

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/22/2019
NAME OF PROVIDER OR SUPPLIER AURORA OF STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 ORA DRIVE STATESVILLE, NC 28625		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on February 18 - 21, 2019, with a telephone exit February 22, 2019.	D 000		
D 132	10A NCAC 13F .0406(b) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to assure five of six sampled staff (Staff A, B, C, D and E) were tested for tuberculosis (TB) disease upon hire. The findings are: 1. Review of the employee record for Staff A, medication aide (MA), revealed: -The hire date for Staff A was 08/03/18. -There was no documentation a TB skin test was completed upon hire. -There was no documentation of any TB skin tests in the employee record. Observation of Staff A on 02/19/19 between 3:45pm and 5:22pm revealed: -Staff A was administering medications in the Special Care Unit (SCU) to the residents.	D 132		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 132	Continued From page 1 -Staff A assisted a resident with ambulation in her wheelchair to the dining room. -Staff A provided feeding assistance to a resident in the SCU. Telephone interview with Staff A on 02/21/19 at 2:47pm revealed: -She had been a MA in the SCU. -Her responsibilities included administering medications, providing personal care to residents and assisting residents in the SCU with ambulation and transfers. -She could not recall a current TB skin test, but thought she had a previous TB skin test "maybe a few years back." Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Administrator on 02/21/19 at 10:40am. 2. Review of the employee record for Staff B, a medication aide (MA), revealed: -The hire date for Staff B was 02/13/19. -There was no documentation a TB skin test was completed upon hire. -There was no documentation of any TB skin tests in the employee record. Observation of Staff B on 02/19/19 between 8:15am and 12:52pm revealed: -Staff B administered medications to the residents in the SCU. -Staff B assisted residents in the SCU into the dining room for the lunch meal. -Staff B placed the resident's prepared lunch meal plate on the table in the dining room. -Staff B provided one on one feeding assistance with a resident in the SCU.	D 132		

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D 132	Continued From page 2 Interview with Staff B on 02/19/19 at 9:45am revealed: -She was a MA in the SCU and had been employed for about 3 weeks. -Her responsibilities included administering medications and providing personal care to the residents in the SCU. -She could not recall a TB skin test performed at the facility. -She was told by the Business Office Manager (BOM) the facility nurse was responsible for administering the TB skin testing, but "I've not seen her." Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Administrator on 02/21/19 at 10:40am. 3. Review of the employee record for Staff C, a medication aide (MA), revealed: -The hire date for Staff C was 10/02/18. -There was no documentation a TB skin test was completed upon hire. -There was no documentation of any TB skin testing in the employee record. Attempted telephone interview with Staff C on 02/22/19 at 2:55pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Administrator on 02/21/19 at 10:40am. 4. Review of the employee record for Staff D, a medication aide (MA), revealed:	D 132			

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D 132	Continued From page 3 -The hire date for Staff D was 11/20/18. -There was no documentation a TB skin test was completed upon hire. -There was no documentation of any TB skin testing in the employee record. Observation of Staff D on 02/19/19 between 7:30am and 8:15am revealed: -Staff D administered medications to the residents in the Assisted Living (AL) side of the facility. -Staff D assisted residents with personal care and transfers. Interview with Staff D on 02/21/19 at 10:00am revealed: -She was sent to a local clinic for a TB skin test when she was hired. -She brought the documentation of the TB skin test to the Administrator. -She thought the nurse in the facility checked the results of the TB skin test. -She did not recall a second TB skin test. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Administrator on 02/21/19 at 10:40am. 5. Review of the employee record for Staff E, a medication aide (MA), revealed: -The hire date for Staff E was 08/06/18. -There was no documentation a TB skin test was completed upon hire. -There was no documentation of any TB skin testing in the employee record. Interview with Staff E on 02/21/19 at 10:15am revealed:	D 132		

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D 132	Continued From page 4 -She received her TB skin test at the facility with the previous Resident Care Coordinator, who was a nurse. -She did not know who completed the paperwork for the screening. -She did not receive a copy of the results. -She did not remember a second TB test. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Administrator on 02/21/19 at 10:40am. Interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am revealed: -She was responsible for all employee records and keeping them up to date. -She had conducted employee record audits about a month ago. -She was responsible for new hires files and completing a "checklist" verifying all new staff had the appropriate documentation in their employee record. -There had been a lot of new staff hired for the facility. -She thought the TB skin tests for the employees were in her office to be filed. -She reported to the Resident Care Coordinator (RCC) and the Administrator for any incomplete employee records. Interview with the Administrator on 02/21/19 at 10:40am revealed: -It was the responsibility of the BOM to complete and review the employee records for compliance. -The BOM had a checklist to be placed in the front of each employee record with the necessary documentation and the date it was received or completed.	D 132			

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D 132	Continued From page 5 -The BOM was responsible for ensuring the initial TB skin test was given and read by the corporate nurse during employee orientation. -The staff person was directed to the Health Department or a local clinic to obtain the TB screening. -The results were brought back to the facility by the employee and kept in the employee record. -The previous RCC was a nurse and completed the TB testing at the facility for employees hired in previous years. -The absence of documentation verifying the TB testing was completed for all employees seemed to be the result of the lax filing system of the BOM. -The BOM reports directly to her. -She had not reviewed the employee records for compliance. -She thought the BOM had audited all the employee records since the previous survey and they were complete. The facility failed to assure 5 of 6 sampled staff (Staff A, B, C, D and E,) were tested for tuberculosis disease upon hire. The facility was unaware of the status of TB skin testing of staff. The facility's failure to assure testing for tuberculosis was completed, was detrimental to the safety, health, and welfare of the residents and constitutes an Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/21/19 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2019.	D 132		

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D 137	Continued From page 6	D 137		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 7 sampled staff (Staff B and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. The findings are: 1. Review of Staff B's, a medication aide (MA), employee record revealed: -Staff B was hired on 02/13/19. -There was no documentation of a HCPR verification prior to hire. Observation of Staff B on 02/19/19 between 8:15am and 12:52pm revealed: -Staff B administered medications to the residents in the Special Care Unit (SCU). -Staff B assisted residents in wheelchairs with ambulation to the dining room for the lunch meal.	D 137		

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D 137	Continued From page 7 -Staff B placed the resident's prepared lunch meal plate on the table in the dining room. -Staff B provided one on one feeding assistance with a resident in the SCU. Interview with Staff B on 02/19/19 at 9:45am revealed: -She was a MA in the SCU and had been employed for about 3 weeks. -Her responsibilities included administering medications and providing personal care to the residents in the SCU. -She did not know why there was not a copy of the HCPR verification in her employee record. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Administrator on 02/21/19 at 10:40am. Refer to interview with the Resident Care Director (RCD) on 02/21/19 at 2:20pm. 2. Review of Staff G's, a medication aide (MA), employee record revealed: -Staff G was hired on 11/28/18. -There was no documentation of a HCPR check prior to hire. -Staff G was no longer employed with the facility and no contact information was provided. Refer to interview with the Administrator on 02/21/19 at 10:40am. Refer to interview with the Resident Care Director (RCD) on 02/21/19 at 2:20pm. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am.	D 137			

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D 137	Continued From page 8 Interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am revealed: -She was responsible for all employee records and keeping them up to date. -She had conducted staff file audits about a month ago. -She was responsible for new hire's records and completing a "checklist" verifying all new staff had the appropriate documentation in their employee record. -There had been a lot of new staff hired for the facility. -She was responsible for checking the HCPR for new employees. -She thought the HCPR for the new employees were in her office to be filed. -She did not know there were HCPR verifications missing from the employee records. -She reported to the RCC and the Administrator any incomplete employee records. Interview with the Administrator on 02/21/19 at 10:40am revealed: -The BOM was responsible for ensuring the employee records were in compliance with the necessary documentation. -The BOM had a checklist in the front of each employee record listing the documentation the record should include. -The HCPR was listed on the checklist. -It was the responsibility of the BOM to verify new employees had no substantiated findings on the HCPR. -A copy of this verification should be kept in the employee record. Interview with the Resident Care Director (RCD) on 02/21/19 at 2:20pm revealed: -The daily responsibilities for the MA's were	D 137		

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D 137	Continued From page 9 administering medications, treatments and personal care of the residents. -She knew the HCPR should be checked on all new employees. -It was the responsibility of the BOM to check the HCPR for any substantiated findings on new employees before the employee started working with the residents. -She did not know the BOM did not have documentation of a HCPR verification for some staff before hire. -She relied on the BOM to have the necessary new employee documentation before she trained the clinical staff. _____ The failure of the facility to ensure 2 of 7 sampled staff (Staff B and G) had a North Carolina Health Care Personnel Registry completed prior to the date of hire, with no substantiated findings listed on the registry, was detrimental to the safety and welfare of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/21/19 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2019.	D 137			
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational	D 161			

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D 161	Continued From page 10 licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure 4 of 6 sampled staff (Staff B, C, D and, F) were competency validated by a registered nurse with return demonstration prior to performing Licensed Health Professional Support tasks. The findings are: 1. Review of Staff B's, a medication Aide (MA), employee record revealed: -Staff B was hired on 02/13/19. -There was no documentation of a Licensed Health Professional Support (LHPS) task competency validation. Observation of Staff B on 02/19/19 between 8:15am and 12:52pm revealed: -Staff B assisted residents in wheelchairs into the dining room for the lunch meal. -Staff B provided one on one feeding assistance with a resident in the Special Care Unit (SCU). Interview with Staff B on 02/19/19 at 9:45am revealed: -She was a MA in the SCU and had been employed for about 3 weeks.	D 161		

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D 161	Continued From page 11 -Her responsibilities included administering medications, obtaining FSBS, administering insulin, and inhalers to the residents in the SCU. -Staff B was responsible for providing personal care and assisting residents with transfers in the SCU. Review of the February 2019 electronic Medication Administration Record (eMAR) revealed Staff B had administered an inhaler to a resident in the SCU on 02/20/19 and on 02/21/19. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Resident Care Coordinator (RCC) on 02/21/19 at 2:20pm. Refer to interview with the Administrator on 02/21/19 at 10:40am. 2. Review of Staff C's, a medication aide (MA), employee record revealed: -Staff C was hired on 10/02/18. -There was no documentation of a LHPS competency validation. Review of a resident's February 2019 electronic Medication Administration Record (eMAR) from 02/01/19-02/18/19 revealed: -Staff C checked fingerstick blood sugars (FSBS) 12 out of 18 opportunities. -Staff C administered 4 units Novolog Flexpen 8 out of 18 opportunities. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Resident Care Coordinator (RCC) on 02/21/19 at 2:20pm.	D 161			

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D 161	Continued From page 12 Refer to interview with the Administrator on 02/21/19 at 10:40am. 3. Review of Staff D's, a medication aide (MA), employee record revealed: -Staff D was hired on 11/20/18. -There was no documentation of a LHPS competency validation in Staff D's personnel record. Review of a resident's February 2019 electronic Medication Administration Record (eMAR) from 02/01/19-02/18/19 revealed: -Staff D checked fingerstick blood sugars (FSBS) 7 out of 17 opportunities. -Staff D administered 4 units Novolog Flexpen 14 out of 34 opportunities. Observation of Staff D on 02/21/19 at 11:35am revealed Staff D was assisting a resident with ambulation in a wheelchair to the common area for a weight. Interview with Staff D on 02/21/19 at 10:00am revealed: -She worked as a MA primarily in the Assisted Living community. -Her daily responsibilities included applying and removing braces, obtaining fingerstick blood sugars, administering medications through injection and inhalation of medication by machine, monitoring of oxygen and continuous positive air pressure (CPAP) devices and assistance with transferring and ambulation of residents in wheelchairs. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am.	D 161			

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D 161	Continued From page 13 Refer to interview with the Resident Care Coordinator (RCC) on 02/21/19 at 2:20pm. Refer to interview with the Administrator on 02/21/19 at 10:40am. 4. Review of Staff F's, a medication aide (MA), employee record revealed: -Staff F was hired on 02/06/19. -There was no documentation of a LHPS competency validation in Staff F's employee record. Review of a resident's February 2019 electronic Medication Administration Record (eMAR) from 02/01/19-02/20/19 revealed Staff F administered Albuterol nebulizer treatments for 13 of 60 opportunities. Attempted telephone interview with Staff F on 02/22/19 at 3:05pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Resident Care Coordinator (RCC) on 02/21/19 at 2:20pm.. Refer to interview with the Administrator on 02/21/19 at 10:40am. Interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am revealed: -She was responsible for all employees records and keeping them up to date. -She had conducted employee record audits about a month ago. -She was responsible for new hires files and completing a "checklist" verifying all new staff had there appropriate documentation in their	D 161		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 14 employee records. -There had been a lot of new staff hired for the facility. -She did not know the LHPS validation for some staff was not in their employee record. -The Resident Care Coordinator (RCC) scheduled the training and LHPS validation for the clinical staff. -She reported to the RCC and the Administrator for any incomplete employee records. Interview with the Administrator on 02/21/19 at 10:40am revealed: -She relied on the BOM to complete new hire employee records. -The BOM had a checklist for each employee record indicating the information needed for compliance. -She relied on the RCC to schedule the MAs for all clinical training and validation needed. -The RCC would schedule the corporate nurse for the clinical skills check off as needed by the staff. -She did not know the clinical staff LHPS validations were not completed. Interview with the RCC on 02/21/19 at 2:20pm revealed: -The BOM was responsible for completing all new employee records. -The corporate nurse was responsible for completing the LHPS validation for clinical staff. -She scheduled the LHPS validation for the staff with the corporate nurse. -She relied on the BOM to let her know which trainings were incomplete for the staff. -She did not know the LHPS validations were not completed for 4 of 6 sampled MAs.	D 161		

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D 167	Continued From page 15	D 167		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 3 of 6 sampled staff member (Staff A, B and E) had completed a course on Cardio-Pulmonary Resuscitation (CPR) and choking management within the past 24 months. The findings are: 1. Review of Staff A's, medication aide (MA), employee record revealed: -The hire date for Staff A was 08/03/18. -There was no documentation Staff A had completed a course on CPR in the past 24 months.	D 167		

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D 167	Continued From page 16 Review of the staffing schedule for the month of December 2018 revealed: -Staff A worked 19 of the 31 days in December 2018. -Staff A had worked on the Special Care Unit (SCU) on 12/16/19 from 3:00pm to 11:00pm. Review of an incident report dated 12/16/18 at 8:00pm, signed by Staff A on 12/16/18 at 11:00pm, revealed: -On 12/16/18 at 8:00pm during rounds a resident was found unresponsive on the floor beside his bed. -Staff A called 911. -Staff A obtained vital signs with a blood pressure (BP) of 63/27. She started chest compressions as Emergency Medical Services (EMS) instructed her to do, and continued with CPR until EMS arrived. -There was documentation EMS used a defibrillator on the resident. -There was documentation the resident was pronounced dead by the EMS at 8:30pm, and the physician was notified. Telephone interview with Staff A on 02/21/19 at 2:47pm revealed: -Staff A was currently on leave from the facility. -Her responsibilities had included administering medications, providing personal care to residents and assisting residents in the Special Care Unit (SCU) with ambulation and transfers. -She had been a MA in the SCU and had worked 3:00pm to 11:00pm on 12/16/18. -There was a personal care aide (PCA) who had worked on 12/16/18 with her on the SCU. -She found a resident unresponsive in his room on the SCU on 12/16/18. -She contacted EMS and they instructed her to perform CPR.	D 167			

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D 167	Continued From page 17 -She had performed CPR on a resident who was unresponsive on 12/16/18. -She asked the PCA to assist with CPR but "the PCA did not know what to do." -The PCA contacted the MA on the Assisted Living (AL) side but the MA on the AL side "did not know what to do or how to perform CPR." -She did chest compressions but had not been instructed to perform "mouth to mouth." -She could not recall when she had completed a CPR class, "but I know what to do." Interview on 02/21/19 at 10:00am with a MA that was working on the AL side on 12/16/18 second shift revealed: -She was hired on 11/20/18. -She did not have CPR prior to completion of the CPR class on 01/08/19. -She was working on 12/16/18 on the AL side. -She did not go over to the SCU when the resident had required CPR. -She did not "feel comfortable doing CPR." -She had heard Staff A had performed CPR on the resident. -She knew EMS had come to the facility the night the resident passed away. Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Administrator on 02/18/19 at 11:52am and on 02/21/19 at 10:40am. Refer to interview with the Resident Care Coordinator (RCC) on 02/18/19 at 11:37am and 02/21/19 at 2:20pm 2. Review of Staff B's, medication aide (MA), employee record revealed:	D 167			

