diagnoses included diabetes mellitus type II (uncontrolled), atrial fibrillation, iron deficiency anemia, osteoarthritis, senile dementia, hypertension, urine incontinence, and Vitamin D deficiency. -There were orders on the FL-2 for multiple	D 367		

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D 367	Continued From page 136 scheduled medications: -Meloxicam 15mg daily. (Meloxicam is for pain and inflammation.) -Metformin 1000mg twice daily. (Metformin lowers blood sugar.) -Losartan 100mg once daily. (Losartan lowers blood pressure.) -Singulair 10mg at bedtime. (Singulair is for breathing problems.) -Lipitor 20mg once daily. (Lipitor lowers cholesterol.) -Omeprazole 20mg once daily. (Omeprazole is for acid reflux.) -Myrbetriq 25mg once daily. (Myrbetriq is for overactive bladder.) -Vitamin B12 1000mcg once daily. (Vitamin B12 is a supplement.) -Aspirin 162mg once daily. (Aspirin is used to prevent heart disease.) -Vitamin B Complex 1 tablet daily. (Vitamin B Complex is a supplement.) -Vitamin D3 1000 units daily. (Vitamin D3 is a supplement.) -Multivitamin 1 tablet daily. (Multivitamin is a supplement.) -Clonazepam 0.5mg twice daily. (Clonazepam is for anxiety.) -Novolog insulin 11 units 3 times a day before meals hold if blood sugar is less than 90. (Novolog is rapid-acting insulin used to lower blood sugar.) -Levemir 40 units daily. (Levemir is long-acting insulin used to lower blood sugar.) Review of Resident #4's subsequent physicians' orders revealed: -There was an order dated 04/04/18 for Prozac 20mg daily. (Prozac is for depression.) -There was an order dated 06/13/18 or Omeprazole 40mg once daily.	D 367		

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D 367	Continued From page 137 -There was an order on 02/02/18 to increase Novolog to 13 units 3 times daily before meals. -There was an order dated 03/27/18 for Premarin vaginal cream 0.5g vaginally twice a week. (Premarin cream is used to treat vaginal dryness and irritation.) -There was an order dated 02/09/18 for Fiberlax 500mg 2 tablets twice a day. (Fiberlax is a laxative.) -There was an order dated 02/09/18 for Miralax 17gram with 8 ounces of fluid once daily. (Miralax is a laxative.) -There was an order for Flonase Nasal Spray use 2 sprays in each nostril once daily. (Flonase is used to treat allergy symptoms.) Review of Resident #4's June 2018 and July 2018 medication administration records (MARs) revealed: -There were electronic MARs for both months but documentation for all medications for 06/28/18 - 07/02/18 was blank and no reason for the omissions documented. -There were computer printed MARs for June 2018 and July 2018 with handwritten documentation for the administration of medications for 06/29/18 - 07/02/18. -The bottom of the first page was page 1 of 11 and pages 2 and 3 were attached. -There was no pages 4 - 11 attached to the handwritten MAR. -These 3 pages had documentation of administration of Novolog insulin, Aspirin, Lipitor, Clonazepam, Multivitamin, Fiberlax, and Prozac. -There was no MAR pages documenting the administration of Meloxicam, Metformin, Losartan, Singulair, Omeprazole, Myrbetriq, Vitamin B12, Vitamin B Complex, Vitamin D3, and Levemir.	D 367		

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D 367	Continued From page 138	D 367		

Interview with Resident #4 on 07/13/18 at 2:55pm revealed:
-The MAs administered medications to her every day.
-She did not recall missing any doses of her medications but she did not know how many medications she was supposed to receive.

Interview with a medication aide (MA) on 07/13/18 at 2:10pm revealed:
-The electronic MARs were not working from 06/29/18 - 07/02/18 due to problems with the internet.
-They used printed copies of the MARs to document administration of medications during that time period.
-She could not recall if she administered medications to Resident #4 during that time period.
-Resident #4 did not usually refuse medications.

Interview with the Administrator on 07/17/18 at 11:20am revealed:
-She was unable to locate pages 4 - 11 for Resident #4's hand documented MARs for 06/29/18 - 07/02/18 when the electronic MAR was not working.
-The resident's medications should have been administered during that time period but they could not find the hand documented MARs.

2. Review of Resident #3's current FL-2 dated 03/08/18 revealed:
-Diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease and hypotension.
-There was an order for hydroxyzine 50mg every six hours as needed (PRN) for agitation.

Review of Resident #3's April, May, June and July

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D 367	Continued From page 139 2018 electronic medication administration record (eMAR) revealed: -There was an entry for hydroxyzine 50mg every six hours PRN agitation. -There were no doses documented as administered in April, May and June 2018. -There was one dose documented as administered on 07/08/18 at 7:42pm. Observation of medications on hand for Resident #3 on 07/12/18 at 10:44am revealed: -There was a bubble pack with a pharmacy label which had Resident #3's name and instructions for hydroxyzine 50mg every six hours PRN for agitation. -The label indicated 12 capsules were dispensed on 04/02/18 and there were eight capsules remaining in the bubble pack. Interview with a medication aide (MA) on 07/12/18 at 10:50am revealed: -She was not able to say what happened to the three hydroxyzine capsule that were not documented as administered for Resident #3 because she was not on the 300 hall medication cart from April through July 2018. -The hydroxyzine was a PRN medication, so anytime a dose was administered the MA should have documented on the eMAR. Telephone interview with the Memory Care Manager (MCM) on 07/19/18 at 11:33am revealed: -Staff were expected to document on the eMAR whenever a PRN medication was administered. -There was a form for all dropped medications; she would have to look into what happened to the three hydroxyzine capsule for Resident #3. Upon request on 07/19/18, a record of dropped	D 367		

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D 367	Continued From page 140 hydroxyzine capsules for Resident #3 was not available for review.	D 367		
D 370	10A NCAC 13F .1004 (m) Medication Administration 10A NCAC 13F .1004 Medication Administration (m) Medication administration supplies, such as graduated measuring devices, shall be available and used by facility staff in order for medications to be accurately and safely administered. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure graduated measuring devices were available and used by staff in order for liquid medications to be accurately and safely measured for 2 of 3 residents sampled (#2, #22) with orders for Morphine Sulfate concentrated oral solution. The findings are: 1. Review of Resident #22's current FL-2 dated 12/20/17 revealed: -Diagnoses included Alzheimer's dementia, diabetes, hypertension, hypothyroidism, coronary artery disease, depression, gastroesophageal reflux disease, allergic rhinitis, iron deficiency anemia, and history of falling. Review of Resident #22's physician's orders revealed: -There was a prescription dated 05/31/18 for Morphine Sulfate oral solution 20mg/ml take 0.25ml every 4 hours as needed for pain,	D 370		

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D 370	Continued From page 141 shortness of breath. (Morphine Sulfate solution is a concentrated narcotic/controlled substance used to treat moderate to severe pain.) Review of Resident #22's June 2018 medication administration record (MAR) revealed: -There was an entry for Morphine Sulfate solution 20mg/ml take 0.25ml (5mg) every 4 hours as needed for pain, shortness of breath -No Morphine Sulfate was documented as administered in June 2018. Review of Resident #22's July 2018 MAR revealed: -There was an entry for Morphine Sulfate solution 20mg/ml take 0.25ml (5mg) every 4 hours as needed for pain, shortness of breath. -Morphine Sulfate 0.25ml was documented as administered 3 times on 07/13/18 at 7:54am, 2:42pm, and 6:59pm. -Morphine Sulfate 0.25ml was documented as administered 2 times on 07/14/18 at 7:49am and 6:00pm. -Morphine Sulfate 0.25ml was documented as administered once on 07/15/18 and once on 07/16/18. -A total of 7 doses (1.75ml) were documented as administered. Review of Resident #22's medications on hand on 07/13/18 at 11:23am revealed: -There was a bottle of 15ml of Morphine Sulfate oral solution dispensed on 05/31/18. -There was an oral 1ml syringe in the box with the Morphine Sulfate bottle. -The oral syringe was marked in 0.1 increments including 0, 0.1, 0.2, 0.3, 0.4, 0.5, 0.6, 0.7, 0.8, 0.9, and 1ml. -There was no marking for 0.25ml.	D 370		

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D 370	Continued From page 142 Interview with a medication aide (MA) on 07/13/18 at 11:25am revealed: -The 1ml oral syringe that came with the Morphine Sulfate solution was the only one they had a the facility. -There was no marking for 0.25ml so she estimated the measurement of Morphine Sulfate by giving an amount half way between the 0.2ml line and the 0.3ml line. -The pharmacy had not been contacted to get a measuring device that would accurately measure 0.25ml to her knowledge. -They would check with the hospice nurse and pharmacy about getting a different measuring device. Observation of the oral syringes stored with Resident #22's Morphine Sulfate oral solution on 07/16/18 at 2:00pm revealed: -The oral syringes were the same kind as observed on 07/13/18. -The 1ml oral syringes were marked in 0.1 increments including 0, 0.1, 0.2, 0.3, 0.4, 0.5, 0.6, 0.7, 0.8, 0.9, and 1ml. -There was no marking for 0.25ml. Interview with the hospice nurse on 07/17/18 at 10:55am revealed: -Hospice ordered the Morphine Sulfate for Resident #22 in May 2018 because the resident was not acting like herself and they wanted the Morphine to be available in case she needed it. -Two days later, the resident was better and acting like herself again. -Resident #22 had not needed any Morphine until last week when she fell on the night of 07/12/18 and was injured. -The oral syringes came with the Morphine when it was dispensed by the hospice pharmacy.	D 370		

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D 370	Continued From page 143 Interview with a MA on 07/16/18 at 2:00pm revealed: -They got more oral syringes from the hospice nurse last week. -It was the same kind of oral syringes as before and there were no markings for 0.25ml. -They were still measuring the dosage for 0.25ml halfway between the 0.2ml marking and the 0.3ml marking. Interview with the memory care manager (MCM) on 07/16/18 at 2:08pm revealed: -She was trying to find an oral syringe / dropper that they could use to accurately measure 0.25ml. -She had spoken with the hospice nurse and the hospice physician may change the resident's order to 0.3ml. Interview with the pharmacist with the primary pharmacy on 07/17/18 at10:32am revealed: -They used the oral syringes that came from the manufacturer of the liquid Morphine they ordered. -The oral syringes for the current manufacturer did not have a marked increment for 0.25ml. -She would check to see if they could order any oral syringes or droppers with 0.25ml marked increments. Interview with the hospice nurse on 07/17/18 at 10:55am revealed: -She had checked with the hospice pharmacy about doing prefilled Morphine syringes but the pharmacy did not do prefilled syringes. -She also checked with the hospice pharmacy and they did not have any oral syringes or droppers on hand with a marking for 0.25ml. -She contacted the hospice physician to request a dosage change for Resident #22 to 0.3ml. 2. Review of Resident #2's current FL-2 dated	D 370		

