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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on January 15 - 18, 2019 and January 22, 2019.	D 000		
D 209	10A NCAC 13F .0604 (2-e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care Other Staffing The following describes the nature of the aide's duties, including allowances and limitations (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure personal care aides in the special care unit were not assigned dietary aide duties for each meal including table settings, preparing beverages and meal plates, clearing tables, cleaning the table, cleaning the dishes and cleaning the dining room. The findings are: Interview with the Executive Director (ED) on 01/15/19 at 9:58am revealed there were 14 residents in the special care unit (SCU). Observation of staff and residents in the SCU on 01/16/19 from 8:56am until 9:42am revealed: -At 8:56am, two female residents were walking	D 209		

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around in the hallway talking about finding a bathroom. A medication aide (MA) was at the opposite end of the hallway at the medication cart administering medications. The Special Care Director (SCD) was in the dining room wiping appliances with a cloth. A personal care aide (PCA) was in the dining room clearing dishes from the tables and wiping tables with a cloth. The two female residents opened the door to resident room #7, went inside, and closed the door. No staff observed the residents go into the room.
-At 9:00am, the PCA was still in the dining room setting tablets for the next meal. There were 4 residents sitting in the dining room who had already finished eating breakfast.
-At 9:02am, the SCD came to the dining room and told a male resident she was going to walk with the resident to his room to get a coat. The SCD and the resident walked out of the dining room and down the hall toward the activity room.
-At 9:05am, one of the female residents who went in resident room #7 came out of the room holding a wash cloth. The resident looked down the hallway, went back in the room, and closed the door. No staff were in the hallway near the resident.
-At 9:06am, both female residents came out of resident room #7 and walked down the hallway toward the activity room.
-At 9:07am, the SCD came back to the dining room and pushed a female resident in a wheelchair out of the dining room and down the hallway toward the activity room. The PCA was still in the dining room cleaning and setting up tables.
-At 9:08am, the SCD came back to the dining room and pushed a second female resident in a wheelchair out of the dining room and down the hallway toward the activity room. The PCA was

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still in the dining room cleaning and setting the tables.
-At 9:11am, the SCD came back to the dining room and pushed the last resident in a wheelchair out of the dining room and down the hallway toward the activity room. The PCA was still in the dining room cleaning and setting tables.
-At 9:15am, the medication aide (MA) was in the hallway at the medication cart, 11 residents were in the activity room with a personal care aide (PCA), the Special Care Director (SCD) was sweeping the kitchen and dining room floor and the second PCA was setting the tables.
-At 9:32am, the MA went to the activity room with the PCA and residents. The second PCA was gathering garbage in the dining room.
-At 9:36am, the second PCA returned to the SCU through the door to the main kitchen with an empty trash can she brought to the dining room.
-At 9:38am, the second PCA left the dining room with a wheeled cart of table linens and left through the door to the main kitchen.
-At 9:39am, the second PCA returned to the dining room.
-At 9:42am, the second PCA closed the dining room doors and walked toward the activity room.

Observations of the lunch meal on the SCU on 01/16/19 from 11:55am until 1:29pm revealed:
-At 11:55am, the SCD and the MA were in the dining room pouring beverages for each table.
-At 12:00pm, 9 residents were seated in the dining room.
-At 12:04pm, two additional residents were assisted to the dining room for a total of 11 residents seated in the dining room.
-At 12:09pm, the SCD was serving soup to residents seated in the dining room and the MA was removing unused clean dishes from tables.
-The MA served premade plates wrapped in a

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plastic wrap to residents at two tables near the exit door in the dining room.
-At 12:40pm, the MA was removing dirty dishes from the tables.
-At 12:48pm, the MA continued removing dirty dishes from tables, the SCD was assisting residents out of the dining room and then accompanied a male resident to room #6 and closed the door.
-At 12:54pm, the MA, a PCA and a second PCA were in the dining room.
-At 12:56pm, there were 6 residents in the activity room and there was no staff present.
-At 1:08pm, the two PCAs and the MA were cleaning the dining room and the AD was in the activity room with 9 residents.
-At 1:23pm, the MA left the SCU through the door to the main kitchen.
-At 1:29pm, the second PCA left the dining room toward the activity room.
-At 1:36pm, the PCA finished cleaning the dining room.

Interview with the SCD on 01/17/19 at 2:31pm revealed:
-She was not aware aides should not be assigned dietary responsibilities.
-She had discussed the concern with the Executive Director (ED) on 01/17/19 and there were plans to hire a dietary aide for the SCU.

Observations of the dinner meal on the SCU on 01/17/19 from 4:57pm until 6:15pm revealed:
-At 4:57pm, a PCA was pouring beverages for each table in the dining room and a MA was assisting a resident in the hall to the dining room.
-At 5:03pm, the PCA continued pouring beverages for tables in the dining room.
-A dietary aide brought three pitchers of beverages and left at 5:09pm.

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-At 5:10pm, the PCA was putting food on resident plates and serving residents.
-At 5:37pm three female residents from the same table stood to leave the dining room and the PCA said, "Hold on ladies, do you want dessert?"
-At 5:38pm, the PCA stopped assisting a resident with eating to serve the three female residents dessert.
-At 5:44pm, the PCA asked the second PCA to finish assisting the resident with eating.
-At 5:49pm the MA left the SCU.
-At 5:55pm, the PCA brought a garbage can to the dining room and the second PCA left the dining room a resident.
-The SCD was at the door of the activity room then walked to the dining room removed some dirty dishes from a few tables and went back to the activity room.
-At 6:05pm, the two PCAs were cleaning the dining room and the SCD was in the activity room with residents.
-At 6:16pm, the PCA was cleaning the dining room, the second PCA was feeding a resident in their room and the SCD was in the activity room with four residents.

Interview with a PCA on 01/15/19 between 3:48pm and 4:00pm revealed:
-She had worked on 2nd shift for approximately six months.
-There were two residents who wandered and a third resident staff kept an eye due to a history of a fall four months ago.
-There were two additional residents who required assistance with eating each meal.
-There were two PCAs for 2nd shift and a MA.
-The MA "floated" between the SCU and the 1st floor on the assisted living (AL).
-The PCAs were responsible for setting up the tables (table cloth, plate setting, and folded cloth

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napkin) for the meal, pouring beverages for each resident, preparing and serving resident plates and cleanup of the dining room when the meal was done.
-Clean up included loading the dishwasher, wiping off the counters and sweeping the floors.
-One PCA was responsible for cleaning the SCU kitchen and dining room and the second PCA would stay "out there (on the SCU)" with the residents.

Interview with a second PCA on 01/16/19 at 8:55am revealed:
-The PCAs would assist all of the residents to the dining room for breakfast once all of the residents were up and dressed.
-After breakfast, one PCA took the residents to the activity room and the 2nd PCA cleaned the kitchen and dining room.
-The PCA stayed with the residents in the activity room until the AD arrived or until the 2nd PCA was done with cleaning the kitchen and dining room.
-The PCA would then complete showers and incontinence care for residents.
-There were usually 1 to 3 showers to complete and all 7 of the residents assigned to the PCA needed incontinence care.
-After resident showers and incontinence care, the PCA took her meal break, then covered while the second PCA took their meal break.
-Residents would be taken to the dining room for lunch; there were two residents who needed total assistance with eating and another two residents who needed encouragement to eat.
-After lunch, one PCA took residents down to the activity room and the other cleaned the SCU kitchen and dining room.
-Cleaning included washing the dishes, cleaning the counter, switching out the table clothes,

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setting the table, sweeping the floor and taking out the garbage.
-It took approximately 30 to 45 minutes for a PCA to clean the SCU kitchen and dining room after each meal.
-There was one resident who needed extra attention because she liked to talk to staff frequently.
-There was a second resident who wandered back and forth in the halls and got agitated and combative toward two other residents.
-There was a third resident the PCAs had to check on because he preferred to stay in his room most of the time.
-After the SCU kitchen and dining room were cleaned, the PCAs did another round of incontinence care which brought them to the end of the 1st shift.

Interview with a MA on 01/15/19 at 4:45pm revealed:
-She was responsible for MA duties on the SCU and the 1st floor of the AL.
-There was one resident who needed total assistance with eating meals, a second resident who needed assistance with eating meals and two additional residents who needed coaching assistance with meals.
-The PCAs were responsible for cleaning the SCU kitchen and dining room after each meal.
-The PCAs were responsible for putting the dishes in the dish washer, sweeping the floors and resetting the tables with clean linens and clean dishes.
-One PCA cleaned the kitchen and dining room and the second PCA stayed with the residents.

Interview with the Wellness Coordinator on 01/18/19 at 3:25pm revealed:
-She had been the acting SCD from August 2018

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D 209	Continued From page 7 until December 2018. -It was a corporate plan to have the PCAs be responsible for dietary aide and housekeeping duties which took the PCAs away from resident care. -There had not been any events as a result, residents were "just unattended" (staff were not able to monitor residents while cleaning). -She had seen two PCAs cleaning the dining room together because they think they can do it faster that way. -She had told the staff to never leave residents unattended, one PCA with the residents and the other cleaned the dining room. Interview with the Executive Director (ED) on 01/17/19 at 6:30pm revealed she would have to follow up with the corporate office because they had made the decision on SCU staff being responsible for dietary aide duties. Interview with the ED on 01/22/19 at 6:13pm revealed: -It was a joint effort to clean the SCU kitchen and dining room. -Staff cleaning of the SCU kitchen and dining room should not interfere with resident care. -Cleaning of the SCU kitchen and dining room should include housekeeping and dietary staff.	D 209		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as	D 234		

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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, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 1 of 5 sampled residents (#3) was tested upon admission for Tuberculosis (TB) disease with a two-step TB skin test in accordance with the control measures adopted by the Commission for Health Services.

Review of Resident #3's current FL-2 dated 06/18/18 diagnoses included dementia.

Review of Resident #3's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 09/25/15.

Review of TB test results dated 09/30/15 for Resident #3 revealed:
-There was documentation of a TB skin test on 09/30/15 read on 10/02/15 with a negative result.
-There was no documentation of a second TB skin test.

Interview with the Wellness Coordinator (WC) on 01/18/19 at 3:25 pm revealed:
-I started working here in April 2018.
-Initial TB skin tests are done prior to admission.
-The Director of Resident Care has done some of the second steps.
-She was responsible for making sure the results are in the record.

Interview with the Special Care Director on

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D 234	Continued From page 9 01/18/19 at 2:25 pm revealed: -The DRC and WC were responsible for assuring the resident's TB skin test are done and recorded in the resident's record. -She did not know that Resident #3 did not have documentation of a second TB skin test. Interview with the Executive Director (ED) on 01/22/19 at 6:13pm revealed the Director of Resident Care (DRC) was responsible for assuring PPD's were completed and documented in the resident's record. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	D 234		
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 health care referral and follow up for 4 of 5 sampled residents (#2, #3, #4, #5) including failure to assure Resident #4 was seen by a gastroenterologist	D 273		

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and cardiologist following two hospitalizations for recurrent gastrointestinal bleeds; failure to notify Resident #4's primary care provider (PCP) that the resident was not wearing compression stockings for lower extremity edema; failure to notify Resident #3's PCP of a 33 pound weight loss from 06/23/18 to 01/18/19; failure to notify Resident #5's PCP of a refusal for a cardiology appointment following hospitalization for myocardial infarction and the resident having a pacemaker; and failure to notify Resident #2's PCP of Physical Therapy's concern about the use of a reverse wedge pillow in Resident #2's wheelchair being a possible restraint for Resident #2.

The findings are:

1. Review of Resident #4's current FL-2 dated 12/10/18 revealed:
-Diagnoses included gastrointestinal bleed, atrial fibrillation, coronary artery disease, bradycardia, chronic combined systolic and diastolic congestive heart failure, acute kidney injury, anemia, and Alzheimer's dementia.
-The resident was intermittently disoriented.
-The resident required assistance with dressing.

Review of Resident #4's assessment and care plan dated 05/21/18 revealed:
-The resident was oriented and his memory was adequate.
-The resident was independent with dressing.

a. Review of a note by Resident #4's primary care provider (PCP) dated 09/13/18 revealed:
-The resident had a fall that morning and was seen by the PCP.
-The PCP reviewed the resident's labwork and his hemoglobin was at 7.0, down from 12.0.

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-The resident had dark stool and a test for blood in the stool was positive.
-The resident needed to be sent to the emergency room (ER) as soon as possible.

Review of Resident #4's resident service note dated 09/13/18 revealed:
-The PCP notified the facility that the resident needed to go to the ER for low hemoglobin and needed a blood transfusion.
-The resident was sent to the ER.

Review of Resident #4's hospital discharge summary dated 09/19/18 revealed:
-The resident was admitted on 09/13/18 with chief complaint of blood in stool, low hemoglobin, and status post fall.
-The resident had a history of hypertension and atrial fibrillation and was receiving Eliquis, a blood thinner.
-The resident's blood work was done in the ER and his hemoglobin was 7.3 (reference range was 12.5 - 17.2).
-The resident was diagnosed with a gastrointestinal (GI) bleed.
-The resident was transfused with 2 units of blood.
-The resident was discharged on 09/19/18 and his hemoglobin was 8.7 on that day.
-The resident was to follow up with a GI physician in 7 to 10 days.

Review of Resident #4's physician visit notes and resident care notes revealed no documentation the resident had been seen by a GI physician after the hospitalization in September 2018.

Review of Resident #4's PCP visit note dated 12/06/18 revealed:
-The resident's hemoglobin was 6.4 which was

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confirmed on repeat analysis.
-The resident needed a full work up to rule out GI bleed.
-The resident had a history of dark stools.
-The resident may need to be transfused.

Review of Resident #4's resident service note dated 12/06/18 revealed the resident would be transported to hospital for blood transfusion due to low hemoglobin.

Review of Resident #4's hospital discharge summary dated 12/10/18 revealed:
-The resident was admitted to the hospital on 12/06/18 with chief complaint of low hemoglobin of 6.8.
-The resident had complaints of feeling weak and black colored stool.
-The resident was diagnosed with a recurrent GI bleed.
-GI and cardiology were consulted and Aspirin and Eliquis were stopped. (Aspirin and Eliquis thin the blood.)
-The Aspirin and Eliquis were to be held until his outpatient follow up appointment with cardiology.
-The resident's hemoglobin was 7.5 on 12/07/18 and 9.9 on 12/08/18.
-The resident was transfused with 3 units of blood during hospitalization.
-The resident's last hospital admission was in September 2018 with the diagnoses of a GI bleed.
-The resident had a history of chronic atrial fibrillation and congestive heart failure (CHF).
-The resident was noted to have bradycardia on Metoprolol (used to treat CHF) and it was discontinued.
-The resident had a follow up appointment with cardiologist on 12/18/18 to re-evaluate the plan for Aspirin, Metoprolol, and Eliquis.

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D 273	Continued From page 13 -The resident was to follow up with a GI physician in 2 weeks. Review of Resident #4's physician visit notes and resident care notes revealed no documentation the resident had been seen by a GI physician or a cardiologist after the hospitalization in December 2018. Interview with Resident #4 on 01/18/19 at 3:50pm revealed: -He had been to the hospital twice for GI bleeds. -He had not seen a GI physician to his knowledge. -He had a cardiologist before he was admitted to the facility but he had not seen a cardiologist since he was admitted to the facility. Interviews with the Director of Resident Care (DRC) on 01/22/19 at 12:45pm and 6:20pm revealed: -She did not know about Resident #4's referrals to see a GI physician after both hospital visits for GI bleeds in September 2018 and December 2018. -She did not know if Resident #4 had seen a GI physician. -She did not know about Resident #4's referral to see a cardiologist on the discharge summary dated 12/10/18. -She did not know if Resident #4 had followed up with a cardiologist or if he went to the appointment on 12/18/18. -She had not made any appointments for the resident. -The medication aides (MAs) usually called and set up any follow up appointments. -The MAs would notify the facility's transportation staff of the scheduled appointments. -Often times, the discharge summaries would	D 273		

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have scheduled appointment times for referrals.
-If not, the MAs were supposed to schedule the appointments.
-The MAs were supposed to read every page of the discharge summaries to make sure all orders, including referrals, were followed.

Interview with the facility's transportation staff person on 01/22/19 at 3:55pm revealed:
-He did not recall being notified of any appointments with a cardiologist or a GI physician for Resident #4.
-He had not transported Resident #4 to any appointments with a cardiologist or GI physician.

Telephone interview with a nurse at Resident #4's GI physician's office on 01/22/19 at 3:26pm revealed:
-They had not seen Resident #4 in their office.
-Resident #4 was seen by one of their providers while in the hospital for GI bleeds.
-They never saw the resident after the GI bleed in September 2018 or in December 2018.
-It was important for the resident to follow up after the GI bleeds because the resident needed to be monitored to make sure the issue was resolved.
-No one had contacted their office to make an appointment for the resident until today, 01/22/19.
-The resident had an appointment to be seen on 01/25/19.