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D 167	Continued From page 18 -The hire date for Staff B was 02/13/19. -There was no documentation Staff B had completed a course on CPR and choking management in the past 24 months. Interview with Staff B on 02/19/19 at 9:45am revealed: -She was a MA in the Special care Unit (SCU) and had been employed for about 3 weeks. -Her responsibilities included administering medications and providing personal care to the residents in the SCU. -The facility had not offered a CPR class since she was hired. -She had completed a CPR course prior to her employment at the facility, but was unsure of the date. 3. Review of Staff E's, medication aide (MA), employee record revealed: -The hire date for Staff E was 08/06/18. -There was no documentation Staff E had completed a course on CPR and choking management in the past 24 months. Interview with Staff E on 02/21/19 at 10:15am revealed: -She thought she had completed a CPR class, but she was unsure of the date. -The Business Office Manager (BOM) should have a copy of my CPR if it is current. -"No one has told me I needed to take the CPR class." Refer to interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to interview with the Administrator on 02/18/19 at 11:52am and on 02/21/19 at 10:40am.	D 167		

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D 167	Continued From page 19 Refer to interview with the Resident Care Coordinator (RCC) on 02/18/19 at 11:37am and 02/21/19 at 2:20pm. Interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am revealed: -She was responsible for all employee records and keeping them up to date. -She had conducted staff record audits about a month ago. -She was responsible for new hire records and completing a "checklist" verifying all new staff had the appropriate documentation in their employee record. -There was a CPR class conducted by a nurse on 01/08/19. -She had a handwritten list of the staff who should have participated in the CPR class offered on 01/08/19. -The staff who completed the course would have received a CPR card through their email. -It was the staff's responsibility to bring a copy of the CPR card to keep in their employee record. -She reported to the Resident Care Coordinator (RCC) and the Administrator for any incomplete employee records. Interview with the Administrator on 02/18/19 at 11:52am and on 02/21/19 at 10:40am revealed: -She relied on the BOM to complete new hire employee records. -The BOM had a checklist for each employee record indicating the information needed for compliance. -She relied on the RCC to schedule the MAs for all clinical training needed. -There was a CPR class on 01/08/19 but she could not find the certificates for the staff who had completed the class.	D 167			

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D 167	Continued From page 20 -She did have a roster of the staff who participated in the CPR class but Staff A, Staff B and Staff E were not on the roster. Interview with the Resident Care Coordinator (RCC) on 02/18/19 at 11:37am and 02/21/19 at 2:20pm revealed: -The BOM was responsible for completing all new employee records. -She scheduled the trainings for the clinical staff. -She relied on the BOM to let her know which trainings were incomplete for the staff. -The corporate nurse and the facility contracted pharmacist completed the CPR classes for staff. -There was a class offered to the staff on 01/08/19. -She was currently CPR certified and worked in the facility 8:00am -5:00pm on Mondays through Fridays. -She was responsible for scheduling staff on all shifts to work in the facility. -She knew at least one CPR certified staff person was required to work on each shift. -She did not identify the staff person who was CPR certified on the schedule. -The staff was not provided a resource to identify a CPR certified staff member who was working on any given shift. -She could not recall the December 2018 schedule for staffing on 12/16/18. -She did not always check for CPR certification of the staff when she made out the schedule. The Administrator failed to assure there was staff on duty for all shifts who had completed a course on cardiopulmonary-resuscitation and choking management within the past 24 months, Staff A performed CPR for a resident in the SCU without CPR training which was unsuccessful. This failure was detrimental to the health, safety, and welfare	D 167			

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D 167	Continued From page 21 of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/21/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 8, 2019	D 167		
D 243	10A NCAC 13F .0704(a)(1) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Information on Home and Resident Register (a) An adult care home administrator or administrator-in-charge shall furnish and review with the resident or responsible person information on the home upon admission and when changes are made to that information. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the home. The information shall include the following: (1) the resident contract to which the following applies: (A) the contract shall specify rates for resident services and accommodations, including the cost of different levels of service, if applicable, and any other charges or fees; (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet pursuant to G.S. 131D-2(a1)(4); (C) the contract shall be signed and dated by the administrator or administrator-in-charge and the	D 243		

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D 243	Continued From page 22 resident or responsible person, a copy given to the resident or responsible person and a copy kept in the resident's record; (D) the resident or responsible person shall be notified as soon as any change is known, but not less than 30 days before the change for rate changes initiated by the facility, of any changes in the contract and be provided an amended contract or an amendment to the contract for review and signature; (E) gratuities in addition to the established rates shall not be accepted; and (F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients is established by the North Carolina Social Services Commission and the North Carolina General Assembly. Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room or a private or semi-private room in a special care unit. This Rule is not met as evidenced by: Based on interviews, and record review the facility failed to initiate and complete a resident record including a resident contract for 1 of 6 sampled residents (Resident #9). The findings are: Review of Resident #9's current FL2 dated 01/03/19 revealed: -Diagnoses included dementia, a communicable disease, and schizophrenia. -"Domiciliary" was documented as the current and recommended level of care. -Admission date on the FL2 was dated 01/13/19.	D 243		

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D 243	Continued From page 23 Review of Resident #9's record on 02/18/19 revealed: -There was an FL2, nurses note, request for new prescription and high cost medication approval request form from the pharmacy, unsigned diet and physician orders paper clipped together with a paperclip located on the Special Care Unit (SCU). -There was no documentation of a resident contract for Resident #9. Interview with a medication aide (MA) on 02/19/18 at 3:45pm revealed: -Resident #9 had been in the SCU for 6 weeks and "no one had made him a resident record." -We do not even know who to call if we need anything for Resident #9 because "he does not have a physician." -"We have no information" on Resident #9. -"We do not know what tasks are needed" for Resident #9, "all we do is give him his meds." Interview with the Resident Care Coordinator (RCC) of the SCU on 02/20/19 at 1:10pm revealed: -She knew Resident #9 did not have a resident record only a few documents paper clipped together. -She had not reviewed Resident #9's documents clipped together with the paperclip to determine what else was needed. -She did not know Resident #9 did not have an assessment within 30 days of admission. -She did not know that Resident #9 did not have a contract on file. Interview with the Administrator on 02/19/19 at 4:58pm revealed: -She knew Resident #9's record was not	D 243			

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D 243	Continued From page 24 complete. -The RCC and the Business Office Manager were responsible for making sure that all required paperwork for the facility was completed, signed, and filed in the resident record. -She did not know why the resident record was not completed. Interview with the Administrator on 02/21/19 at 9:08am revealed: -Resident #9 was admitted to the SCU 01/13/19 from another facility. -She had gone to Resident #9's former facility and assessed him prior to admitting him to the facility. -Resident #9 did not have a physician until 02/21/19, because she could not find a physician to provide care for him due to his insurance. Interview with the RCC of the SCU on 02/21/19 at 4:08pm revealed: -She had been hired as the RCC on the SCU by the facility about 3 weeks ago. -The RCC was responsible for assembling the resident records. -The RCC was responsible for making sure that all paperwork in the resident record was correct and completed.	D 243		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as	D 254		

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D 254	Continued From page 25 required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on observation, interviews, and record review the facility failed to initiate an initial assessment within 30 days of admission for 1 of 6 sampled residents (Resident #9). The findings are: Review of Resident #9's current FL2 dated 01/03/19 revealed diagnoses included dementia, a communicable disease, and schizophrenia. Review of Resident #9's record on 02/18/19 revealed: -There was an FL2, nurses note, unsigned diet and physicians orders, a new prescription medication request form and high cost medication approval request form from the pharmacy that were paper clipped together with a paperclip located in the residents records room on the Special Care Unit (SCU).	D 254		

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D 254	Continued From page 26 -There was no documentation that the assessment had been completed within 30 days of admission for Resident #9. Interview with a medication aide (MA) on 02/19/18 at 3:45pm revealed: -Resident #9 had been in the SCU for 6 weeks and did not have a resident record. -We do not even know who to call if we need anything for Resident #9 because "he does not have a physician." -"We have no information" on Resident #9. -"We do not know what tasks are needed" for Resident #9, "all we do is give him his meds." Interview with the Administrator on 02/19/19 at 4:58pm revealed: -She knew Resident #9 did not have an assessment completed within 30 days of admission. -The Resident Care Coordinator (RCC) and the Business Office Manager were responsible for making sure that all required paperwork for the facility was completed, signed, and filed in the resident record. -She did not know why the resident record was not completed. Interview with the RCC of the SCU on 02/20/19 at 1:10pm revealed: -She knew Resident #9 did not have a resident record only a few documents paper clipped together. -She had not reviewed Resident #9's documents clipped together with the paperclip to determine what else was needed. -She did not know Resident #9 did not have an assessment within 30 days of admission. Interview with the Administrator on 02/21/19 at	D 254		

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D 254	Continued From page 27 9:08am revealed: -Resident #9 was admitted to the SCU 01/13/19 from another facility. -She had gone to Resident #9's former facility and assessed him prior to admitting him to the facility. -Resident #9 did not have a physician until 02/19/19, because she could not find a physician to provide care for him due to his insurance. Interview with the RCC of the SCU on 02/21/19 at 4:08pm revealed: -She had been hired as the RCC on the SCU by the facility about 3 weeks ago. -The RCC was responsible for assembling the resident records. -The RCC was responsible for making sure that all paperwork in the resident record was correct and completed.	D 254		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/22/2019
NAME OF PROVIDER OR SUPPLIER AURORA OF STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 ORA DRIVE STATESVILLE, NC 28625		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 28 Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 7 sampled residents who resided in the Special Care Unit (SCU) as evidenced by two residents, both of whom had a diagnoses of dementia and one who had a diagnosis of a communicable disease and were known by staff to engage in sexual activity (#9 and #10), Resident (#6) with dementia and sexually aggressive behaviors who assaulted multiple residents, including Resident (#8), and two residents with a history of elopements (Residents #6 and #8). The findings are: 1. Interview with the Administrator on 02/19/19 at 2:49pm revealed the facility did not have a policy on supervision. Telephone interview with Resident #9's guardian on 02/20/19 at 12:05pm revealed: -He felt Resident #9 needed to be transferred from previous facility to a SCU due to an organic brain disorder. -He did not know Resident #9 had a girlfriend in the SCU at the facility. -He was opposed to Resident #9 having a sexual relationship because "he might forget to use protection with his memory". -The facility staff had not contacted him and notified him that Resident #9 was sexually active. -He thought the facility had staff supervising the residents to prevent them from engaging in sexual activity. Interview with a first shift medication aide (MA) on 02/19/19 at 9:20am revealed: -She knew Resident #9 engaged in sexual intercourse with another resident on the SCU.	D 270		

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D 270	Continued From page 29 -She did not know if there was a facility policy regarding SCU residents to engage in sexual activity. -The Administrator supplied condoms for Resident #9 and a female resident on the SCU, and told her it was the "residents right" to engage in sexual activity. -She was never told to provide additional supervision to Resident #9 more that every two hours, which was the policy for residents' in the SCU. Telephone interview with the former Resident Care Coordinator (RCC) on 02/20/19 at 10:15am revealed: -She knew that Resident #9 had engaged in sexual activity with another resident. -The Administrator had informed her that Resident #9 had engaged in sexual activity with another resident in the SCU. -She talked with Resident #9 in her office and told him that he had to inform the other resident about his communicable disease. -The Administrator told her that it was the "residents right to have sex", and provided condoms for Resident #9 to use during sexual activity with the other resident in the SCU. -She educated Resident #9 and the other resident and "I told them there was a medication to prevent the transport of the virus and I would check with the doctor the see if it could be ordered". -She explained her knowledge of this communicable disease to Resident #9 and the female resident, and then "I googled some more information about it". -She had not been professionally trained to educate about sexually transmitted diseases (STD's).	D 270			

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D 270	Continued From page 30 a. Review of Resident #9's record revealed there was no documentation the SCU staff had provided increased supervision to monitor Resident #9's behavior. 1. Review of Resident #9's current FL2 dated 01/03/19 revealed: -Diagnoses included dementia, a communicable disease, and schizophrenia. -"Domiciliary" was documented as the current and recommended level of care. -The admission date to the facility in the SCU was documented as 01/13/19. -There was not any documentation on the FL2 that Resident #9 was to be admitted to the SCU. Review of Resident #9's record on 02/18/19 revealed the record consisted of an FL2, a nurses note, a new prescription request and high cost medication approval request from the pharmacy, and unsigned physician orders and diet order paper clipped together and were kept in the resident's records room on the SCU. Interview with Resident #9 on 02/19/19 at 9:42am revealed: -He did not know why he was placed in the SCU. -He had to sign a consent given to him by the facility staff that he would wear a condom during sexual intercourse. -He engaged in oral sex with the another resident and when she engaged in oral sex with him, he wore a condom. -He informed Resident #10 that he had a communicable disease after he was told by the Resident Care Director he had to inform his partner. -He had sex with another SCU resident in his room, and staff were aware. -The staff never told him not to engage in sex	D 270			

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D 270	Continued From page 31 with the other resident in the SCU. Review of Resident #9's record on 02/19/19 revealed: -There was no documentation of a consent signed by Resident #9 that he would wear a condom during sexual activity. -A request for a copy of the signed consent by Resident #9 to use protection during sexual activity was not provided by the facility. -There was no documentation of increased supervision by staff of Resident #9 Interview with the Administrator on 02/19/19 at 5:00pm revealed: -Resident #9 was admitted to the SCU on 01/13/19 and did not have a current medical provider. -The staff reported to her that Resident #9 was engaging in sexual intercourse with another resident in the SCU. -She instructed the Resident Care Coordinator (RCC) to talk to Resident #9 and he must inform the female resident that he had a communicable disease. -The RCC provided education regarding the communicable disease to both residents. -After the RCC spoke to the residents the Administrator supplied the condoms for Resident's #9 and #10 to use. -Resident #9 was admitted to the SCU per request of the guardian. -She did not know if Resident #9 and the female residents guardians were notified by the RCC that they had engaged in sexual activity with another resident. Interview with second shift MA on 02/19/19 at 5:30pm revealed: -Resident #9 had never requested a condom	D 270			

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D 270	Continued From page 32 from her. -Other staff members reported to her that they saw him engaging in sexual activity in his room on her shift with a female resident. -She reported to the RCC that Resident #9 and another resident were engaging in sexual activity. -After she spoke to the RCC the Administrator provided condoms to Resident #9 to continue to engage in sexual activity with the other resident in the SCU. Review of Resident #9's January 2019 electronic medication administration record (eMAR) revealed: -There was a computer generated entry for Genvoya take 1 tablet once daily with a meal or snack. -Genvoya was documented as administered daily at 9:00am from 01/15/19 to 01/27/19. -Genvoya was not documented as administered from 01/28/19 to 01/31/19 with documentation medication was on order. Review of Resident #9's February 2019 eMAR revealed: -There was a computer generated entry for Genvoya take 1 tablet once daily with a meal or snack. -Genvoya was documented as administered daily at 9:00am on 02/04/19, 02/10/19, and 02/14/19 to 02/21/19. -Genvoya was not documented as administered from 02/01/19 to 02/03/19, 02/05/19 to 02/09/19, and 02/11/19 to 02/13/19 with documentation medication was on order. Telephone interview with Resident #9's former health care provider on 02/20/19 at 1:17pm revealed: -If medication doses of Genvoya were missed for	D 270		

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D 270	Continued From page 33 2-3 weeks; it could "increase the viral load resulting in an increase of symptoms of the communicable disease" and it increased the risk to transfer the disease with sexual activity. -He was not Resident #9's current primary care provider (PCP). -Resident #9 had cognitive decline which decreased his ability to make safe practice decisions regarding sexual activity. Telephone interview with the local Health Department (HD) Disease Management Nurse on 02/21/19 at 1:00pm revealed the HD department had recommended STD testing for all residents in the SCU. Interview with the Administrator on 02/21/19 at 9:08am revealed she thought it was the "residents right to have sex even on the SCU." b. Review of Resident #10's current FL2 dated 07/12/18 revealed: -Diagnoses included dementia, schizophrenia, cognitive communication deficit. -Resident #10's documented level of orientation was constantly confused. -The document recommended placement for Resident #10 in the SCU. Interview with Resident #10 on 02/19/19 at 9:05am revealed: -She did not know anything about communicable diseases except that communicable diseases included sexually transmitted diseases. -The former RCC told her it would be safe to have sex as long as she used a condom. -Condoms were stored on the medication cart and provided by the MAs upon request. -The former RCC told her that "it would take a cup full of seminal fluid to infect her" with the	D 270		

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D 270	Continued From page 34 communicable disease. Interview with a first shift MA on 02/19/19 at 9:20am revealed: -She knew Resident #10 engaged in sexual intercourse with another resident in the SCU. -She did not know if a policy existed from the facility for SCU residents to engage in sexual activity. -The Administrator supplied condoms for Resident #10 and another male resident in the SCU, and told her it was the "residents right" to engage in sexual activity. Review of Resident #10's record revealed there was no documentation staff had increased supervision for Resident #10. Telephone interview with the primary care provider on 02/19/19 at 4:45pm revealed: -She was not notified by the facility that the Resident #10 engaged in sexual intercourse with another resident. -She did not think Resident #10 was able to understand the disease process of a communicable disease. -She did not think Resident #10 was able to consent to sex since she resided in a SCU with a diagnosis of dementia. Interview with a second shift MA on 02/19/19 at 6:00pm revealed she provided Resident #10 with a condom "once" upon request. Telephone interview with Resident #10's mental health nurse practitioner on 02/20/19 at 9:50am revealed: -She knew that Resident #10 had a sexual relationship with another resident. -She knew that the other resident had a	D 270		