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D 370	Continued From page 144 04/04/18 revealed: -Diagnoses included dementia of the Alzheimer's type, unspecified depressive disorder, hypertension, hypothyroidism, osteoarthritis, and atrial fibrillation. Review of Resident #2's physician's orders revealed an order dated 12/04/17 for Morphine Sulfate oral solution 20mg/ml give 0.25ml (5mg) under the tongue every 2 hours as needed for pain. (Morphine Sulfate solution is a concentrated narcotic/controlled substance used to treat moderate to severe pain.) Review of Resident #2's May 2018 - July 2018 medication administration records (MAR) revealed: -There was an entry for Morphine Sulfate solution 20mg/ml give 0.25ml (5mg) under the tongue every 2 hours as needed for pain. -No Morphine Sulfate was documented as administered from May 2018 - June 2018. Review of Resident #2's medications on hand on 07/13/18 at 11:23am revealed: -There was a bottle of 30ml of Morphine Sulfate oral solution dispensed on 12/04/17. -The amount of liquid bottle was slightly below the 30ml marking. -There was an oral 1ml syringe in the box with the Morphine Sulfate bottle. -The oral syringe was marked in 0.1 increments including 0, 0.1, 0.2, 0.3, 0.4, 0.5, 0.6, 0.7, 0.8, 0.9, and 1ml. -There was no marking for 0.25ml. Review of a handwritten controlled substance (CS) log for Resident #2 revealed: -The resident's name and "liquid Morphine" were written at the top of the page.	D 370		

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D 370	Continued From page 145 -The quantity received was handwritten as 29.75ml. -There was no date on the form. -There was no documentation of when the 0.25ml was administered. -The amount dispensed on 12/04/17 of 30ml was not documented on the form. Interview with a medication aide (MA) on 07/13/18 at 11:25am revealed: -She was not sure when Resident #2 had received Morphine Sulfate. -The 1ml oral syringe that came with the Morphine Sulfate solution was the only one they had at the facility. -There was no marking for 0.25ml so she estimated the measurement of Morphine Sulfate by giving an amount half way between the 0.2ml line and the 0.3ml line. -The pharmacy had not been contacted to get a measuring device that would accurately measure 0.25ml to her knowledge. -They would check with the hospice nurse and pharmacy about getting a different measuring device. Observation of the oral syringes stored with Resident #2's Morphine Sulfate oral solution on 07/16/18 at 2:05pm revealed: -The oral syringes were the same kind as observed on 07/13/18. -The 1ml oral syringes were marked in 0.1 increments including 0, 0.1, 0.2, 0.3, 0.4, 0.5, 0.6, 0.7, 0.8, 0.9, and 1ml. -There was no marking for 0.25ml. Interview with the hospice nurse on 07/17/18 at 10:55am revealed: -Resident #2 was not currently a hospice resident and had been discharged from hospice in March	D 370		

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D 370	Continued From page 146 2018. -The oral syringes came with the Morphine when it was dispensed by the hospice pharmacy.	D 370		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 4 of 7 residents (#2, #4, #9, #22) sampled including two residents receiving pain medications (#9, #22) and two residents receiving medications for anxiety and agitation (#2, #4). The findings are: 1. Review of Resident #22's current FL-2 dated 12/20/17 revealed diagnoses included Alzheimer's dementia, diabetes, hypertension, hypothyroidism, coronary artery disease, depression, gastroesophageal reflux disease, allergic rhinitis, iron deficiency anemia, and history of falling. Review of Resident #22's physician's orders revealed: -There was a prescription dated 05/31/18 for	D 392		

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D 392	Continued From page 147 Morphine Sulfate oral solution 20mg/ml take 0.25ml every 4 hours as needed for pain, shortness of breath. (Morphine Sulfate solution is a concentrated narcotic/controlled substance used to treat moderate to severe pain.) -The prescription was written for a quantity of 15ml with no refills. Review of Resident #22's June 2018 medication administration record (MAR) revealed: -There was an entry for Morphine Sulfate solution 100mg/5ml (20mg/ml) take 0.25ml (5mg) every 4 hours as needed for pain, shortness of breath -No Morphine Sulfate was documented as administered in June 2018. Review of Resident #22's July 2018 MAR revealed: -There was an entry for Morphine Sulfate solution 100mg/5ml (20mg/ml) take 0.25ml (5mg) every 4 hours as needed for pain, shortness of breath. -Morphine Sulfate 0.25ml was documented as administered 3 times on 07/13/18 at 7:54am, 2:42pm, and 6:59pm. -Morphine Sulfate 0.25ml was documented as administered 2 times on 07/14/18 at 7:49am and 6:00pm. -Morphine Sulfate 0.25ml was documented as administered once on 07/15/18 and once on 07/16/18. -A total of 7 doses (1.75ml) were documented as administered. Review of Resident #22's medications on hand on 07/13/18 at 11:23am revealed: -There was only one 15ml bottle of Morphine Sulfate oral solution dispensed on 05/31/18. -The amount of Morphine Sulfate remaining in the 15ml bottle was at the 15ml marking.	D 392		

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D 392	Continued From page 148 Review of Resident #22's handwritten controlled substance (CS) log for Morphine Sulfate on 07/16/18 revealed: -The date received was 05/31/18. -The quantity received was 30ml. -The first dose of 0.25ml was documented as administered on 07/13/18 at 7:54am leaving a balance of 29.75ml. -The last dose of 0.25ml was documented as administered on 07/16/18 at 6:30am leaving a balance of 28.25ml. -There were 7 doses (1.75ml) documented as administered. Review of Resident #22's electronic CS log also started with a quantity of 30ml for the Morphine Sulfate and noted the same dosages and amounts as indicated on the handwritten CS log. Review of Resident #22's medications on hand on 07/16/18 at 2:00pm revealed: -There was only one 15ml bottle of Morphine Sulfate oral solution dispensed on 05/31/18. -The amount of Morphine Sulfate remaining in the 15ml bottle fell slightly below the marking for 15ml but above the next marking of 12ml. -This did not match the 28.25ml balance on the CS log. Interview with a medication aide (MA) on 07/16/18 at 2:00pm revealed: -She remembered documenting the quantity received on Resident #22's CS log for the Morphine Sulfate. -She must have documented 30ml in error instead of 15ml. -There were other resident's with Morphine Sulfate with 30ml so she must have thought the 15ml bottle had 30ml also. -She had not noticed the difference in the amount	D 392		

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D 392	Continued From page 149 in the bottle and the amount documented on the CS log. Interview with the hospice nurse on 07/17/18 at 10:55am revealed: -Resident #22 had not needed any Morphine until last week when she fell on the night of 07/12/18 and was injured. -One 15ml bottle of Morphine was dispensed to the resident on 05/31/18 and that was the only supply that had been dispensed to the resident. Interview with the memory care manager (MCM) on 07/16/18 at 2:08pm revealed: -When checking the amount of liquid Morphine on hand during CS shift counts, the MAs should look at the measurement lines on the bottle and document how much was left in the bottle. -They would correct Resident #22's CS log for Morphine to reflect the current balance. 2. Review of Resident #9's current FL-2 dated 04/05/18 revealed: -Diagnoses included type 1 diabetes mellitus without complications, anemia, acute respiratory failure with hypoxia (01/24/18), and methicillin resistant Staphylococcus aureus pneumonia (01/24/18). -There was an order for Hydrocodone/Acetaminophen (APAP) 7.5/325mg take 1 to 2 tablets every 4 hours and as needed. (Hydrocodone/APAP is a narcotic/controlled substance used to treat moderate to severe pain.) Review of Resident #9's physician's orders revealed: -There was an order dated 04/09/18 for Hydrocodone/APAP 7.5/325mg take 1 to 2 tablets every 4 hours as needed for pain (moderate).	D 392		

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D 392	Continued From page 150 -There was a clarification order dated 04/10/18 for Hydrocodone/APAP 7.5/325mg take 1 tablet every 4 hours as needed for pain. -There was an order dated 04/18/18 for Hydrocodone/APAP 7.5/325mg take 1 tablet every 4 hours as needed for pain, do not exceed 6 doses in 24 hours. -There was a verbal order dated 05/06/18 to hold Hydrocodone/APAP until 05/18/18. -There was an order dated 05/10/18 to discontinue current Hydrocodone/APAP 7.5/325mg orders and start 1 tablet twice a day as needed for pain. -There was a verbal order dated 05/26/18 to hold Hydrocodone/APAP until 05/30/18. -There was an order dated 06/21/18 for Hydrocodone/APAP 7.5/325mg take 1 tablet 3 times a day. -There was an order dated 06/28/18 for Hydrocodone/APAP 7.5/325mg take 1 tablet 3 times a day. Review of Resident #9's April 2018 medication administration record (MAR) revealed: -There was an entry for Hydrocodone/APAP 7.5/325mg take 1 tablet every 4 hours as needed for pain. -There were 26 doses of Hydrocodone/APAP documented as administered from 04/11/18 - 04/20/18. -There was a second entry for Hydrocodone/APAP 7.5/325mg take 1 tablet every 4 hours as needed for pain, not to exceed 6 doses in 24 hours. -There were 30 doses of Hydrocodone/APAP documented as administered from 04/20/18 - 04/30/18. -A total of 56 tablets were documented as administered in April 2018.	D 392		