Telephone interview with a nurse at Resident #4's cardiologist's office on 01/22/19 at 2:05pm revealed:
-Resident #4 had an appointment to be seen at their office on 12/18/18 at 3:00pm for a follow up visit from a hospital discharge on 12/10/18.
-The resident was a "no show" for the appointment and no one had called to reschedule it.

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-The resident had a history of atrial fibrillation and was still in active atrial fibrillation when an echocardiogram was done on 12/10/18 at the hospital prior to discharge.
-The follow up visit was to address whether to start the resident back on Aspirin or Eliquis (both blood thinners) or the Metoprolol (used to treat high blood pressure and control heart rate).
-It was very concerning that the resident had not been seen for the follow up appointment because he was at high risk of developing blood clots, having a stroke, and exacerbation of CHF.
-The cardiologist would have evaluated those risks with his history of GI bleeds to determine whether those medications would be restarted.

b. Observation of Resident #4 on 01/15/19 at 10:20am revealed:
-The resident was sitting in a chair in his room with his feet resting on the floor.
-The resident was wearing white athletic socks and black shoes.
-Both of the resident's lower extremities were swollen.
-The left ankle was swollen more than the right ankle.

Interview with Resident #4 on 01/15/19 at 10:20am revealed:
-Both of his lower legs were usually swollen every day.
-His left leg was always swollen more than his right leg.

Review of Resident #4's resident service notes revealed:
-On 05/02/18, the resident complained about his legs being swollen.
-On 05/03/18, the resident's legs were swollen. The resident was encourage to elevate his legs

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when sitting down for long periods at a time.
-On 05/04/18, the resident had swelling in his left leg.
On 05/07/18, the PCP ordered a diuretic for swelling in lower extremities.
-On 05/21/18, an order was received to apply compression stockings in addition to the diuretic.

Review of Resident #4's physician order dated 05/21/18 revealed an order for compression stockings to be put on in the morning and removed at bedtime.

Review of Resident #4's measure form for compression stockings dated 5/31/18 revealed the resident was measured for knee high compression stockings.

Review of Resident #4's June 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were not documented as applied on 5 days including 06/01/18, 06/02/18, 06/04/18, 06/05/18, and 06/25/18 with no reasons noted.

Review of Resident #4's July 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were not documented as applied on 07/24/18 and not documented as removed on 07/17/18 with no reasons noted.

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Review of Resident #4's August 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were not documented as removed on 08/29/18 with no reason noted.

Review of Resident #4's September 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were documented as applied from 09/01/18 - 09/13/18.
-The resident was in the hospital from 09/13/18 - 09/19/18.
-Documentation for compression stockings was blank from 09/20/18 - 09/24/18 with no reasons noted.
-There was a handwritten entry for compression stockings on at 9:00am and remove at 9:00pm that was dated 09/24/18.
-Staff initials were circled for the application of compression stockings at 9:00am from 09/25/18 - 09/27/18 and 09/29/18 - 09/30/18 with no reasons noted.
-Staff initials were circled for the removal of compression stockings at 9:00pm from 09/25/18 - 09/27/18.
-Staff documented the compression stockings were removed on 09/29/18 and 09/30/18 but they were not documented as applied on those two days.

Review of Resident #4's resident service notes

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revealed:
-On 09/21/18, the resident complained about pain in his left lower leg and he had swelling in his left foot. The PCP was notified and an order for medication was received for swelling in his feet.
-On 09/22/18, the resident stayed in bed and said his left foot was hurting. He still had swelling in his feet.
-On 09/23/18, the resident still had swelling in his left foot.
-On 09/24/18, the resident's left foot was still swollen.
-On 09/28/18, the resident still had swelling in both lower legs.

Review of Resident #4's October 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were not documented as applied on 5 days from 10/02/18 - 10/06/18 with no reasons noted.
-Compression stockings were not documented as removed on 6 days including 10/02/18, 10/03/18 and 10/05/18 - 10/08/18.
-Compression stockings were documented as removed on 10/04/18 but not documented as applied on that day.
-Compression stockings were documented as applied on 10/08/18 but not documented as removed that night.

Review of Resident #4's resident service notes revealed:
-On 10/01/18, the resident ate breakfast in his room due to discomfort from swelling in his feet.
-On 10/02/18, the resident's feet were still swollen

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where he could not put on his compression stockings.
-On 10/08/18, the resident's swelling in his feet had gone down but the left foot still had some swelling.
-On 10/15/18, the resident has gotten his compression stockings on today.

Review of Resident #4's November 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were documented as applied and removed daily from 11/01/18 - 11/30/18.

Review of Resident #4's December 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were documented as applied and removed daily from 12/01/18 - 12/04/18.
-Compression stockings were not documented as applied or removed on 12/05/18 with no reason noted.
-Compression stockings were documented as applied on 12/06/18.
-The resident was in the hospital from the evening of 12/06/18 - 12/10/18.
-Documentation for application and removal of the compression stockings was blank from 12/11/18 - 12/31/18 with no reasons noted.

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Review of Resident #4's resident service notes revealed:
-On 12/05/18, the resident's left leg was swollen and red and he complained of itching. PCP was notified.
-On 12/06/18, the resident was seen by the PCP for red, swollen legs.
-On 12/25/18, the resident stated his feet were really cold and his feet could not get warm.

Review of Resident #4's January 2019 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were documented as applied at 9:00am from 01/01/19 - 01/22/19.
-Compression stockings were documented as removed at 9:00pm from 01/01/19 - 01/20/19 except it was blank on 01/03/19.
-Compression stockings were documented as applied on 01/18/19 and 01/21/19 but not documented as removed on those two days due to the stockings were "not on".

Review of Resident #4's resident service notes revealed:
-On 01/01/19, the resident stated his legs were less cold.
-On 01/03/19, the resident was complaining about his feet being cold.
-On 01/07/19, the resident was seen by the PCP.

A second observation of Resident #4 on 01/17/19 at 6:05pm revealed:
-Resident #4 was sitting in a chair in his room with his feet on the floor.
-The resident was not wearing compression

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stockings.
-The resident was wearing white athletic socks.
-Both of his lower legs were swollen and his left ankle was swollen more than the right ankle.

Interview with Resident #4 on 01/17/19 at 6:05pm revealed:
-He had worn compression stockings but he stopped wearing them about 3 to 4 weeks ago.
-His feet were always cold so he had been wearing two pairs of socks at times to try to keep them warm.
-Staff did not usually check to see if he was wearing his compression stockings except about once a week someone would ask him but that stopped too.
-The compression stockings helped "a little bit" with the swelling in his legs.
-He did not know if his PCP knew he was not wearing the compression stockings.
-The swelling in his legs was not improving much.
-His legs and feet tingled and hurt from being cold.

A third observation of Resident #4 on 01/18/19 at 3:50pm revealed:
-The resident was sitting in a chair in his room with his feet on the floor.
-The resident was not wearing compression stockings.
-He was wearing athletic socks.

Interview with Resident #4 on 01/18/19 at 3:50pm revealed no one came to put his compression stockings today or ask to see if he was wearing them.

Interview with a medication aide (MA) on 01/18/19 at 4:15pm revealed:
-Resident #4 had white compression stocking

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and he kept them in his room.
-She usually worked second shift and Resident #4 did not usually have his compression stockings on when she would check to remove them at night.
-The resident could remove the compression stockings himself so she thought the resident removed them at night so she would document them as removed on the MAR.
-She did not realize the resident was not wearing the compression stockings.
-She last saw the resident's compression stockings "about a week ago" in his room hanging on his walker.
-The resident's legs had been swollen for "a couple of months" and the left lower leg was usually swollen more than his right leg.

A fourth observation of Resident #4 on 01/22/19 at 11:14am revealed:
-The resident was sitting in a chair in his room with his feet on the floor.
-The resident was wearing gray athletic socks.
-The resident was not wearing compression stockings.
-The resident's lower legs were swollen and the left ankle was swollen larger than his right leg.

Interview with Resident #4 on 01/22/19 at 11:14am revealed:
-He was not wearing compression stockings because he did not know where the stockings were located.
-His compression stockings were white but he had not seen them "in a while".
-He would wear the compression stockings if he could find them.
-His legs were swollen so badly "about 3 months ago" that the compression stockings would not fit.
-No one offered to get a bigger pair of

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compression stockings during that time.
-Staff did not offer to help the resident put on the compression stockings.
-No staff came to him this morning, 01/22/19, to offer to put the compression stockings on or to ask if he was wearing them.
-One staff asked the resident a couple of days ago if he was wearing the compression stocking and he told her no.

Interview with a first shift MA on 01/22/19 at 11:32am revealed:
-Resident #4 usually put the compression stockings on himself.
-If he had any difficulty getting them on, he could use his call bell and get staff.
-She thought Resident #4 was wearing his compression stockings this morning (01/22/19) since she documented they were applied on the MAR.
-She could not recall for sure if they were on and she did not remember the color of his compression stockings but she thought they were beige.
-She usually tried to visually check to see if the resident was wearing the compression stockings on the mornings she worked.
-She could not explain why she would document the resident's compression stockings were on when she did not always physically check to see if they were on.
-She could not recall the last time she saw Resident #4 wearing the compression stockings.
-Resident #4's lower legs were always swollen but some days they were swollen more than other days.
-The resident's left leg was always swollen more than the right leg.
-Second shift staff were supposed to remove the compression stockings.

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-Resident #4 would sometimes take off his compression stockings before he was supposed to.
-She had not notified the PCP that the resident would take off the compression stockings too soon.
-The resident's compression stockings were supposed to be kept in his room.
-She would check his room for the compression stockings.

Observation on 01/22/19 at 11:55am revealed:
-The MA checked Resident #4's bedroom and living room for his compression stockings.
-She could not find the compression stockings.

Interview with Resident #4's primary care provider (PCP) on 01/17/19 at 12:35pm revealed:
-Resident #4 had swelling in both lower extremities.
-The swelling had improved when his diuretic was increased.
-The resident had an order to wear compression stockings and that order had not been discontinued.
-The resident should wear the compression stockings every day.
-No one had reported to her that the resident was not wearing the compression stockings.
-She was not aware the resident had been unable to wear the compression stockings in the past because they would not fit.
-She expected the facility staff to notify her if the resident was not wearing the compression stockings.

Interview with the Director of Resident Care (DRC) on 01/22/19 at 12:45pm revealed:
-She had seen Resident #4 wear his compression stockings.

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-She thought the last time she observed the resident wearing his compression stockings was one day last week.
-The resident would sometimes take the compression stockings off himself.
-The PCP should have been notified if the resident was not wearing the compression stockings.
-The MAs were supposed to physically check and make sure the resident was wearing the compression stockings prior to documenting on the MAR.
-If the resident was not wearing the compression stockings, the MAs should notify her and the PCP.

A second interview with the DRC on 01/22/19 at 6:20pm revealed:
-They had ordered a new pair of compression stockings for Resident #4.
-The new compression stockings would be delivered by the pharmacy later tonight.

2. Review of Resident #3's current FL-2 dated 06/18/18 revealed diagnoses included dementia.

a. Review of Resident #3's current FL-2 dated 06/18/18 revealed there was an order for weekly weights.

Observations of Resident #3 in the SCU dining room on 01/16/19 at 12:54 pm revealed:
-The resident was seated in a wheelchair at a dining room near the rear exit doors.
-Resident #3 was seated at the dining table wearing very loose fitting clothing, shirt and pants were several sizes too big, with shoulder blades visible through the shirt.

Interview with a PCA on 01/16/18 at 12:54 pm

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revealed:
-Resident #3 had not eaten much of her lunch meal because she did not like the food; the resident preferred sweets like chocolate pudding.
-The clothes that Resident #3 had on on 01/16/19, were the resident's clothes.

Observation on 01/18/19 at 9:51 am for Resident #3 revealed:
-Three personal care aides (PCAs), the Special Care Director (SCD), and the Director of Resident Care (DRC) used a hydraulic lift to weigh Resident #3
-Resident #3 weighed 87.1 lbs. clothed with tennis shoes on.

Telephone interview with Resident #3's family member on 01/21/19 at 7:40 pm revealed:
-She visited Resident #3 as often as she could, the last visit was three or four days ago (01/17/19 or 01/18/19).
-Resident #3 had gradually lost weight over three to four months (October 2018).
-Resident #3's Power of Attorney (POA) was going to request a weight chart because the resident had lost "a lot" of weight and "gotten very thin."

Review of Resident #3's June 2018 Medication Administration Record (MAR) revealed:
-There was a preprinted entry to check weights every Saturday.
-There was a weight documented on 06/23/18 of 120 lbs.

Review of Resident #3's August 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There was a weight documented on 08/04/18 of

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117.5 lbs.

Review of Resident #3's September 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There was a weight documented on 09/01/18 of 114 lbs.
-There was a weight documented on 09/15/18 of 124 lbs.

Review of Resident #3's October 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There was a weight documented on 10/06/18 and 10/20/18 of 73.5 lbs.

Review of Resident Service Notes dated 06/23/18 to 10/30/18 for Resident #3 revealed there was no documentation the resident's physician was notified of the 46.5 lbs weight loss from 06/23/18 to 10/06/18.

Review of Resident #3's November 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There were no weights documented in November 2018.

Review of Resident #3's December 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There were no weights documented in December 2018.

Review of Resident #3's January 2019 MAR revealed:

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-There was a preprinted entry to check weights every Saturday.
-There were three weights documented on 01/05/19, 01/12/19 and 01/19/19, each 85.5 pounds.

Based on Review of Resident #3's MARs from 06/18/18 to 01/22/19 revealed:
-There were 31 opportunities for Resident #3's weight to be done.
-There were only 9 weights were documented.

Interview with second PCA on 01/18/19 at 9:55 am revealed:
-She had been employed at the facility since November 2018.
-She noticed that Resident #3 had lost some weight.
-She did not remember reporting the weight loss.

Interview with third PCA on 01/18/19 at 9:56 am revealed:
-She had been employed at the facility since August 2018.
-She noticed that Resident #3 had lost some weight.
-"I can tell Resident #3 has lost weight by the way her clothes fit."
-Residents were weighed monthly.

Interview with Medication Aide (MA) on 01/18/19 at 11:11 am revealed:
-The MAs were responsible to do weights and everyone helped.
-She documented the weights on a piece of paper and "passed it on" to the Wellness Coordinator (WC) for the month of January 2019, but could not remember who she passed the documented weights to for prior months.
-She was not sure of what happened to the

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weights once she gave them to the WC.
-She had noticed the weight loss for Resident #3 and reported it to the WC, but could not remember when.

Telephone interview with the Clinical Director at Resident #3's Physician's office on 01/18/19 at 10:00 am revealed:
-She did not see documentation of an order for weekly weights in Resident #3's office chart.
-She did not see documentation of any contact from the facility staff since June 2018.
-Resident #3's last visit was in September 2018.
-Resident #3's weight at that visit was noted to be 130 lbs.
-The doctor would have been concerned of a 33 lbs. weight loss that occurred from 06/23/18 until current weight on 01/18/19 .

Interview with WC on 01/18/19 at 3:25 pm revealed:
-Weights were done monthly unless ordered more frequently by the doctor.
-The MA would document weights on the MAR when weights were done more often than once a month.
-The monthly weights were documented on the weight sheet or census sheet.
-The weights were given to Director of Resident Care (DRC) when they were done.
-The MA reported the weight to the DRC and/or WC.
-Documentation of the notification of the doctor should be in the Residents Service Notes at the end of the shift.
-She was "not totally aware of the numbers of Resident #3's weight loss, but had noticed in my rounds that she had lost weight."
-She did a weekly walk through the SCU and spent time with each resident on a weekly basis.

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-She first noticed Resident #3's weight loss on or about the first of December 2018.
-She did not recall if attempts to notify Resident #3's doctor were documented or not, but it would have been documented in the Residents Notes.

Interview with the SCD on 01/18/19 at 2:55 pm revealed:
-She had been hired in December 2018.
-She knew Resident #3 had lost weight, but she did not know exactly how much.
-Last week (01/11/19), she and the DRC had "reached out" to Resident #3's family to discuss hospice care due to the weight loss.
-She did not know if Resident #3's doctor had been contacted.
-She was not sure of the process for weighing residents, documenting the weight and reporting weight changes.

Review of Resident Service Notes dated 01/11/19, 01/17/19 and 01/18/19 for Resident #3 revealed:
-The SCD documented calling the family of Resident #3 to discuss hospice care on 01/11/19.
-The SCD met with Resident #3's family member on 01/17/19 at the facility regarding hospice.
-On 01/17/19, Resident #3's family member requested to know how much weight Resident #3 had lost.
-On 01/18/19, the SCD documented she informed the family member of Resident #3's current weight of 87 lbs.

Interview with DRC on 01/22/19 at 12:00 pm revealed:
-She called or faxed the physician regarding any orders or changes.
-A copy of the fax was kept in the residents chart.
-Weights were done the first of the month, at

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least by the 5th.
-The staff obtained the weights, wrote them on a Resident Roster, and gave them to me and I put them in the system.
-If weights were ordered other than monthly, it would be documented on the MAR.
-The staff verbally reported any concerns during "stand up" every morning.