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D 270	Continued From page 35 communicable disease. -They moved Resident #10 to the SCU because she tried to leave the facility; "not because of dementia or cognitive decline". -Resident #10 had a diagnosis of dementia, but it was in the early phases. -She thought that Resident #10 was competent enough to consent to sexual activity with another resident. -She had not completed any education to Resident #10 to determine if she understood the consequences of engaging in sexual activity or contracting communicable diseases. Telephone interview with the former RCC on 02/20/19 at 10:15am revealed: -She knew that Resident #10 had engaged in sexual activity with another resident. -The Administrator had informed her that Resident #10 engaged in sexual activity with another male resident in the SCU. -The Administrator informed her that it was the "residents right to have sex", and provided condoms for Resident #10 to use during sexual activity with the other resident in the SCU. -She educated Resident #10 and the male resident about the communicable disease and "I told them there was a medication to prevent the transport of the virus and I would check with the doctor the see if it could be ordered". -She explained her knowledge of this communicable disease to Resident #10 and the male resident and then "I googled some more information about it". -She had not been professionally trained to educate about STD's. Interview with Resident #10 on 02/21/19 at 11:05am revealed: -Resident #10 was lying on her bed resting.	D 270			

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D 270	Continued From page 36 - "I am very depressed". - She acknowledged a relationship with a male resident in the SCU, "...he is my boyfriend." - She reported that her family member couldn't visit because "he has arthritis so it's nice to have a boyfriend." - She had sexual relations with the male resident before the facility provided condoms. "I don't remember how many times, not a lot." - The condoms were kept on the medication cart. - Resident #10 or her partner requested condoms from the MAs when needed. - Her partner used a condom when she performed oral sex. - The former RCC had spoken to her regarding a communicable disease. She knew her partner had a communicable disease. - The former RCC told her there was a medication she could take to protect herself. - She did not know if the medication had been ordered for her. Telephone interview with Resident #10's family member on 02/22/19 at 10:19am revealed: - He was Resident #10's emergency contact. - Resident #10's mental condition fluctuated and "sometimes it was ok and sometimes it was bad". - "She is delayed and sometimes childlike with her thinking." - Resident #10 was not competent to make decisions regarding her safety and well being. They would talk about something and then 15-20 minutes later she would ask the same question again. - He was notified by the facility that Resident #10 had engaged in sexual activity with another resident. - He did not think that she could make the decision to have sexual intercourse with another resident. "She doesn't fully comprehend	D 270		

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D 270	Continued From page 37 anything". -He thought the facility's staff were supervising Resident #10. Interview with the Administrator on 02/21/19 at 9:08am revealed she thought it was the "residents right to have sex even on the SCU." 2. Review of Resident #8's current FL2 dated 07/10/18 revealed: -Diagnoses included "possible early onset Alzheimer's" and neurocognitive disorder. -She was constantly disoriented and was a wanderer. -The documented recommended placement for Resident #8 was a Special Care Unit (SCU). Review of Resident #8's Psychiatric Nurse Practitioner's visit summary note dated 01/16/19 revealed: -Diagnoses included early onset Alzheimer's disease, anxiety, and schizoaffective disorder. -She was pleasantly confused and struggled to follow directions and perform simple tasks causing irritability. Review of an incident report completed by facility staff on 01/27/19 at 2:30pm revealed: -The type of incident was documented as "other, elopement." -The documented description was "resident was found walking in town by the [bank]. -There was documentation a personal care aide (PCA) had left the facility and "went and got resident, brought the resident back to the building." -There was documentation vital signs were obtained, B/P 146/76, pulse 78, and respirations 18. -There was documentation Emergency Medical	D 270			

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D 270	Continued From page 38 Services (EMS) was not contacted nor was the resident taken to the hospital. -There was no documentation the family or the physician was notified on the incident report. Review of a family member documentation of the incident that occurred on 01/27/19 at 2:30pm revealed: -There was documentation she and a friend were visiting her family member in the SCU on 01/27/19. -There was documentation she and her friend had left the facility around 1:00pm to get lunch. -They had driven about a mile from the facility and had seen a person who they thought might be a resident from the SCU. -They had taken a picture of the woman and returned to the facility to inform the facility. -They showed the picture of the resident who was walking on the road to the SCU staff and staff confirmed the woman resided in the SCU. -A staff person left to go get the resident. Telephone interview on 02/20/19 at 4:00pm with the family member who reported Resident #8 missing revealed: -She had visited a family member on 01/27/19 in the SCU. -She decided to leave for lunch on 01/27/19 around 1:00pm. -When she was driving down the road she saw a woman she thought might reside at the facility from the SCU. -The resident was dressed in a light jacket, jogging pants and shoes. -She remembered it was cold that day because, "I had on my coat from church that morning." -The resident looked disoriented but was persistently walking down the road. -There were restaurants and a hotel across the	D 270			

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D 270	Continued From page 39 street from where she was walking. -The interstate was only about ¼ miles away. -"I took a picture of the resident with my cell phone and drove back to the facility." -"I showed the staff the picture of the woman and they said she belonged to them." -A staff person left in a car and brought the resident back to the facility. -The staff was probably gone about 20 minutes. Review of a document attached to the incident report from a PCA on the SCU dated 01/27/19 revealed: -She had worked the day Resident #8 eloped from the SCU. -She and the MA were together in a resident room on the SCU on 01/27/19 around 1:30pm. -A family member had ask to be let out of the locked SCU. -The PCA was in the dining room for about 10 minutes; the family member returned to the SCU and showed her a picture of [Resident #8] walking up the road. -She had left in her car to go and find Resident #8. -The PCA and a dietary aide had returned Resident #8 back to the SCU. Review of another document attached to the incident report from a medication aide (MA) on the SCU dated 01/27/19 revealed: -She had worked the day Resident #8 eloped from the SCU. -A family member had showed her a picture of Resident #8 walking down the road near the [bank]. -The MA sent the PCA to go get Resident #8 and bring her back to the SCU. -The physician and the administrator had been called on 01/27/19.	D 270		

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D 270	Continued From page 40 Observation of facility surroundings and roads on 02/21/19 revealed: -The location where Resident #8 was picked up was approximately 1.1 miles from the facility. -The road leaving the facility was curvy and did not have sidewalks. -There were dogs and multiple wooded areas around the facility. -There was a 2 lane road located approximately 0.5 miles away from facility. -There was a major 4 lane highway located approximately 0.7 miles from the facility. Review of Resident #8's Nurses Notes dated 01/27/19 to 01/28/19 revealed facility staff had documented checks on the resident every 15 minutes for a total of 48 hours following the elopement on 01/27/19. Interview with a PCA on 02/20/19 at 3:20pm revealed: -She did not know Resident #8 had eloped from the SCU on 01/27/19. -"I could see how she got out." -The assisted living (AL) residents who smoked liked to keep a rock at the door to keep it opened, this way they could get back inside the building without waiting on staff to let them in using the push code. -"The residents had been told not to prop the door open many of times." -Management were aware the courtyard door was being propped open with a rock because a SCU resident got out all the time and went into the Administrator's office. -The Administrator told the AL residents they could smoke out in the courtyard designated for the SCU, "They must smoke in the courtyard off the dining room area now."	D 270		

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D 270	Continued From page 41 Interviews with residents in the AL outside courtyard smoking area near the dining room on 02/20/19 at 4:20pm revealed: -They had to smoke in the courtyard near the dining room now. -We use to smoke on the other side but we were told we could not smoke there anymore. -"A woman got out". -Someone put a rock at the door to keep it open. -It was hard to find staff to let you back into the AL side when you were outside in the courtyard. Observation of the facility smoking courtyard area on 02/19/19 at 2:30pm revealed: -There was a back hallway that led from the AL side the SCU. -There were two doors on the right side of that hallway that led to the outside smoking courtyard. -One door was on the AL side and was only accessible by using the key pad code to get in and out. -The other door was on the SCU had no key pad code, the resident's in the SCU could walk in and out easily through this door. -From the outside the two door were side by side. -The courtyard was secured by a fence and locked key code pad. Interview with the maintenance director on 02/20/19 at 4:28pm revealed: -He and the MAs were the only ones now that knew the code to get out of onto the courtyard smoking areas. -It was for the SCU resident who smoked to use only, since the SCU resident eloped on 01/27/19. -The SCU residents could move freely from the SCU to the outside courtyard, "It is secured so they will not get out." -The AL door did lead to the courtyard, but it was	D 270		

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D 270	Continued From page 42 not being used unless it was an emergency. Interviews with a resident in the AL outside courtyard smoking area near the dining room on 02/21/19 at 8:30am revealed: -The facility had two smoking areas one for the AL and one for the SCU. -There was a resident in the SCU that got out all the time and walked to the Administrator's office. -Someone propped the door open and a resident got out of the SCU about a month ago. Interview with Resident #8's legal guardian on 02/18/19 at 3:47pm revealed: -The facility had contacted her in regards to Resident #8's elopement on 01/27/19. -She had visited Resident #8 immediately after the elopement. -She had suggested to the Administrator to contact the police to let them know about the elopement. -Resident #8 had never tried to elope before this incident. -Resident #8 was severely demented but usually did not want to be alone. -"I do not feel the outside courtyard area is secured for the dementia and Alzheimer's residents in the SCU." Interview with a second shift MA from the SCU on 02/20/19 at 3:15pm revealed: -She was not working on the day the elopement occurred. -She was responsible for completing 15 minutes checks on Resident #8 the day following the elopement. -A resident in the SCU had told her someone had propped the door leading to the assisted living hall open with a rock, allowing Resident #8 to escape the SCU.	D 270		

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D 270	Continued From page 43 -Resident #8 had never tried to elope before but had recently become more dependent on staff for help with bathing and grooming. -She had never been trained on the facility policy on elopement. Interview with the Nurse Practitioner (NP) from Resident #8's primary care provider's office on 02/21/19 at 10:39am revealed: -Facility staff had informed her of Resident #8's elopement the following Tuesday on 1/29/19. -She did not know how Resident #8 was able to leave the SCU. -Resident #8 had a diagnosis of dementia and should not be outside of the SCU walking alone. -The facility staff should be trained to follow the facility policy and procedures if someone eloped from the SCU. -The facility staff was responsible for contacting Resident #8's guardian and providers. Telephone interview with the Psychiatric NP from Resident #8's primary care provider's office on 02/21/19 at 1:00pm revealed: -She did not know Resident #8 had eloped from the SCU. -She had received reports from SCU staff that Resident #8 was having increased anxiety. -She adjusted Resident #8's medication to improve her anxiety. -The SCU was a locked unit and residents should not be able to leave the SCU alone. -The residents in the SCU should be watched and monitored at all times. Interview with the Administrator on 02/21/19 at 9:15am revealed: -She knew about Resident #8's elopement from the SCU. -The SCU was a locked unit and residents should	D 270			

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D 270	Continued From page 44 not be able to leave the SCU unattended. -The SCU staff were responsible for completing checks on each resident every 2 hours to make sure each resident was safe and accounted for. -The AL residents shared a smoking area with SCU residents. -The door from the SCU to the smoking area was always unlocked but the door from the assisted living hall was supposed to be kept locked. -Facility staff were responsible for monitoring the smoking area. -Resident #8 eloped from the SCU because someone had propped the door from the SCU smoking area to the assisted living hall open with a rock. -She did not know who propped the door open. -Another resident's family member saw Resident #8 down the road from the facility and took a picture of her. -The family member returned to the facility to determine if Resident #8 was a resident of the facility. -Resident #8 was identified and two facility staff picked her up and brought her back to the facility. -Resident #8's guardian, the provider, and local officials were notified about the incident. 4. Review of Resident #6's FL2 dated 05/15/18 revealed: -Diagnoses included dementia, hypertension, seizures and movement disorder. -The resident was constantly disoriented with wandering behavior, verbally abusive. Review of Resident #6's Care Plan dated 06/15/18 revealed: -The resident had inappropriate behavior with staff and other residents (grabbed their breasts and buttocks as well as sexually verbally inappropriate).	D 270		

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D 270	Continued From page 45 Review of Resident #6's Licensed Health Professional Support (LHPS) dated 07/04/18 revealed Resident #6 was abusive to staff and residents at times, and required a secure unit due to wandering and dementia behaviors. Interview with the NP from Resident #6's physician's office on 02/21/19 at 10:39am revealed: -She was aware of Resident #6 sexually assaulting a female resident on 01/05/19. -She talked with the Emergency Room (ER) physician on 01/05/19 in reference to Resident #6 being tested for STDs instead of a female resident. -On 01/05/19 she gave a verbal order to the Special Care Unit (SCU) Resident Care Coordinator (RCC) to increase supervision with Resident #6 to "24/7". -She expected the facility staff to increase the supervision on Resident #6 because of his increased sexual behaviors. Review of Resident #6's mental health visit notes revealed: -On 01/09/19 the staff reported Resident #6's "sexual behaviors continue to worsen with verbal and physical inappropriate behaviors". -The plan was to order the Depo-Provera 150mcg/ml intramuscular injection every 2 weeks to treat the sexual behaviors. Review of Resident #6's Nurses Notes revealed: -On 01/12/19 Resident #6 was talking inappropriately to the staff today, and grabbed a medication aide's breast on second shift -On 01/19/19 Resident #6, on first shift was banging on the main door saying his keys were up front and he needed to leave.	D 270		

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D 270	Continued From page 46 -On 01/22/19 Resident #6, on first shift wandered into other resident's rooms and got in their beds. Interview with a medication aide (MA) on 02/18/19 at 3:24pm revealed: -She worked all shifts that were needed in the SCU. -Resident #6 had increased sexual behaviors. -Resident #6 was sexually aggressive to the staff and female residents. -Resident #6 grabbed the female staff's breasts and buttocks and said very explicit sexual comments. -In December 2018, she reported his sexually aggressive behavior to the SCU RCC and the Assisted Living (AL) RCC. -There was no change in his level of supervision after his behavior or after she reported. -The normal checks performed on each resident was every 2 hours. -There was one MA and one PCA on the SCU at a time. -She felt 8 residents required increased supervision because of their behaviors, two staffs members were needed to keep the residents "safe". -There was no change in Resident #6's level of supervision after his behavior or after she reported the behaviors. Interview with a second MA on 02/18/19 at 4:18pm revealed: -She worked all shifts that were needed in the SCU. -Resident #6 was very sexually inappropriate both verbally and physically to the staff and residents. -Resident #6 had sexually assaulted two other female residents in December 2018. -All incidents were reported to the SCU RCC and the Administrator.	D 270		

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D 270	Continued From page 47 -Incident reports were completed and the physicians were notified. -"Only one" female resident was sent out to the ER and one staff was sent out to the ER due to Resident #6's assaults. -Residents in the SCU were routinely checked by staff every two hours. -She was never told to increase supervision for Resident #6 after his incidents. -A MA and a PCA on the SCU was not enough given the increased incidents with Resident #6 and other residents in the SCU. It was "not safe" for anyone, staff or residents. Telephone interview with Resident #6's Behavioral Health physician on 02/21/18 at 1:12pm revealed: -She was aware of Resident #6's hyper sexual behaviors. -She treated him with medications and after the 01/05/19 incident she started the Depo-provera (a medication to control hormones) injections every 2 weeks to curb the sexual behaviors. -She ordered the facility staff on 01/05/19 to increase the supervisor for Resident #6 to "24/7" and to keep him away from the female residents. a. Review of Resident #7's FL2 dated 07/05/18 revealed: -Diagnoses included dementia, schizophrenia, and epilepsy. -The resident was constantly disoriented with wandering behavior and verbally abusive. Review of Resident #7's ER visit dated 01/05/19 revealed: -The chief complaint was documented as the resident was sexually assaulted by a male resident. -Resident #7 was extremely demented and	D 270		

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D 270	Continued From page 48 non-verbal. -A visual inspection was preformed of Resident #7's vaginal area and the vaginal area was free of lacerations and or bruising to the vaginal area. -The ER physician had spoken with the facility in reference to the perpetrator being tested for STDs and to be separated from Resident #7. -The ER physician was informed by the facility, the male resident perpetrator was in the process of being moved to another facility. -The ER physician spoke with Resident #7's family at the hospital and was in agreement with the perpetrator being tested for STDs and kept away from Resident #7 and being moved to a different facility. -The police were already involved. -There were strict return precautions provided. -The discharge instructions included; to keep the male resident away from Resident #7, and the male resident should be tested for STDs. -A sexually assault information packet was provided for Resident #7 along with the discharge instructions. Review of Incident Reports revealed there were no reports filed involving Resident #6 and #7. Interview with a medication aide (MA) on 02/18/19 at 3:24pm revealed: -On 01/05/19, a MA and a PCA reported to her Resident #6 was on top Resident #7 and neither of the residents had any clothing on. -She and the other two staff reported this incident to the SCU RCC and the AL RCC. -The physician's for Resident #6 and #7 were notified immediately after the incident on 01/05/19. -The physician for Resident #7 wanted Resident #7 to be sent to the ER. -Resident #7 was sent to the ER and she filled	D 270		