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D 392	Continued From page 151 Review of the electronic CS log for April 2018 for Resident #9 revealed: -The starting entry for April 2018 was 04/11/18 but the starting balance was not documented. -On 04/11/18 at 5:28pm, 1 dose was noted to be administered leaving a -1.00 balance. -The next entry on 04/11/18 at 10:57pm noted 28 tablets were received leaving a balance of 28 tablets. -There were duplicate entries where more than 1 tablet was deducted and noted as administered at the same time. -For example, there were two rows deducting 1 tablet on each row for administration on 04/15/18 at 8:04pm but only 1 tablet was documented as administered on the MAR at that time. -On 04/16/18 at 4:03am and again at 4:04am, 1 tablet was deducted each time as administered (none was documented as administered on the MAR at either time), leaving a balance of 11 tablets. -On 04/16/18 at 7:11am, 2 tablets were added back to the count as "received" with no comment or explanation, increasing the balance back to 13 tablets. -There was none documented as administered on 04/16/18 at 11:31am on the CS log as indicated on the MAR. -On 04/16/18 at 3:18pm, 1 tablet was deducted as wasted but not documented on the MAR, decreasing the count to 12 tablets. -There was 1 tablet administered on 04/17/18 at 9:20am and deducted from the balance but was not documented on the MAR. -One tablet was documented as administered on the MAR on 04/17/18 at 12:05pm but none was documented and deducted from the CS log for that time. -After administration of 1 tablet on 04/20/18 at 2:34pm, the CS log showed a balance of -1.00	D 392		

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D 392	Continued From page 152 tablets. -The next entry on 04/20/18 at 3:12pm noted 1 tablet was received leaving a balance of 0. -The next entry on 04/20/18 at 11:19pm noted 42 tablets were received and 42 tablets was the balance. -There was an entry on 04/23/18 at 6:56am for 1 tablet wasted but 1 tablet was documented as administered at 6:48am on 04/23/18 and none documented as wasted. -On 04/23/18 at 3:01pm, 1 tablet was documented as received. -On 04/25/18 at 5:59pm, 1 tablet was documented as administered but it was documented at 10:35pm on the MAR. -On 04/26/18, there were two entries for 11:23am, deducting 2 tablets for the same time but only 1 documented on the MAR. -On 04/26/18 at 7:09pm, 1 tablet was "received" back into the balance. -For the April 2018 CS log, there was a beginning balance of -1.00 on 04/11/18 and an ending balance of 13 tablets on 04/30/18. -There was a total of 59 tablets documented as administered on the CS log from 04/11/18 - 04/30/18 but only 56 tablets documented on the MAR. -There were 75 tablets documented as received and 2 tablets documented as wasted. Review of Resident #9's May 2018 MAR revealed: -There was an entry for Hydrocodone/APAP 7.5/325mg take 1 tablet every 4 hours as needed for pain, not to exceed 6 doses in 24 hours. -There were 13 doses of Hydrocodone/APAP documented as administered from 05/01/18 - 05/05/18. -The order was noted to be discontinued on 05/18/18.	D 392		

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D 392	Continued From page 153 -No Hydrocodone/APAP was documented as administered from 05/06/18 - 05/17/18. -There was a second entry for Hydrocodone/APAP 7.5/325mg take 1 tablet twice daily as needed for pain. -There were 14 doses of Hydrocodone/APAP documented as administered from 05/18/18 - 05/31/18. -A total of 27 tablets were documented as administered in May 2018. Review of the electronic CS log for May 2018 for Resident #9 revealed: -The starting balance continued from the April 2018 CS log was 13 tablets. -There were 13 doses of Hydrocodone/APAP documented as administered from 05/01/18 - 05/05/18 leaving a balance of 0. -The next entry started 05/18/18 at 10:38am indicating 13 tablets were received. -On 05/21/18 at 8:19am, 1 tablet was documented as administered but was documented at 11:33am on the MAR. -The last of the 13 tablets was documented as administered on 05/25/18 at 11:21am leaving a balance of 0. -On 05/31/18 at 3:33pm, 14 tablets were documented as received. -One other tablet was documented on 05/31/18, leaving a balance of 13 tablets. -There were 27 tablets documented as administered on the CS log and the MAR. Review of Resident #9's June 2018 MAR revealed: -There was an entry for Hydrocodone/APAP 7.5/325mg take 1 tablet twice daily as needed for pain. -There were 31 doses of Hydrocodone/APAP documented as administered from 06/01/18 -	D 392		

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06/22/18.
-The order was noted to be discontinued on 06/22/18.
-There was a second entry for Hydrocodone/APAP 7.5/325mg take 1 tablet 3 times daily and it was scheduled to be administered at 6:00am, 2:00pm, and 10:00pm.
-There were 26 doses of Hydrocodone/APAP documented as administered from 06/22/18 - 06/30/18.
-A total of 57 tablets were documented as administered in June 2018.

Review of the electronic and handwritten CS logs for June 2018 for Resident #9 revealed:
-The starting balance on the electronic CS log continued from the May 2018 CS log was 13 tablets.
-One tablet was documented as wasted on 06/02/18 at 9:12pm but it was not documented on the MAR.
-Twelve tablets were documented as administered and 1 as wasted from 06/01/18 - 06/08/18 leaving a balance of 0.
-On 06/08/18 at 5:19pm, 14 tablets were documented as received.
-On 06/09/18 at 3:24pm, 1 tablet was documented as wasted on the CS log but not on the MAR.
-On 06/13/18 at 7:17pm, 1 tablet was documented as wasted on the CS log but not on the MAR.
-The last of the 14 tablets was documented on 06/15/18 and 14 more tablets were received on 06/18/18.
-There were 21 more tablets received on 06/21/18 at 11:35pm increasing the balance to 29 tablets.
-On 06/22/18 at 5:58am, 21 tablets were wasted with a comment of "other", leaving a balance of 7

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tablets.
-There were no entries or deductions on the CS log for 2 tablets documented on the MAR as administered on 06/22/18 at 2:00pm and 10:00pm.
-The next entry for June was 06/23/18 at 5:59am noting 1 tablet administered and leaving a balance of 25 tablets.
-On 06/26/18 at 10:50pm, 1 tablet was wasted on the CS log but not on the MAR.
-On 06/29/18, 21 tablets were received and 1 was administered, leaving a balance of 27 tablets.
-The ending balance on the electronic June 2018 CS log was 27 tablets.
-There was a handwritten CS log for 06/29/18 and 06/30/18 that started with a balance of 27 tablets.
-There were 5 tablets documented as administered on 06/29/18 - 06/3018, leaving a balance of 22 tablets.
-There were 55 tablets administered on the CS log but 57 tablets documented as administered on the MAR.
-There were 25 tablets wasted on the CS log and none on the MAR.
-There were 70 tablets received.

Interview with the Administrator on 07/17/18 at 11:20am revealed:
-The 7 wasted tablets on Resident #9's CS log on 06/22/18 may have been related to the time period when the resident needed prior authorization to have the medication filled.
-She was not sure why 7 tablets were documented as wasted.

Interview with the Administrator on 07/17/18 at 3:43pm revealed on 06/22/18, the 7 wasted tablets noted on Resident #9's CS log was related to the order changing from prn (as needed) to

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D 392	Continued From page 156 scheduled and there was an inventory adjustment. Review of Resident #9's July 2018 MARs revealed: -There was an entry for Hydrocodone/APAP 7.5/325mg take 1 tablet 3 times daily and it was scheduled to be administered at 6:00am, 2:00pm, and 10:00pm. -There were 37 doses of Hydrocodone/APAP documented as administered from 07/01/18 - 07/13/18 at 6:00am. Review of the electronic and handwritten CS logs for July 2018 for Resident #9 revealed: -There was a handwritten CS log for 07/01/18 - 07/03/18 that started with a balance of 22 tablets. -There were 8 tablets documented as administered on 07/01/18 - 07/03/18, leaving a balance of 14 tablets. -The starting balance on the electronic CS log continued on 07/03/18 with a balance of 14 tablets. -There were 21 tablets received on 07/06/18 at 12:37am, increasing the balance to 28 tablets. -There were 21 tablets received on 07/12/18 at 11:04pm, increasing the balance to 28 tablets. -After administration of doses from 07/01/18 - 07/13/18 (6:00am), there was a balance of 27 tablets. -There were 37 tablets administered on the CS log and the MAR from 07/01/18 - 07/13/18 (6:00am). -There 42 tablets received from 07/01/18 - 07/13/18. Review of Resident #9's medications on hand on 07/13/18 revealed: -There was a supply of Hydrocodone/APAP 7.5/325mg dispensed on 07/05/18.	D 392		

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D 392	Continued From page 157 -There were 6 of 21 tablets remaining in the supply. -There was a second supply of Hydrocodone/APAP 7.5/325mg dispensed on 07/12/18. -There were 21 of 21 tablets remaining in the second supply. -There was a total of 27 tablets on hand on 07/13/18 at 2:20pm. Interview with a medication aide (MA) on 07/13/18 at 2:20pm revealed: -There had been a problem with Resident #9's insurance and the day supply with the Hydrocodone/APAP tablets. -Sometimes the resident would receive a 1 or 2 week supply at a time. -The medication was unavailable at times when they were trying to get the issue resolved. -Resident #9's primary care provider (PCP) was aware of the issues and wrote orders to hold the Hydrocodone/APAP when it was unavailable. Interview with Resident #9 on 07/09/18 at 11:51am revealed: -There were issues about a month ago with his insurance and his pain medication and he was out of the pain medication for 2 weeks. -There was also a mix up and he was only getting a 1 week supply at one time. -He could take up to 6 Hydrocodone tablets per day when it was prn but he usually took 2 to 3 per day. -He was now taking the Hydrocodone on a scheduled basis. -His primary care provider was aware of the issues with his pain medication and the insurance. -The Administrator and the RCM took care of the problem.	D 392		

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D 392	Continued From page 158 -He had not had any more problems getting his pain medication. Refer to interview with a medication aide (MA) on 07/09/18 at 5:10pm. Refer to interview with a second MA on 07/17/18 at 2:31pm. Refer to interview with the MA/supervisor (MA/S) on 07/16/18 at 1:12pm. Refer to interview with the Administrator on 07/11/18 at 12:00pm. Refer to interview with the resident care manager (RCM) on 07/16/18 at 2:30pm. Refer to interview with a representative from the computer software company used for the facility's electronic MARs on 07/17/18 at 12:50pm. 3. Review of Resident #2's current FL-2 dated 04/04/18 revealed: -Diagnoses included dementia of the Alzheimer's type, unspecified depressive disorder, hypertension, hypothyroidism, osteoarthritis, and atrial fibrillation. Review of physician's orders for Resident #2 revealed: -There was an order dated 03/27/18 for Lorazepam 1mg 1 tablet 3 times a day as needed for anxiety and agitation. (Lorazepam is a controlled substance used to treat anxiety.) -There were orders dated 04/09/18 and 06/07/18 for Lorazepam 1mg 1 tablet twice daily. Review of pharmacy dispensing records dated 01/01/18 - 07/17/18 for Resident #2 revealed:	D 392		