Interview with a PCA on 01/17/19 at 1:58 pm revealed:
-Whenever there was a concern about a resident the PCAs reported the concern during the daily "stand up".
-The daily stand up was a meeting held each morning on the SCU and including all direct care staff in the facility and management.
-Direct care staff would talk about what was happening on all floors in the facility.

Second telephone interview with the Clinical Director at Resident #3's Physician's office on 01/22/19 at 3:41 pm revealed:
-She had called the facility on 01/22/19 to request updated notes on Resident #3.
-Resident #3's family member called on 09/04/18 regarding a puncture wound to her hand and the resident was seen in the office on 09/05/19 by the Physician's Assistant.
-The last phone call from the doctor's office received regarding Resident #3 was on 11/15/18 from the home health (HH) agency requesting to extend HH services for wound care.
-Prior to Resident #3's family member calling on 09/04/18, the last call received was in April 2018.
-"There were no phone calls between 04/27/18 and 09/04/18."
-"Resident #3's physician would definitely want to know any significant changes like a weight loss."

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D 273	Continued From page 32 Interview with the DRC on 01/18/19 at 4:06 pm revealed: -She had contacted Resident #3's doctor's office on several occasions, but the doctor was difficult to get in touch with. -The attempts to contact Resident #3's doctor were not documented. -She had spoken with Resident #3's family prior to the holidays in December 2018, regarding the resident's weight loss and the possibility of hospice. Attempted interview with Resident #3's family member on 01/17/18 11:12 am was unsuccessful. Attempted interview with Resident #3's POA on 01/18/19 at 5:14 pm was unsuccessful. b. Observations of Resident #3 on 01/17/19 at 5:00pm revealed Resident #3 was lying in the bed and there were heel protector booties on Resident #3's bedside table. Observations of Resident #3 with two personal care aides (PCAs) on 01/18/19 at 9:51am revealed: -Resident #3 had a butterfly shaped area of redness approximately the diameter of a grapefruit on her sacral area and buttocks. -There were raised red bumps on the outer edge of the redness on Resident #3's right buttock. -There was redness approximately the diameter of a golf ball on Resident #3's right elbow. -There a nickel sized area of redness with a light colored scab on Resident #3's left inner heel. -There was redness to Resident #3's inner right ankle and entire right heel. -There was a red bruise on the top of Resident #'s right foot	D 273		

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Interview with a personal care aide (PCA) on 01/18/19 at 9:51am revealed:
-The PCAs applied barrier cream and notified the medication aide (MA) whenever a resident developed redness on their buttocks.
-The redness on Resident #3's right elbow came from the resident leaning on her wheelchair.
-The redness on Resident #3's buttocks had started over the past week (01/11/19).
-She reported the redness because the PCAs had to get the barrier cream from the MA, but she could not remember which MA she reported to.

Interview with a MA on 01/18/19 at 11:11am revealed:
-She was aware of the redness on Resident #3's bottom, but did not know how long the redness had been there.
-She did not remember the day the redness on Resident #3's bottom was reported to her or the PCA who had reported it.
-The PCAs had kept cream on Resident #3's bottom all that week after it was first reported.
-She was off for the weekend and returned to work to find Resident #3 had an open area on her bottom.
-The PCA had reported the redness on Resident #3's right elbow and both feet on 01/18/19.
-The heel protectors were not on Resident #3's medication administration record, but if staff noticed the resident's heels were red then they would put the heel protectors on the resident.
-Resident #3 was not currently being seen by home health (HH).

Telephone interview with the Clinical Director at Resident #3's Physician's office on 01/18/19 at 10:00am revealed:
-The office had not received contact by phone or fax from the facility since June 2018.

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-The last contact regarding any skin or wound care concerns came from HH.
-The office had a HH note dated 12/17/18 which documented Resident #3 was stable for discharge from HH and the stage II pressure ulcer on the resident's buttocks was healed.

Telephone interview with the HH Office Manager on 01/18/19 at 4:00pm revealed:
-Resident #3 was admitted for HH services on 10/07/18 and discharged on 12/05/18.
-Resident #3 was seen by skilled nursing for wound care of a stage II pressure ulcer on her left buttock.
-The last visit documented all of Resident #3's wounds were healed.

Telephone interview with Resident #3's family member on 01/21/19 at 7:40pm revealed:
-Staff had reported Resident #3 had some irritation on her "backside."
-Skin irritation was "always a concern when she's (Resident #3) in bed so much, but they (staff) put cream on it."

Interview with the Special Care Director (SCD) on 01/18/19 at 2:55pm revealed:
-She was not aware of the reddened areas on Resident #3's sacrum, buttocks, elbow and feet prior to 01/18/19.
-She was not sure if she was supposed to be made aware by staff.
-She had been the SCD for one month and was still learning the role and responsibilities from the Executive Director (ED), Wellness Coordinator and the Director of Resident Care (DRC).

Interview with the Wellness Coordinator on 01/18/19 at 3:25pm revealed:
-Resident #3 had HH for a sore on her hand and

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some redness on her bottom that had healed and so there was no HH since approximately November 2018.
-She had not heard about any skin concerns for Resident #3 within the last week (01/11/19).
-She was now responsible for resident care issues in the assisted living (AL); the SCD was responsible for the SCU.
-The SCD was new and still training and would come to her if she needed anything; the SCD had not come to the Wellness Coordinator for any concerns related to Resident #3.

Interview with the DRC on 01/18/19 at 4:06pm revealed:
-Resident #3 had reddened areas on her buttocks and heels before, received HH services and the areas healed.
-Resident #3's skin would always be compromised because she had skin breakdown before.
-She had seen Resident #3's bottom last week (01/11/19) and that was when staff "started putting her (Resident #3) down in the bed to get the pressure off of her butt."
-There was no specific time frames for how long Resident #3 sat up in her wheelchair or laid in her bed; they were trying more time in the bed since the breakdown on her buttocks had been noticed.
-Staff were expected to reposition Resident #3 every two hours and apply barrier cream when the resident was in the bed.
-She had contacted Resident #3's doctor's office on several occasions, but the doctor was difficult to get in touch with.
-The attempts to contact Resident #3's doctor were not documented.

Attempted interview with Resident #3's POA on 01/18/19 at 5:14 pm was unsuccessful.

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3. Review of Resident #5's current FL-2 dated 07/12/18 revealed diagnoses included dementia, atrial fibrillation, knee pain, tachycardia, aortic stenosis, hypertension, osteoporosis and cardiac pacemaker.

a. Review of hospital discharge instructions for Resident #5 dated 04/16/18 revealed:
-Resident #5 presented to the hospital on 04/14/18 with chest pain.
-The chest pain was due to aortic stenosis which was critical; with Resident #5's "dementia and multiple medical problems it was best to offer a conservative approach."
-There was an appointment scheduled for Resident #5 to follow up with a cardiologist on 04/19/18 at 9:45am.

Review of Resident Service Notes for Resident #5 dated 04/26/18 and 07/04/18 revealed:
-On 04/26/18, the former Special Care Director (SCD) documented Resident #5 had an appointment with the cardiologist, but the office stated it got canceled.
-The former SCD called Resident #5's POA to get more information as to why the appointment was canceled and if there was some sort of plan for a cardiology follow up visit.
-The next entry was dated 07/04/18 where a medication aide (MA) documented Resident #5 was sent to the emergency room with chest pain.

Interview with the former SCD on 01/22/19 at 5:28pm revealed:
-Resident #5 had an appointment with the cardiologist after leaving the hospital in April 2018.
-She had contacted Resident #5's Power of Attorney (POA) to confirm that the POA would

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meet Resident #5 at the appointment.
-The POA told the former SCD Resident #5 was not going and canceled the appointment; the POA did not give a reason for the cancellation.
-She mentioned the cardiology appointment being canceled to Resident #5's former Physician who said she would make note of it.
-She usually documented contact with the physician in the resident service notes.

Telephone interview with Resident #5's POA on 01/17/19 at 11:06am revealed:
-She and other family members declined to take Resident #5 for a cardiology referral after the April 2018 hospitalization because they did not feel the appointment was necessary.
-The POA and family members did not want the cardiology follow up because of Resident #5's age and dementia diagnosis.
-Resident #5 had history of palpitations and a pacemaker which might need to have the battery replaced at some point.

Attempted telephone interview with Resident #5's former Physician on 01/22/19 at 10:47am was unsuccessful.

Telephone interview with Resident #5's Physician's Assistant (PA) on 01/22/19 at 10:52am and 6:55pm revealed:
-She worked with Resident #5's former Physician and had access to her notes.
-There was no documentation of the facility contacting the former Physician of Resident #5's family's refusal for a cardiology appointment for the resident.
-She had been seeing Resident #5 since February 2018 and the facility had not contacted her regarding the family's refusal of the cardiology appointment for the resident.

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-She would have wanted to been made aware because Resident #5 had a pacemaker and should have cardiology follow up to check the functioning of the resident's pacemaker and review medications.

Interview with the Director of Resident Care (DRC) on 01/18/19 at 4:06pm revealed:
-She was not aware of the family's refusal for Resident #5's cardiology referral.
-She did not know if Resident #5's PCP had been notified.
-Normally she scheduled referrals from hospital discharge paperwork and followed up with transportation and the resident's family with the appointment date and time.
-Sometimes referral appointments scheduled by the hospital were missed by the medication aide (MA) reviewing the discharge paperwork.

Interview with the Executive Director (ED) on 01/18/19 at 4:06pm revealed:
-She was not aware of the family's refusal for Resident #5's cardiology referral.
-She did not know Resident #5's PCP should have been notified if the family had refused.
-The DRC would follow up with Resident #5's PCP regarding the family's refusal for a cardiology referral.

4. Review of Resident #2's FL-2 dated 09/18/18 revealed:
-Diagnoses included edema to extremities, aortic stenosis, hypertension, hyperlipidemia, delirium.
-She is semi-ambulatory.

Review of Resident #2's records revealed:
-A physician order dated 12/11/18 for a reverse wedge pillow to be ordered for Resident #2's wheelchair to help decrease falls.

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-There was also a note below order stating that "this (reverse wedge pillow) is not considered a restraint".

Interview with Resident #2 on 01/16/19 at 10:50 a.m. revealed
-She did not remember having a cushion in her wheelchair.
-She had not seen anything that looked like a wedge in her room.

Interview with a personal care aide (PCA) on 01/16/19 at 03:22 p.m. revealed:
-She could not recall ever seeing a pillow shaped like a wedge in Resident #2's wheelchair or room.
-She could not recall ever been told about a wedge pillow for Resident #2's wheelchair.

Interview with a medication aide (MA) on 01/16/19 at 03:20 p.m. revealed:
-That Resident #2 did not have any wedge cushion in her wheelchair.
-She did not know about the physician's order for a wedge for Resident #2's wheelchair.

Interview with Resident #2's primary care physician (PCP) on 01/17/19 at 11:40 a.m. revealed:
-She ordered the reverse wedge pillow for Resident #2 wheelchair because it would help prevent her from slipping/ falling out of her wheelchair or her recliner.
-She was not aware if reverse wedge pillow was ordered.
-She could not recall seeing the reverse wedge pillow in Resident #2's wheelchair.

Interview with the Director of Resident Care (DRC) on 01/17/19 at 03:36 p.m. revealed:
-She discussed the order for the reverse wedge

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pillow with the physical therapist.
-She was informed that because of the way Resident #2 sat in her wheelchair the reverse wedge pillow would act as a restraint.
-Resident #2 would not be able to propel herself in her wheelchair and would have difficulty getting up from wheelchair.
-She had not informed Resident #2's PCP of her concern and discussion with the physical therapist about the reverse wedge pillow acting as a restraint for the resident.
-She would make sure to inform Resident #2's PCP about the discussion she had with the physical therapist concerning the use of the reverse wedge pillow.

Interview with the physical therapist on 01/22/19 at 11:06 a.m. revealed:
-She did have a discussion with the DRC about the order for the reverse wedge pillow for Resident #2 to use in her wheelchair been a restraint.
-The reverse wedge pillow would be considered a restraint for Resident #2 because physical therapy would not be able to get her up and she would need maximum assistance to stand up from the wheelchair.

A second interview with Resident #2's PCP on 01/22/19 at 07:00 p.m. revealed:
-She was informed by the DRC on 01/21/19 about her discussion with physical therapy concerning the use of the reverse wedge pillow been a restraint for Resident #2 because it would affect resident's mobility.
-She would have expected that the facility would have informed her about any concerns they had about the order for the use of the reverse wedge pillow for Resident #2 when the order was written.

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D 273	Continued From page 41 The facility failed to assure referral and follow up for the acute health care needs for 4 of 5 sampled residents (#2, #3, #4, #5). The facility failed to assure Resident #4 was seen by a gastroenterologist after a hospitalization for a gastrointestinal bleed in September 2018 resulting in the resident having a second hospitalization for a recurrent GI bleed in December 2018. The facility again failed to have Resident #4 follow up with a gastroenterologist after the hospitalization in December 2018. Resident #4 missed a cardiology appointment for follow up to the hospitalization in December 2018 when the resident was in atrial fibrillation during the hospitalization, leaving the resident at high risk of a blood clot, stroke, and exacerbation of congestive heart failure. The facility failed to notify the PCP that Resident #4, who had chronic swelling in both lower extremities, was not wearing compression stockings as ordered. Resident #3's PCP was not notified of a 33 pound weight loss from 06/23/18 to 01/18/19. Resident #5's PCP was not notified of a refusal for a cardiology appointment following hospitalization for myocardial infarction and the resident having a pacemaker. Resident #2's PCP was not notified of Physical Therapy's concern about the use of a reverse wedge pillow in Resident #2's wheelchair being a possible restraint for Resident #2. The facility's failure to follow up and coordinate health care resulted in serious harm and serious neglect of the residents and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/18/19 for this violation. CORRECTION DATE FOR THE TYPE A1	D 273		

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D 273	Continued From page 42 VIOLATION SHALL NOT EXCEED FEBRUARY 21, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 3 of 5 sampled residents (#3, #4 and #5) which included weekly weights (#3), weekly blood pressures (#4 and #5), and compression stockings (#4). The findings are: 1. Review of Resident #3's current FL-2 dated 06/18/18 revealed: -Diagnosis of dementia. -There was an order for weekly weights. Review of Resident #3's June 2018 Medication	D 276		

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Administration Record (MAR) revealed:
-There was a preprinted entry to check weights every Saturday.
-There was a weight documented on 06/23/18 of 120 lbs.
-There was no weight documented on the MAR for 06/30/18.
-There were no refusals documented.

Review of Resident #3's July 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There were no weights documented on the MAR.
-There were no refusals documented.

Review of Resident #3's August 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There was 1 weight documented on 08/04/18 of 117.5 lbs.
-There were no weights documented on the MAR for 08/11/18, 08/18/18, and 08/28/18.
-There were no refusals documented.

Review of Resident #3's September 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There was a weight documented on 09/01/18 of 114 lbs. and on 09/15/18 of 124 lbs.
-There were no weights documented on the MAR for 09/08/18, 09/22/18, and 09/29/18.
-There were no refusals documented.

Review of Resident #3's October 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There was a weight documented on 10/06/18 of

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73.5 lbs. and on 10/20/18 of 73.5 lbs.
-There were no weights documented on the MAR for 10/13/18 and 10/27/18.
-There were no refusals documented.

Review of Resident #3's November 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There were no weights documented on the MAR.
-There were no refusals documented.

Review of Resident #3's December 2018 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There were no weights documented on the MAR.
-There were no refusals documented.

Review of Resident #3's January 2019 MAR revealed:
-There was a preprinted entry to check weights every Saturday.
-There were weights documented on 01/05/18, 01/12/18, and 01/19/18 of 85.5 lbs. for each date.

Interview with the DRC on 01/22/19 at 5:45 pm revealed:
-She had spoken with the staff on the SCU regarding Resident #3's weights in November 2018.
-The weights were documented on Resident #3's MAR a few times, "then it fell off" (they were not done).

Interview with third Personal Care Aide (PCA) on 01/18/19 at 9:56 am revealed:
-She had been employed here at the facility since August 2018.
-Residents were weighed monthly.