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D 270	Continued From page 49 out an incident report. -She was not instructed to increase supervision on Resident #7 after the incident involving Resident #6 and #7. Interview with a second MA on 02/18/19 at 4:18pm revealed: -Resident #6 was observed on top of Resident #7 "at least 3 times in January 2019". -All incidents were reported to the SCU RCC and the Administrator. -Incident reports were completed and the physicians were notified. -Resident #7 was sent out to the hospital due to Resident #6's assault. -The normal checks performed on each resident was every 2 hours. -The normal checks did not increase after the incidents involving Resident #7. -She was never told to increase supervision for Resident #7 after Resident #6's incident. Interview with a MA on 02/20/19 at 7:49am revealed: -After Resident #6 was found on top of Resident #7 she told the Administrator that day. -She notified Resident #7's family and the Administrator on 01/05/19 when Resident #6 was observed naked on top of Resident #7, who was also naked. -The Administrator told her the incident with Resident #6 and #7 was "consensual" because Resident #7 did not "scream" until Resident #7 hurt Resident #6. -The Administrator told her not to call the physicians, family or police but she had already called all three. -Resident #6's physician told her she would see Resident #6 and check for sexually transmitted diseases (STDs) per the hospital's	D 270			

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D 270	Continued From page 50 recommendation for Resident #7. -It was easier to check Resident #6 rather than Resident #7. -The normal checks were done every 2 hours in the SCU. -The normal checks did not increase after the incidents involving Resident #7. -After the incident involving Resident #6 and #7, Resident #7 became very scared all of the time. -Resident #7 was afraid to go to her room by herself, be alone without someone and would scream for someone if she found herself alone. -A week after the incident with Resident #6, Resident #7 would "cringe" or become upset at the sight of Resident #6. -Resident #7 complained about Resident #6 hurting her for about a week after the incident. Telephone interview with the previous SCU RCC on 02/20/19 at 9:45am revealed: -She was aware of at three incidents involving Resident #6 assaulting Resident #7 and the last incident was 01/05/19. -She reported all of the incidents with Resident #6 and #7 to the Administrator with the incident reports. -The normal safety check in the SCU were every 2 hours and they did not increase after the incidents involving Resident #7. -She was responsible for making sure all of the incidents reports were filled out, physicians and family were notified and any new orders were implemented. -There was no increased supervision in the SCU because the staff was always providing care for the residents. Interview with a personal care aide (PCA) on 02/20/19 at 3:34pm revealed: -She worked in the SCU all shifts for 7 years.	D 270			

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D 270	Continued From page 51 -Resident #7 was not the same after the incident with Resident #6 on 01/05/19. -Resident #7 would not be alone or she would scream for someone to come and get her. -She would help Resident #7 walk her to her room because Resident #7 was afraid to go alone. -Resident #7 told her a day or two after the incident that Resident #6 hurt her and reported it to the SCU RCC. -The routine safety checks were done every 2 hours in the SCU. -There was not any increase in the routine safety checks for Resident #7 after the incidents with Resident #6. -There were 2 other incidents where she caught Resident #6 on top of Resident #7 in December 2018. -She filled out incident reports, notified the SCU RCC and notified the MA. -The SCU RCC was to notify the physician. -She had told the Administrator about Resident #6 being on top of Resident #7 "many times" but nothing was done about it. Observation of Resident #7 in the SCU on 02/19/19 between 9:43am and 9:54am revealed, Resident #7 was crawling on her hands and knees down the hallways, she crawled for about 30 feet and then rocked back and forth on her hands and knees. After 2 minutes she crawled to the right side of the wall and using the side rails attempted to rise three times before she stood in an upright position, she walked down the hallway toward the dining room area. A MA was administering medications approximately 5 feet from Resident #7 when this occurred. Telephone interview with Resident #7's hospice Nurse on 02/21/19 at 8:46am revealed:	D 270		

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D 270	Continued From page 52 -She was aware of the incident where Resident #6 was found on top of Resident #7, both without clothes on. -She did not know about the other two incidents involving Resident #7 and #6 in December. -She indicated the hospice progress notes in Resident #7's record documented that Resident #7 was sent to the hospital for evaluation of sexual assault, the Hospice physician was notified, and the family was called. -She had spoken to Resident #7's family member on 02/04/19 in reference to Resident #7 safety and she referred him to the facility's Administrator. -There were documented behavior changes in Resident #7 by the staff at the facility since the incident on 01/05/19 such as "crawling " on the floor, screaming when left alone, and hiding in the bedroom closet and her being afraid to go back to her room without a staff member. -In a discussion with the hospice physician she and the physician considered the screaming when Resident #7 was left alone, Resident #7 crawling on the floor and Resident #7 being afraid to go back to her room alone as a sign of post-traumatic stress disorder (PTSD) as a result of the assault on 01/05/19. -There was also documentation in Resident #7's record of Resident #7 decreased appetite and sleep interruptions. -There was a verbal order for the staff to monitor Resident #7, keeping Resident #7 in their sights at all times and to keep Resident #7 away from Resident #6. Telephone interview with Resident #7's family member on 02/21/19 at 12:20pm revealed: -He was informed on 01/05/19 about a "rape" that happened to Resident #7. -The hospice Nurse called him on 01/05/19 and	D 270			

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D 270	Continued From page 53 he came to the facility to talk to the Administrator. -The Administrator told him she would try to move the responsible perpetrator to another facility. -The Administrator told him the facility staff would keep a "tighter eye" on Resident #7 meaning "all the time". -He voiced his concerns to the Administrator about Resident #7 and he thought the other female residents were to be protected from the perpetrator. -The Hospice Nurse called him every week with an update of Resident #7. -He visited Resident #7 weekly since 01/05/19. -He noticed a change in Resident #7's behavior and was told by the Hospice Nurse that it was associated with the assault on 01/05/19. -He told the Administrator several times after the assault on 01/05/19 he was concerned about Resident #7's safety and the perpetrator needed to be moved because the facility staff was not capable of watching Resident #7 at all times. -The Administrator told him the perpetrator was being moved to another facility. -He was not told as of today (02/21/19) the perpetrator was moved. Interview with the Administrator on 02/19/19 at 11:58am revealed: -She knew of the assault on Resident #7 by Resident #6 on 01/05/19. -She notified the family and physicians for both Resident #6 and #7 on 01/05/19. -She was not able to produce the incident reports involving Resident #6 and #7. -Resident #6 and #7 were put on every 15 minute safety checks on 01/05/19 until Resident #6 was seen by the physician on 01/08/19. -The safety checks on Resident #6 would have been stopped on 01/08/19 because Resident would have seen his physician.	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 54 -The MAs and PCAs were responsible for completing the safety checks and the SCU RCC was responsible for making sure the safety checks were done. -The MAs were responsible for documenting in the resident record on the safety check sheet every 15 minutes. -She was not able to produce any the completed safety check sheets for any of the residents in the SCU. -The safety check sheet was to be kept in the resident record at all times. -She was not able to produce the safety check sheets for Resident #6 or #7. -She did not observe any of the safety checks being preformed in the SCU. -She was not able to discharge Resident #6 after the sexual assault on Resident #7 because she could not find placement for Resident #6. b. Review of Resident #20's FL2 dated 06/21/18 revealed: -Diagnoses included dementia, hypertension, and anxiety. -The resident was constantly disoriented with wandering behaviors, injurious to others. Review of an Incident Report dated 12/25/18 at 7:30pm revealed: -Resident #20 was in Resident #6's bed and Resident #6 was naked with his arms around Resident #20. -It was documented as Resident #6 "was going to have sex" with Resident #20. Interview with a medication aide (MA) on 02/18/19 at 3:24pm revealed: -She worked in the Special Care Unit (SCU). -On 12/25/18, she found Resident #20 in Resident #6's bed. Resident #6 had his pants and	D 270		

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D 270	Continued From page 55 briefs pulled down and was on top of Resident #20 trying to stick his penis into Resident #20's mouth. -She notified Resident #6's family and physician. -She filled out an incident report at the time and gave it to the SCU RCC. -The SCU RCC told her not to call Resident #20's family because Resident #20 was fully dressed and no injury occurred. -She was not instructed to do anything more for supervision. Telephone interview with the previous SCU RCC on 02/20/19 at 9:45am revealed: -She was not aware of an incident involving Resident #6 and #20. -She was not given an incident report by the MA involving an incident with Resident #6 and #20. Interview with the Administrator on 02/19/19 at 11:58am revealed: -She was not aware of an incident involving Resident #6 and #20. -She was not given an incident report by the SCURCC involving an incident with Resident #6 and #20. _____ The facility failed to provide supervision to residents who resided on the Special Care Unit (SCU) resulted in Resident #9 with diagnosis of communicable disease engaging in oral sex and sexual intercourse with another Resident (#10) both residents with diagnosis of dementia, Resident #8 eloped from the SCU and was found over a mile away by visitors leaving the facility, Resident #6 who had a diagnosis of dementia sexually assaulted multiple residents, one being Resident #7 in the SCU who required an emergency room admission after the assault. This failure to assure supervision of the residents	D 270			

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D 270	Continued From page 56 resulted in risk for serious physical harm and neglect and constitutes a Type A1 Violation. The facility did not provide an acceptable Plan of Protection for the residents and was provided a directed plan of protection which was implemented February 22, 2019. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 24, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 6 sampled residents related to one resident who had a fall and was not administered an anticonvulsant as ordered (Resident #12), one who antiviral medication was not available for administration for 14 days (Resident #9), and one resident with orders for labwork not being drawn (Resident#6).	D 273		

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D 273	Continued From page 57 The Findings are: 1. Review of Resident #12's current FL2 dated 07/31/18 revealed: -Diagnoses included major neurocognitive disorder, dementia and schizophrenia. -Requested level of care was documented as Special Care Unit (SCU). Review of the facility incident and accident report for Resident #12 dated 12/14/18 at 4:00pm revealed: -There was documentation Resident #12 had fallen on 12/14/18 at 4:00pm. -There was documentation Resident #12 had "lost his balance near the soda machine" in the SCU. -There was documentation "vitals were obtained, resident was checked for bruising, resident was not send out because he did not hit his head." -Vital signs were documented as blood pressure 137/65, pulse 70 and respirations 16. -There was documentation the physician was notified on 12/14/18 at 4:15pm. -The report was signed by the medication aide (MA) and the Resident Care Coordinator (RCC). Interview with the Nurse Practitioner (NP) for Resident #12 on 02/19/19 at 4:30pm revealed: -She did not know Resident #12 had fallen on 12/14/18 at 4:00pm because she was not working that day. -Another NP in her office had covered for her on 12/14/18 when the facility contacted the office. -There were orders given to obtain neurological checks for 24 hours and to obtain a urinalysis for Resident #12. Review of the facility progress notes for Resident #12 revealed:	D 273		

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D 273	Continued From page 58 -There was documentation on 12/13/18 on 3:00pm-11:00pm shift Resident #12 had trouble walking, no other symptoms. "Just seemed off balance", B/P 110/68, Respiration 18, pulse 62, temperature 98.9 and pulse ox 98%. -There was do documentation Resident #12's physician was notified of his altered gait. -There was documentation on 12/15/18 on 3:00pm-11:00pm shift Resident #12 was getting up several times and had to be re-directed to sit down due to "being way too imbalanced" vital signs consisted of B/P at 4:00pm 153/82, at 8:00pm 142/78 and at 11:00pm 143/78. -There was no documentation Resident #12's physician was notified of the resident's condition. Review of a second incident and accident report for Resident #12 dated 12/16/18 at 9:56am revealed: -There was documentation Resident #12 had fallen on 12/16/18 at 9:56am. -There was documentation Resident #12 "was walking down the hall and tripped over his own feet." -There was documentation the medication aide (MA) and the personal care aide (PCA) had gotten Resident #12 off the floor, the MA checked his vital signs. -Vital signs were documented as blood pressure 90/48 and pulse 91. -There was documentation Resident #12 was not taken to the hospital and that EMS was not called. -There was documentation a message was left for the physician on 12/16/18 at 10:00am. -There was additional documentation at 3:00pm "Dr. hasn't returned call." -The report was signed by the Administrator on 12/17/18.	D 273			

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D 273	Continued From page 59 Review of the facility progress notes for Resident #12 revealed: -There was documentation on 12/16/18 on 7:00am-3:00pm shift Resident #12 "fell walking down the hall from his room." -There was documentation Resident #12 had "tripped over his own feet." -There was documentation the RCC and the NP were notified. -There was documentation the MA had "left a message for the DR to call back." -There was documentation "[Resident #12] was not injured." -There was documentation "[Resident #12's] Dr hasn't returned call yet, gave report to 2nd shift medtech." Interview with the Nurse Practitioner (NP) for Resident #12 on 02/19/19 at 4:30pm revealed: -She did not know Resident #12 had fallen on 12/16/18 at 9:56am. -The facility staff had not contacted the office or her when Resident #12 had fallen on 12/16/18 at 9:56am. -If she would had known Resident #12 had fallen and had a B/P of 90/48 she would had sent Resident #12 out to the Emergency Room (ER) for an evaluation. -Resident #12 was not on any hypertension medications. Review of a third facility incident and accident report for Resident #12 dated 12/16/18 at 8:00pm revealed: -There was documentation on 12/16/18 at 8:00pm Resident #12 was "found on the floor in room unresponsive." -"Staff found [Resident #12] on the floor of his room unresponsive." -There was documentation vitals were taken,	D 273			

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D 273	Continued From page 60 EMS was called, CPR preformed, the RCC was contacted and the family was attempted to be notified but the number was not in service. -There was documentation the B/P was 63/27, pulse was 103 and the respirations were 5 and shallow. -There was documentation the MA and EMS had notified the physician on 12/16/18 at 8:28pm. -The report was signed by the MA and the Administrator. -Resident #12 was pronounced dead by EMS personnel on 12/16/18. Review of an addition to the incident report dated 12/16/18 at 8:00pm signed by the MA and the PCA on 12/16/18 at 11:00pm revealed: -There was documentation "Resident was given night meds at 7:15pm and resident was alert and talking at this time." -There was documentation on 12/16/18 at 8:00pm during rounds Resident #12 was found on the floor beside his bed. -There was documentation the MA had "sat on the floor beside him, called his name and felt for a pulse. The resident did not respond to my voice and I could not find a pulse." -There was documentation the MA called 911. -There was documentation the MA obtained vital signs B/P 63/27, she started chest compression as EMS instructed her to do, and continued with CPR until EMS arrived. -There was documentation EMS used a defibrillator on Resident #12. -There was documentation Resident #12 was pronounced dead by EMS and the physician was notified. Telephone interview with the Mental Health Nurse Practitioner on 02/20/19 at 9:30am revealed: -She did not know Resident #12 had fallen on	D 273		

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D 273	Continued From page 61 12/14/18 or on 12/16/18 until after the incident of his death had occurred on 12/16/18 at 8:00pm. -The facility did not make her aware of the falls on either occasions. -She did not know Resident #12's B/P was 90/48 after one of the falls on 12/16/18, "If I would had known I would had sent him out." -The facility never contacted me with resident incidents, "They just wait till I get there and tell me." -I have told them (the facility staff) to call me with any concern or issue regarding any of my residents." Interview with a MA on 02/19/18 at 3:45pm revealed: -She had worked on the SCU on 12/15/18 and obtained vital signs for Resident #12 which include B/P. -The NP had given orders to obtain neurological checks for Resident #12 for 24 hours that was why she had obtained blood pressures three times on her shift on 12/15/18. -She had worked second shift in the SCU on 12/16/18. -She was given report by the first shift MA on 12/16/18 but was not told Resident #12 B/P was 90/45. -She was told by the first shift MA the physician was left a message Resident #12 had fallen on 12/16/18 at 10:00am, but they had never called back. -We have direct numbers to the NP and they always call us back within 5 minutes." -If a resident is sent to the ER we must get permission from the RCC before sending them out." Interview with the SCU Resident Care Coordinator (RCC) on 02/20/19 at 11:20am	D 273			