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D 392	Continued From page 159 -There were 90 Lorazepam 1mg tablets dispensed on 04/05/18. -There were 60 Lorazepam 1mg tablets dispensed on 05/08/18. -There were 60 Lorazepam 1mg tablets dispensed on 07/07/18. Review of Resident #2's May 2018 medication administration record (MAR) revealed: -There was an entry for Lorazepam 1mg 1 tablet 3 times a day as needed for anxiety and agitation but not was documented as administered. -There was an entry for Lorazepam 1mg twice daily and it was scheduled to be administered at 8:00am and 8:00pm. -Lorazepam 1mg was documented as administered twice a day for a total of 62 tablets from 05/01/18 - 05/31/18. Review of the electronic controlled substance (CS) logs for April 2018 - July 2018 for Resident #2 revealed: -The CS log was a computer printed form with entries from April 2018 - July 2018 for Lorazepam 1mg. -The CS log entries did not flow chronologically by the month meaning several entries for one month may be mixed in with entries from a different month. -Several days were duplicated on different pages making it difficult to follow the balance of tablets on hand. Review of the electronic CS log for May 2018 for Resident #2 revealed: -The starting balance for 05/01/18 was 22 tablets. -There were 64 tablets documented as administered on the CS log but only 62 documented on the MAR. -There were 2 tablets documented as	D 392		

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administered on 05/21/18 at 7:36pm and 1 tablet at 7:38pm.
-Two tablets were documented as received on 05/21/18 at 9:57pm.

Review of Resident #2's June 2018 MARs revealed:
-There was an entry for Lorazepam 1mg 1 tablet 3 times a day as needed for anxiety and agitation but not was documented as administered.
-There was an entry for Lorazepam 1mg twice daily.
-There were 56 Lorazepam 1mg tablets documented as administered from 06/01/18 - 06/30/18.

Review of the electronic and handwritten CS logs for June 2018 for Resident #2 revealed:
-The starting balance for 06/01/18 was 21 tablets.
-There were 60 tablets received on 06/07/18 at 9:29pm increasing the balance to 89 tablets.
-There was 89 tablets wasted on 06/07/18 at 9:41pm with comment of "other", leaving a balance of 0.
-There were 59 tablets received on 06/07/18 at 9:42pm giving a balance of 67 tablets.
-On 06/08/18 at 8:10am, 1 tablet was administered but showed a balance of -1.00 tablet.
-On 06/08/18 at 6:50pm, 1 tablet was received leaving a balance of 0.
-On 06/08/18 at 9:51pm, 67 tablets were received giving a balance of 66 tablets.
-On 06/08/18 at 9:53pm, 66 tablets were wasted with comment of "other", leaving a balance of 0.
-On 06/08/18 at 9:57pm, 1 tablet was wasted leaving a balance of 65 tablets.
-The ending balance on 06/30/18 was 26 tablets.
-There were 54 tablets documented as administered on the CS log but 56 documented

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D 392	Continued From page 161 on the MAR from 06/01/18 - 06/30/18. Review of Resident #2's July 2018 MARs revealed: -There was an entry for Lorazepam 1mg 1 tablet 3 times a day as needed for anxiety and agitation but not was documented as administered. -There was an entry for Lorazepam 1mg twice daily. -There were 18 Lorazepam 1mg tablets documented as administered from 07/01/18 - 07/11/18 (9:00am). Review of the electronic and handwritten CS logs for July 2018 for Resident #2 revealed: -The starting balance for 07/01/18 was 26 tablets. -On 07/03/18 at 3:34pm, 3 tablets were wasted with comment of "other", leaving a balance of 20 tablets. On 07/08/18, 2 tablets were documented as administered and 2 tablets were documented as a received. -There were 19 tablets documented as administered on the CS log but 18 documented on the MAR from 07/01/18 - 07/11/18 (9:00am). Review of Resident #2's medication on hand and CS log on 07/13/18 at 10:50am revealed there were 66 Lorazepam 1mg tablets on hand and a balance of 66 on the log. Interview with the memory care manager (MCM) on 07/19/18 at 12:07pm revealed: -The MA documented 60 tablets were received for Resident #2 but only 30 tablets were actually received on 06/07/18. -When 60 tablets were added to the balance on hand of 29, it showed 89 were on hand. -In order to correct the error, all 89 tablets were documented as wasted on the CS log.	D 392		

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D 392	Continued From page 162 -There was an option to make a comment on the CS log but no comment was made to explain the discrepancy. -The CS logs had no comments documented because staff had not been trained to document in the comment section. -They were setting up an in-service with the computer software company which would include training on documenting on the electronic CS logs. Refer to interview with a medication aide (MA) on 07/09/18 at 5:10pm. Refer to interview with a second MA on 07/17/18 at 2:31pm. Refer to interview with the MA/supervisor (MA/S) on 07/16/18 at 1:12pm. Refer to interview with the Administrator on 07/11/18 at 12:00pm. Refer to interview with the resident care manager (RCM) on 07/16/18 at 2:30pm. Refer to interview with a representative from the computer software company used for the facility's electronic MARs on 07/17/18 at 12:50pm. 4. Review of Resident #4's current FL-2 dated 01/31/18 revealed: -Diagnoses included diabetes mellitus type II (uncontrolled), atrial fibrillation, iron deficiency anemia, osteoarthritis, senile dementia, hypertension, urine incontinence, and Vitamin D deficiency. -There was an order for Clonazepam 0.5mg twice daily. (Clonazepam is a controlled substance used to treat anxiety.	D 392		

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D 392	Continued From page 163 Review of Resident #4's May 2018 medication administration record (MAR) revealed: -There was an entry for Clonazepam 0.5mg twice daily and it was scheduled to be administered at 8:00am and 8:00pm. -There were 62 tablets documented as administered from 05/01/18 - 05/31/18. Review of the electronic controlled substance (CS) log for May 2018 for Resident #4 revealed: -The starting balance on 05/01/18 was 60 tablets. -There were 67 tablets documented as administered. -There were 3 tablets documented as administered on 05/13/18 from 8:59am - 9:01am but only 1 on the MAR at that time. -There were 3 tablets documented as administered on 05/19/18 from 8:45pm - 8:46pm but only 1 on the MAR at that time. -There were 2 tablets documented as administered on 05/31/18 at 8:34pm but only 1 on the MAR. -The ending balance on 05/31/18 was 4 tablets. Review of Resident #4's June 2018 MAR revealed: -There was an entry for Clonazepam 0.5mg twice daily and it was scheduled to be administered at 8:00am and 8:00pm. -There were 54 tablets documented as administered from 06/01/18 - 06/30/18. Review of the electronic and handwritten CS logs for June 2018 for Resident #4 revealed: -The starting balance on 06/01/18 was 4 tablets. -There were 2 tablets documented as administered on 06/02/18 from 8:37am - 8:38am but only 1 on the MAR at that time. -There were 59 tablets documented as	D 392		

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administered on the CS log but 54 on the MAR.
-The ending balance on 06/30/18 was 67 tablets.

Review of Resident #4's July 2018 MAR revealed:
-There was an entry for Clonazepam 0.5mg twice daily and it was scheduled to be administered at 8:00am and 8:00pm.
-There were 19 tablets documented as administered from 07/01/18 - 07/10/18 (8:00am).

Review of the electronic and handwritten CS logs for July 2018 for Resident #4 revealed:
-The starting balance on 07/01/18 was 67 tablets.
-There were 19 tablets documented as administered.
-On 07/03/18 at 4:01pm, there were 6 tablets wasted with comment of "other', leaving a balance of 62 tablets.
-The ending balance on 07/10/18 at 9:14am was 47 tablets.

Refer to interview with a medication aide (MA) on 07/09/18 at 5:10pm.

Refer to interview with a second MA on 07/17/18 at 2:31pm.

Refer to interview with the MA/supervisor (MA/S) on 07/16/18 at 1:12pm.

Refer to interview with the Administrator on 07/11/18 at 12:00pm.

Refer to interview with the resident care manager (RCM) on 07/16/18 at 2:30pm.

Refer to interview with a representative from the computer software company used for the facility's electronic MARs on 07/17/18 at 12:50pm.

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D 392	Continued From page 165 Interview with a medication aide (MA) on 07/09/18 at 5:10pm revealed: -At the end of each shift, the oncoming MA would count and call out the number of any controlled substances in the medication cart. -The other MA would key the number into the electronic CS logs. -If there was a discrepancy, it would flag the system and they would have to get the RCM or MCM to correct the issue. -She thought the discrepancies were sometimes caused by the MAs forgetting to document prn (as needed) controlled substances on the MAR or on the CS log. -They also had issues with the internet network and it would cause the numbers not to match up. Interview with a second MA on 07/17/18 at 2:31pm revealed: -At the end of each shift, the MAs count the controlled substances with the oncoming MA. -If the internet went down, sometimes the electronic CS log would take off more tablets than were administered. -The RCM or MCM would have to go into the computer system to correct the counts. -The internet at the facility was not working from 06/28/18 - 07/02/18 and they had to print and use paper MARs and CS logs. Interview with the MA/supervisor (MA/S) on 07/16/18 at 1:12pm revealed: -The MAs were supposed to document the administration of controlled substances on the MAR and the CS log at the same time. -They had issues with the electronic CS screen because the system would keep going back to that screen after they clicked on it so they may click on the CS log screen again to get the	D 392		

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computer to move on to the next screen.
-The extra clicking would cause the CS log to be inaccurate.