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D 276	Continued From page 45 Interview with Medication Aide (MA) on 01/18/19 at 11:11 am revealed: -The MA's were responsible to do weights and everyone helped. -She documented the weights on a piece of paper and "passed it on" to the Wellness Coordinator (WC) for the month of January 2019, but could not remember who she passed the documented weights to for prior months. -She was not sure what happened to the documented weights once she passed it on. Interview with WC on 01/18/19 at 3:25 pm revealed: -Weights were done monthly unless ordered more frequently by the doctor. -The MA would document weights on the MAR when weights were done more often than once a month. -The monthly weights were documented on the weight sheet or census sheet. -The weights were given to Director of Resident Care (DRC) when they were done. -She was not sure what happened to the weights after they were given to the DRC. -The MAs reported the weight to the DRC and/or WC. Interview with the DRC on 01/22/19 at 5:45pm revealed: -She had spoken with the staff on the SCU regarding Resident #3's weights after the pharmacy review dated 11/07/18. The weights were documented on Resident #3's MAR a few times, "then it fell off" (they did not weigh Resident #3). Telephone interview with the Clinical Director at Resident #3's Physician's office on 01/18/18 at	D 276		

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D 276	Continued From page 46 10:00 am revealed: -There are no weekly weights noted in Resident #3's office record. -There were no weight reports noted in Resident #3's office record. Interview with the Special Care Director (SCD) on 01/17/19 at 2:31pm revealed: -She was not sure who was responsible for checking resident weights. -The DRC would know. Interview with the DRC on 01/16/19 between 2:20pm revealed weights were documented in the weight book. Interview with the DRC on 01/22/19 at 11:50am revealed: -She was not aware the weekly weights for Resident #3 had not been documented on the MAR. -The staff on the SCU weighed residents every month by the 5th of the month. -The staff documented the weight on a resident roster and turned into the DRC. -Weekly weights would have been documented on the MAR. -Staff were expected to report any concerns regarding residents' weights directly to the SCD, the DRC or during the daily stand up meeting. Interview with the Executive Director on 01/18/19 at 4:06 pm revealed she did not have any further information to add to the DRC's interview. 2. Review of Resident #5's current FL-2 dated 07/12/18 revealed diagnoses included dementia, atrial fibrillation, knee pain, tachycardia, aortic stenosis, hypertension, osteoporosis and cardiac pacemaker.	D 276		

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Review of a pharmacy consultation report for Resident #5 dated 11/07/19 revealed:
-Resident #5 was ordered to receive furosemide (a diuretic), lisinopril (an antihypertensive), and metoprolol (an antihypertensive) for hypertension.
-There was a recommendation to monitor Resident #5's blood pressure (BP) at least weekly or as advised by the physician.
-There was an order to check Resident #5's BP weekly and document.
-There was an order to notify the primary care provider (PCP) if the systolic BP was greater than 180 or less than 100 and if the diastolic BP was greater than 100 or less than 50.
-The order was signed by the PCP and dated 11/08/18.

Review of Resident #5's November 2018 medication administration record (MAR) revealed there was no entry for weekly BP checks and there were no BP results documented.

Review of Resident #5's December 2018 MAR revealed:
-There was a preprinted entry to check BP once weekly and notify the primary care provider (PCP) if the systolic BP was greater than 180 or less than 100 and if the diastolic BP was greater than 100 or less than 50.
-There was a hand mark "D/C" (discontinue) written over the preprinted entry.
-There were no BP results documented.

Review of Resident #5's January 2019 MAR revealed there was no entry for weekly BP checks and there were no BP results documented.

Interview with a personal care aide (PCA) on

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D 276	Continued From page 48 01/17/19 at 1:58pm revealed the medication aides (MAs) did resident BP checks and documented results. Interview with a MA on 01/18/19 at 11:11am revealed: -She did not know anything about an order for weekly BP checks for Resident #5. -Normally if there was an order to check a BP, the MAs checked residents' BPs and documented the result on the MAR. Telephone interview with Resident #5's Power of Attorney (POA) on 01/17/19 at 11:06am revealed: -Resident #5 had history of palpitations and a pacemaker. -Resident #5's blood pressure fluctuated with palpitations, but there were no other blood pressure issues. Interview with Resident #5's Physician's Assistant (PA) on 01/17/19 at 11:45am revealed: -She thought she might have seen some BP results on the MAR for Resident #5. -The staff did not give a reason for why Resident #5's BP had not been checked weekly as ordered, but it was possible that the resident had refused. -She had not been notified by staff of Resident #5 refusing BP checks between November 2018 and January 2019. -She had ordered the weekly BP checks because Resident #5 was on multiple BP medications. -The BP checks were so a trend could monitored for any needed medication adjustments; she did not want to adjust BP medications based on one result. -Resident #5's BP had been stable "as of lately" when she checked the resident's BP during the PA's visits at the facility.	D 276		

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D 276	Continued From page 49 Interview with the Special Care Director (SCD) on 01/17/19 at 2:31pm revealed: -She was not sure who was responsible for checking resident BPs. -The Director of Resident Care (DRC) would know. Interview with the DRC on 01/16/19 at 2:20pm revealed BPs were done by the MAs and documented on the MAR. Interview with the Wellness Coordinator on 01/18/19 at 3:25pm revealed: -Vital signs including BPs were done as ordered on the MAR. -The MA was responsible for checking BPs and documenting the result on the MAR. -If there were written parameters to notify the doctor then the MA would notify the doctor and document in the resident service notes by the end of their shift. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable. 3. Review of Resident #4's current FL-2 dated 12/10/18 revealed: -Diagnoses included gastrointestinal bleed, atrial fibrillation, coronary artery disease, bradycardia, chronic combined systolic and diastolic congestive heart failure, acute kidney injury, anemia, and Alzheimer's dementia. -The resident was intermittently disoriented. -The resident required assistance with bathing and dressing. Review of Resident #4's assessment and care plan dated 05/21/18 revealed:	D 276		

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-The resident was oriented and his memory was adequate.
-The resident was ambulatory with use of a "walking stick".
-The resident was independent with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

a. Review of Resident #4's physician order dated 05/21/18 revealed an order for compression stockings to be put on in the morning and removed at bedtime.

Review of Resident #4's measure form for compression stockings dated 5/31/18 revealed the resident was measured for knee high compression stockings.

Review of Resident #4's resident service notes revealed:
-On 05/02/18, the resident complained about his legs being swollen.
-On 10/02/18, the resident's feet were still swollen where he could not put on his compression stockings.
-On 10/08/18, the resident's swelling in his feet had gone down but the left foot still had some swelling.
-On 10/15/18, the resident has gotten his compression stockings on today.
-On 12/05/18, the resident's left leg was swollen and red and he complained of itching. The primary care provider (PCP) was notified.
-On 12/06/18, the resident was seen by the PCP for red, swollen legs.

Observations of Resident #4 revealed:
-The resident was not wearing compression stockings on 01/15/19 at 10:20am, 01/17/19 at 6:05pm, 01/18/19 at 3:50pm, and 01/22/19 at

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D 276	Continued From page 51 11:14am. -Both of the resident's lower extremities were swollen during each observation. -The left ankle was always swollen more than the right ankle. Interview with Resident #4 on 01/17/19 at 6:05pm and 01/22/19 at 11:14am revealed: -He had worn compression stockings but he stopped wearing them about 3 to 4 weeks ago. -He was not wearing compression stockings because he did not know where the stockings were located. -His compression stockings were white but he had not seen them "in a while". -He would wear the compression stockings if he could find them. -His legs were swollen so badly "about 3 months ago" that the compression stockings would not fit. -No one offered to get a bigger pair of compression stockings during that time. -Staff did not offer to help the resident put on the compression stockings. -Staff did not usually check to see if he was wearing his compression stockings except about once a week someone would ask him but that stopped too. -One staff asked the resident a couple of days ago if he was wearing the compression stocking and he told her no. -The compression stockings helped "a little bit" with the swelling in his legs. -The swelling in his legs were not improving much. Review of Resident #4's June 2018 MAR revealed: -There was a computer printed entry to apply compression stockings every morning and remove at bedtime.	D 276		

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-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were not documented as applied on 5 days including 06/01/18, 06/02/18, 06/04/18, 06/05/18, and 06/25/18 with no reasons noted.

Review of Resident #4's July 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were not documented as applied on 07/24/18 and not documented as removed on 07/17/18 with no reasons noted.

Review of Resident #4's August 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were not documented as removed on 08/29/18 with no reason noted.

Review of Resident #4's September 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were documented as applied from 09/01/18 - 09/13/18.
-The resident was in the hospital from 09/13/18 - 09/19/18.
-Documentation for compression stockings was blank from 09/20/18 - 09/24/18 with no reasons

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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noted.
-There was a handwritten entry for compression stockings on at 9:00am and remove at 9:00pm that was dated 09/24/18.
-Staff initials were circled for the application of compression stockings at 9:00am from 09/25/18 - 09/27/18 and 09/29/18 - 09/30/18 with no reasons noted.
-Staff initials were circled for the removal of compression stockings at 9:00pm from 09/25/18 - 09/27/18.
-Staff documented the compression stockings were removed on 09/29/18 and 09/30/18 but they were not documented as applied on those two days.

Review of Resident #4's October 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were not documented as applied on 5 days from 10/02/18 - 10/06/18 with no reasons noted.
-Compression stockings were not documented as removed on 6 days including 10/02/18, 10/03/18 and 10/05/18 - 10/08/18.
-Compression stockings were documented as removed on 10/04/18 but not documented as applied on that day.
-Compression stockings were documented as applied on 10/08/18 but not documented as removed that night.

Review of Resident #4's November 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and

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remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were documented as applied and removed daily from 11/01/18 - 11/30/18.

Review of Resident #4's December 2018 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were documented as applied and removed daily from 12/01/18 - 12/04/18.
-Compression stockings were not documented as applied or removed on 12/05/18 with no reason noted.
-Compression stockings were documented as applied on 12/06/18.
-The resident was in the hospital from the evening of 12/06/18 - 12/10/18.
-Documentation for application and removal of the compression stockings was blank from 12/11/18 - 12/31/18 with no reasons noted.

Review of Resident #4's January 2019 MAR revealed:
-There was a computer printed entry to apply compression stockings every morning and remove at bedtime.
-The compression stockings were scheduled to be applied at 9:00am and removed at 9:00pm.
-Compression stockings were documented as applied at 9:00am from 01/01/19 - 01/22/19.
-Compression stockings were documented as removed at 9:00pm from 01/01/19 - 01/20/19 except it was blank on 01/03/19.

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-Compression stockings were documented as applied on 01/18/19 and 01/21/19 but not documented as removed on those two days due to the stockings were "not on".

Interview with a medication aide (MA) on 01/18/19 at 4:15pm revealed:
-Resident #4 had white compression stocking and he kept them in his room.
-She usually worked second shift and Resident #4 did not usually have his compression stockings on when she would check to remove them at night.
-The resident could remove the compression stockings himself so she thought the resident removed them at night and she would document them as removed on the MAR.
-She did not realize the resident was not wearing the compression stockings.
-She last saw the resident's compression stockings "about a week ago" in his room hanging on his walker.
-The resident's legs had been swollen for "a couple of months" and the left lower leg was usually swollen more than his right leg.

Interview with a medication aide (MA) on 01/22/19 at 11:32am revealed:
-Resident #4 usually put the compression stockings on himself.
-If he had any difficulty getting them on, he could use his call bell and get staff.
-She thought Resident #4 was wearing his compression stockings this morning (01/22/19) since she documented they were on the MAR.
-She could not recall for sure if they were on and she did not remember the color of his compression stockings but she thought they were beige.
She usually tried to visually check to see if the

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resident was wearing the compression stockings on the mornings she worked.
-She could not explain why she would document the resident's compression stockings were on when she did not always physically check to see if they were on.
-She could not recall the last time she saw Resident #4 wearing the compression stockings.
-Resident #4's lower legs were always swollen but some days they were swollen more than other days.
-The resident's left leg was always swollen more than the right leg.
-Second shift staff were supposed to remove the compression stockings.
-Resident #4 would sometimes take off his compression stockings before he was supposed to.
-The resident's compression stockings were supposed to be kept in his room.
-She would check his room for the compression stockings.

Observation on 01/22/19 at 11:55am revealed:
-The MA checked Resident #4's bedroom and living room for his compression stockings.
-She could not find the compression stockings.

Interview with Resident #4's primary care provider (PCP) on 01/17/19 at 12:35pm revealed:
-Resident #4 had swelling in both lower extremities.
-The resident had an order to wear compression stockings and that order had not been discontinued.
-The resident should wear the compression stockings every day.

Interview with the Director of Resident Care (DRC) on 01/22/19 at 12:45pm revealed:

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D 276	Continued From page 57 -She had seen Resident #4 wear his compression stockings. -She thought the last time she observed the resident wearing his compression stockings was one day last week. -The resident would sometimes take the compression stockings off himself. -The MAs were supposed to physically check and make sure the resident was wearing the compression stockings prior to documenting on the MAR. -If the resident was not wearing the compression stockings, the MAs should notify her and the PCP. A second interview with the DRC on 01/22/19 at 6:20pm revealed: -They had ordered a new pair of compression stockings for Resident #4. -The new compression stockings would be delivered by the pharmacy later tonight. b. Review of Resident #4's physician order dated 10/04/18 revealed an order to check blood pressure weekly, notify PCP if systolic blood pressure (SBP) is greater than (>) 170 or less than (<) 100, diastolic blood pressure (DBP) > 100 or <50. Review of Resident #4's October 2018 medication administration record (MAR) revealed: -There was a handwritten entry to check blood pressure once weekly, notify physician if SBP >170 or <100, DBP >100 or <50. -The blood pressure was scheduled to be taken on 3pm to 11am shift once a week. -The blood pressure scheduled to be checked on 10/19/18 was blank with no reason documented. -The blood pressure was taken 3 out 4 weeks and ranged from 126/72 - 130/70.	D 276		

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D 276	Continued From page 58 -The resident was receiving 3 medications that lowered blood pressure including Furosemide, Metoprolol, and Hyzaar. Review of Resident #4's November 2018 MAR revealed: -There was a computer printed entry to check blood pressure once weekly, notify physician if SBP >170 or <100, DBP >100 or <50. -There was no time scheduled and no dates marked to check the blood pressure. -There were no blood pressures documented for November 2018. -The resident was receiving 3 medications that lowered blood pressure including Furosemide, Metoprolol, and Hyzaar. Review of Resident #4's December 2018 MAR revealed: -There was a computer printed entry to check blood pressure once weekly, notify physician if SBP >170 or <100, DBP >100 or <50. -The blood pressure was scheduled to be taken on 3pm to 11am shift once a week. -The blood pressure scheduled to be checked on 12/07/18 was not done due to the resident being in the hospital from 12/06/18 - 12/10/18. -The blood pressures scheduled to be checked on 12/14/18, 12/21/18, and 12/28/18 were blank with no reason documented. -The resident was receiving 3 medications that lowered blood pressure including Furosemide, Metoprolol, and Hyzaar. Review of Resident #4's January 2019 MAR revealed: -There was a computer printed entry to check blood pressure once weekly, notify physician if SBP >170 or <100, DBP >100 or <50. -There was no time scheduled and no blood	D 276		

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pressure was documented for January 2019.
-There was a handwritten note, "D/C" (discontinue), but no initials or date documented.
-The resident was receiving 2 medications that lowered blood pressure including Furosemide and Hyzaar.

Interview with Resident #4's primary care provider (PCP) on 01/17/19 at 12:35pm revealed:
-Resident #4's blood pressure was supposed to be checked weekly.
-She was not aware the resident's blood pressure was not being checked as ordered.
-No one had contacted her about the resident's blood pressure order.
-The resident's blood pressure had been stable during his visits with her.

Interview with Resident #4 on 01/18/19 at 3:50pm revealed he could not recall when staff last checked his blood pressure.

Interview with a medication aide (MA) on 01/18/19 at 4:15pm revealed:
-She had not checked Resident #4's blood pressure this month because it was noted as discontinued on the MAR.
-For the previous months, if the resident's blood pressure was checked it would be documented on the MAR.
-She did not know why the resident's blood pressure had not been checked as ordered.

Interview with the Director of Resident Care (DRC) on 01/22/19 at 12:45pm revealed:
-Resident #4's weekly blood pressures should have been done and documented on the MARs.
-There was no order to discontinue the blood pressure checks.

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D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a registered nurse completed an on-site Licensed Health Professional Support (LHPS) review and evaluation quarterly including a physical assessment for 2 of 5 residents (#3, #4) sampled including Resident #4 who had orders to wear	D 280		

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compression stockings and Resident #3 who required assistance with transferring and assistance with ambulating with an assistive device

The findings are:

1. Review of Resident #4's current FL-2 dated 12/10/18 revealed diagnoses included gastrointestinal bleed, atrial fibrillation, coronary artery disease, bradycardia, chronic combined systolic and diastolic congestive heart failure, acute kidney injury, anemia, and Alzheimer's dementia.

Review of Resident #4's assessment and care plan dated 05/21/18 revealed the resident's licensed health professional support (LHPS) task was wearing compression stockings daily.

Review of Resident #4's physician order dated 05/21/18 revealed an order for compression stockings to be put on in the morning and removed at bedtime.

Observations of Resident #4 revealed:
-The resident was not wearing compression stockings on 01/15/19 at 10:20am, 01/17/19 at 6:05pm, 01/18/19 T 3:50pm, 01/22/19 at 11:14am,
-Both of the resident's lower extremities were swollen during each observation.
-The left ankle was always swollen more than the right ankle.

Interview with Resident #4 on 01/17/19 at 6:05pm and 01/22/19 at 11:14am revealed:
-He had worn compression stockings but he stopped wearing them about 3 to 4 weeks ago because his feet were cold and tingled.