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D 273	Continued From page 62 revealed: -She was the RCC for the SCU but only started three weeks ago. -If a resident had fallen or had changes in condition the MAs were required to contact the physician. -She was not aware Resident #12 had fallen on 12/14/18 or on 12/16/18. Telephone interview with the former SCU RCC on 02/20/19 at 10:00am revealed: -She had worked on 12/16/18 day shift when Resident #12 had fallen at 10:00am. -The MA had told her Resident #12 did not have any injury or hit his head. -She did not know Resident #12's B/P was 90/45 on 12/16/18 at 10:00am after the fall. -The MAs are responsible for contacting the physician after a resident had fallen. -She had not notified the physician after Resident #12 had fallen on 12/16/18 at 10:00am. -She did not know if the physician was notified of the fall on 12/16/18 at 10:00am or the B/P 90/45. -She did know Resident #12 was found unresponsive and had died on 12/16/18 at 8:00pm in the facility. Interview with the Administrator on 02/19/19 at 4:58pm revealed: -She knew Resident #12 had fallen on 12/14/18 and on 12/16/18. -The MAs were responsible for contacting the physician after a resident fell. -She did not know the physician was not notified on 12/16/18 at 10:00am Resident #12 had fallen. -She did not know Resident #12 B/P was 90/45 after the fall on 12/16/18 at 10:00am. -The physician should have been called for the fall and a "blood pressure that low." -The MAs were to contact the physicians and	D 273			

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D 273	Continued From page 63 complete an incident report after a fall had occurred. -She knew Resident #12 was found unresponsive on 12/16/18 at 8:00pm in the SCU and CPR was performed by her staff. -She knew EMS was called and Resident #12 had died in the facility on 12/16/18. Review of the facility MAs "meeting notes" dated 01/25/19 revealed: -Physicians must be notified prior to calling EMS or transporting a resident to the hospital unless it is an emergency. -All areas of the incident report must be completed before the RCC and the Administrator will sign the report. Review of the facility falls policy revealed: -The MAs were to obtain vital signs, checking B/P lying, sitting and standing to assess for postural hypotension and document vitals on the accident report. -The MAs were to notify the physician as defined on the incident /accident report. -Notify the physician for a review of medications and evaluation for repeat falls. b. Review of Resident #12's current FL2 dated 07/31/18 revealed: -Diagnoses included major neurocognitive disorder, dementia and schizophrenia. -The requested level of care was documented as special care unit (SCU). -Medication orders included divalproex (a mood stabilizer used to treat manic episodes and decrease behaviors) sprinkles 500 mg three times daily. Review of the December 2018 electronic medication administration record (eMAR)	D 273			

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D 273	Continued From page 64 revealed: -There as an entry for divalproex 500 mg take two tablets three times daily scheduled at 2:00am, 9:00am and 9:00pm. -There was documentation the divalproex 500mg was not administered from 12/01/18 to 12/15/18 at 2:00am, the reason documented was "resident asleep." Review of Resident #12's record revealed a valproic acid level (used to determine the therapeutic level for divalproex in the blood) dated 10/26/18 with result of 10.5 (normal range is 50-125). Interview with a MA on 02/19/18 at 3:45pm revealed: -She knew resident #12 was ordered divalproex 500mg three times daily. -She did not know the third shift MA did not administer the medication at 2:00am due to "resident sleeping." -She was never told by the other shifts to ask to change the times or to contact the physician concerning the times.. -Resident #12 always took his medications on second shift. -She had never contacted the physician in regard to the missed 2:00am divalproex 500mg. -If a resident missed three consecutive days of his medications the MAs were to contact the physician. Telephone interview with another MA on 02/19/18 at 5:15pm revealed: -She worked as a MA in the SCU on third shift. -Her responsibilities included administering medication to the residents in the SCU and in the Assisted Living (AL). -She had documented Resident #12 was a sleep	D 273		

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D 273	Continued From page 65 at 2:00am when she worked. -She had administered the divalproex 500mg. -She had not contacted the physician or the NP in regards to the not administering the divalproex. -Resident #12 was always sleeping at 2:00am. -She had never informed the other shifts Resident #12 never took his medication at 2:00am. -The facility policy was if a resident missed three days taking his medication the MAs were to call the physician, but "[Resident #12] only missed one dose at 2:00am each day, not three whole days taking his meds." Interview with the Nurse Practitioner (NP) for Resident #12 on 02/19/19 at 4:30pm revealed she was not made aware Resident #12 was not administered divalproex 500mg at 2:00am. Telephone interview with Resident #12's Mental Health Nurse Practitioner on 02/20/19 at 9:30am revealed: -Resident #12 was prescribed divalproex 500mg for behaviors. -She was not aware Resident #12 had not been administered divalproex 500 mg at 2:00am from 12/01/18 to 12/15/18 the reason given was "resident asleep". -"This is unacceptable." -If the staff would have brought it to her attention she could change the times or the dosages of the divalproex 500mg. -The facility never reached out to her with this concern. -The facility never contacted her in regards to Resident #12 not having being administered his 2:00am dose of divalproex. Interview with the Administrator on 02/19/19 at 4:58pm revealed:	D 273		

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D 273	Continued From page 66 -She did not know Resident #12 had not been administered the divalproex 500mg at 2:00am from 12/01/18 to 12/15/18. -The policy was if a resident missed three days of taking his medications the physician should be notified. -"Certainly if Resident #12 missed 16 days, someone should have made the physician aware." -The RCC was responsible for reviewing the eMARs monthly for missed medications and holes. -She relied on the RCC to oversee the MAs and to review the eMARs and medications on the med carts. 2. Review of Resident #6's FL2 dated 05/15/18 revealed diagnoses included dementia, hypertension, seizures and movement disorder. Interview with a medication aide (MA) on 02/20/19 at 7:49am revealed: -After Resident #6 was found on top of a female resident she notified the female's physician and obtained an order to send her to the emergency room (ER) for evaluation for a sexual assault. -The female resident was sent to the ER. -The Administrator told her not to call the physicians, family or police but she had already done so. -Resident #6's physician told her she would see Resident #6 and check for sexually transmitted diseases (STDs). Interview with the NP from Resident #6's physician's office on 02/20/19 at 8:02am revealed: -She knew Resident #6 sexually assaulted a female resident on 01/05/19. -She talked with the ER physician on 01/05/19 in	D 273			

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D 273	Continued From page 67 reference to Resident #6 being tested for STDs. -The ER physician was to put the order on the discharge papers and the facility staff would give her the order if that was his final decision. -She did not receive the discharge paperwork after requesting the discharge paperwork from the ER visit. -She expected the facility to let her know of all new orders from any visits to the ER. Review of Resident #7's ER visit dated 01/05/19 revealed: -The chief complaint was documented as the resident was sexually assaulted by a male resident. -Resident #7 was extremely demented and non-verbal. -A visual inspection was performed of Resident #7's vaginal area and the vaginal area was free of lacerations and or bruising to the vaginal area. -The ER physician had spoken with the facility in reference to the perpetrator being tested for STDs and to be separated from Resident #7. -The ER physician was informed by the facility, the male resident perpetrator was in the process of being moved to another facility. -The ER physician spoke with Resident #7's family at the hospital and was in agreement with the perpetrator being tested for STDs and kept away from Resident #7 and being moved to a different facility. -The police were already involved. -There were strict return precautions provided. -The discharge instructions included; to keep the male resident away from Resident #7, and the male resident should be tested for STDs. -A sexual assault information packet was provided for Resident #7 along with the discharge instructions.	D 273		

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D 273	Continued From page 68 Review of Resident #6's record as of 02/20/19 at 8:02am revealed there was no documentation of Resident #6 was tested for STD's as recommended and ordered by the emergency room physician. Telephone interview with the Special Care Unit Resident Care Coordinator (SCU RCC) on 02/20/19 at 9:45am revealed: -She was responsible for all new orders and getting lab work set up through the lab. -Resident #6 had STD labs obtained after the assault on the female resident. -The labs were done at the facility. -She did not remember who she set them up with, just they were done and they were "fine". Interview with the Administrator on 02/21/19 at 11:00am revealed: -She thought the labs for STDs "were already done". -She was not able to locate the lab results and spoke with Resident #6's NP. -The MAs were responsible for getting all new orders to the SCU RCC for processing. -The SCU RCC should have notified the lab for processing the STD lab work or called the physician for clarification. 3. Review of Resident #9's current FL2 dated 01/03/19 revealed: -Diagnoses included dementia, a communicable disease, and schizophrenia. - "Domiciliary" was documented as current and recommended level of care. -There was no documentation on the FL2 Resident #9 was to be admitted to the SCU. -Admission date to the facility was 01/13/19. Observation of Resident #9's record on 02/18/19	D 273		

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D 273	Continued From page 69 revealed: -There was an FL2, nurses note, new prescription request and high cost medication approval request form, and unsigned diet and physician's orders paper clipped together and not filed in a record. -Resident #9 did not have a medical provider. Interview with Resident #9 on 02/18/19 at 11:00am revealed he had not seen a health care provider since his admission to the facility on 01/13/19. Telephone interview with the Clinical Coordinator (CC) of the facility's contracted pharmacy on 02/19/19 at 10:25am revealed: -There was an FL2 dated 01/03/19 with an order for Genvoya (a combination drug of 4 antiviral medications used to treat a communicable disease). The pharmacy was not able to fill the medication Genvoya at the time due to billing issues. -A medication request for refill was sent by the facility on 01/28/19 to the pharmacy. -The pharmacy faxed a High Cost Medication Approval Request form back to the facility on 02/04/19. The medication was approved on 02/12/19. -The Genvoya prescription was filled and delivered to the facility on 02/13/19. Interview with the Resident Care Coordinator (RCC) on 02/19/19 at 3:45pm revealed that she was unaware of who Resident #9's medical provider was. Telephone interview with the former health care provider on 02/20/19 at 1:17pm revealed: -He was not notified by the facility that Resident #9 was out of the medication Genvoya.	D 273		

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D 273	Continued From page 70 -If medication doses of Genvoya were missed for 2-3 weeks; it could "increase the viral load" resulting in increased symptoms of the communicable disease. -He was not Resident #9's current medical provider. Interview with the Administrator on 02/21/19 at 9:08am revealed: -The SCU coordinator was responsible for making sure medications were ordered for the residents. -The Business Office Manager made sure that the residents were assigned a health care provider. -She did know that his assigned health care provider group had rejected him as a patient. -Resident #9 was excepted by the facility medical provider on 02/21/19. Interview with the nurse practitioner (NP) on 02/21/19 at 10:40am revealed: -The Administrator had ask her to accept Resident #9 as a new patient on 02/21/19. -She did not know Resident #9 was out of Genvoya. -She was not familiar with Resident #9. -She was seeing Resident #9 to establish new resident care on 02/21/19. Telephone interview with the CC at the facility's contracted pharmacy on 02/21/19 at 3:28pm revealed: -The original order for Genvoya on the FL2 was on 01/19/19. -The pharmacy sent weekly notifications to the facility that the medication had not been approved by insurance. -Genvoya was rejected due to billing issues. -The pharmacy did not hear back from the facility	D 273		

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D 273	Continued From page 71 so "we handled the approval of the medication". -The pharmacy had to order the medication on 02/13/19 because they did not have it on hand. The facility failed to assure referral and follow-up to meet the acute healthcare needs in reporting a low blood pressures, changes in gait and several falls to (Resident #12) physician, which resulted in findings him unresponsive on the floor of the SCU requiring CPR and defibrillation, both of which were unsuccessful. Resident #9 regarding the medication Genvoya used to treat a communicable disease, not available for administration for multiple days with the potential of increasing the viral load while failing to notify his provider of oral sex and sexual activity with another resident in the SCU, and Resident #6 in the SCU regarding testing for STD after an sexual assault by another resident in the SCU. This failure to assure referral and follow up to meet the resident's needs resulted in serious physical harm and neglect and constitutes a Type A1 Violation. The facility did not provide an acceptable Plan of Protection for the residents and was provided a directed plan of protection which was implemented February 22, 2019. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 24, 2019.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	D 358		

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D 358	Continued From page 72 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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 5 of 6 sampled residents (#3, #5, #9, #12, #13, and #17) were administered medications as ordered by a licensed prescribing practitioner related to lorazepam not administered as ordered (Resident #3), missing multiple doses of Genvoya, sulfamethoxazole, and lorazepam (Resident #9), Depakote not administered as ordered (Resident #12), Norco not administered as ordered (Resident #13), and administering sodium polystyrene sulfate (Resident #17). The findings are: 1. Review of the Resident #9's current FL2 dated 01/03/19 revealed diagnoses included dementia, schizophrenia, and a communicable disease. a. There was a medication order for Genvoya (a combination drug of four antiviral medications	D 358		

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D 358	Continued From page 73 used to treat a communicable disease infection) take 1 tablet daily. Genvoya is usually taken by mouth as a tablet with food daily. If missed a dose you can take up to 12 hours late. It is important to take Genvoya and do not missed any doses due to the amount of virus in your blood will increase if the medication is stopped for even is missed short time (www.genvoya.com). Review of Resident #9's January 2019 electronic medication administration record (eMAR) revealed: -There was a computer generated entry for Genvoya take 1 tablet once daily with a meal or snack. -Genvoya was documented as administered daily at 9:00am from 01/15/19 to 01/27/19. -Genvoya was not documented as administered from 01/28/19 to 01/31/19 with documentation medication was on order. Review of Resident #9's February 2019 eMAR revealed: -There was a computer generated entry for Genvoya take 1 tablet once daily with a meal or snack. -Genvoya was documented as administered daily at 9:00am on 02/04/19, 02/10/19, and 02/14/19 to 02/21/19. -Genvoya was not documented as administered from 02/01/19 to 02/03/19, 02/05/19 to 02/09/19, and 02/11/19 to 02/13/19 with documentation medication was on order. Telephone interview with a medication aide (MA) on 2/18/19 at 2:45pm revealed: -She worked on the SCU as a MA. -Resident #9 had been without his Genvoya	D 358			

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D 358	Continued From page 74 medication for weeks. -Resident #9 takes the medication to control a communicable disease. -The Administrator and the RCC were both aware the medication is not available to administer as ordered. -We can not notify a physician because Resident #9 does not have a medical provider. Interview with Resident #9 on 02/18/19 at 11:00am revealed: -He knew he was taking Genvoya daily for a communicable disease. -He believed that the facility was providing him all of his ordered medications without any missed doses. -He had not seen a health care provider since his admission to the facility on 01/03/19. -He did not know if all of his medications were ordered. Telephone interview with the clinical coordinator (CC) from the facility's contracted pharmacy on 02/19/19 at 10:25am revealed: - "Genvoya is an expensive medication." -Resident #9 must have brought some of the medications with him from the facility that he had transferred from. -Resident #9 did not have insurance at the time Genvoya was ordered on 01/03/19 and the medication was not filled. -A medication request for refill was sent by the facility on 01/28/19 to the pharmacy. -The pharmacy faxed a High Cost Medication Approval Request form back to the facility on 02/04/19. -The medication was approved on 02/12/19. -The Genvoya prescription was dispensed and delivered to the facility on 02/13/19.	D 358		

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D 358	Continued From page 75 Telephone interview with Resident #9's former health care provider on 02/20/19 at 1:17pm revealed: -He was not notified by the facility that Resident #9 was out of Genvoya. -If medication doses of Genvoya were not administered for 2-3 weeks; it could "increase the viral load" resulting in increased symptoms of the communicable disease. -He was not the residents current physician. -The facility never contacted him in regards to obtain a prescription for the Genvoya for Resident #9. Interview with the Administrator on 02/21/19 at 9:08am revealed: -She knew Resident #9 did not have current medical provider. -The Special Care Unit (SCU) coordinator was responsible for making sure medications are ordered for the resident's. -She was unaware that Resident #9 missed multiple doses of Genvoya. Telephone interview with the CC at the facility's contracted pharmacy on 02/21/19 at 3:28pm revealed: -The original order for Genvoya from the FL2 was dated 01/19/19. -Genvoya was rejected due to billing issues. -The pharmacy sent weekly notifications to the provider and facility that Genvoya had not been approved by insurance. -"We handled the approval of Genvoya". -The pharmacy had to order Genvoya on 02/13/19 because they did not have it on hand. Interview with the Resident Care Coordinator (RCC) on 02/21/19 at 4:50pm revealed: -She did not know why Resident #9 missed doses	D 358			

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D 358	Continued From page 76 of his medications. -Resident #9 "probably needed a new prescription and he did not have a physician." Refer to the interview with a second shift medication aide (MA) on 02/19/19 at 5:05pm. Refer to the interview with the RCC on 02/18/19 at 12:57pm. Refer to the interview with the Administrator on 02/20/19 at 12:07pm. Refer to the review of the facility medication administration audit policy. b. Review of Resident #9's FL2 dated 01/03/19 revealed there was a medication order for sulfamethoxazole-TMP DS (used to treat and prevent infection) 1 tablet daily. Review of Resident #9's January 2019 eMAR revealed: -There was a computer generated entry for sulfamethoxazole-TMP DS 1 tablet daily. -Sulfamethoxazole-TMP DS was documented as administered from 01/15/19 to 01/27/19. -Sulfamethoxazole-TMP DS was documented as not administered from 01/28/19 to 01/31/19 and documented the medication was on order. Review of Resident #9's February 2019 eMAR revealed: -There was a computer generated entry for sulfamethoxazole-TMP DS 1 tablet daily. -Sulfamethoxazole-TMP DS was documented as administered on 02/04/19, and 02/10/19 to 02/21/19. -Sulfamethoxazole-TMP DS was documented as not administered from 01/01/19 to 01/03/19 and	D 358		