Interview with the Administrator on 07/11/18 at 12:00pm revealed:
-The CS count and the CS log sometimes varied because of internet issues.
-They were always able to go back and account for any discrepancies because it was usually related to the MAs clicking too many times on the electronic CS log screen.
-The resident care manager (RCM), the memory care manager (MCM), and the Administrator were the only ones that had access to go into the computer system and correct the CS log count.
-The MAs counted all controlled substances at the end of each shift prior to the next MA taking over the keys to the carts.
-The MAs counted the controlled substances and entered the quantity on hand into the electronic system.
-The MAs could not see a current balance on the computer screen so they had to enter the amount they actually counted.
-If the amount entered during shift counts by the MAs did not match the balance on the CS logs, they would have to count a second time and re-enter the number.
-If it did not match the second time, the MAs had to get either the RCM or the MCM to correct the count in the electronic system or the computer would lock the MA out of the system.
-The RCM or MCM would do an inventory adjustment to correct any extra clicks made by staff.
-These adjustments were usually made at the end of a shift when the shift counts were done but the extra clicks causing the CS log to be inaccurate may have occurred at the beginning of

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D 392	Continued From page 167 the shift. -The CS logs would not accurately reflect the quantity on hand until the adjustments were made at the end of the shift. Interview with the resident care manager (RCM) on 07/16/18 at 2:30pm revealed: -The issue with the CS logs was more of an issue with the internet not working well at the facility. -She and the memory care manager (MCM) would have to correct the count at the end of the shift if the balance counted did not match the balance on the CS log. -They would correct by documenting received or wasted to get the count to match. -The discrepancies on the CS log were mostly caused by staff clicking more than once when they were having issues with the internet. Interview with a representative from the computer software company used for the facility's electronic MARs on 07/17/18 at 12:50pm revealed: -In June 2018, the computer system was timing out for 10 seconds and staff were clicking twice on the CS log screen and not giving the system enough time to move to the next screen. -They updated the computer system on 06/02/18 to take care of the time out problem. -She was not aware the facility was still having problems with the electronic CS logs timing out. -No one from the facility had notified her. -There were drop down boxes that allowed staff to note administered, received, returned, or wasted doses. -Staff could also make comments for explanations if needed but they had to manually input the comment. -The facility's internet went down from 06/28/18 - 07/02/18 and they were not able to use the electronic MARs.	D 392		

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D 392	Continued From page 168 -The facility could use the offline version and print MARs to document during that time. -She was scheduled to do routine training on 07/18/18 on the electronic MAR system that had been planned previously since the system was new to the facility.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure injuries of unknown origin were reported to the Health Care Personnel Registry for 2 of 4 sampled residents (#3, and #8) who had large bruises on both sides of the chest (#3), and bruises to the side and back on two separate occasions (#8). The findings are: 1. Review of Resident #3's current FL-2 dated 03/08/18 revealed diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease and hypotension. Telephone interview with Resident #3's Power of	D 438		

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Attorney (POA) on 07/13/18 at 9:41am revealed:
-There was an incident where Resident #3 had bruises which were purple and yellow and went all the way across his chest.
-Staff were never able to say what happened to Resident #3.

Telephone interview with Resident #3's family member on 07/13/18 at 10:00am revealed:
-She was concerned about finding bruises that were already yellow on 06/30/18 on Resident #3's chest.
-If the staff was changing Resident #3's shirt every day they would have noticed bruises that went from his "collar bones down to his pecs [sic]."

Review of a photo of Resident #3's chest revealed:
-The photo was dated and time stamped for 06/30/18 at 11:49am.
-There were yellow bruises on both sides of Resident #3's chest with scattered small areas of purple and red at the center of the right sided, chest bruise.
-Both bruises extended from approximately the breast line to the neck area of the collar bones.
-The bruise on the right side was darker in color and larger in size.

Interview with a personal care aide (PCA) on 07/13/18 at 1:00pm revealed:
-She had documented providing assistance with dressing Resident #3 on 06/26/18 and 06/27/18, but had not noticed any bruising on the resident's chest.
-She saw the bruises on Resident #3's chest when the family reported the bruises (06/29/18) "because they were faded".
-She reported the bruises on Resident #3's chest

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to the MA the same day (06/29/18).

Interview with a second PCA on 07/13/18 at 10:57am revealed:
-She had not seen the bruises on Resident #3's chest.
-Her name was on Resident #3's record as assisting Resident #5 with dressing on 06/28/18, but that did mean she actually assisted Resident #3 because sometimes she would enter her pin number into the electronic record for another PCA to document.
-Sometimes, staffs' pin numbers did not work.

Interview with a medication aide (MA) on 07/11/18 at 5:52am revealed:
-She had seen the bruises on Resident #3's chest approximately two weeks ago (06/29/18).
-The bruises were yellow at that time "like it was trying to clear up" and covered from the breast area to just under the shoulder area on one side.
-She did not know what caused the bruises on Resident #3's chest.

Telephone interview with a second MA on 07/18/18 at 10:03am revealed:
-She could not recall off hand documenting that she assisted with dressing Resident #3 on 06/24/18 and 06/29/18 because she did not have the record available for review.
-She only worked weekends at the facility and could not remember anything other than what she documented in a resident's record.

Review of an electronic progress note dated 06/29/18 at 10:00am revealed:
-The Resident Care Manager (RCM) documented Resident #3's family member reported Resident #3 had bruising on his chest.
-The RCM documented she assessed Resident

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#3 and the resident did not complain of pain.
-The RCM documented the PCP was notified and an order for an x-ray was obtained.
-There was no documentation of the size, color or character of the bruises on Resident #3's chest.

Interview with the Resident Care Manager (RCM) on 07/13/18 at 4:40pm revealed:
-There was no bruising of any nature when she saw Resident #3's chest on the day the family reported the bruises (06/29/18).
-When she saw Resident #3's chest, the area was red, not bruised; she did not know what happened to Resident #3.
-She notified the doctor and completed an incident report.
-The Administrator was responsible for completing the 24 hour and 5 day reports so she did not know if the reports had been done for the bruising on Resident #3's chest.

Interview with the Administrator on 07/11/18 at 12:05pm revealed:
-She was not sure if a 24 hour initial and 5 working day report had been completed for the bruises on Resident #3's chest.
-The RCM had interviewed the personal care aides and no one knew of a fall for Resident #3.

Interview with the Administrator on 07/11/18 at 4:35pm revealed a 24 hour initial report and 5 day working report, including an investigation, had not been done for the bruises to Resident #3's chest found on 06/29/18.

Refer to interview with the Administrator on 07/11/18 at 12:05pm.

2. Review of Resident #8's current FL-2 dated 09/19/17 revealed:

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D 438	Continued From page 172 -Diagnoses included dementia without behavioral disorder, altered mental status, chronic atrial fibrillation, type II diabetes mellitus, history of falls, muscle weakness, unsteady on feet and anxiety. -Resident #8 was intermittently disoriented, had wandering behaviors and was semi-ambulatory with the use of a wheelchair. a. Review of an incident report dated 11/03/17 for Resident #8 revealed: -A personal care aide (PCA) found bruising on Resident #8's left side while toileting the resident at 1:45am. -Resident #8 was sent to the emergency department (ED) and diagnosed with bruising of the left side and hypertension. -Resident #8's power of attorney (POA) and primary care provider (PCP) were notified. Telephone interview with the PCA on 07/18/18 at 9:56am revealed she found the bruise on Resident #8's side on 11/03/17, but did not remember the specific incident of Resident #8 having bruises on her side or what was done for Resident #8 after the bruises were found. Telephone interview with Resident #8's Power of Attorney (POA) on 07/17/18 at 7:58pm revealed: -In January 2018, Resident #8 had "pretty ugly bruises on her arm and leg," but he did not recall seeing a bruise on her left side. -Staff were not able to say what happened to cause the bruises to Resident #8. b. Review of an incident report dated 01/30/18 for Resident #8 revealed: -A MA observed a bruise and swelling on the right side of Resident #8's back at 3:30pm. -There was no documentation that Resident #8	D 438		

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had a fall.
-Resident #8 was sent to the ED and diagnosed with a fall and a back contusion.
-Resident #8's POA and PCP were notified.

Review of care notes and electronic progress notes for Resident #8 revealed there was no documentation of a fall in January 2018.

Telephone interview with the PCA on 07/18/18 at 11:46am revealed:
-She was giving Resident #8 a shower and found the bruise on Resident #8's back which was purple and looked like it was a new bruise.
-She reported the bruise the MA and did not know what happened after that.

Telephone interview with the MA on 07/18/18 at 10:56am revealed she remembered Resident #8 having a bruise on her back on 01/30/18, but she could not recall which side or if the bruise came from a fall and what was done to protect Resident #8 from future injuries.

Telephone interview with Resident #8's POA on 07/17/18 at 7:58pm revealed the bruise in January 2018, was on Resident #8's back near the kidney area which was "a very peculiar place to come from a fall;" the staff were not able to say what happened to Resident #8.

Telephone interview with the Memory Care Manager (MCM) on 07/18/18 at 12:25pm revealed:
-If she signed the incident report then she had been made aware, but she could not remember the specifics of Resident #8 having had a bruise on her side on 11/03/17 or a bruise on her back on 01/30/18.
-She did not know if a 24 hour initial and 5

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D 438	Continued From page 174 working day report had been completed for Resident #8 for the injuries on 11/03/17 and 01/30/18. -Normally the Administrator completed the 24 hour and 5 day reports; if the Administrator was out sick or on vacation, the MCM completed the reports. Review of a faxed response from the Administrator dated 07/18/18 revealed there were no 24 hour initial reports, investigations or 5 working day reports completed for Resident #8 for the left side bruises on 11/03/17, and the right back bruise on 01/30/18. Refer to interview with the Administrator on 07/11/18 at 12:05pm. Interview with the Administrator on 07/11/18 at 12:05pm revealed: -Typically the Resident Care Manager (RCM) or Memory Care Manager (MCM) completed the 24 hour initial and 5 working day reports and she helped with the investigation. -"It really just depended on who had more time." The facility failed to report injuries of an unknown origin for 2 of 4 sampled residents. The failure of the facility to report injuries sustained by Residents #3 and #8 within 24 hours and to conduct an investigation into the cause of the injuries for each resident placed Residents #3 and #8 at risk for further injury from the unidentified cause. The noncompliance was detrimental to the safety and wellbeing of Residents #3 and #8 which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/18 for	D 438		

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D 438	Continued From page 175 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 2, 2018.	D 438		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the Power of Attorney for an	D 454		

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unwitnessed and undocumented fall which occurred two days prior to the resident's (#8) death at the facility.

The findings are:

Review of Resident #8's current FL-2 dated 09/19/17 revealed diagnoses included dementia without behavioral disorder, altered mental status, chronic atrial fibrillation, type II diabetes mellitus, history of falls, muscle weakness, unsteady on feet and anxiety.