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D 280	Continued From page 62 -He was not wearing compression stockings because he did not know where the stockings were located. -His legs were swollen so badly "about 3 months ago" that the compression stockings would not fit. -The swelling in his legs were not improving much. Review of Resident #4's LHPS reviews revealed: -There was a LHPS review dated 08/17/18 and 01/14/19. -There was no quarterly LHPS review completed in November 2018. Review of Resident #4's LHPS review dated 01/14/19 revealed: -The resident's LHPS task was applying and removing compression stockings. -The LHPS nurse noted the resident's skin was warm and dry and he had compression stockings applied daily and removed at night. -The LHPS nurse noted "there is no edema". -There was no documentation in the assessment to indicate if staff or the resident applied and removed the compression stockings. -There was no documentation regarding the missed applications and removals on the MARs. -There was no documentation to indicate the resident was wearing the compression stocking during the assessment. -There was no documentation of the resident's recent complaints of his feet being cold and tingling. Telephone interview with the LHPS Registered Nurse (RN) on 01/22/19 at 6:45pm revealed: -She knew the LHPS reviews were supposed to be done quarterly. -She was responsible for doing LHPS reviews at this facility.	D 280		

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-She had gotten behind with the LHPS reviews at this facility.
-The protocol was for her to include a physical assessment with the LHPS reviews.
-She did not do a quarterly LHPS review for Resident #4 when it was due in November 2018 because she was running behind on the reviews.
-She did the LHPS review on 01/14/19 when she saw the resident near the dining room area.
-The resident pulled the bottom of his pants up and he was wearing compression stockings.
-She could not recall the color of the resident's compression stockings.
-She did not pull the compression stockings down or physically touch the resident's legs to assess for swelling.
-The resident's legs did not appear to be swollen.
-She did not check the skin integrity of the resident's legs.
-She physically assessed skin integrity and physically checked for pitting edema (swelling) during previous LHPS evaluations.
-She could not explain why she did not do that for this LHPS review.
-She did not know Resident #4 had been complaining about his feet being cold and tingling.
-She did not recall seeing the documentation in the resident's record about the recent concerns and symptoms of cold feet.

2. Review of Resident #3's current FL-2 dated 6/18/18 revealed diagnoses included Dementia.

Review of a Licensed Health Professional Support (LHPS) review for Resident #3 dated 01/31/18 revealed:
-An assessment and evaluation was completed on 01/31/18 for Resident #3.
-LHPS tasks for Resident #3 included 2 person

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assistance with transfers using sit to stand lift, feeding assistance, and ambulation assistance with wheelchair.
-There were no recommendations for follow up.

Review of a Licensed Health Professional Support (LHPS) review for Resident #3 dated 06/22/18 revealed:
-An assessment and evaluation was completed on 06/22/18 for Resident #3.
-LHPS tasks for Resident #3 included 2 person assistance with transfers using sit to stand lift and ambulation assistance with wheelchair.
-There was no mention of feeding assistance.
-There were no recommendations for follow up.

Review of a LHPS review for Resident #3 dated 01/14/19 revealed:
-An assessment and evaluation was completed on 01/14/19 for Resident #3.
-LHPS tasks for Resident #3 included 2 person assistance with transfers lift and ambulation assistance with wheelchair.
-There was no mention of feeding assistance.
-There were no recommendations for follow up.

Review of LHPS reviews for Resident #3 dated 01/31/18 through 01/14/19 revealed there was no assessment completed for the second (March 2018) and third (September 2018) quarters.

Interview with the Regional Nurse on 01/22/19 at 6:23 pm revealed:
-She did not know Resident #3 did not have an LHPS review completed quarterly.
-She was currently working on setting up a tickler to show all the residents dates due for LHPS reviews so she could see the list on her computer even if she was not in the facility.

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D 280	Continued From page 65 Interview with the Regional Nurse Consultant Region 14 on 01/22/19 2 6:45 pm revealed: -She knew Resident #3 did not have a quarterly LHPS completed. -She stated "I got behind in that particular community." -She was responsible for LHPS assessments at the facility.	D 280		
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: Based on observations and interviews, the facility failed to assure the special care unit kitchen and dining room areas including the sink splash, counters, refrigerator, beverage dispenser, exit doors, walls and floors were kept clean and free of contamination. The findings are: Observations of the special care unit (SCU) dining room and kitchen on 01/15/19 between 10:37am and 10:50am revealed: -There were dried yellow, brown and red drip marks and splatter spots on the dining room wall next to the kitchen sink. -There were dried brown and dark brown drip marks and splatter spots on the wall behind the kitchen sink. -There was a dried brown substance on the side	D 282		

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of the paper towel dispenser on the wall next to the kitchen sink.
-There was a heavy accumulation of dried red drip marks on the front of the beverage dispenser.
-There was a thick layer of dust built up on the side vent of the beverage dispenser.
-There were dried brown stains, red/brown stains and spilled shredded cheese on the inside bottom of the refrigerator.
-There was a moderate amount of food crumbs under the tables and in the corners on the floor.
-There were dried yellow, brown and red drip marks and splatter spots on the dining room wall facing the rear windows.
-There was a heavy accumulation of black spots along all of the edges of the exit doors to the outside patio.

Interview with a housekeeper on 01/16/19 at 8:53am revealed:
-She cleaned the SCU kitchen and dining room twice each week.
-She sanitized and wiped down the sink, cabinets and counter, swept and mopped the floors.
-She was not sure who was responsible for cleaning the refrigerator and beverage dispenser.

Interview with a personal care aide (PCA) on 01/15/19 at 3:48pm revealed:
-The PCAs were responsible for cleanup of the SCU kitchen and dining room when each meal was done.
-Clean up included loading the dishwasher, wiping off the counters and sweeping the floors.
-The 1st shift PCA was responsible for cleaning the beverage dispenser; it was supposed to be cleaned after each use.
-The medication aide (MA) was responsible for checking the cleanliness of the SCU kitchen and

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dining room each shift.

Interview with a second PCA on 01/16/19 at 8:55am revealed:
-The PCAs were responsible for cleaning the SCU kitchen and dining room after each meal.
-Cleaning included washing the dishes, cleaning the counter, switching out the table clothes, setting the table, sweeping the floor and taking out the garbage.
-The beverage dispenser was cleaned twice each week; if she did not clean it then the 2nd shift PCA cleaned the beverage dispenser.
-She cleaned spatter and spills from the SCU kitchen and dining room whenever she noticed them.
-The refrigerator was cleaned on 01/16/19 by the Special Care Director (SCD); normally a 1st or 2nd shift PCA cleaned the refrigerator in the SCU dining room once or twice each month.

Interview with a medication aide (MA) on 01/15/19 at 4:45pm revealed:
-She was responsible for MA duties on the SCU and the 1st floor of the assisted living (AL).
-The PCAs were responsible for cleaning the SCU kitchen and dining room after each meal.
-The PCAs were responsible for putting the dishes in the dish washer, sweeping the floors and resetting the tables with clean linens and clean dishes.
-The 3rd shift PCA was responsible for mopping the floor in the SCU kitchen and dining room.

Interview with the Maintenance Director on 01/15/19 at 11:26am revealed:
-The PCAs did "some cleaning" in the SCU dining room and kitchen daily.
-The housekeeping staff swept and mopped the SCU dining room and kitchen floor twice each

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D 282	Continued From page 68 week. -He was not sure whether PCAs or housekeepers were responsible for cleaning the refrigerator. -Housekeeping staff reported to the Maintenance Director; he was responsible for checking the quality of work done by the housekeeping staff. Interview with the Special Care Director (SCD) on 01/15/19 at 3:40pm revealed: -The housekeeper did a "detailed" cleaning of the SCU kitchen and dining room twice each week. -The PCAs swept the floors and cleaned the counters daily in the SCU kitchen and dining room. -She was not sure who was responsible for cleaning the refrigerator and beverage dispenser. -She was not sure who was responsible for checking the cleanliness of the SCU kitchen and dining room on a daily basis. Interview with the Wellness Coordinator on 01/18/19 at 3:25pm revealed it had never been clear who (PCAs or housekeeping) was responsible for cleaning the SCU kitchen and dining room which resulted in things frequently not being cleaned. Interview with the Executive Director (ED) on 01/22/19 at 6:13pm revealed: -It was a joint effort to clean the SCU kitchen and dining room. -Cleaning of the SCU kitchen and dining room should include housekeeping and dietary staff.	D 282		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes:	D 297		

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D 297	Continued From page 69 (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure there was at least 10 hours between the breakfast and evening meal with breakfast served at 8:00am and dinner served at 4:00pm. The findings are: Interview with the Wellness Coordinator on 01/15/19 at 4:35pm revealed: -The meal times for the assisted living (AL) were 7:30am for breakfast, 11:30am for lunch and 4:00pm for dinner. -The meal times for the special care unit (SCU) were 8:00am for breakfast, 12:00pm for lunch and 5:00pm for dinner. Interview with a resident on 01/17/19 at 6:00pm revealed the only thing she did not like was eating supper at 4:00 pm and waking up at midnight and staring at the ceiling because she was hungry. Observation on 01/16/19 at 8:45am revealed there were residents in the main dining room on the 1st floor eating breakfast. Observation on 01/16/19 at 8:56am revealed a personal care aide (PCA) was clearing dishes from the tables and wiping the tables with a cloth. Observation on 01/16/19 at 4:40pm revealed there were resident who had finished the dinner meal and were leaving the 1st floor main dining room.	D 297		

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D 297	Continued From page 70 Observations on 01/16/19 at 5:15pm revealed there were 12 residents eating dinner in the SCU dining room. Interview with a personal care aide (PCA) on 01/17/19 at 1:58pm revealed on the SCU breakfast was served at 8:00am, lunch at 12:00pm and dinner at 5:00pm. Interview with the Executive Chef on 01/17/19 at 2:40pm revealed: -The meal times had been standard since he started working at the facility five years ago. -He thought the 10 hours meant between the dinner meal and breakfast the next morning. Interview with the Executive Director (ED) on 01/17/19 at 6:30pm revealed: -She was not aware that the facility meal times were a problem. -The Executive Chef was going to follow up on the meal times.	D 297		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure snacks were	D 298		

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consistently served three times daily to residents on the Assisted Living Unit.

The findings are:

Review of the facility official menu titled "Southern FW 18 FVE" and dated 11/12/18 revealed:
-There were meal items listed for regular, mechanical soft, puree, consistent carbohydrate, heart healthy and no added salt diets.
-Each page was for one meal, for example, the dinner meal for the above listed diets was on one page.
-There were no snacks listed.

Observations on the assisted living (AL) 3rd floor on 01/15/19 from 1:55 pm until 2:45 pm revealed:
-The snack cart was delivered at 1:55 pm and left outside the Tea Room's doors.
-The snack cart contained 13 small plastic dessert cups which contained the following:
-There were 5 cups of pretzels.
-There were 6 cups of pears.
-There were 2 cups of yellow pudding with vanilla wafer type cookies.
-There was a plastic beverage pitcher containing ice and a reddish brown clear liquid.
-At 2:45 pm, the snack cart was still present by The Tea Room's doors with the same items listed above.

Observations on the assisted living (AL) 3rd floor on 01/16/19 from 1:45 pm until 2:34 pm revealed:
-The snack cart was delivered at 1:45 pm and left outside the Tea Room's doors.
-The snack cart contained 42 small plastic dessert cups which contained the following:
-There were 3 cups of pretzels.
-There were 4 cups of pears.
-There were 32 cups of brown pudding.

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-There were 3 cups of mixed diced fruit.
-There was 1 cup of strawberries.
-There were 2 plastic beverage pitchers (1-clear &1 blue) containing ice and liquids.
-The clear pitcher contained light amber colored liquid with ice.
-The liquid in the blue pitcher was not observable due to the color of the pitcher.
-At 2:34 pm, the snack cart was still present by the Tea Room's doors with the same items listed above.

Observations on the assisted living (AL) 3rd floor on 01/17/19 from 9:05am until 11:45am revealed there was no 10:00am snack served to residents.

Interview with a resident on the AL on 01/17/19 at 6:00 pm revealed sometimes she would get snacks at night every now and then, but it was not consistent.

Confidential interview with a resident revealed:
-Snacks were offered occasionally but not much.
-The resident usually received a snack about once a week during the daytime.

Confidential interview with a second resident revealed:
-The resident got some snacks at the facility.
-The resident could not say how often the resident got snacks but it was not every day.

Confidential interview with a third resident revealed the resident got snacks only once or twice a week.

Observation on 01/17/19 at 6:46pm revealed:
-A care manager (CM) delivered a cup of banana pudding and red fruit punch to two residents.
-One resident told the CM that the resident did

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not like bananas.
-The CM left the banana pudding for the resident and did not offer an alternative snack.

Confidential interview with the two residents revealed:
-They had never received a snack a bedtime.
-This was the first time they had ever received a bedtime snack.
-They usually got snacks about once a week.

Interview with the Executive Chef on 01/15/2019 at 4:34 pm revealed:
-He has been employed for 5 years as the Executive Chef.
-His department was responsible for prepping, and preparing snacks for the residents.
-Snacks and drinks were provided to the residents at 10:00 am, 2:00 pm, and 6:30pm.
-There were residents with diets of regular, mechanical soft, puree, regular consistent CHO (controlled carbohydrate), heart healthy, and NAS (no added salt).
-Dietary staff prepared snacks to compliment the diets of all residents, from chocolate, vanilla puddings, pretzels, to fresh fruit, etc.
-Dietary staff placed the snacks, drinks, cups, and eating utensils on a black cart.
-Dietary staff delivered the black carts to the elevator area to each floor (there were three floors at the facility).
-Dietary staff went to the facility front desk and made a page to nursing to pick up snack carts and provide snacks to the residents.

Interview with a dietary aide on 01/15/2019 at 3:51 pm revealed:
-Her department was responsible for getting the snacks together for the residents.
-Dietary staff pushed the carts to the elevator

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area and go to the front desk and page the nursing staff to come get the carts and serve the residents their snacks.
-The resident snack times were 10:00 am, 2:00pm, and 6:30pm.
-Once the nursing staff were done with snack time, they usually bring the carts back to the kitchen.

Observation of the same 3 shelf rolling black cart, had no staff present and no residents provided snacks. The black cart was left unattended on the assisted living (AL) 3rd floor near the tea room and elevator on 1/16/2019 from 2:29 pm to 3:06 pm revealed:
-The top shelf of the rolling black cart contained 42 small plastic dessert cups, with see thru plastic lids which contained the following:
-There were 31 cups of brown pudding substance
-There were 3 cups of cut up pears
-There were 3 cups of pretzels
-There were 2 cups of cut up strawberries
-There were 3 cups of fruit cocktail
-There were a pile of several white plastic spoons enclosed in plastic
-There were 1 stack of (10) 12 ounce beverage cups beside a (1) 60 ounce brown plastic beverage pitcher with liquid and ice wrapped with plastic saran wrap.
-There were 1 stack of (8) 12 ounce beverage cups beside a 1 dark blue plastic beverage pitcher with liquid and ice wrapped with plastic saran wrap.
-Two personal care aide (PCA) got off the elevator on the 3rd floor, after exiting the elevator, saw the unattended black cart with the snacks near the elevator and continued to walk down the hallway towards a resident room.
-A different PCA at 3:07 pm at the 3rd floor elevator poured tea and began giving residents

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D 298	Continued From page 75 snacks. -The scheduled time for resident snacks were 10:00 am, 2:00 pm, and 6:30pm.	D 298		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents (#3) with a primary care provider order for nectar thick liquids received thickened milk for meals. The findings are: Review of Resident #3's current FL-2 dated 06/18/18 revealed diagnoses included dementia. Review of a diet order sheet for Resident #3 dated 06/18/18 revealed there was an order for a pureed diet and nectar thickened liquids. Review of the undated diet list for the special care unit (SCU) revealed there was one resident (#3) listed on thickened liquids.	D 299		

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D 299	Continued From page 76 Observation on 01/15/19 at 10:50am and 01/16/19 at 5:20pm revealed there was no nectar thickened milk in the refrigerator on the special care unit (SCU). Observations of the lunch meal on the special care unit (SCU) on 01/16/19 from 12:25pm until 1:01pm revealed: -At 12:25pm, Resident #3 was served a cup of honey thick tea, nectar thick water and nectar thick cranberry juice with her lunch meal. -At 1:01pm, Resident #3 left the dining room and no thickened milk had been served. Observations of the dinner meal on the SCU on 01/16/19 at 5:16pm revealed: -A personal care aide (PCA) was assisting Resident #3 with eating the dinner meal in her room (#12). -Resident #3 had a pureed meal and nectar thick cranberry juice; there was no thickened milk with the meal. Observation on 01/17/19 at 1:58pm revealed there was a container of premade nectar thick milk in the refrigerator on the SCU with a hand written open date of 01/17/19. Observations during the dinner meal on the SCU on 01/17/19 from 6:07pm until revealed: -A PCA was assisting Resident #3 with eating the dinner meal in her room. -Resident #3 had a pureed meal and nectar thick cranberry juice; there was no thickened milk with the meal. Interview with a PCA on 01/17/19 at 1:58pm revealed: -Premade thickened milk was served to residents	D 299		

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with each meal the same as regular milk.
-The facility kept stock of premade thickened milk.
-The kitchen staff was supposed to bring premade thickened liquids to the SCU.
-Sometimes the PCA would have to go to the kitchen and get premade thickened liquids for the SCU.
-The thickened liquids were set up in an organized way in the main kitchen of the facility, so PCAs knew where to go and what to get.
-PCAs knew which residents needed thickened liquids because it was verbally reported by the medication aide (MA) for a new resident, there was a diet list in the PCA communication book and it was also documented on the medication administration record (MAR).