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D 358	Continued From page 77 01/05/19 to 01/09/19 and documented as medication on order. Interview with Resident #9 on 02/18/19 at 11:00am revealed: -He believed that the facility was providing him all of his ordered medications without any missed doses. -He had not seen a health care provider since his admission to the facility on 01/03/19. -He did not know if all of his medications were ordered. Interview with the Administrator on 02/21/19 at 9:08am revealed: -The SCU Coordinator was responsible for ordering medications for the resident's. -She did not know that Resident #9 missed multiple doses of sulfamethoxazole-TMP DS. Telephone interview with the CC at the facility's contracted pharmacy on 02/21/19 at 3:28pm revealed: -The pharmacy dispensed a bubble pack of sulfamethoxazole-TMP DS 30 day supply on admission 01/13/19 for Resident #9. -The pharmacy dispensed a bubble pack for sulfamethoxazole-TMP DS 30 day supply on 02/09/19 for Resident #9. -The facility should have received enough sulfamethoxazole to be administered all days in January 2019 and February 2019. -"It is very important that Resident #9 receives sulfamethoxazole to prevent a fungal infection." Refer to the interview with a second shift MA on 02/19/19 at 5:05pm. Refer to the interview with the RCC on 02/18/19 at 12:57pm.	D 358			

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D 358	Continued From page 78 Refer to the interview with the Administrator on 02/20/19 at 12:07pm. Refer to the review of the facility medication administration audit policy. c. Review of Resident #9's FL2 dated 01/03/19 revealed there was a medication order for lorazepam (used to treat agitation) 1mg three times daily. Review of Resident #9's January 2019 eMAR revealed: -There was a computer generated entry for lorazepam 1mg three times daily at 9:00am, 3:00pm, 9:00pm. -Lorazepam 1mg three times daily was documented as administered from 01/15/19 to 01/21/19. -Lorazepam 1mg three times daily was documented as not administered from 01/22/19 to 01/31/19 and documented as waiting on hardscript and medication on order. Review of Resident #9's February 2019 eMAR revealed: -There was a computer generated entry for lorazepam 1mg three times daily at 9:00am, 3:00pm, 9:00pm. -Lorazepam 1mg three times daily and documented as administered on 02/04/19 at 9:00am and 3:00pm, 02/16/19 at 9:00am, and 02/18/19 at 9:00pm. -Lorazepam 1mg three times daily was documented as not administered from 02/01/19 to 02/21/19 except for four doses documented on 02/04/19 x2 doses, 02/16/19, and 02/19/19 and documented as waiting on hardscript and medication on order.	D 358			

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D 358	Continued From page 79 Interview with Resident #9 on 02/18/19 at 11:00am revealed: -He believed that the facility was providing him all of his ordered medications without any missed doses. -He had not seen a health care provider since his admission to the facility on 01/03/19. -He did not know if all of his medications were ordered. Interview with the Administrator on 02/21/19 at 9:08am revealed: -The SCU Coordinator was responsible for making sure medications were ordered for the resident's. -She did not know that Resident #9 missed multiple doses of lorazepam. Telephone interview with the CC at the facility's contracted pharmacy on 02/21/19 at 3:28pm revealed: -They did not receive a prescription for Resident #9's lorazepam. -The pharmacy contacted the provider and the facility 6 times and told them they needed a prescription. Refer to the interview with a second shift MA on 02/19/19 at 5:05pm. Refer to the interview with the RCC on 02/18/19 at 12:57pm. Refer to the interview with the Administrator on 02/20/19 at 12:07pm. Refer to the review of the facility medication administration audit policy.	D 358		

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D 358	Continued From page 80 d. Review of Resident #9's FL2 dated 01/03/19 revealed there was a medication order for lorazepam (used to treat agitation) 0.5mg daily as needed. Review of Resident #9's January 2019 eMAR revealed: -There was a computer generated entry for lorazepam 0.5mg daily as needed. -There were no doses of lorazepam 0.5mg daily as needed documented as administered to Resident #9. Review of Resident #9's February 2019 eMAR revealed: -There was a computer generated entry for lorazepam 0.5mg daily as needed. -There were no doses of lorazepam 0.5mg daily as needed documented as administered to Resident #9. Interview with Resident #9 on 02/18/19 at 11:00am revealed: -He believed that the facility was providing him all of his ordered medications without any missed doses. -He had not seen a health care provider since his admission to the facility on 01/03/19. -He did not know if all of his medications were ordered. Interview with the Administrator on 02/21/19 at 9:08am revealed: -The SCU Coordinator was responsible for making sure medications were ordered for the resident's. -She did not know if Resident #9 had lorazepam available to be administered as needed. Telephone interview with the CC at the facility's	D 358		

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NAME OF PROVIDER OR SUPPLIER AURORA OF STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1902 ORA DRIVE STATESVILLE, NC 28625		
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D 358	Continued From page 81 contracted pharmacy on 02/21/19 at 3:28pm revealed: -They did not receive a prescription for the Resident #9's lorazepam. -The pharmacy contacted the provider and the facility 6 times and told them they needed a prescription. Refer to the interview with a second shift MA on 02/19/19 at 5:05pm. Refer to the interview with the RCC on 02/18/19 at 12:57pm. Refer to the interview with the Administrator on 02/20/19 at 12:07pm. Refer to the review of the facility medication administration audit policy. 2. Review of Resident #12's current FL2 dated 07/31/18 revealed: -Diagnoses included major neurocognitive disorder, dementia and schizophrenia. -There was a medication order for divalproex (a mood stabilizer used to treat manic episodes and decrease behaviors) sprinkles 500 mg three times daily. Review of Resident #12's subsequent physician's order dated 01/22/19 revealed an order for divalproex sprinkles 500 mg three times daily. Review of Resident #12's December 2018 electronic Medication Administration Record (eMAR) revealed: -There as an entry for divalproex 500 mg take two tablets three times daily scheduled at 2:00am, 9:00am and 9:00pm. -There was documentation the divalproex 500mg	D 358			

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D 358	Continued From page 82 was not administered from 12/01/18 to 12/15/18 at 2:00am, the reason documented was "resident asleep." Review of Resident #12's record revealed a valproic acid level (used to determine the therapeutic level for divalproex in the blood) dated 10/26/18 with result of 10.5 (normal range is 50-125). Interview with a medication aide (MA) on 02/19/18 at 3:45pm revealed: -She knew resident #12 was taking divalproex 500mg three times daily. -She did not know the third shift MAs were not administering the divalproex 500mg as ordered at 2:00am due to "resident asleep." -Resident #12 always took his medications on the 3:00pm to 11:00pm shift. -She never contacted the physician in regard to the missed 2:00am divalproex 500mg. -If a resident missed three consecutive days of medications, the MAs were to contact the physician. Telephone interview with another MA on 02/19/18 at 5:15pm revealed: -She worked as a MA in the Special Care Unit (SCU) on third shift. -Her responsibilities included administering medications to the residents in the SCU and the AL side. -When she worked on third shift she documented on the eMAR, Resident #12 was sleeping at 2:00am. -She had not administered the divalproex 500mg at 2:00am as ordered. -She had not contacted the physician or the NP in regards to the missed dose of divalproex 500mg at 2:00am.	D 358			

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D 358	Continued From page 83 -She had never informed the other shifts Resident #12 never took his medication at 2:00am. -[Resident #12] only missed one dose at 2:00am each day, not three whole days taking his meds." Interview with the Nurse Practitioner (NP) for Resident #12 on 02/19/19 at 4:30pm revealed: -She was not made aware Resident #12 was not administered divalproex 500mg at 2:00am as ordered. -The psychiatric medications for Resident #12 were reviewed and ordered by the Mental Health NP. Telephone interview with the Mental Health Nurse Practitioner for Resident #12 on 02/20/19 at 9:30am revealed: -Resident #12 was prescribed divalproex 500mg for controlling his behaviors. -She was not aware Resident #12 had not been administered divalproex 500 mg at 2:00am as ordered from 12/01/18 to 12/15/18 due to the resident being asleep. -"This is unacceptable." -If the staff would had brought it to her attention she could change the time or the dosages of the divalproex 500mg. -The facility never reached out to her with this concern. -The facility never contacted her in regards to Resident #12 not administered his 2:00am dose of divalproex. -She expected the facility staff to administer medications as she had ordered. Interview with the Administrator on 02/19/19 at 4:58pm revealed: -She did not know Resident #12 had not been administered the divalproex 500mg at 2:00am as	D 358		

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D 358	Continued From page 84 ordered from 12/01/18 to 12/15/18. -"Certainly if [Resident #12] missed 16 days of medications, someone should had made the physician aware." Refer to the interview with a second shift MA on 02/19/19 at 5:05pm. Refer to the interview with the RCC on 02/18/19 at 12:57pm. Refer to the interview with the Administrator on 02/20/19 at 12:07pm. Refer to the review of the facility medication administration audit policy. 3. Review of Resident #3's current FL2 dated 06/21/18 revealed: -Diagnoses included dementia, anxiety, falls and insomnia. -There was a medication order for lorazepam 0.5mg (used for anxiety and behaviors) take one tablet daily. Review of Resident #3's subsequent physician's order dated 10/24/18 revealed an order for lorazepam 0.5mg take one daily for anxiety. Review of Resident #3's January 2019 electronic Medication Administration Record (eMAR) revealed: -There was as an entry for lorazepam 0.5mg tablet take once daily for anxiety scheduled at 8:00am. -There was documentation the lorazepam 0.5mg was not administered as ordered for 11 of 31 opportunities on 01/13/19 through 01/23/19. -There was documentation the reason was "other see note".	D 358			

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D 358	Continued From page 85 -The "other see notes" documentation included, "waiting on hard scrip, med reordered, med refill and med on ordered." Review of Resident #3's February 2019 eMAR revealed: -There was as an entry for lorazepam 0.5mg tablet take once daily for anxiety scheduled at 8:00am. -There was documentation the lorazepam 0.5mg was not administered as ordered from 02/01/19 to 02/07/19. -There was documentation the reason was "other see note". -The "other see notes" were documented as, "waiting order clarification." Observation of medications on hand for Resident #3 on 02/19/18 at 11:35am revealed there were 69 lorazepam 0.5mg available for administration. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 02/19/19 at 10:00pm revealed: -The pharmacy dispensed lorazepam 0.5mg to Resident #3 on 11/09/18 for a supply of 30 tablets for a 30 day supply and again on 12/11/18 for a supply of 30 tablets for a 30 day supply. -The pharmacy received a facility request to dispense the lorazepam 0.5mg again on 01/23/19, but could not dispense due to "no hard script." -The pharmacy reached out via email to the facility and Resident #3's provider requesting a hard prescription for the lorazepam 0.5mg prior to dispensing. -The pharmacy documented on 01/13/19, 01/14/19, 01/15/19, 01/18/19 and on 01/23/19 the facility and the medical provider were notified Resident #3's needed a prescription for refilling	D 358		

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D 358	Continued From page 86 the lorazepam 0.5mg. -The pharmacy had received a hard scrip for Resident #3's lorazepam 0.5mg take one tablet daily on 01/23/19 and dispensed 30 tablets for a 30 day supply. -The pharmacy dispensed lorazepam 0.5mg take one tablet as needed for acute agitation times 2 doses for Resident #3 on 02/06/19 and dispensed 90 tablets. Interview with a medication aide (MA) on 02/19/18 at 3:45pm revealed: -She was responsible for faxing medication orders to the pharmacy. -She was responsible for completing weekly audits of the medication cart compared to the eMAR. -The Resident Care Coordinator (RCC) was responsible for obtain the hard scripts for the residents from the NP, if they needed one. Interview with the Nurse Practitioner (NP) for Resident #3 on 02/19/19 at 4:30pm revealed: -She was not made aware Resident #12 was not administered lorazepam 0.5mg as ordered. -The lorazepam was used for anxiety and behaviors. -The lorazepam 0.5mg for Resident #3 was ordered by the Mental Health NP. Telephone interview with the Mental Health Nurse Practitioner on 02/20/19 at 9:30am revealed: -Resident #3 was prescribed lorazepam 0.5mg for controlling anxiety which could lead to behaviors. -She was not aware Resident #3 had not been administered lorazepam 0.5mg as ordered for 11 of 31 opportunities in January 2019, from 01/13/19 through 01/24/19. -She could not recall a request from the facility for	D 358			

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D 358	Continued From page 87 "hard script" for the lorazepam 0.5mg for Resident #3. -She was in the facility every Monday and was never informed by the staff Resident #3 needed a hard scrip for pharmacy to dispense the lorazepam 0.5mg. -She was available via phone for the facility staff if there were any concerns related to resident care. Interview with the Administrator on 02/19/19 at 4:58pm revealed: -She did not know Resident #3 had not been administered the lorazepam 0.5mg as ordered for 11 of 31 opportunities in January 2019, from 01/13/19 through 01/24/19. -The MAs were supposed to tell the RCC if any medications were not available to administer to the residents. -The RCC was responsible for reviewing the eMARs monthly for "missed medications and holes." -She relied on the RCC to oversee the MAs and to review the eMARs and medications on the med carts. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Refer to the interview with a second shift MA on 02/19/19 at 5:05pm. Refer to the interview with the RCC on 02/18/19 at 12:57pm. Refer to the interview with the Administrator on 02/20/19 at 12:07pm. Refer to the review of the facility medication administration audit policy.	D 358			

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D 358	Continued From page 88 4. Review of Resident #17's current FL2 dated 06/21/18 revealed: -Diagnoses included dementia, diabetes, coronary heart disease, systolic heart failure, and anemia. -There was a medication order for sodium polystyrene sodium (SPS) (used to lower potassium levels) take 30gms (120ml) daily on Monday, Wednesday, and Friday. Review of Resident #17's physician's order dated 01/22/19 revealed a physician's order for SPS powder mix 30gm in 120ml of water daily on Monday, Wednesday, and Friday (avoid administration with three hours of other meds). Observation of medication pass and medications on hand on Tuesday, 02/19/19 at 9:18am on the Special Care Unit (SCU) revealed: -Resident #17 was administered SPS 30 gm mixed in a 5 ounce cup of water along with ten oral medications. -The medication aide (MA) filled the 5 ounce cup to the top with water but did not measure the amount of water. -Resident #17 had a partially used container (approximately 1/4 remaining in container) of SPS available for administration dispensed on 11/18/18 from the facility's contracted pharmacy. -The label on the bottle of SPS stated to administer on Monday, Wednesday, and Friday only. Interview with a MA from SCU on 02/20/19 at 11:51am revealed: -The SPS for Resident #17 had "popped" on the eMAR on Tuesday morning along with the other morning medications for the resident so she administered the medication.	D 358		

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D 358	Continued From page 89 -She administered the SPS daily to Resident #17 because it was "popping" on the eMAR daily. -She was responsible for checking each medication order on the eMAR before administering medication. -She should have caught the order for SPS was for Monday, Wednesday, and Friday only. -She did not know the SPS was not supposed to be administered with other medications. -She used the available cups on the medication cart to mix the powder in water before administering the SPS to Resident #17. -The pharmacy or the RCC were responsible for entering orders on the electronic Medication Administration Record (eMAR). Review of Resident #17's December 2018 eMAR revealed: -There was a computer generated entry for SPS mix 30gm in 120ml of water and give daily only on Monday, Wednesday, and Friday (avoid administration within three hours of other medications) scheduled to be administered at 9:00am. -SPS was documented as administered daily at 9:00am along with other morning medications from 12/01/18 to 12/31/18. Review of Resident #17's January 2019 eMAR revealed: -There was a computer generated entry for SPS mix 30gm in 120ml of water and give daily only on Monday, Wednesday, and Friday (avoid administration within three hours of other medications) scheduled to be administered at 9:00am. -SPS was documented as administered daily at 9:00am along with other morning medications from 01/01/19 to 01/31/19 except on 01/29/19 when medication was noted to be on order.	D 358		

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D 358	Continued From page 90 Review of Resident #17's February 2019 eMAR revealed: -There was a computer generated entry for SPS mix 30gm in 120ml of water and give daily only on Monday, Wednesday, and Friday (avoid administration within three hours of other medications) scheduled to be administered at 9:00am. -SPS was documented as administered daily at 9:00am along with other morning medications from 02/01/19 to 02/20/19 except on 02/14/19 when medication was noted to be administered only on Monday, Wednesday, and Friday. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/19/19 at 12:36pm revealed: -The pharmacy dispensed a 454gm container of SPS to Resident #17 on 11/18/18 and 12/16/18 with the directions to mix 30gm in 120ml of water and give daily only on Monday, Wednesday, and Friday. -The SPS powder was dispensed because the suspension was not available. -Resident #17 had enough medication to cover approximately 10 weeks of administration as prescribed. -Resident #17 should have ran out of medication around 01/27/19 if administered as prescribed. -The SPS should be completely dissolved in the water before being administered to Resident #17. -Resident #17 could be at risk for low potassium if SPS was not administered as prescribed. Interview with the Resident Care Coordinator (RCC) on 02/20/19 at 12:07pm revealed: -She did not know why Resident #17's medication order for SPS was "popping" on the eMAR daily for the MA to administer medication.	D 358		