Review of an incident report dated 07/18/18 for Resident #8 revealed:
-A MA observed Resident #8 face down on the floor in her room with no injury noted on 06/30/18 at 4:06pm.
-There was a notation that the doctor and the family member were notified on 06/30/18 at 4:09pm.
-The form documented the report was completed on 07/18/18 at 4:09pm.
-There was no documentation the report was reviewed by the Administrator or the Memory Care Manager (MCM)

Attempted interview with the MA on 07/19/18 was unsuccessful.

Review of electronic progress notes for Resident #8 revealed the last entry was dated 06/23/18 and there was no documentation of Resident #8 falling on 06/30/18.

Review of care notes for Resident #8 revealed the last entry was dated 04/10/18 and there was no documentation of Resident #8 falling on 06/30/18.

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D 454	Continued From page 177 Review of fax notifications to Resident #8's primary care provider (PCP) revealed there was no fax notification to the PCP regarding Resident #8 falling on 06/30/18. Telephone interview with Resident #8's Power of Attorney (POA) on 07/18/18 at 6:30pm revealed he did not know anything about Resident #8 having had a fall two days (06/30/18) before she died on 07/02/18. Telephone interview with the PA on 07/19/18 at 10:40am revealed she was not notified of Resident #8 falling on 06/30/18 because Resident #8 was managed by hospice, so staff would have notified hospice. Telephone interview with a hospice LPN on 07/18/18 at 10:13am revealed: -The facility staff notified hospice Resident #8 was found on the floor on 06/30/18. -The facility staff reported Resident #8 was found on the floor at the end of her bed and had apparently tried to get up and walk. -The facility staff reported Resident #8 did not have any injuries from the fall. Interview with a medication aide (MA) on 07/11/18 at 5:39am revealed: -Resident #8 died at the facility (07/02/18). -Resident #8 fell just before she died, but the MA could not remember the details. -Whenever there was an incident or accident involving a resident, the MA charted a note in the computer system and completed an accident and incident report on the computer. -If the computer was down, the MA wrote a note in the resident's chart. -The MA contacted the doctor and the family.	D 454		

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D 454	Continued From page 178 Telephone interview with the MCM on 07/18/18 at 12:25pm revealed: -She could not recall the specifics of each of Resident #8's falls and injuries. -If she signed the incident report, then she was made aware at the time of the incident. -She was not aware that Resident #8 fell on 06/30/18. Telephone interview with the Administrator on 07/19/18 at 12:09pm revealed she was not aware Resident #8 fell on 06/30/18 or any notifications to the doctor or family member.	D 454		
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: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of Special Care Unit residents on 17 of 36 shifts resulting in inadequate staff to supervise residents, provide personal care assistance such as bathing, dressing, toileting and nail care with respect and	D 465		

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dignity; and to assure health care follow up and implementation.

The findings are:

Confidential interview with a family member revealed:
-The family member had visited the special care unit (SCU) daily and would frequently see staff "hang out" in the television room off of the dining room "braiding each other's hair" and "on cell phones" during 2nd shift.
-The family member could not remember the date, but recalled visiting on an evening shift where there were just two aides, one personal are aide (PCA) and one medication aide (MA) working on the SCU.
-The family member went around the entire SCU and counted the names on the doors and there were 44 residents.
-Most times there were just four aides total on the 1st shift; it was hard to tell whether the staff was a PCA or an MA.

Confidential interview with a second family member revealed:
-"Sometimes they (the facility) is short of help."
-"They (the facility) turn over staff a lot."

Confidential interview with a staff revealed "we are very short staffed."

Confidential interview with a second staff revealed a couple of months ago, there were only 3 PCAs and 1 MA working on third shift in the SCU.

Interview with a MA on 07/09/18 at 1:10pm revealed:
-First shift staff hours were from 7:00 a.m. to 3:00

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p.m.
-Second shift staff hours were from 3:00 p.m. to 11:00 p.m.
-Third shift staff hours were from 11:00 p.m. to 7:00 a.m.

Interview with the Administrator on 07/16/18 at 6:10pm revealed:
-There was no record of a staffing schedule that specified which staff worked on the assisted living (AL) side and which staff worked on the SCU each shift.
-When staff reported to work on each shift, a dry erase board was used to note which staff were working on each side of the facility.
-Staff who were training were not counted in the required aide hours.
-The Resident Care Manager (RCM) was usually available Monday through Friday from 8:30am - 5:00pm to work as an aide if needed.
-The Administrator would assist the RCM or Memory Care Manager (MCM) with their duties if they were filling in and providing care to residents.

Upon request census reports for 03/02/18, 03/03/18, 03/04/18, 04/08/18, 04/09/18, 05/23/18, 05/24/18, 06/26/18, 06/27/18, 06/28/18, 07/07/18 and 07/08/18 were not available for review.

Review of the "Punch Detail" timecard report dated 03/02/18 revealed:
-There was a handwritten entry at the top of the page that noted the census in the SCU was 42 which required 42 hours of staff time for first and second shift.
-There were 35.79 staff hours provided on first shift leaving the SCU short 6.21 aide hours.
-There were 36.16 staff hours provided on second shift leaving the SCU short 5.84 aide

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hours.

Review of the "Punch Detail" timecard report dated 03/03/18 revealed:
-There was a handwritten entry at the top of the page that noted the census in the SCU was 42 which required 42 hours of staff time for second shift.
-There were 37.78 staff hours provided on second shift leaving the SCU short 4.22 aide hours.

Review of the "Punch Detail" timecard reports dated 04/08/18 revealed:
-There was a handwritten entry at the top of the page that noted the census in the SCU was 43 which required 43 hours of staff time for the first shift.
-There were 35.42 staff hours provided on first shift leaving the SCU short 7.58 aide hours.

Review of the "Punch Detail" timecard reports and time adjustment sheets dated 04/09/18 revealed:
-There was a handwritten entry at the top of the page that noted the census in the SCU was 43 which required 43 hours of staff time for the first and second shifts, and 34.4 hours of staff time for the third shift.
-There were 35.43 staff hours provided on first shift leaving the SCU short 7.57 aide hours.
-There were 30.28 staff hours provided on second shift leaving the SCU short 12.72 aide hours.
-There were 20.37 staff hours provided on third shift leaving the SCU short 14.03 aide hours.

See Tag 270, Finding #1 and #3.

Review of the "Punch Detail" timecard reports

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D 465	Continued From page 182 dated 05/23/18 revealed: -There was a hand written entry at the top of the page that noted the census for the SCU was 48 residents which required 48 hours of staff time for first and second shift, and 38.4 hours of staff time for third shift. -There were 45.35 staff hours provided on first shift leaving the SCU short 2.65 aide hours. -There were 42.07 staff hours provided on second shift leaving the SCU short 5.93 aide hours. Review of the "Punch Detail" timecard reports dated 06/26/18 revealed: -There was a handwritten entry at the top of the page that noted the census in the SCU was 45 which required 45 hours of staff time for the first shift and 36 hours of staff time for the third shift. -There were 33.02 staff hours provided on first shift leaving the SCU short 11.98 hours. -There were 31.06 staff hours provided on third shift leaving the SCU short 4.94 hours. Review of the "Punch Detail" timecard reports dated 06/27/18 revealed: -There was a handwritten entry at the top of the page that noted the census in the SCU was 45 which required 45 hours of staff time for the first shift. -There were 25.58 staff hours provided on first shift leaving the SCU short 19.42 hours.. Review of the "Punch Detail" timecard reports dated 06/28/18 revealed: -There was a handwritten entry at the top of the page that noted the census in the SCU was 45 which required 45 hours of staff time for the first shift. -There were 21.80 staff hours provided on first shift leaving the SCU short 23.20 hours.	D 465		

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D 465	Continued From page 183 See Tag 270, Finding #3. Review of the "Punch Detail" timecard report dated 07/07/18 revealed: -There was a handwritten entry at the top of the page that noted the census in the SCU was 43 which required 43 hours of staff time for the first and second shifts. -There were 25.6 staff hours provided on first shift leaving the SCU short 17.4 aide hours. -There were 22.75 staff hours provided on second shift leaving the SCU short 20.25 aide hours. Review of the "Punch Detail" timecard report dated 07/08/18 revealed: -There was a handwritten entry at the top of the page that noted the census in the SCU was 43 which required 43 hours of staff time for the first and second shifts, and 34.4 hours of staff time for the third shift. -There were 33.27 staff hours provided on first shift leaving the SCU short 9.73 aide hours. -There were 28.93 staff hours provided on third shift leaving the SCU short 4.31 aide hours.. Confidential interviews with a staff revealed: -The facility wasn't like this before, it was hard to keep good staff because of the workload. -Staff had to help pass out and clean up the plates in the dining room, wash residents' personal laundry and try to take care of the residents; "it was too much". -A lot of staff left because of the "kind of residents" that were in the SCU; residents who had dementia with behaviors such as being combative with staff, urinating on the floor, smearing feces everywhere and trying to eat off the floor and from other residents' plates.	D 465		

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D 465	Continued From page 184 Interview with the MCM on 07/19/18 at 11:31am revealed: -She made the schedule for the nursing staff (MAs and PCAs) for the whole facility, SCU and AL every two weeks. -There were usually changes in the schedule at least once or twice in a two week period. -A staff person from the SCU usually covered the 1 hour break for the third shift staff on the AL if there was only 1 staff assigned to the AL. -Staff on break do not leave the premises while on their 1 hour break. -If staff called out, she tried to find coverage. -If she was unable to find coverage, someone was supposed to stay until a relief staff person came to the facility. -If no staff volunteered to stay to cover a shift, they would draw a name out of a hat. -Management staff also stayed to cover shifts "a lot" from week to week. -She had to fill in this morning to do the medication pass in the SCU to cover staffing. -It was routine for staff to work double shifts at times to cover the shortages. -There was a lot of staff turnover and it was difficult to find new employees in their location. -She thought staffing had gotten better recently. Interview with the Administrator on 07/19/18 at 12:07pm revealed: -Staff got a 1 hour break during their shift but they were not allowed to leave the building while on break. -If a resident needed something while staff was on break, the expectation was that staff would clock back in and help. -Sometimes staff may work part of their shift on the AL side and part of the shift in the SCU.	D 465		

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D 465	Continued From page 185 The facility failed to assure adequate staffing to meet the needs of Special Care Unit (SCU) residents on 17 of 36 shifts. The failure resulted in Resident #2 falling and experiencing a head injury on 1st shift on 04/09/18 which was short 7.57 aide hours; Resident #8 falling out of bed with a side rail, bed alarm and floor mat in use and sustained a traumatic head hematoma and fractured right hip on the 3rd shift on 04/09/18 which was short 14.03 aide hours; and Resident #2 having an unwitnessed fall and sustaining a wrist fracture on 1st shift on 06/28/18 which was short 24 aide hours. The facility's failure placed residents at substantial risk for serious harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/19/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 18, 2018.	D 465		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure residents were treated with respect and dignity as	D911		

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evidenced by Resident #11 being separated from, but in view of other residents during meals and served meals after the meal time; by Resident #12 being told to soil herself with urine and feces by staff instead of assisting the resident with toileting as requested by Resident #12; and by Resident #20 being talked to in loud, disrespectful tone.