Interview with the Executive Chef on 01/17/19 at 2:40pm revealed usually the SCU staff went to the main kitchen stock room and took whatever they needed as far as premade thickened liquids.

Interview with the Special Care Director (SCD) on 01/17/19 at 2:31pm revealed:
-Staff were expected to served milk thickened and regular with all three meals.
-If a resident was not in the dining room for a meal, she expected staff to pour the thickened milk and take it to the resident's room.
-She was not sure of the process, but thought the SCU staff let the Executive Cook know which thickened liquids were needed on the SCU so it could be ordered.
Interview with the Executive Director (ED) on 01/22/19 at 6:13pm revealed:
-Staff were expected to serve thickened the same as regular milk.
-There were trays available to carry meals and drinks to resident rooms when the resident did

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D 299	Continued From page 78 not eat in the dining room. -There were premade thickened liquids stored in the main kitchen; kitchen staff delivered and staff was able to pick up what they needed also. -Premade nectar thick milk was available and should have been served to Resident #3. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 299		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents (#3) with a primary care provider order for nectar thick liquids received thickened water for meals. The findings are: Review of Resident #3's current FL-2 dated 06/18/18 revealed diagnoses included dementia. Review of a diet order sheet for Resident #3 dated 06/18/18 revealed there was an order for a pureed diet and nectar thickened liquids. Review of the undated diet list for the special care	D 306		

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unit (SCU) revealed there was one resident (#3) listed on thickened liquids.

Observations of the dinner meal on the SCU on 01/16/19 at 5:16 pm revealed:
-A personal care aide (PCA) was assisting Resident #3 with eating the dinner meal in her room.
-Resident #3 had a pureed meal and nectar thick cranberry juice; there was no thickened water with the meal.

Observations during the dinner meal on the SCU on 01/17/19 from 6:07 pm until revealed:
-A PCA was assisting Resident #3 with eating the dinner meal in her room.
-Resident #3 had a pureed meal and nectar thick cranberry juice; there was no thickened water with the meal.

Interview with a PCA on 01/17/19 at 1:58 pm revealed:
-Thickened water were served to residents with each meal the same as regular water.
-The facility kept stock of thickened water.
-The kitchen staff was supposed to bring premade thickened liquids to the SCU.
-Sometimes the PCA would have to go to the kitchen and get thickened liquids for the SCU.
-The thickened liquids were set up in an organized way in the main kitchen of the facility, so PCAs knew where to go and what to get.
-PCAs knew which residents needed thickened liquids because it was verbally reported by the medication aide (MA) for a new resident, there was a diet list in the PCA communication book and it was also documented on the medication administration record (MAR).

Interview with the Executive Chef on 01/17/19 at

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D 306	Continued From page 80 2:40 pm revealed usually the SCU staff went to the main kitchen stock room and took whatever they needed as far as thickened liquids. Interview with the Special Care Director (SCD) on 01/17/19 at 2:31 pm revealed: -Staff were expected to serve water, thickened and regular with all three meals. -If a resident was not in the dining room for a meal, she expected staff to pour the thickened water and take it to the resident's room. -She was not sure of the process, but thought the SCU staff let the Executive Cook know which thickened liquids were needed on the SCU so it could be ordered. Interview with the Executive Director (ED) on 01/22/19 at 6:13 pm revealed: -Staff were expected to serve thickened water the same as regular water. -There were trays available to carry meals and drinks to resident rooms when the resident did not eat in the dining room. -There were premade thickened liquids stored in the main kitchen; kitchen staff delivered and staff was able to pick up what they needed also. -Premade nectar thick water was available and should have been served to Resident #3. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional	D 310		

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D 310	Continued From page 81 supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents (#3) received nectar thickened beverages including water, tea, milk and juice. The findings are: Review of Resident #3's current FL-2 dated 06/18/18 revealed diagnosis of dementia. Review of a diet order sheet for Resident #3 dated 06/18/18 revealed there was an order for a pureed diet and nectar thickened liquids. Review of the undated diet list for the special care unit (SCU) revealed there was one resident (#3) listed on thickened liquids. Observations of the lunch meal on the SCU on 01/16/19 at 12:25pm revealed Resident #3 was served a cup of honey thick tea, nectar thick water and nectar thick cranberry juice with her lunch meal. Observations during the dinner meal on the SCU on 01/17/19 from 6:07pm until revealed: -At 6:07 pm, the second PCA returned with premade honey thickened liquids and the PCA	D 310		

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sent the second PCA back for "nectar thick, not honey thick".
-At 6:10 pm, the second PCA left the dining room with a plate wrapped in plastic wrap and went towards the activity room and Resident #3's room.
-At 6:13 pm, the second PCA sat down to assist Resident #3 with eating the dinner meal.

Interview with a personal care aide (PCA) on 01/17/19 at 1:58pm revealed:
-She did not pour the honey thick tea for Resident #3's lunch meal on 01/16/19, so she did not know what happened and that had not happened before to her knowledge.
-The kitchen staff was supposed to bring thickened liquids to the SCU.
-Sometimes the PCA would have to go to the kitchen and get thickened liquids for the SCU.
-The thickened liquids were set up in an organized way in the main kitchen of the facility, so PCAs knew where to go and what to get.
-PCAs knew which residents needed thickened liquids because it was verbally reported by the medication aide (MA) for a new resident, there was a diet list in the PCA communication book and it was also documented on the medication administration record (MAR).
-The facility kept stock of thickened water, milk, tea and juice.

Telephone interview with Resident #3's family member on 01/21/19 at 7:40pm revealed:
-Resident #3 was "on a pureed diet with thickened liquids so she (Resident #3) did not choke."
-It was hard for Resident #3 to swallow.

Interview with the Executive Chef on 01/17/19 at 2:40 pm revealed usually the SCU staff went to

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D 310	Continued From page 83 the main kitchen stock room and took whatever they needed as far as thickened liquids. Interview with the Special Care Director (SCD) on 01/17/19 at 2:31 pm revealed: -She was not sure of the process, but thought the SCU staff let the Executive Cook know which thickened liquids were needed on the SCU so it could be ordered. -Staff were expected to serve thickened liquids as ordered with all three meals. -If a resident was not in the dining room for a meal, she expected staff to pour the thickened liquids and take to the resident's room. Interview with the Executive Director (ED) on 01/22/19 at 6:13 pm revealed: -Staff were expected to serve thickened liquids as ordered. -There were thickened liquids stored in the main kitchen; kitchen staff delivered and staff were able to pick up what they needed also. -Nectar thick tea, juice, water and milk were available and should have been served to Resident #3. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 310		
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.	D 338		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure dignity, respect and consideration for one resident (#3) by failing to provide timely feeding assistance in a manner that included Resident #3 in the meal service for two observed meals resulting in Resident #3 waiting 25 minutes for assistance with eating while seated in the special care unit (SCU) dining room as other residents ate their lunch meal and Resident #3 being in her room during the dinner meal and not served or provided assistance until one hour and 15 minutes after the meal was served in the dining room.

The findings are:

Review of Resident #3's current FL-2 dated 06/18/18 revealed diagnoses included dementia.

Review of Resident #3's current care plan dated 04/16/18 revealed she required extensive assistance with eating.

Observations on the SCU on 01/16/19 from 11:55am until 1:29pm revealed:
-At 11:55am, the Special Care Director (SCD) and the medication aide (MA) were in the dining room pouring beverages for each table.
-At 12:00pm, 9 residents were seated in the

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dining room, including Resident #3.
-At 12:09pm, the SCD was serving soup to residents seated in the dining room and the MA was removing unused clean dishes from tables.
-The MA served premade plates wrapped in a plastic wrap to residents at two tables near the exit door in the dining room.
-At 12:12pm, a personal care aide (PCA) assisted a 12th resident to the dining room.
-At 12:15pm, a second PCA walked through the entrance door to the SCU.
-At 12:21pm, the second PCA was assisting a resident with eating the lunch meal at the table where Resident #3 was seated, but Resident #3 still did not have any beverage or a plate.
-At 12:23pm, the PCA entered the dining room with thickened beverages.
-At 12:25pm, the PCA sat down to assist Resident #3 with eating the lunch meal.
-At 12:42pm, Resident #3's plate was removed from the table with less than 10% of the meal eaten.
-At 12:48pm, the PCA was assisting Resident #3 with eating chocolate pudding.
-At 12:58pm, Resident #3 finished eating her chocolate pudding.
-At 1:01pm, Resident #3 left the dining room.

Interview with a PCA on 01/17/19 at 1:58pm revealed:
-There were two PCAs and a MA for the breakfast meal, but the MA would be administering medications.
-The SCD helped out when she could.
-There were five residents including Resident #3 that needed staff assistance with eating meals and there were only two PCAs on duty.
-There were more residents that needed assistance than there were staff to help, so some residents would have to wait for staff to help.

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D 338	Continued From page 86 -The SCD was aware of how many residents needed assistance and how many staff there were. Interview with the Special Care Director (SCD) on 01/17/19 at 2:31pm revealed: -She was aware of the 25 minute delay in assisting Resident #3 with her lunch meal on 01/16/19. -There were only two residents including Resident #3 who needed assistance with eating meals, the other three residents were able to feed themselves with encouragement. -The corporate office had determined the number of staff and the duties each shift were responsible for. -She did not know PCAs should not be assigned dietary responsibilities that interfered with resident care. -She had discussed the concern with the Executive Director on 01/17/19 and there were plans to hire a dietary aide for the SCU. Observations on the SCU on 01/16/19 from 5:15pm until 5:20pm revealed: -There were 12 residents eating the dinner meal in the dining room. -The MA was assisting a male resident with eating and a PCA was assisting a female resident with eating in the dining room. -A second PCA was assisting Resident #3 with eating the dinner meal in her room. Interview with the second PCA on 01/16/19 at 5:15pm revealed: -It was "hard to feed her (Resident #3), "but we try." -Resident #3 frequently closed her mouth when the PCA attempted to offer a spoonful of food. -Resident #3 was not in the dining room for the	D 338		

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dinner meal because the 1st shift staff had told him when Resident #3 was up out of the bed for 1st shift, "it was better for her (Resident #3) to be in the bed for 2nd shift."

Observations of the dinner meal on the SCU on 01/17/19 from 4:57pm until 6:15pm revealed:
-At 4:57pm, a PCA was pouring beverages for each table in the dining room and a MA was assisting a resident in the hall to the dining room.
-At 5:00pm, Resident #3 was lying in her bed with a blanket to her waist and her shirt raised revealing her side, abdomen and back.
-Resident #3 was emaciated with a sunken in abdomen and individual rib bones visible.
-Resident #3's room was in the corner of a small hallway, off of a small hallway to the main hallway on the SCU.
-At 5:10pm, the PCA was putting food on resident plates and serving residents in the dining room.
-At 5:21pm, there were 13 residents in the dining room; Resident #3 was not in the dining room.
-From 5:25pm until 5:49pm, the PCA and the MA were assisting residents in the dining room with the dinner meal; at 5:49pm, the MA left the SCU.
-From 5:55pm until 6:10pm, there were two PCAs assisting residents to the activity room and cleaning the SCU kitchen and dining room.
-At 6:10pm, the second PCA left the dining room with a plate wrapped in plastic wrap and went towards the activity room and resident room #12.
-At 6:12pm, the second PCA left the dining with a cloth napkin, a spoon and a glass of nectar thick cranberry juice and went to Resident #3's room (#12).
-At 6:13pm, the second PCA sat down to assist Resident #3 with eating the dinner meal.

Interviews with the MA on 01/17/19 between 4:57pm and 5:31pm revealed:

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-There was one PCA and her working on the SCU for 2nd shift on 01/17/19.
-The second PCA who was scheduled to work had not come in yet.
-She was told by the Director of Resident Care (DRC) that the second PCA would be in at 5:40pm.

Interview with the second PCA on 01/17/19 at 6:23pm revealed:
-The 1st shift staff had put Resident #3 in the bed just before 3:00pm.
-Staff put Resident #3 in the bed so that the resident's buttocks got some rest.
-He usually fed Resident #3 in her room for the dinner meal.

Interview with the SCD on 01/17/19 at 5:40pm and 6:17pm revealed:
-She did know the second PCA was not going be at work until 5:40pm.
-She did not know that Resident #3 was not in the dining room for the dinner meal.
-Staff had informed her right before the second PCA arrived for work at 5:38pm.
-Resident #3 was usually up out of bed for meals.
-There was usually someone to cover when a staff was late coming to work, but no one covered for the second PCA especially through the dinner meal on 01/17/19.

Interview with the Executive Director (ED) on 01/17/19 at 6:30pm revealed:
-She did not know that Resident #3 had delays 25 minutes to over one hour in getting eating assistance due to staff performing dietary aide duties and assisting other residents.
-She did not know why Resident #3 was in her room during the dinner meal on 01/17/19.
-She would discuss Resident #3's meal routine

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D 338	Continued From page 89 with the staff on the SCU and develop a plan to provide timely eating assistance that included Resident #3 in the meal service. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	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: TYPE B VIOLATION 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 (#6, #7, #8, #9, #10) observed during the medication passes including errors with medications used to	D 358		

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treat high blood pressure and depression (#9, #10), application of a patch to treat nerve pain with no instructions noted on the order (#10), administration of a medication to treat Parkinson's disease given at the wrong time (#8), crushing and administering a medication that should not be crushed (#6) and missed doses of a medication for constipation (#7); and for 1 of 5 residents (#4) sampled whose diuretic was not administered as ordered.

The findings are:

1. The medication error rate was 25% as evidenced by the observation of 8 errors out of 32 opportunities during the 9:00am and 10:00am medication passes on 01/16/19, and 8:00am and 9:00am medication passes on 01/17/19.

a. Review of Resident #6's current FL-2 dated 01/7/19 revealed:
-Diagnoses included hypertension, benign prostatic hyperplasia and vascular dementia.
-There was an order for Aspirin 81mg EC 1 tablet daily. (Aspirin can be used to prevent blood cells from forming a clot. Aspirin EC is enteric coated and should not be crushed or chewed.)

Review of physician orders for Resident #6 revealed an order on 01/14/19, medications could be crushed and place in applesauce or pudding for ease of swallowing.

Observation of the morning medication pass on 01/16/19 revealed:
-The medication aide (MA) crushed all of Resident #6's oral pills, including Aspirin EC, and administered them in pudding to the resident at 8:55am. (Aspirin EC was enteric coated and should not be crushed.)