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D 358	Continued From page 91 -She did know that Resident #17's medication order for SPS was supposed to be administered on Monday, Wednesday, and Friday only. -She did not know the medication order for SPS stated to avoid administration within 3 hours of other medications. -She did not know the MAs were administering the SPS daily. -A medication order "should not pop for the MA to administer unless the order was scheduled for that specific date and time." -The MAs were responsible for reading the medication order on the eMAR and comparing the order to the medication label before administering medication to the resident. -The MAs should not be administering medications just because they "pop" on the eMAR. -The MAs were responsible for making sure each medication was administered as ordered by a physician. Telephone interview with a nurse practitioner (NP) from Resident #17's primary care provider's office on 02/19/19 at 4:45pm revealed: -Resident #17 should be administered SPS 30gm daily on Monday, Wednesday, and Friday only. -Resident #17 was at risk for low potassium which could lead to diarrhea, weakness, fatigue, heart palpitation, muscle cramps and aches, and breathing difficulties. -Resident #17's last potassium level was 4.7 (normal range 3.5-5) on 11/09/19. -She ordered a basic metabolic panel, including a potassium level, on 02/05/19 but labs had not been drawn. Based on observations, interviews, and record reviews, it was determined Resident #17 was not interviewable.	D 358			

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D 358	Continued From page 92 Refer to the interview with a second shift MA on 02/19/19 at 5:05pm. Refer to the interview with the RCC on 02/18/19 at 12:57pm. Refer to the interview with the Administrator on 02/20/19 at 12:07pm. Refer to the review of the facility medication administration audit policy.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 1 of 1 residents sampled (Resident #13) who were prescribed controlled substances including Hydrocodone. Review of Resident #13's FL2 dated 10/10/18 revealed: -There were no diagnoses listed on the FL2. -There was a medication order for Hydrocodone/APAP 5/325mg every 4 hours as needed for pain.	D 392		

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D 392	Continued From page 93 Observation of Resident #13's medications on hand on 02/18/19 at 9:45am revealed: -There was 1 of 3 bubble packs with a label for Hydrocodone/APAP 5/325mg every 4 hours as needed for pain dispensed on 11/07/18 with a quantity of 180 with 47 out of 60 tablets remaining. -A bubble pack with a label for Hydrocodone/APAP 5/325mg every 4 hours as needed for pain dispensed on 11/28/18 with a quantity of 40 with 36 out of 40 tablets remaining. Review of Resident #13's Control Substance Count Sheet (CSCS) on 02/18/19 at 9:45am revealed: -A hand written CSCS for Hydrocodone/APAP 5/325mg for a quantity received of 94 tablets on 01/28/19. -There were 11 doses documented as administered on 01/31/19, 02/05, 02/05, 02/06, 02/09, 02/10, 02/11, 02/12, 02/13, 02/14, and 02/15/19. -A hand written CSCS for Hydrocodone/APAP 5/325mg without a date and quantity received was not filled out completely by a Special Care Unit (SCU) Resident Care Coordinator (RCC) on 12/08/18 with several corrected amounts left ranging from 94-100 tablets remaining but none of them were documented as administered. Review of the contracted facility pharmacy receipts on 02/20/19 at 10:00am revealed the facility was not able to produce pharmacy receipts for the dispense dates of 11/07/18 or 11/28/18 containing Resident #13's Hydrocodone. Review of Resident #13's November 2018 electronic Medication Administration Record (eMAR) revealed:	D 392			

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D 392	Continued From page 94 -There was a computer generated entry for Hydrocodone/APAP 5/325mg every 4 hours as needed for pain. -There were no doses documented as administered of Hydrocodone/APAP 5/325mg every 4 hours as needed for pain. Review of Resident #13's December 2018 eMAR revealed: -There was a computer generated entry for Hydrocodone/APAP 5/325mg every 4 hours as needed for pain -There were no doses documented as administered of Hydrocodone/APAP 5/325mg every 4 hours as needed for pain. Review of Resident #13's January 2019 eMAR revealed: -There was a computer generated entry for Hydrocodone/APAP 5/325mg every 4 hours as needed for pain. -There were no doses documented as administered of Hydrocodone/APAP 5/325mg every 4 hours as needed for pain. Review of Resident #13's February 2019 eMAR revealed: -There was a computer generated entry for Hydrocodone/APAP 5/325mg every 4 hours as needed for pain. -There were 5 doses documented as administered of Hydrocodone/APAP 5/325mg every 4 hours as needed for pain on 02/10/19, and 02/12/19-02/15/19 Interview with a Pharmacy representative on 02/18/19 at 12:13pm revealed: -Hydrocodone/APAP 5/325mg every 4 hours as needed for pain was dispensed on 11/07/18 with a quantity of 180 tablets and delivered to the	D 392		

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D 392	Continued From page 95 facility on 11/07/18. -Hydrocodone/APAP 5/325mg every 4 hours as needed for pain was filled and dispensed on 11/28/18 with a quantity of 40 tablets and delivered to the facility on 11/28/18. -Out of the 220 tablets dispensed there were only 11 doses documented as administered on the CSCS. -There were 83 tablets in the bubble packs remaining which left 126 tablets unaccounted for. Interview with the Special Care Unit Resident (SCU) Care Coordinator (RCC) on 02/18/19 at 12:13pm revealed: -The CSCS for Resident #13 was handwritten and not the CSCS from the pharmacy that the facility always use. -She was not sure why Resident #13 had a handwritten CSCS. -She did not have the copy of Resident #13's Hydrocodone deliveries from the pharmacy on 11/07/18 and 11/28/18. -When she took over as SCU RCC, 3 weeks ago, Resident #13's Hydrocodone count matched the handwritten CSCS of 94 tablets left to be administered. -There was no CSCS to account for the other 126 tablets that were dispensed by the pharmacy. -She thought the missing doses were handled before she came to work there 3 weeks ago. -She never questioned the handwritten CSCS or the missing CSCS/doses. -A medication aide (MA) was to administer the Hydrocodone, document on the CSCS and on the resident's eMAR. -Per the facility's policy there was a controlled substance count done before every shift and a shift count sheet was to be signed by the off shift and on shift MAs. -She and other MAs were to count and sign the	D 392		

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D 392	Continued From page 96 shift count sheet before every shift and they "forgot" to sign the shift count that morning. -She was responsible for checking the accuracy for all of the CSCS and shift count sheets monthly. -All of the CSCS were correct but the shift count sheets the MAs were to sign documenting that they completed the shift counts were not completed (they were missing signatures). -She could not answer why she or the other MAs were not filling out the shift count sheets per their policy. Interview with a MA on 02/18/19 at 3:24pm revealed: -She worked on the SCU all shifts. -At the beginning of every shift the oncoming MA and the off going MA would count all controlled substances and match the medication count with the CSCS. They would then sign the shift count sheet. -She would administer a controlled substance, sign the CSCS and eMAR as administered. -If the count was ever off it was reported to the SCURCC. -There were missing Hydrocodone tablets for Resident #13 in December 2018. -Another MA told her in December 2018 the last SCU RCC removed all of Resident #13's Hydrocodone from the medication cart and put them in her office in December 2018. -On 01/29/19 the last SCU RCC gave a MA 2 bubble packs containing 94 Hydrocodone/APAP 5/325mg tablets that were placed in the medication cart. -There were no CSCS found for Resident #13's Hydrocodone/APAP 5/325mg tablets so the MA filled out a new CSCS with the count of 94 tables remaining when the MA received them. -The last SCU RCC left the building and never	D 392			

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D 392	Continued From page 97 returned to work. -The count was reported to the Administrator and the Assisted Living (AL) Resident Care Coordinator (RCC) on 01/29/19 after the Hydrocodone was counted and the other tablets were not found. -The Administrator said the missing Hydrocodone was handled. Interview with a second MA on 02/18/19 at 4:18pm revealed: -She worked in the SCU on all shifts. -At the beginning of every shift the oncoming MA and the off going MA would count all controlled substances and match the medication count with the CSCS. They would then sign the shift count sheet. -She would administer a controlled substance, sign the CSCS and eMAR as administered. -If the count was ever off it was reported to the SCU RCC. -On 01/29/19 the previous SCU RCC brought her Resident #13's handwritten CSCS for the Hydrocodone/APA 5/325mg that was blank and said there were 95 Hydrocodone's, laid down 2 bubble packs containing the Hydrocodone (dispense dates of 11/07/18 and 11/28/18) and left the building. -She and another staff member immediately counted Resident #13's Hydrocodone/APAP 5/325mg and filled out the CSCS with a starting quantity of 94 tablets. -She reported the incident to the AL RCC and the Administrator on 01/29/19. -The police never called her or the facility to investigate the missing Hydrocodone's. -The last SCU RCC never returned to work and did not know why. -She asked the Administrator about Resident #13's Hydrocodone never being found and if the	D 392		

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D 392	Continued From page 98 police were going to call her and was told that it was handled. -All of the other residents with controlled substances use the pharmacy CSCI but Resident #13 does not because some of the Hydrocodone was missing. A follow up interview with the second MA on 02/20/19 at 7:49am revealed: -The previous SCU RCC took Resident #13's Hydrocodone/APAP 5/325mg bubble packs off of the cart in November 2018 just after the facility received them. -She thought the previous SCU RCC sent them back to the pharmacy. -She saw Resident #13's Hydrocodone/APAP 5/325mg 180 count tablet bubble packs picked up by the previous SCU RCC and put in the SCU RCC's office. -The reason the previous SCU RCC gave for removing Resident #13's Hydrocodone/APAP 5/325mg 180 count tablets was because the medication was discontinued. -The next time she had seen Resident #13's Hydrocodone/APAP 5/325mg was when the previous SCU RCC had just dropped off the Hydrocodone before leaving the facility. -On 01/19/19 she and another facility staff counted the Hydrocodone and there were 94 tablets of resident #13's Hydrocodone/APAP 5/325mg. -The handwritten CSCI was placed in the CSCI book and the Hydrocodone/APAP 5/325 mg was placed in the medication cart controlled substance drawer. Telephone interview with the previous SCU RCC on 02/20/19 at 9:45am revealed: -She started working in the SCU as the RCC December 16, 2018.	D 392		

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D 392	Continued From page 99 -Around November 28, 2019 she removed Resident #13's Hydrocodone/APAP 5/325mg bubble packs of 180 count and 40 count with only 4 tablets missing and put them in her office because the medication was discontinued. -She did not call the pharmacy or returned the medication to the pharmacy but forgot about them until 01/29/19. -On 01/29/19 she was leaving her job and came across the Hydrocodone/APAP 5/325mg in her office. -She returned Resident #13's Hydrocodone/APAP 5/325mg, with 95 tablets remaining and gave them to the MA to put in the medication cart. -She left the facility without recounting the medication with that MA. -She found another job. -She did not investigate the missing Hydrocodone/APAP 5/325mg tablets. -She did not report the missing controlled substances to the Administrator because she was not the SCURCC at the time and "she did not have to". -She was responsible for the Hydrocodone/APAP 5/325mg at the time. -It was not the policy to store controlled substances in her office. -All of the controlled substances were to be store in the locked medication cart in a separate locked drawer. -There was no CSCS for Resident #13 when she removed the medications from the medication cart on December 9 or 10, 2018 so she filled out one when she returned the medications on 01/29/19. -Her office was left unlocked sometimes and there was no reason she left the unlocked office with controlled substances in the office. -There was no reason why she did not let the Administrator know about the missing	D 392		

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D 392	Continued From page 100 Hydrocodone/APAP 5/325mg other than it was not her responsibility. Telephone interview with Resident #13's Hospice Nurse on 02/21/19 at 9:15am revealed: -Resident #13 was taking the Hydrocodone/APAP 5/325 mg for osteoarthritis pain control. -There were 2 orders written for Hydrocodone/APAP 5/325mg, one on 11/07/18 for 180 tablets and one on 11/28/19 for 40 tablets. -There were notes in Resident #13's record on and after 01/31/19 requesting to give the as needed Hydrocodone/APAP to Resident #13 for pain. -She was not aware of any missing doses or there were no returned Hydrocodone/APAP 5/325mg to Hospice. They never accept any unused medications under any circumstances. Interview with the Administrator on 02/19/19 at 11:58 revealed: -She did not know Resident #13's Hydrocodone/APAP 5/325mg was missing or was taken off of the cart and stored in the SCU RCC's office. -There was no investigation done because she did not know about the missing Hydrocodone/APAP 5/325mg. -The staff member that found the missing medications was to let the SCU RCC know and the SCU RCC was responsible for letting her know. -There was no comment after she was told 2 of her MA reported the missing Hydrocodone to her on 01/19/19.	D 392			
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records	D 433			

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D 433	Continued From page 101 (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5),	D 433			

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D 433	Continued From page 102 (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure resident records were maintained in an orderly manner for 1 of 9 sampled residents (#9). The finding are: Review of Resident #9's current FL2 dated 01/03/19 revealed: -Diagnoses included dementia, a communicable disease, and schizophrenia. -Domiciliary was documented as current level of care, and domiciliary was documented as recommended level of care. -There was no order on the FL2 Resident #9 was to be admitted to the Special Care Unit (SCU). -The FL2 was signed by a medical health provider. -Admission date on the FL2 was dated 01/13/19. Observation of paper clipped together on the SCU on 02/18/19 revealed there were a few pieces of paper clipped together with a paperclip located on the SCU with Resident #9's name on them. Review of the papers for Resident #9 revealed: -There was no documentation of a medical provider for Resident#9. -There was no documentation of a Resident Registry, house rules, declaration of Resident Rights, civil rights, grievance procedures, orders from a medical provider, no documentation of influenza virus or consent to not receive the immunization, a resident contract, admission to the SCU, diet order, an assessment care plan,	D 433			

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D 433	Continued From page 103 medication review, disclosure statement to the SCU or a pre-screening to the SCU. Interview with Resident #9 on 02/18/19 at 11:00am revealed he had not seen a health care provider since his admission to the SCU on 01/13/19 or knew why he was in a locked SCU. Interview with the Resident Care Coordinator (RCC) on the Assisted Living (AL) on 02/19/19 at 3:45pm revealed she did not know who Resident #9's medical provider was, or why he did not have a complete resident record. Interview with a medication aide (MA) on 02/19/18 at 3:45pm revealed: -Resident #9 had been in the SCU for 6 weeks and "no one had made him a resident record." -We do not even know who to call if we need anything for Resident #9 because "he does not have a physician." -"We have no information on Resident #9." -We do not know what tasks are needed for Resident #9, "all we do is give him his meds." -"He should not be back on the SCU." Interview with the SCU Coordinator on 02/20/19 at 1:10pm revealed: -She was responsible for assembling the resident records. . -She was responsible for making sure that all paperwork in the resident records were correct and completed. -She was not aware why Resident #9's record was not completed. -She had been hired by the facility and working as the SCU Coordinator on the SCU for about 3 weeks. Interview with the Administrator on 02/19/19 at	D 433		

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D 433	Continued From page 104 4:58pm and on 02/21/19 at 9:08am revealed: -Resident #9 was admitted to the SCU 01/13/19 from another facility. -The Administrator had gone to Resident #9's former facility and assessed him prior to admitting him to the facility. -Resident #9 did not have a physician until 02/19/19, because she could not find a physician to provide care for him due to his insurance. -She knew Resident #9 did not have an assessment completed within 30 days of admission. -The RCC and the business office were responsible for making sure that all required paperwork for the facility was completed, signed, and filed in the resident record. -She was not aware why the resident record was not completed. Interview with the Nurse Practitioner (NP) on 02/21/19 at 10:40am revealed: -She was seeing Resident #9 for the first time as a patient on 02/21/19. -She accepted Resident #9 as a new patient on 02/21/19. -She could not say why Resident #9 was in the SCU. -She deferred to Resident #9's mental health provider to see if he was appropriate for the SCU. Review of the papers for Resident #9 on 12/20/19 revealed he did not have a mental health provider.	D 433			
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit	D 463			

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D 463	Continued From page 105 In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record review the facility failed to assure 1 of 5 sampled resident's (Resident #9) had a physician's order, a pre-admission screening for appropriate placement, and a disclosure regarding policies and procedures in the Special Care Unit (SCU). The findings are: Review of Resident #9's current FL2 dated 01/03/19 revealed: -Diagnoses included dementia, a communicable disease, and schizophrenia. -"Domiciliary" was documented as the current and recommended level of care. -The admission date on the FL2 was documented	D 463		