The findings are:

1. Review of Resident #11 FL-2 dated 03/15/18 revealed:
-Diagnoses included: dementia, osteoarthritis, hypothyroidism, post-traumatic stress syndrome, aphasia, hyperlipidemia, traumatic brain injury, history of thyroid cancer, bradycardia, chronic cognitive disorders, renal tubular dysgenesis and dementia with behavioral disturbances.
-The resident was constantly disoriented.

Review of Resident #11's care plan dated 03/20/18 revealed:
-Resident #11 required limited assistance with mobility and eating.
-There was no documentation that Resident #11 required supervision during meals.

Observation of Resident #11 on 07/09/18 at 11:30am revealed:
-Resident #11 was standing in the TV room.
-The resident was looking through the large window watching other residents eat lunch in the dining room.
-The door from the TV room into the dining room was locked.

Observation of Resident #11 on 07/09/18 at 11:57pm revealed:
-One of the staff opened the locked door between

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the TV room and the dining room.
-The residents requiring feeding assistance came into the dining room to get lunch.
-The resident was sitting while eating for part of his lunch.
-The resident stood up while eating the second part of his lunch.
-The resident did not use eating utensils and ate with his hands.
-The resident dropped part of his meal on the floor of the dining room.
-The personal care aide (PCA) sitting next to Resident #11 told him not to eat off of the floor.
-Resident #11 ate the food that dropped on the floor.

Observation of Resident #11 on 07/09/18 at 12:18pm revealed his shirt had large food stains all over the front area.

Interview with a PCA on 07/10/18 at 8:53am revealed:
-Resident #11 "had his behaviors".
-The resident could be aggressive but that was mostly in the dining room.
-Resident #11 could be redirected when he was aggressive.

Interview with a second PCA on 07/10/18 at 9:16am revealed Resident #11 took food off of other resident's plates in the dining room.

Interview with a third PCA on 07/10/18 at 10:15am revealed Resident #11 "would rather have someone else's food".

Observation of Resident #11 on 07/10/18 at 12:12pm revealed:
-There were 3 residents, including Resident #11, in the TV room that was adjacent to the dining

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room.
-Resident #11 was pacing from the window to look at the other residents eating lunch, to the locked door and to the couch several times.
-When the resident looked out of the window into the dining room, he had his hands down his pants or was picking at an area on his wrist.
-The resident bit his fingernails intermittently.
-The resident picked something up off of the couch and ate it.
-There was no staff in the TV room with the residents.

Confidential interview with a resident revealed:
-Resident #11 urinated in the hallway about 11:00pm one night this week and staff were "screaming at him" then put Resident #11 in his room.
-Resident #11 always put his hands in other residents' plates and picked up food from the floor and ate it.
-Staff would put Resident #11 in the TV room during meals and shut the door.
-Staff would not let Resident #11 out of the TV until all of the residents had eaten.

Observation of dining room on 07/11/18 from 7:44am to 8:44am revealed:
-Residents were served breakfast.
-Resident #11 was not in the dining room during breakfast.

Interview with a fourth PCA on 07/11/18 at 8:44am revealed:
-The resident had not eaten breakfast.
-She thought the medication aide (MA) checked to see if Resident #11 ate breakfast that day.
-She thought Resident #11 was in his room.

Observation of Resident #11 at 07/11/18 at

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D911	Continued From page 189 8:48am revealed the resident was asleep on the couch in the TV room adjacent to the dining room. Interview with a MA on 07/11/18 at 8:48 am revealed: -She did not check on Resident #11 to see if he ate breakfast. -After prompting, she asked the kitchen for a breakfast plate for Resident #11. Observation of Resident #11 on 07/11/18 at 8:58am revealed: -The resident was served a breakfast of reheated scrambled eggs, reheated oatmeal, mandarin oranges, orange juice and milk. -The resident was being fed by a PCA. -The resident attempted to reach for the food several times during the meal. -The PCA did not allow the resident to feed himself. Interview with a fifth PCA on 07/11/18 at 9:01am revealed: -The resident always ate with his hands. -Resident #11 never used utensils. -The resident was being fed because "this food just came out of the microwave and it's hot". Observation of the TV room adjacent to the dining room on 07/11/18 at 12:05pm to 12:10pm revealed: -Resident #11 was asleep on the couch. -Two other residents that required feeding assistance were looking through the window at the other residents that were eating. -One of the residents who was looking through the window was tapping on the glass of the window. -The resident was asleep on the couch in the TV	D911		

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room.
-The PCA brought Resident #11 into the dining room.
-The resident was served lunch at 12:15pm in the dining room.

Interview with a second MA on 07/11/18 at 6:30am revealed:
-The resident was unable to speak and "doesn't communicate at all".
-Resident #11 wanted to stand up while eating.
-The resident ate food off of other resident's plates.

Interview with the memory care manager (MCM) on 07/11/18 at 12:15pm revealed:
-She watched at least one meal per shift at least once per week.
-Resident #11 was "somewhat challenging to redirect".
-Resident #11 was "hard to care for because of communication".
-She had not thought of feeding Resident #11 before the other residents.
-She had not thought of offering finger foods to Resident #11.

Observation of Resident #11 on 07/12/18 at 5:30pm revealed he was locked in the TV room with his hands in his pants while looking into the dining room through the window at other residents eating dinner.

Interview with a sixth PCA on 07/19/18 at 4:40pm revealed Resident #11 "picked off the plates" of other residents.

Interview with the Administrator on 07/11/18 at 12pm revealed:
-She was not aware that Resident #11 was being

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held in the TV room while other residents ate their meals first.
-It had been discussed with staff about using a feeding table or having the resident sit at a table with staff.
- Staff should not take Resident #11 into the television room during meal times when other residents were eating.

2. Review of Resident #12's current FL-2 dated 02/09/18 revealed:
-Diagnoses included dementia, type II diabetes mellitus, hypothyroidism, atrial fibrillation and back pain.
-Resident #12 was continent of bladder and bowel and used a hearing aid.

Review of Resident #12's current care plan dated 07/17/18 revealed:
-Resident #12 was ambulatory with a wheeled walker and used a hearing aid.
Resident #12 had occasional bladder and bowel incontinence.
-There was a notation under toileting that Resident #12 was assisted to the bathroom every two hours and as needed for incontinence.

Interview with Resident #12 on 07/10/18 at 8:55am revealed:
-She did not hear very well and preferred questions and comments be written using an erase board and she would answer verbally.
-Staffed checked on her "maybe once" throughout the day; "I hardly see them at all except when I have to move my bowels, then I pull the string up there and then they're forever coming."

Observations on 07/10/18 from 8:55am until 9:20am revealed:

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D911	Continued From page 192 -Resident #12 stated she needed to use the bathroom and pulled the call light at 8:59am. -A PCA entered the room at 9:06am and asked Resident #12 what she needed. -Resident #12 told the PCA she needed to use the bathroom; the PCA told the resident to "just go ahead and go in your diaper". -The PCA then told Resident #12 she would be back to change her; Resident #12 stated, "I think I've already messed up my diaper". -The PCA assisted Resident #12 with incontinence care; there were no reddened areas or wounds on Resident #12's buttocks or groin area. Interview with the personal care aide (PCA) on 07/10/18 at 9:06am revealed staff "usually just let (Resident #12) go in her diaper and then come back". Second interview with the PCA on 07/13/18 at 11:45am revealed: -Staff normally had Resident #12 "go" in her brief. Resident #12 would then pull the call light and staff would come in and change her brief. -The hospice PCA had gotten Resident #12 up to the bathroom, but she never had gotten the resident up out of the bed. -She was "just doing what she had been told" by the medication aides (MAs). Telephone interview with Resident #12's Power of Attorney (POA) on 07/19/18 at 7:04am revealed: -Getting Resident #12 up for 30 minutes before and after meals was an order she requested because there was so many problems with the aides getting Resident #12 up. -When Resident #12 returned to the facility from the hospital after breaking her hip, the doctors had said not to get Resident #12 up out of bed.	D911		

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D911	Continued From page 193 -There was a staff who was insistent that Resident #12 got up so that she would heal faster. -The POA had to have many conversations with the Memory Care Manager (MCM) and Administrator about not getting Resident #12 up before she healed from the hip fracture; this might have been where the confusion came with getting Resident #12 up or not. -Since then, there was an order to get Resident #12 up out of the bed for meals; if Resident #12 was allowed to get up for meals, she was certainly allowed to get up to use the bathroom. Telephone interview with the Memory Care Manager (MCM) on 07/18/18 at 12:25pm revealed: -Resident #12's POA did not want Resident #12 to be moved after the resident broke her hip (04/16/18). -The order written to get Resident #12 up, only stated to get the resident up for meals so staff would get Resident #12 up then. -The facility had to be cautious and respect the POA's concerns related to Resident #12's care. -The MCM and the Administrator have had conversations with staff about getting Resident #12 up if the resident asked because that was her right. 3. Confidential interview with a resident revealed: -Staff talk loud and disrespectful to the resident and other residents in the SCU. -Staff gave the resident "dirty looks" at times and were not friendly. -Staff C "ordered" residents around and told them what to do. -Staff H talked "mean" to the residents and "bosses" them around.	D911		