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D 358	Continued From page 91 -The MA did not use a do not crush (DNC) list to determine which medications could be crushed. Review of Resident #6's January 2019 medication administration record (MAR) revealed: -There was an entry for Aspirin EC 81mg every day at 8:00am. -Aspirin EC was documented as administered daily from 01/01/19 - 01/16/19. -There was no documentation on the MAR related to crushing the resident's Aspirin EC. Observation of Resident #6's medications on hand on 01/16/19 revealed: -There was one supply of Aspirin EC dispensed on 12/24/18. -The bubble card had a sticker that read, "Do Not Chew or Crush, Swallow Whole". Interview with the MA on 01/16/19 at 1:35pm revealed: -She had not noticed there was a label on the Aspirin EC bubble card indicating the pill should not be crushed. -She had not seen a DNC list at the facility. -She was trained two years ago but doesn't remember if the training include a DNC review. -She would check to see if a DNC list was in the Director of Resident Care's office. Interview with the Director of Resident Care (DRC) on 01/16/19 at 2:45pm revealed: -They did not have a DNC list that was kept on the medication carts. -The MAs were supposed to check the MARs and the medication labels for information about crushing the medications. -If there was an order to crush medications, and the medication label indicated the pill should not be crushed, the MA should call the physician.	D 358		

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D 358	Continued From page 92 -She would contact Resident #6's primary care provider (PCP) regarding the Aspirin EC 81mg order to see if it can be changed to chewable. Based on observation, interview, and record review, Resident #6 was not interviewable. Interview with Resident #6's PCP on 01/17/19 at 12:15pm revealed: -Medications were to be crushed for Resident #6 since he had recently had an issue with aspiration. -She was not aware they were crushing Resident #6's Aspirin EC. -She ordered chewable Aspirin today. -Her concern with Resident #6 receiving crushed Aspirin EC was with stomach upset and irritability. b. Review of Resident #7's current FL-2 dated 11/27/18 revealed: -Diagnoses included delirium, Alzheimer's disease with behavioral disturbances, gastroesophageal reflux disease, mild QT prolongation (heart rhythm disorder) and obstructive sleep apnea. -There was an order for Bisacodyl 10mg take every other day. (Bisacodyl is used to treat constipation.) Observation of the 8:00am medication pass on 01/16/19 revealed: -Resident #7's morning medications were prepared and administered to the resident at 9:00am. -Bisacodyl 10mg was not given to Resident #7. Review of Resident #7's January 2019 MAR revealed: -There was no entry for Bisacodyl 10mg on the MAR.	D 358		

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D 358	Continued From page 93 -No Bisacodyl 10mg was documented as administered. Review of Resident #7's December 2018 medication administration record (MAR) revealed: -There was no entry for Bisacodyl 10mg on the MAR. -No Bisacodyl 10mg was documented as administered. Observation of Resident #7's medications on hand on 01/16/19 at 1:35pm revealed there was no Bisacodyl 10mg available for administration. Interview with the medication aide (MA) on 01/16/19 at 1:35pm revealed: -Resident #7 was previously getting Bisacodyl 10mg but maybe it was stopped because of loose stools. -There had not been any reports that Resident #7 had loose stools. Interview with the Director of Resident Care (DRC) on 01/16/19 at 2:45pm revealed: -The DRC, Wellness Coordinator and the MAs were all responsible for making sure all orders were faxed to the pharmacy. -They had all been trained about faxing and checking medication orders. -Every month they performed three checks of the MARs that involved the first two checks performed by a different MA and the third check was performed by the DRC. -She didn't know Resident #7 had an order for Bisacodyl that was not implemented. -She would contact Resident #7's primary care provider (PCP) about the Bisacodyl. Based on observation, interview, and record review, Resident #7 was not interviewable.	D 358		

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D 358	Continued From page 94 Interview with Resident #7's PCP on 01/17/19 at 12:15pm revealed: -She didn't know that Resident #7 had missed 9 doses of Bisacodyl until yesterday. -She would have expected to have been told that the doses were missed. -The resident now had regular bowel movements so she would change the order to as needed. Interview with a personal care aide (PCA) on 01/22/19 at 10:20am revealed: -Resident #7 went to the bathroom on his own. -He had not had an issue with constipation that she was aware of. -The staff stand outside the door of the bathroom to make sure he was going, whether he urinated or had a bowel movement. c. Review of Resident #8's current FL-2 dated 05/18/18 revealed: -Diagnoses included Parkinson's disease, spinal stenosis lumbar region, hypertension, stenosis of right carotid artery, hyperlipidemia, insomnia, and depression. -There was an order for Carbidopa-Levodopa 25mg-100mg (Sinemet 25/100) one tablet three times daily.(Sinemet is used to treat Parkinson's disease.) Review of Resident #8's physician orders for 10/15/18 revealed an order to change the first dose of Sinemet to 6:00am. Review of Resident #8's January 2019 medication administration record (MAR) revealed: -There was a computer printed entry for Sinemet 25/100mg tablet, one three times daily. -The computer printed scheduled time for administration was 6:00am, 1:00pm, 9:00pm.	D 358		

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D 358	Continued From page 95 -Sinemet 25/100mg was documented as administered at 6:00am, 1:00pm, and 9:00pm in January 2019. Observation of the 10:00am medication pass on 01/16/19 revealed: -Sinemet 25/100mg was administered to Resident #8 at 9:23am but documented as administered at 1:00pm. -The 6:00am dose of Sinemet was already documented as administered on the MAR during the 10:00am medication pass. Interview with the medication aide (MA) on 01/16/19 at 3:23pm revealed: -She didn't know that Resident #8's Sinemet morning dose time changed to 6:00am. -She did not recall giving Resident #8 Sinemet at 9:23am today. -The third shift MA would give the 6:00am dose and the next dose should have been administered at 1:00pm. Interview with the Director of Resident Care (DRC) on 01/16/19 at 2:45pm revealed: -She didn't know that Resident #8's Sinemet morning dose time changed to 6:00am. -The third shift MA should have given the 6:00am dose; it should not have been given at 9:23am. -She would notify Resident #8's primary care provider (PCP). Interview with Resident #8 on 01/16/19 at 5:25pm revealed: -She took Sinemet daily at 6:00am, 1:00pm and 9:00pm for her Parkinson's disease. -She had her medication today at 6:00am and 1:00pm. -She did not recall if she had received Sinemet at the 9:00am medication pass.	D 358		

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-The morning dose was recently moved to 6:00am because she was nauseated.
-She had not had any increase in rigidity, stiffness or shakiness lately.

Interview with Resident #8's PCP on 01/17/19 at 12:15pm revealed:
-She was not sure why the neurologist changed Resident #8's Sinemet morning dose time to 6:00am.
-Her concern was that Resident #8 would get overdosed by receiving a dose at 6:00am, 9:23am and then again at 1:00pm.
-Her concern was also that Resident #8 may have increase in tremors, rigidity and stiffness putting her at risk for falls if her Sinemet was not given at times ordered.

d. Review of Resident #9's current FL-2 dated 11/13/18 revealed:
-Diagnoses included hyponatremia, hypertension, and type II diabetes mellitus.
-There was an order for Lisinopril 20 mg daily (Lisinopril is used to treat high blood pressure).

Review of Resident #9's physician's orders dated 11/15/18 revealed an order to discontinue Lisinopril 20mg daily.

Observation of the morning medication pass on 01/16/19 revealed the medication aide (MA) administered Lisinopril 20mg to Resident #9 at 9:48am.

Review of Resident #9's January 2019 medication administration record (MAR) revealed:
-There was an entry for Lisinopril 20mg every day at 9:00am.
-Lisinopril 20mg was documented as administered daily from 01/01/19 - 01/16/19.

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D 358	Continued From page 97 Review of Resident #9's December 2018 MAR revealed: -There was an entry for Lisinopril 20mg every day at 8:00am beginning 12/07/18. -Lisinopril 20mg was documented as administered daily from 12/07/18 - 12/31/18. Review of Resident #9's November 2018 MAR revealed: -There was an entry for Lisinopril 20mg every day at 9:00am beginning 11/14/18 and discontinued on 11/15/18. -Lisinopril 20mg was documented as administered daily from 11/14/18 - 11/15/18. Observation of Resident #9's medications on hand on 01/16/19 at 1:35pm revealed: -There was one supply of Lisinopril 20mg dispensed on 01/01/19. -The bubble card had 17 tabs of the original 30 tabs remaining. Interview with the MA on 01/16/19 at 1:35pm revealed: -Resident #9 always received Lisinopril 20mg every day. -She didn't know that the medication had been discontinued. -She didn't know if Resident #9 had any weakness or dizziness. Interview with the Director of Resident Care (DRC) on 01/16/19 at 2:45pm revealed: -The DRC, Wellness Coordinator and the MAs were all responsible for making sure all orders were faxed to the pharmacy. -They had all been trained about faxing and checking medication orders. -Every month they performed three checks of the	D 358		

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MARs that involved the first two checks performed by a different MA and the third check was performed by the DRC.
-She didn't know Resident #9 had an order to discontinue Lisinopril that was not implemented.
-She would contact Resident #9's primary care provider (PCP) about the Lisinopril.

Interview with Resident #9's PCP on 01/17/19 at 12:15pm revealed:
-Resident #9's Lisinopril was discontinued on 11/15/18.
-She was not informed that Resident #9 was given Lisinopril after 11/15/18.
-Resident #9's blood pressures were within normal range.

Interview with Resident #9 on 01/17/19 at 6:00pm revealed:
-She took a pill each day for her blood pressure.
-Her blood pressure had been normal since she was admitted to the facility.

e. Review of Resident #9's current FL-2 dated 11/13/18 revealed there was an order for Sertraline 12.5mg daily (Sertraline is used to treat depression).

Observation of the 9:00am medication pass on 01/16/19 revealed:
-Resident #9's morning medications were prepared and administered to the resident at 9:48am.
-Sertraline 12.5mg was not given to Resident #9.

Review of Resident #9's January 2019 medication administration record (MAR) revealed:
-There was an entry for Sertraline 12.5mg every day at 9:00am.
-There was a handwritten note over the entry that

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read "D/C".
-No Sertraline was documented as administered.

Review of Resident #9's December 2018 MAR revealed:
-There was an entry for Sertraline 12.5mg every day at 9:00am.
-Sertraline 12.5mg was documented as administered 12/01/18-12/04/18, and 12/06/18-12/18/18.
-There was a handwritten note over the dates 12/19/18-12/31/18 that read "D/C".

Review of Resident #9's November 2018 MAR revealed:
-There was an entry for Sertraline 12.5mg every day at 9:00am.
-Sertraline 12.5mg was documented as administered 11/14/18-11/30/18.

Observation of Resident #9's medications on hand on 01/16/19 at 1:35pm revealed there was no Sertraline available for administration.

Review of Resident #9's physician orders revealed there was no order to discontinue Sertraline.

Interview with the medication aide (MA) on 01/16/19 at 1:35pm revealed:
-When Resident #9 was admitted she was taking Sertraline 12.5mg every day and it was since discontinued, but she did not recall the date.
-Resident #9 did not seem depressed now like she did when she was first admitted.

Interview with the Director of Resident Care (DRC) on 01/16/19 at 2:45pm revealed:
-The DRC, Wellness Coordinator and the MAs were all responsible for making sure all orders

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were faxed to the pharmacy.
-They had all been trained about faxing and checking medication orders.
-Every month they performed three checks of the MARs that involve the first two checks performed by a different MA and the third check was performed by the DRC.
-She didn't know Resident #9 did not have an order to discontinue Sertraline 12.5mg.
-She would contact Resident #9's primary care provider (PCP) about the Sertraline 12.5mg

Interview with Resident #9 on 01/17/19 at 6:00pm revealed:
-She liked living at the facility but was a little sad that everyone around her had dementia.
-She felt like she was adapting "okay" to the new move.

Interview with Resident #9's PCP on 01/17/19 at 12:15pm revealed:
-She had not discontinued the Sertraline order.
-She was not informed that Resident #9 was not given Sertraline after 12/18/18.
-She would expect to be told if it was not given.
-Resident #9 had been given the Sertraline to help her with adjusting to the facility after her admission.

f. Review of Resident #10's current FL-2 dated 08/22/18 revealed:
-Diagnoses included memory loss, hypothyroidism, chronic back pain and unsteady gait.
-There was an order for Propranolol 10mg tablet daily (Propranolol is a medication that can be used to treat tremors).

Review of Resident #10's physician's order dated 12/06/18 revealed increase Propranolol to 20mg

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twice a day; the Propranolol may improve her tremor.

Review of Resident #10's physician's order dated 12/20/18 revealed Resident #10 was seen for a fall; stop Propranolol 20mg twice a day; start Propranolol 10mg twice a day.

Observation of the 9:00am medication pass on 01/17/19 revealed:
-Resident #10's morning medications were prepared and administered to the resident at 10:34am.
-Propranolol was not administered to Resident #10.

Review of Resident #10's January 2019 medication administration record (MAR) revealed:
-There was an entry for Propranolol 20mg every day at 8:00am and 8:00pm.
-There was a handwritten line through the 20mg and written beside it "10mg".
-There was a handwritten note over the entire entry that revealed "D/C".
-No Propranolol was documented as administered.

Review of Resident #10's December 2018 MAR revealed:
-There was an entry for Propranolol 10mg every day at 9:00am.
-Propranolol 10mg was documented as administered 12/01/18-12/07/18.
-There was an entry for Propranolol 20mg twice a day at 9:00am and 9:00pm.
-Propranolol 20mg was documented as administered at 9:00am and 9:00pm 12/08/18-12/20/18.
-There was an entry for Propranolol 10mg twice a day at 9:00am and 9:00pm.

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D 358	Continued From page 102 -Propranolol 10mg was documented as administered at 9:00am and 9:00pm 12/21/18 and 12/26/18-12/31/18. Observation of Resident #10's medications on hand on 01/17/19 at 2:40pm revealed there was no Propranolol 10mg available for administration. Interview with the medication aide (MA) on 01/17/19 at 2:40pm revealed Resident #10 no longer took Propranolol; it was discontinued in December and the medication was returned to her family. Interview with the Director of Resident Care (DRC) on 01/17/19 at 3:00pm revealed: -The DRC, Wellness Coordinator and the MAs were all responsible for making sure all orders were faxed to the pharmacy. -They utilized a "New Order Tracking Form" for the process, but lately the forms were not consistently being completed and "things are slipping through the cracks". -She thought that Resident #10's Propranolol had been discontinued because they thought the Propranolol was causing her tremors to be worse. -She would contact Resident #10's primary care provider (PCP) about the Propranolol. Observation of Resident #10 on 01/17/19 at 5:25pm revealed: -Resident #10 was being assisted by the MA to the table to eat her supper. -Resident #10's hands and arms were trembling continuously. Interview with Resident #10 on 01/17/19 at 5:25pm revealed: -Her hands shook all the time. -The staff knew and always tried to help her.	D 358		

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D 358	Continued From page 103 Interview with a second MA on 01/17/18 at 6:10pm revealed Resident #10 had always had tremors in her arms and hands and was not sure if it had increased lately. Interview with Resident #10's PCP on 01/18/19 at 4:56pm revealed: -He was not aware that Resident #10 was not receiving her Propranolol as ordered. -He would have expected to be notified by the facility. -His concern with Resident #10 not receiving Propranolol as directed would be with having an increase in tremors. g. Review of Resident #10's current FL-2 dated 08/22/18 revealed there was an order for Wellbutrin XL 150mg tablet ER take one tablet daily. (Wellbutrin may be used to treat depression.) Review of a subsequent physician's order for Resident #10 dated 12/06/18 revealed increase Wellbutrin XL 300mg tablet ER take one tablet daily; to improve motivation. Observation of the morning medication pass on 01/17/19 at 10:34am revealed the MA administered Wellbutrin XL 150mg tablet ER to Resident #10 instead of Wellbutrin XL 300mg tablet ER as ordered. Review of Resident #10's January 2019 medication administration record (MAR) revealed: -There was an entry for Wellbutrin XL 150mg tablet ER take one tablet daily. -There was a handwritten line through the one tablet and two tablets was written in. -Wellbutrin XL 150mg tablet two tablets daily was	D 358		

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documented as administered at 9:00am 01/01/19-01/17/19.

Review of Resident #10's December 2018 MAR revealed:
-There was an entry for Wellbutrin XL 150mg tablet ER take two tablets daily.
-Wellbutrin XL 150mg tablet two tablets daily was documented as administered at 9:00am 12/08/18-12/18/18, 12/20/18-12/21/18 and 12/27/18-12/31/18.
-There was no documentation that Wellbutrin was administered on 12/19/18 and 12/22/18-12/26/18.

Observation of Resident #10's medications on 01/17/19 at 2:40pm revealed:
-There were 12 tablets of Wellbutrin XL 150mg tablets on hand for administration.
-There was no change of direction sticker on the Wellbutrin bottle.

Interview with the medication aide (MA) on 01/17/19 at 2:40pm revealed:
-She went by the label on the Wellbutrin bottle when she administered one 150mg tablet that morning on 01/17/19.
-She knew the MAR indicated to administer two tablets because for the previous amount dispensed two tablets were equal to 150mg.

Interview with the Director of Resident Care (DRC) on 01/17/19 at 3:00pm revealed:
-She didn't know Resident #10 had received the wrong dose of Wellbutrin.
-All MAs had been trained to stop and validate the order if the MAR did not match what was on the medication label.
-She would re-emphasize this information to the staff.
-She would contact Resident #10's primary care

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provider (PCP) about the Wellbutrin.

Interview with a personal care aide (PCA) on 01/17/19 at 5:35pm revealed Resident #10 stays in bed more lately and didn't want to get out of bed.

Interview with Resident #10's PCP on 01/18/19 at 4:56pm revealed:
-He did not know Resident #10 was not receiving her Wellbutrin as ordered.
-He would have expected to be notified by the facility.
-His concern with Resident #10 not receiving Wellbutrin as directed would be that she would have a lack of motivation and possibly depression that would cause a delay in care.
-He would see Resident #10 in a week and would look for any delays in her progress for improvement.

Review of a signed fax from Resident #10's primary PCP dated 01/18/19 confirmed that Wellbutrin 300mg should be given daily.

h. Review of Resident #10's current FL-2 dated 08/22/18 revealed there was an order for Lidocaine 5% patch external daily as needed. (Lidocaine patch is used to relieve nerve pain.)

Review of Resident #10's physician's order dated 10/10/18 revealed:
-There was an order for Lidocaine 5% patch; apply 1 patch externally daily.
-The order did not indicate where the patch should have been applied and how long it was to stay on the resident.