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D911	Continued From page 194 Review of Resident #20's current FL-2 dated 08/24/17 revealed: -Diagnoses included dementia of the Alzheimer's type with behavioral disturbance and major depressive disorder (single episode - severe). -The resident was intermittently disoriented. Confidential interview with a resident revealed: -Staff would sometimes "holler" at Resident #20 when they changed Resident #20's incontinence briefs. -Staff would talk loud and say "turn over" to Resident #20 in a "stern and disrespectful" manner. -If Resident #20 did not turn over, staff would "yell" at the resident. Interview with Staff H on 07/13/18 at 10:57am revealed: -She stated, "I have always been told, it was not what I say but how I said it ...can be a little street sometimes." -Being street meant being blunt and "sassy," but she did not mean anything bad by talking that way. -She knew how she spoke to coworkers and residents was something she needed to work on. -She was not intentionally rude or disrespectful, it was just how she was. Based on observations, interviews, and record reviews it was determined Resident #20 was not interviewable. _____ The facility failed to assure each resident was treated with dignity and respect by placing Resident #11in a room adjacent to the dining room in full view of other residents who were eating their meals; by instructing Resident #12, who was otherwise continent, to urinate and	D911		

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D911	Continued From page 195 defecate in an incontinent brief; and by yelling and talking disrespectfully to Resident #20 while staff provided personal care. The facility's noncompliance was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/11/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 2, 2018.	D911		
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 observations, interviews and record reviews, the facility failed to ensure each resident received the services necessary to maintain their physical health, safety and wellbeing, as related to the implementation of residents' rights; personal care, supervision, health care referral, follow up and implementation; special care unit staffing, nutrition and food service and health care personnel registry. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to assure the	D914		

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	HAL084009	A. BUILDING: _____ B. WING _____	R 07/19/2018

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D914	Continued From page 196	D914		

management, operations, and policies and procedures of the facility were implemented to maintain each residents' right which resulted in significant noncompliance with state rules and regulations related to personal care, supervision, health care, staffing in the special care unit, residents' rights, food and nutrition, health care personnel registry, and reporting incidents and accidents. [Refer to Tag 980 G.S.131D-25 Implementation (Type A1 Violation)]

2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 6 sampled residents (#2, #4, and #8) as evidenced by not performing 15 and 30 minute checks in acordance with the resident's care plan and the facility's falls management team protocol; and failing to assure safety devices such as bed and chair alarms, fall mats and side rails, as ordered, were in place for three residents (#2, #4, #8) at high risk to fall with histories of falls with injuries such as head traumas, bruises and skin tears (#2, #4, #8). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]

3. Based on observations, interviews, and record reviews, the facility failed to assure the routine and acute healthcare needs were met for 4 of 6 residents sampled (#1, #3, #4, #11) as related to failing to notify the physician of Resident #4's weakness and difficulty standing and walking and to follow up on a request for physical therapy and obtain a knee x-ray for Resident #4; failing to schedule podiatry care for Resident #1, a diabetic, who had long, ingrown, and thickened toenails; failing to notify the physician of chest bruises of unknown origin and combative behavior for Resident #3; and for behaviors involving eating and smearing feces for Resident

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D914	Continued From page 197 #11. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)] 4. Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of Special Care Unit residents on 17 of 36 shifts resulting in inadequate staff to supervise residents, provide personal care assistance such as bathing, dressing, toileting and nail care with respect and dignity; and to assure health care follow up and implementation. [Refer to Tag 465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A2 Violation)] 5. Based on observations, interviews and record reviews, the facility failed to assure the implementation of physician's orders for 2 of 5 sampled residents (#2 and #3) by not implementing a fall mat and bed alarm to prevent falls and injuries for Resident #2, who had a history of falls with head injuries; and an order to record meal intake after each meal for Resident #3 for three months. [Refer to Tag 276 10A NCAC 13F .0902(c) Health Care (Type A2 Violation)] 6. Based on observations, interviews and record reviews, the facility failed to assure residents were free of abuse as evidenced by allegations of at least four staff (Staff C, Staff G, Staff H and Staff I) handling residents roughly (#20) with three residents known to have bruises of an unknown origin (Resident #3, Resident #5 and Resident #20). [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights (Type B Violation)] 7. Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance (toileting, mouth care, dressing and nail care) in accordance with the care plan and	D914		

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D914	Continued From page 198 the needs of the residents for 3 of 7 sampled residents (Resident #1, #11, and #12). [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)] 8. Based on observations, interviews, and record reviews, the facility failed to assure foods were free from contamination related to a build-up substance in two ice machines, rusty shelves in the cooler and surrounding areas, dusty air vents, black build up under the storage racks and storage room shelving units that were cracked and peeling. [Refer to Tag 282 10A NCAC 13F .0904(a)(1) Nutrition and Food Service (Type B Violation)] 9. Based on observations, interviews and record reviews, the facility failed to assure injuries of unknown origin were reported to the Health Care Personnel Registry for 2 of 4 sampled residents (#3, and #8) who had large bruises on both sides of the chest (#3), and bruises to the side and back on two separate occasions (#8). [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)] 10. Based on observations, interviews and record reviews, the facility failed to assure residents were treated with respect and dignity as evidenced by Resident #11 being separated from, but in view of other residents during meals and served meals after the meal time; by Resident #12 being told to soil herself with urine and feces by staff instead of assisting the resident with toileting as requested by Resident #12; and by Resident #20 being talked to in loud, disrespectful tone. [Refer to Tag 911 G.S.131D-21(1) Residents' Rights (Type B Violation)]	D914		

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D980	Continued From page 199	D980		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' right which resulted in significant noncompliance with state rules and regulations related to personal care, supervision, health care, staffing in the special care unit, residents' rights, food and nutrition, health care personnel registry, and reporting incidents and accidents. The findings are: Confidential interview with a family member revealed: -Staff on the SCU frequently congregated in that little room with the windows while residents wandered up and down the halls with their pants falling down and no socks on, and rooms that were dirty. -There were four to five staff in the little room at a time "a lot" when the family came to the SCU. -The Administrator was made aware, but nothing changed.	D980		

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D980	Continued From page 200 Confidential interview with a second family member revealed: -Any concerns brought to the management (Administrator and/or Care Managers) about how residents were treated or cared for were negated to cover up the mismanagement of the facility. -The family member became afraid of reporting concerns out of fear of retaliation, that staff would mistreat the residents by ignoring and/or mistreating the residents. Confidential interviews with a staff revealed: -The facility wasn't like this before, it was hard to keep good staff because of the workload. -The staff were hired from "off the streets," they did not know anything about working with people who had dementia and complained about working on the SCU all the time. -There was not enough training for staff; watching videos did not help staff, they needed hands on training. 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 6 sampled residents (#2, #4, and #8) as evidenced by not performing 15 and 30 minute checks in acordance with the resident's care plan and the facility's falls management team protocol; and failing to assure safety devices such as bed and chair alarms, fall mats and side rails, as ordered, were in place for three residents (#2, #4, #8) at high risk to fall with histories of falls with injuries such as head traumas, bruises and skin tears (#2, #4, #8). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)] 2. Based on observations, interviews, and record reviews, the facility failed to assure the routine and acute healthcare needs were met for 4 of 6	D980		

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D980	Continued From page 201	D980		

residents sampled (#1, #3, #4, #11) as related to failing to notify the physician of Resident #4's weakness and difficulty standing and walking and to follow up on a request for physical therapy and obtain a knee x-ray for Resident #4; failing to schedule podiatry care for Resident #1, a diabetic, who had long, ingrown, and thickened toenails; failing to notify the physician of chest bruises of unknown origin and combative behavior for Resident #3; and for behaviors involving eating and smearing feces for Resident #11. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]

3. Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of Special Care Unit residents on 17 of 36 shifts resulting in inadequate staff to supervise residents, provide personal care assistance such as bathing, dressing, toileting and nail care with respect and dignity; and to assure health care follow up and implementation. [Refer to Tag 465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A2 Violation)]

4. Based on observations, interviews and record reviews, the facility failed to assure the implementation of physician's orders for 2 of 5 sampled residents (#2 and #3) by not implementing a fall mat and bed alarm to prevent falls and injuries for Resident #2, who had a history of falls with head injuries; and an order to record meal intake after each meal for Resident #3 for three months. [Refer to Tag 276 10A NCAC 13F .0902(c) Health Care (Type A2 Violation)]

5. Based on observations, interviews and record reviews, the facility failed to assure residents were free of abuse as evidenced by allegations of

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D980	Continued From page 202 at least four staff (Staff C, Staff G, Staff H and Staff I) handling residents roughly (#20) with three residents known to have bruises of an unknown origin (Resident #3, Resident #5 and Resident #20). [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights (Type B Violation)] 6. Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance (toileting, mouth care, dressing and nail care) in accordance with the care plan and the needs of the residents for 3 of 7 sampled residents (Resident #1, #11, and #12). [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)] 7. Based on observations, interviews, and record reviews, the facility failed to assure foods were free from contamination related to a build-up substance in two ice machines, rusty shelves in the cooler and surrounding areas, dusty air vents, black build up under the storage racks and storage room shelving units that were cracked and peeling. [Refer to Tag 282 10A NCAC 13F .0904(a)(1) Nutrition and Food Service (Type B Violation)] 8. Based on observations, interviews and record reviews, the facility failed to assure injuries of unknown origin were reported to the Health Care Personnel Registry for 2 of 4 sampled residents (#3, and #8) who had large bruises on both sides of the chest (#3), and bruises to the side and back on two separate occasions (#8). [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)] 9. Based on observations, interviews and record reviews, the facility failed to assure residents were treated with respect and dignity as	D980		

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D980	Continued From page 203 evidenced by Resident #11 being separated from, but in view of other residents during meals and served meals after the meal time; by Resident #12 being told to soil herself with urine and feces by staff instead of assisting the resident with toileting as requested by Resident #12; and by Resident #20 being talked to in loud, disrespectful tone. [Refer to Tag 911 G.S.131D-21(1) Residents' Rights (Type B Violation)] The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing personal care, supervision, health care, special care unit staffing, residents' rights, health care personnel registry and food service. The Administrator's failure to assure responsibility resulted in physical injuries including a fractured wrist (Resident #2), a scalp laceration requiring staples (Resident #4) and a fractured hip and traumatic hematoma of the head (Resident #8); and resulted in serious neglect including not receiving podiatry care for long ingrown thickened toenails having (Resident #1) who was a diabetic, behaviors involving eating non-edible items (feces and items off the floor), as well smearing feces and urinating in the common areas of the facility unaddressed with no intervention. The Administrator's failure to assure responsibility for implementation of rules and regulations governing assisted living facilities 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 on 07/19/18 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 18,	D980		

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D980	Continued From page 204 2018.	D980		