Review of Resident #10's physician's orders revealed no documentation the physician was

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D 358	Continued From page 106 contacted to clarify the Lidocaine 5% patch order. Review of Resident #10's January 2019 medication administration record (MAR) revealed: -There was an entry for Lidocaine 5% patch, place one patch to back daily topically. -There was documentation that the patch was applied at 9:00am and taken off at 9:00pm on 01/01/19-/1/17/19. Observation of the 9:00am medication pass on 01/17/19 revealed: -The medication aide (MA) placed one Lidocaine 5% patch to Resident #10's middle lower back at 10:34am. -The label on the Lidocaine box indicated to apply one patch to the skin externally daily. Interview with the MA on 01/17/19 at 2:40pm revealed: -She always applied the Lidocaine 5% patch to Resident #10's lower back because the MAR said to put it on her back. -She never had to take a patch off on the mornings she applied one. Interview with the Director of Resident Care (DRC) on 01/16/19 at 2:45pm revealed: -She did not know Resident #10 had an incomplete order for the Lidocaine patch. -All MAs had been trained to stop and validate the order if the MAR did not match what was on the medication label. -She would re-emphasize this information to the staff. -She would contact Resident #10's primary care provider (PCP) about the Lidocaine 5% order. Interview with Resident #10 on 01/17/19 at 5:25pm revealed:	D 358		

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D 358	Continued From page 107 -She always had back pain and leg pain. -The staff knew and always tried to help her. -The Lidocaine patch on her back helped her a lot. Interview with Resident #10's PCP on 01/18/19 at 4:56pm revealed: -Resident #10 has the Lidocaine 5% patch ordered for her chronic lower back pain. -He expected the patch to be applied once per day and removed 12 hours later. -He would write a clarification to the order to include directions. Review of a signed fax from Resident #10's primary PCP dated 01/18/19 revealed apply Lidocaine patch 5% every morning to area of maximum pain on lower back, per package instructions. 2. Review of Resident #4's current FL-2 dated 12/10/18 revealed diagnoses included gastrointestinal bleed, atrial fibrillation, coronary artery disease, bradycardia, chronic combined systolic and diastolic congestive heart failure, acute kidney injury, anemia, and Alzheimer's dementia. Review of Resident #4's physician order dated 10/08/18 revealed an order for Furosemide 20mg take 1 tablet at 8:00am and 1 tablet at 2:00pm. (Furosemide is a diuretic used to treat swelling.) Review of Resident #4's physician order dated 12/06/18 for Lasix 20mg twice a day. Review of Resident #4's current FL-2 and a hospital discharge summary dated 12/10/18 revealed an order for Furosemide 20mg daily at 8:00am.	D 358		

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D 358	Continued From page 108 Review of Resident #4's December 2018 medication administration record (MAR) revealed: -There was a computer printed entry for Furosemide 20mg at 8:00am and 2:00pm. -Furosemide 20mg was documented as administered at 8:00am and 2:00pm from 12/01/18 - 12/06/18 except documentation was blank at 8:00am on 12/05/18. -The resident was in the hospital on 12/07/18 - 12/10/18. -There was a handwritten entry dated 12/10/18 for Furosemide 20mg once daily scheduled to be administered at 9:00am. -Furosemide 20mg was documented as administered once daily at 9:00am from 12/11/18 - 12/31/18. Review of Resident #4's January 2018 MAR revealed: -There was a computer printed entry (with start date of 12/06/18) for Furosemide 20mg twice daily scheduled at 10:00am and 9:00pm. -Furosemide 20mg was documented as administered twice daily from 01/01/19 - 01/22/19. -The order dated 12/10/18 for Furosemide 20mg once daily at 8:00am was not transcribed on the MAR. -The resident received Furosemide 20mg twice daily instead of once daily from 01/01/19 - 01/22/19. Interview with Resident #4 on 01/15/19 at 10:20am revealed: -Both of his lower legs were usually swollen every day. -His left leg was always swollen more than his right leg. -He thought he took medication for the swelling in	D 358		

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D 358	Continued From page 109 his legs but he could not recall how often. Interview with a medication aide (MA) on 01/18/19 at 4:15pm revealed: -Resident #4 received Furosemide twice a day. -She did not know the order changed when the resident returned from the hospital on 12/10/18. -She administered the Furosemide according to the instructions on the MAR. -The resident's legs had been swollen for "a couple of months" and the left lower leg was usually swollen more than his right leg. Observation of Resident #4's medications on hand on 01/18/19 at 4:15pm revealed: -There was one supply of Furosemide 20mg tablets dispensed on 12/27/18. -The instructions on the label were to take 1 tablet twice daily. Interview with a medication aide (MA) on 01/22/19 at 11:32am revealed: -Resident #4's lower legs were always swollen but some days they were swollen more than other days. -The resident's left leg was always swollen more than the right leg. -She administered the Furosemide according to the instructions on the MAR. -The MAs could process new medication orders but most of the time new orders were implemented by the DRC. -The MAs could transcribe the order on the MAR and fax the order to the pharmacy if the DRC was not available. -The MAs assisted with checking the new month's MARs and comparing them with the previous month's MARs. -If something did not match, they were supposed to check the medication cart.	D 358		

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D 358	Continued From page 110 Telephone interview with a pharmacist at the facility's primary pharmacy on 01/22/19 at 1:40pm revealed: -The pharmacy never received the FL-2 or hospital discharge summary dated 12/06/18 with the order for Lasix 20mg daily. -They continued to print the most current order they had on file for Lasix 20mg twice daily on the MAR. -The facility was supposed to fax any new orders, including FL-2s and discharge summaries to the pharmacy. Interviews with Resident #4's primary care provider (PCP) on 01/17/19 at 12:35pm and 01/22/19 at 6:55pm revealed: -Resident #4 had swelling in both lower extremities. -She did not know Resident #4 was receiving the wrong dosage of Furosemide. -She would review the resident's hospital discharge information and assess the resident to determine what dosage of Furosemide the resident should receive. Interview with the Director of Resident Care (DRC) on 01/22/19 at 12:45pm revealed: -She did not know Resident #4's Furosemide order had not been changed on the MAR when the resident returned from the hospital on 12/10/18. -The resident should be receiving Furosemide 20mg once daily. _____ The failure of the facility to administer medications as ordered and in accordance with the facility's policies for 5 of 6 residents resulted in two residents with high blood pressure and depression having medication errors, one	D 358		

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D 358	Continued From page 111 resident with severe back pain having no instructions for application of a patch to relieve the pain, a resident with Parkinson's disease at risk for adverse side effects due to medication being given at the wrong time, a resident at risk for stomach irritability due a medication being crushed that should not have been, a resident at risk for constipation due to missed doses of a laxative, and a resident at risk for increased swelling in legs due to a diuretic not administered as ordered. This failure was detrimental to the health, safety, 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 01/17/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 8, 2019.	D 358		
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.	D 376		

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D 376	Continued From page 112 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure compliance with the facility's policies and procedures for the self-administration of medications related to 1 of 2 sampled residents (#12) not taking two prescribed medications. The findings are: Review of the facility's Resident Self-Administration of Medication policy revealed: -If a resident wishes to self-administer his/her medications, the Director of Resident Care (DRC), or designee, will assess the resident's ability upon request and will be documented on the Self-Administration of Medication Assessment Form ("Form"). -Based on the assessment, a decision is made as to whether or not the resident is a candidate for Self-Administration and is documents on the Form. -Residents may secure medications as long as they are kept safe and secure from other residents. -A valid written physician's order is required. -The DRC assess accuracy and compliance of Self-Administration by periodic observation. -If the DRC determines the resident is unwilling/unable to take medications as prescribed, he/she meets with the resident and contacts the resident's physician regarding concerns. -Self-Administration of medications is documented in the resident's service plan. -An updated list of the resident's medications is maintained in the resident medication administration record (MAR).	D 376		

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D 376	Continued From page 113 -The DRC documents communication with the resident and his/her physician regarding medications in the resident's record. Review of Resident #12's current FL-2 dated 11/12/18 revealed: -Diagnoses included hypertension, osteoporosis, osteoarthritis, and chronic back pain. -There were medication orders for Aspirin 81mg tablet chew daily, Benazepril 20-12.5mg tablet 2 tablets daily, Biotin 1000mcg tablet daily, Daily-Vite tablet daily, Colace 100mg daily, Miralax 17gm with 4-8 ounces of fluid daily, Senokot 8.6mg two tablets daily, Refresh 6% droperette instill one drop into both eyes twice daily, Tramadol 50mg tablet take one three times daily, Lexapro 10mg tablet once daily, and Diazepam 5mg daily. (Aspirin is used to prevent heart disease. Benazepril lowers blood pressure. Biotin and Daily Vite are vitamins. Colace, Miralax, and Senokot are used for constipation. Refresh is a lubricant eye drop. Tramadol is for pain. Lexapro is an anti-depressant. Diazepam is for anxiety.) -There was an order to self-administer medications. Review of Resident #12's Care Plan dated 05/09/18 revealed: -Resident #12 self-administered her medications. -Resident #12 was alert, oriented and had adequate memory. Review of the Medication Assistance Assessment dated 05/09/18 for Resident #12 revealed: -The resident was assessed for medication self-administration. -The assessment was completed by the DRC. -The assessment outcome was that the resident can safely self-administer medications.	D 376		

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D 376	Continued From page 114 Interview with Resident #12 on 01/22/18 at 5:15pm revealed: -She has been at the facility for almost two years. -She had always self-administered her own medications and she kept her medications in her room locked in the secure metal box. -She does not take Colace or Senokot anymore since the Miralax works for her to have normal bowel movements. -She does not take Lexapro and does not remember ever taking it. -The facility staff do not check with her regarding what medications she takes because she knows what she takes. Observation of medications in Resident #12's room on 01/22/18 at 5:15pm revealed: -Aspirin 81mg tablet chew daily, Benazepril 20-12.5mg tablet 2 tablets daily, Biotin 1000mcg tablet daily, Daily-Vite tablet daily, Colace 100mg daily, Miralax 17gm with 4-8 ounces of fluid daily, Refresh 6% droperette instill one drop into both eyes twice daily, Tramadol 50mg tablet take one three times daily, and Diazepam 5mg daily -There was no Senokot 8.6mg tablets, or Lexapro 10mg tablets found in Resident #12's room. Review of Resident #12's record revealed there were no physician orders to discontinue Colace 100mg daily, Senokot 8.6mg two tablets daily, or Lexapro 10mg tablet once daily. Attempted interview with Resident #12's primary care provider (PCP) on 01/22/19 at 5:30pm was unsuccessful. Interview with the DRC on 01/22/19 at 6:55pm revealed: -She assessed Resident #12 on 05/09/18 for	D 376		

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D 376	Continued From page 115 medication self-administration and validated all current medication orders corresponded with all medications the resident had in her room. -The assessment outcome was that the resident can safely self-administer medications. -She did not know that the resident did not take Colace 100mg daily, Senokot 8.6mg two tablets daily, or Lexapro 10mg tablet once daily. -She would contact Resident #12's PCP regarding the Colace, Senokot and Lexapro.	D 376		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 464		

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facility failed to assure in addition to requirements for a care plan that a quarterly profile assessment including special care specific assessment data was completed for 2 of 2 sampled residents (#3 and #5).

The findings are:

1. Review of Resident #3's FL-2 dated 06/18/18 revealed:
-Diagnoses included dementia.
-Resident #3 was constantly disoriented.
-There was documentation for a "secured locked unit" under level of care.

Review of Resident #3's Resident Register revealed the resident was admitted to the Special Care Unit on 09/25/15.

Review of Resident #3's medical record revealed:
-There were no quarterly updated resident profiles.
-The most current care plan was dated 04/30/18.

Interview with the Regional Nurse on 01/22/19 at 6:23 pm revealed:
-She did not know Resident #3 did not have a quarterly review completed.
-She was currently working on setting up a tickler to show all the residents dates due for quarterly review, so she sees the list on her computer even if she was not in the facility.

Interview with the Executive Director on 01/18/19 at 4:06 pm revealed she did not have any further information to add to the Regional Nurse's interview.

Refer to interview with the Wellness Director on 01/18/19 at 3:25pm.

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D 464	Continued From page 117 Refer to interview with the Special Care Director (SCD) on 01/17/19 at 2:31pm. Refer to interview with the Director of Resident Care (DRC) on 01/22/19 at 11:50am and 5:45pm. Refer to interview with the Regional Director of Health Services (RDHS) on 01/22/19 at 6:05pm. 2. Review of Resident #5's current FL-2 dated 07/12/18 revealed: -Diagnoses included dementia, atrial fibrillation, knee pain, tachycardia, aortic stenosis, hypertension, osteoporosis and cardiac pacemaker. -There was documentation for a "locked secure unit" under level of care. Review of Resident #5's Resident Register revealed the resident was admitted on 02/18/15. Observation on 01/15/19 at 11:20am and 3:48pm revealed Resident #5 was asleep in her bed. Interview with a personal care aide (PCA) on 01/15/19 at 3:48pm revealed: -Resident #5 was frequently awake all night. -Resident #5 had not gone to sleep until after 8:00am on 01/15/19. Interview with a second PCA on 01/16/19 at 8:55am revealed: -Resident #5 was awake all night. -Usually when the PCA came in at 7:00am for 1st shift, Resident #5 would still be awake from the night before. -If Resident #5 was tired after breakfast then the PCA would put the resident in her bed to rest.	D 464		

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	HAL092156	A. BUILDING: _____ B. WING _____	01/22/2019

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Observations of the lunch meal on the SCU on 01/16/19 at 11:55am revealed Resident #5 was asleep in her bed.

Interview with the second PCA on 01/16/19 at 12:15pm revealed Resident #5 did not want to get up for lunch; the PCA would set a plate aside for the resident.

Observation of the dinner meal on the SCU on 01/16/19 from 5:15pm until 5:20pm revealed Resident #5 was asleep in her bed.

Review of Resident #5's current care plan dated 01/30/19 revealed:
-Resident #5 had a history of wandering behaviors.
-There was a notation Resident #5 had no behaviors at present, had falls with injury in the last quarter and reddened extremities.
-Resident #5 was ambulatory with a walker and incontinent of bowel and bladder.
-Resident #5 was always disoriented and had significant memory loss.
-Resident #5 needed supervision with eating and transferring, limited assistance with ambulating and was totally dependent on staff for toileting and bathing.
-There was no documentation specific to Resident #5's behavioral patterns, special management needs and degree of cognitive impairment.
-There was no documentation of how Resident #5's meals and socialization were accommodated when the resident slept all day.

Review of a "Bridge to Rediscovery Program Care Plan/Profile 90 Day Review form for Resident #5 revealed on 06/04/18, 09/06/18 and 12/13/18, the Special Care Director (SCD) signed

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D 464	Continued From page 119	D 464		

the form certifying the residents care plan/profile was current and accurate.

Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.

Refer to interview with the Wellness Director on 01/18/19 at 3:25pm.

Refer to interview with the Special Care Director (SCD) on 01/17/19 at 2:31pm.

Refer to interview with the Director of Resident Care (DRC) on 01/22/19 at 11:50am and 5:45pm.

Refer to interview with the Regional Director of Health Services (RDHS) on 01/22/19 at 6:05pm.

_____

Interview with the Wellness Director on 01/18/19 at 3:25pm revealed:
-The SCD was responsible for the resident quarterly profiles.
-She had never completed any as acting SCD from August 2018 until December 2018.

Interview with the SCD on 01/17/19 at 2:31pm revealed she was not sure who was responsible for completing quarterly profiles for residents on the special care unit (SCU).

Interview with the Director of Resident Care (DRC) on 01/22/19 at 11:50am and 5:45pm revealed:
-She was responsible for completing care plans for residents.
-She did not know of a profile and assessment being done quarterly for residents in the SCU.
-Any updated information related to a change in condition or resident needs would be documented

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D 464	Continued From page 120 on the medication administration record (MAR). -Something like home health for wound care would be trigger a licensed health professional support assessment and evaluation. -She was not aware the quarterly profile was in addition to the resident care plan and should include assessment information such as behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and degree of cognitive impairment. -She would have to follow up with the Regional Director of Health Services (RDHS). Interview with the RDHS on 01/22/19 at 6:05pm revealed: -She was not aware that the facility form documenting the resident care plan was current and accurate each quarter did not meet the requirements for a SCU quarterly profile. -The facility had traditionally documented any behavioral needs under the mental health section on the care plan and cognitive abilities under the cognitive assessment on the care plan "and so on." -She did not have a response to documentation of assessment data which included dementia care specifically such as wandering and interventions for safety of a wandering resident.	D 464		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 121	D912		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care and medication administration.

The findings are:

1. Based on observations, interviews, and record reviews, the facility failed to assure health care referral and follow up for 4 of 5 sampled residents (#2, #3, #4, #5) including failure to assure Resident #4 was seen by a gastroenterologist and cardiologist following two hospitalizations for recurrent gastrointestinal bleeds; failure to notify Resident #4's primary care provider (PCP) that the resident was not wearing compression stockings for lower extremity edema; failure to notify Resident #3's PCP of a 33 pound weight loss from 06/23/18 to 01/18/19; failure to notify Resident #5's PCP of a refusal for a cardiology appointment following hospitalization for myocardial infarction and the resident having a pacemaker; and failure to notify Resident #2's PCP of Physical Therapy's concern about the use of a reverse wedge pillow in Resident #2's wheelchair been a possible restraint for Resident #2. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to administer

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D912	Continued From page 122 medications as ordered and in accordance with the facility's policies for 5 of 6 residents (#6, #7, #8, #9, #10) observed during the medication passes including errors with medications used to treat high blood pressure and depression (#9, #10), application of a patch to treat nerve pain with no instructions noted on the order (#10), administration of a medication to treat Parkinson's disease given at the wrong time (#8), crushing and administering a medication that should not be crushed (#6) and missed doses of a medication for constipation (#7); and for 1 of 5 residents (#4) sampled whose diuretic was not administered as ordered. [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		