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D 463	Continued From page 106 as 01/13/19. -The FL2 was signed by a medical health provider. Review of Resident #9's record revealed: -Resident #9's record consisted of an FL2, nurses note, a new prescription request form and a high cost medication approval request form from the pharmacy, and unsigned diet and physician orders paper clipped together with a paper clip located in the residents records room in the Special Care Unit (SCU). -There was no physician's order to be admitted to the SCU. -There was no documentation of a pre-admission screening prior to admission to the SCU. -There was no documentation that a disclosure form was provided by the facility to family members or the guardian. Interview with Resident #9 on 02/18/19 at 11:00am revealed he had not seen a medical provider since he had ben admitted to the SCU on 01/13/19. Interview with Resident #9 on 02/19/19 at 9:42am revealed: -He does not know why he was placed in the SCU. -He was not in a SCU at the previous facility. -He asked staff at the facility why he was placed in the SCU "but I never got an answer." -He does not like being "locked up", and would like to reside on the assisted living side instead so that he could "walk to the store if I want to." Interview with the Administrator on 02/19/19 at 5:00pm revealed: -She knew Resident #9 did not have a physician order to be admitted to the SCU.	D 463		

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D 463	Continued From page 107 -Resident #9 was placed in the SCU on 01/13/19 without a physician's order. -Resident #9 did not have a current medical provider. -Resident #9's guardian had requested placement to the SCU, so the Administrator placed Resident #9 in the SCU. -She knew residents were required to have a physician's order prior to admission to the SCU. Interview with the facility medical nurse practitioner (NP) on 02/21/19 at 10:40am revealed: -The Administrator had ask her to accept Resident #9 as a new patient on 02/21/19. -She was not familiar with Resident #9. -She was seeing Resident #9 to establish new resident care on 02/21/19. -She knew Resident #9 was in the SCU, but she did not know Resident was admitted to he SCU without a physician order. -She could not say if Resident #9 was appropriate for admission to the SCU. Telephone interview with Resident #9's guardian on 02/20/19 at 12:05pm revealed: -He knew Resident #9 must have a physician's order to be admitted to the SCU. -The guardian wanted Resident #9 transferred to a SCU due to his "organic brain disorder". -Resident #9 had not been in a SCU at the previous facility. -Resident #9 would "threaten to run away" from the previous facility, "He would walk off, change his mind, and then come back to the facility." -He did not know how far Resident #9 had walked away from the previous facility before returning. Review of Resident #9 current FL2 dated 01/03/19 revealed there was no documentation	D 463		

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D 463	Continued From page 108 Resident #9 wanderer. Interview with a medication aide (MA) on 02/19/18 at 3:45pm revealed: -Resident #9 did not have a physician's order to be on the SCU. -Resident #9 had been in the SCU for 6 weeks. -We did not know who to call if we need anything for Resident #9 because "he does not have a physician." -"We have no information on Resident #9." -"He should not be back on the SCU." He does not seem appropriate. -He seemed to be more high functioning than the other residents in the SCU. Interview with the Administrator on 02/19/19 at 4:58pm and on 02/21/19 at 9:08am revealed: -She knew Resident #9 did not have a level of care indicating a secure unit. -Resident #9 was admitted to the SCU on 01/13/19 from another facility. -She assessed Resident #9 at his previous facility prior to admission date of 01/13/19. -She did not document a pre-admission screening after assessing the resident. -The business office manager (BOM) was responsible for having the disclosure information signed by the responsible party. -She did not know the disclosure document was not signed. -Resident #9's guardian insisted he be placed in a secure unit due to his wandering. -She knew Resident #9 did not have an order to be admitted to the SCU. -The Resident Care Coordinator (RCC) and the BOM were responsible for making sure that all required paperwork for the facility was completed, signed, and filed in the resident record.	D 463			

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D 463	Continued From page 109 Interview with the SCU Coordinator on 02/20/19 at 1:10pm and on 02/21/19 at 4:08pm revealed: -The RCC was responsible for making sure all the paperwork in the resident record was correct and completed. -She knew Resident #9 did not have a resident record, only a few papers clipped together. -She had not reviewed Resident #9's paperwork to determine what was included and what was missing, because she had just started as the RCC. -She did not know Resident #9 did not have a a level of care indicated by a physician for the SCU, a pre-admission screening or a signed disclosure statement by his responsible party. -She did not think Resident #9 should be in the SCU due to his higher function level. -Resident #9 was admitted to the SCU prior to her starting as the RCC, she relied on the Administrator to handle the necessary papers for the admission to the SCU. Telephone interview with the Administrator on 02/22/19 at 12:05pm revealed Resident #9 was admitted to the assisted living side on 02/22/19. Refer to tag 270 The failure of the facility to assure that the requirements are met for admission to the special care unit for Resident #9 admitted without a physician's order, a pre-admission screening for appropriate placement, or a disclosure regarding policies and procedures in the Special Care Unit (SCU) resulting in the resident feeling imprisoned. This failure is detrimental to the safety and welfare of the resident 20 resident's residing in the SCU and constitutes a Type B violation. A plan of protection was requested from the	D 463		

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D 463	Continued From page 110 facility in accordance with G.S. 131D-34 on 02/21/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 8, 2019.	D 463			
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 observation, interviews, and record review the facility failed to assure 1 of 5 sampled residents (Resident #9) had a care plan based on the resident profile, developed in conjunction with the resident assessment, within 30 days following	D 464			

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D 464	Continued From page 111 admission. The findings are: Review of Resident #9's current FL2 dated 01/03/19 revealed: -Diagnoses included dementia, a communicable disease, and schizophrenia. -The admission date on the FL2 was documented as 01/13/19. Review of Resident #9's record on 02/18/19 revealed: -The documents in the record consisted of an FL2, nurses note, new prescription request form, unsigned physician's orders and diet order paper clipped together with a paperclip located in the residents records room in the Special Care Unit (SCU). -There was no documentation a resident assessment or care plan had been completed for Resident #9 within 30 days of admission. Interview with a medication aide (MA) on 02/19/18 at 3:45pm revealed: -Resident #9 had been in the SCU for 6 weeks. -The staff did not know who to call regarding task needed for Resident #9 because "he does not have a physician." -"We had no information" on Resident #9. -We did not know what care to provide for Resident #9, "all we do is give him his meds." Interview with the Administrator on 02/19/19 at 4:58pm revealed Resident #9 was admitted to the SCU 01/13/19 from another facility. Interview with the Resident Care Coordinator (RCC) in the SCU on 02/20/19 at 1:10pm	D 464		

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D 464	Continued From page 112 revealed: -The RCC was responsible for making sure all of the documentation was in the resident record, correct, and completed. -She did not know Resident #9 did not have an assessment or care plan within 30 days of admission. Interview with the Administrator on 02/21/19 at 9:08am revealed: -Resident #9 did not have a physician until 02/21/19, because she could not find a physician to provide care for him due to his insurance. -She knew Resident #9 did not have an assessment completed within 30 days of admission. -The Resident Care Coordinator (RCC) and the Business Office Manager were responsible for making sure that all required paperwork for the facility was completed, signed, and filed in the resident record. -She did not know why the resident record was not completed.	D 464			
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that	D 468			

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D 468	Continued From page 113 identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff A) assigned to the Special Care Unit (SCU) had completed 20 hours of training, specific to the needs of the residents in the SCU within the first six months of employment 3 of 3 sampled staff (Staffs A, B, and C) completed 6 hours of training within the first week of employment. The findings are: Observation of a resident in the SCU on 02/18/19 at 9:45am revealed: -The resident was yelling and demanding a drink. -The SCU RCC told Resident #4 to "sit down" and wait.	D 468		

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D 468	Continued From page 114 -The resident became more agitated. -The SCU RCC told the PCA to get the resident a drink. -The resident calmed down after he received his drink. Interview with the SCU RCC on 02/18/19 at 9:45am revealed: -The resident in the SCU had those behaviors/outbursts every day. -The resident was aggressive to the staff every day. -The resident becomes aggressive with the staff and pushed his way out of the SCU many times to get to the drink machine or to go to the Administrator's office located on the AL side to get money and cigarettes. -It was best to just let him get out than to stop him because of his aggression would turn physical. Observation of the SCU on 02/18/19 at 12:10pm revealed: -The resident was yelling he "wanted a [name brand soda]". -A dietary aide came through the SCU door when the resident pushed the dietary aid out of the way to exit the SCU. -The resident was on the AL side and headed to the front of the building. Interview with the dietary aide on 02/18/19 at 12:10pm revealed: -The resident was very aggressive and she "stayed out of his way". -The resident will "hurt you", he had hurt other staff before. Interview with the SCU RCC on 02/18/19 at 12:10pm revealed: -The resident wanted a soda so he goes straight	D 468			

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D 468	Continued From page 115 to the Administrators office on the AL side. -The staff lets him do that because it was easier than him getting physical with the staff. -The staff gave him what he wanted, because we don't want him mad. a. Review of the employee staff records revealed Staff A, B and C, assigned to the SCU had completed training, specific to the needs of the residents in the SCU. 1. Review of Staff A's employee record revealed: -Staff A was hired as a Medication Aide (MA) in the SCU on 08/03/18. -There was no documentation of completion of the six hour SCU training within the first week of employment. -There was no documentation of a total of 20 hours of SCU training within 6 months of hire. Interview with Staff A from the SCU on 02/20/19 at 3:15pm revealed: -A resident in the SCU had told her someone had propped the door leading to the assisted living hall open with a rock, allowing a resident to escape the SCU. -The Resident had never tried to elope before but had recently become more dependent on staff for help with bathing and grooming. -She had never been trained on the SCU policy on elopement. Interview with Staff A on 02/22/19 at 1:40pm revealed: -Her orientation included videos with training on dementia. -She never received a employee handbook with policies for the SCU. -She was not sure if the videos satisfied the 6 hour requirement, but there were several short	D 468		

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D 468	Continued From page 116 videos. -She did not receive a certificate of completion for her orientation training. -She did not receive any additional training after orientation specific to the population being served in the SCU. Refer to the interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to the interview with the Administrator on 02/21/19 at 10:40am. Refer to the interview with the Resident Care Coordinator (RCC) on 02/21/19 at 2:20pm. Refer to the interview with the SCU Coordinator on 02/21/19 at 4:10pm. 2. Review of Staff B's employee record revealed: -Staff B was hired as a Medication Aide (MA) in the SCU on 02/13/19. -There was no documentation of completion of the six hour SCU training within the first week of employment. -There was no documentation of completion of SCU training. Interview with Staff B on 02/20/19 at 11:51am revealed she was not been trained on how to handle residents on the SCU when they had disruptive behaviors, such as yelling and cursing. Observation of a resident in the SCU on 02/19/19 between 9:25am and 9:35am revealed there was a resident sitting in the floor leaning against the door in the activity room. The SCU Supervisor was leading an activity approximately 10 feet from resident along with 7 other residents. Staff B came into the activity room to administer	D 468			

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D 468	Continued From page 117 medications to a resident. Both facility staff members did not acknowledge the resident on the floor by the door. Observation of a resident in the SCU on 02/19/19 between 9:43am and 9:54am revealed, resident was crawling on her hands and knees down the hallways, she crawled for about 30 feet and then rocked back and forth on her hands and knees. After 2 minutes she crawled to the right side of the wall and using the side rails attempted to rise three times before she stood in an upright position, she walked down the hallway toward the dining room area. A MA was administering medications approximately 5 feet from the resident when this occurred. Interview with Staff B on 02/19/19 at 9:45am revealed: -The resident crawls on the floor all the time, she can pull herself up. -The resident thinks she is a baby. -We just let her crawl on the floor, "I was not told to do anything different for the resident." -She was a MA in the SCU and had been employed for about 3 weeks. -She had not received any SCU training on how to care for the residents or treat their behaviors in the SCU. -Her responsibilities included administering medications and providing personal care to the residents in the SCU. Refer to the interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to the interview with the Administrator on 02/21/19 at 10:40am. Refer to the interview with the RCC on 02/21/19	D 468			

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D 468	Continued From page 118 at 2:20pm. Refer to the interview with the SCU Coordinator on 02/21/19 at 4:20 pm. 3. Review of Staff C's employee record revealed: -Staff C was hired as a Medication Aide (MA) in the SCU on 10/28/18. -There was no documentation of completion of the six hour SCU training within the first week of employment. -There was no documentation of completion of SCU training. Attempted telephone interview with Staff C on 02/22/19 at 2:55pm was unsuccessful. Refer to the interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am. Refer to the interview with the Administrator on 02/21/19 at 10:40am. Refer to the interview with the Resident Care Coordinator (RCC) on 02/21/19 at 2:20pm. Refer to the interview with the SCU Coordinator on 02/021/19 at 4:20 pm. Interview with the Business Office Manager (BOM) on 02/18/19 at 10:47am revealed: -She was responsible for all employee records and keeping them current. -She was responsible for new hire records and completing a "checklist" verifying all new staff had their appropriate documentation in their employee record. -She was responsible for new employees completing the six hour SCU training within the first week of hire.	D 468		

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D 468	Continued From page 119 -New employees watched several hours of videos during orientation. The 6 hour dementia training was included in these videos. -She thought all staff had completed these videos during orientation week. -She did not know if there was a certificate of completion provided which could be included in their employee record. -There was no documentation produced verifying new employees had completed the 6 hour SCU training within their first week of employment. Interview with the Administrator on 02/21/19 at 10:40am revealed: -She knew residents had eloped from the SCU. -She knew a resident had behaviors and the SCU staff did not know how to handle the behaviors. -She did not know staff were letting a female resident in the SCU crawl around on the floor on her hands and knees. -The BOM was responsible for ensuring the employee record contained the required training documentation. -The BOM had a checklist in the front of each employee record listing the documentation the employee record should include. -The 6 hour and 20 hour dementia training was listed on the checklist. -It was the responsibility of the BOM to ensure employees had received the 6 hour dementia training during orientation, the first week of hire. -The corporate nurse was responsible for completing a total of 20 hours of SCU training with the staff within 6 months of hire. -A copy of this training should be kept in the employee record. -She did not know why there were not copies of the dementia training in the employee records of all the staff working in the Special Care Unit (SCU).	D 468			

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NAME OF PROVIDER OR SUPPLIER AURORA OF STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 ORA DRIVE STATESVILLE, NC 28625		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	Continued From page 120 -She thought the BOM had all the necessary documentation in the employee records. -She had not audited the employee records with the BOM. Interview with the Resident Care Coordinator (RCC) on 02/21/19 at 2:20pm revealed: -She knew employees were required to have the 6 hour dementia training before providing care for residents in the SCU. -It was the responsibility of the BOM to ensure employees received the 6 hour dementia training during orientation. -She did not know why there were not copies of the dementia training in the employee records of all the staff working in the SCU. -She relied on the BOM to have the necessary new employee documentation before she trained the clinical staff. -The previous SCU Coordinator provided the 20 hour training to the staff. -She did not know who would be providing the training now. -She did not know if the SCU staff had received the 6 hour and 20 hour SCU training without documentation since the SCU Coordinator in charge of training was not available to interview. Interview with the SCU Coordinator on 02/21/19 at 4:10pm revealed: -She had been hired early February, 2019 and had finished training on 02/15/19. -She had not had a chance to go over the policies and procedures manual the Administrator had provided her. -She was not sure of her responsibilities. -She did not know if the staff in the SCU had received the 6 hour and 20 hour training. -She had not reviewed any employee records. -She had not requested this information from the	D 468		

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D 468	Continued From page 121 BOM or the Administrator. The failure of the facility to provide training for the SCU staff specific to residents with dementia related diseases resulting in staff being unable to provide appropriate care and services including not addressing a resident's violent behavior and allowing a resident to crawl on the floor. This failure is detrimental to the 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 02/21/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 8, 2019.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received 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 122 related to supervision, health care referral and follow-up, medication administration, residents' rights, implementation, admission to the SCU, adult care home infection prevention requirements, testing for tuberculosis, other staff qualifications, special care unit training and training on cardio-pulmonary resuscitation. The findings are: 1. Based on interviews and record reviews, the facility failed to assure five of six sampled staff (Staff A, B, C, D and E) were tested for tuberculosis (TB) disease upon hire. [Refer to Tag 132 10A NCAC 13F .0406 Test For Tuberculosis. (Unabated Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 7 sampled staff (Staff B and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256.[Refer to tag 137 10A NCAC 13F .0407(a) (5) Other Staff Qualifications (Unabated Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 7 sampled residents who resided in the Special Care Unit (SCU) as evidenced by two residents, both of whom had a diagnoses of dementia and one who had a diagnosis of a communicable disease and were known by staff to engage in sexual activity (#9 and #10), Resident (#6) with dementia and sexually aggressive behaviors who assaulted multiple residents, including Resident (#8), and two residents with a history of elopements (Residents #6 and #8). [Refer to Tag 0270 10A NCAC .0901(b) Personal Care and Supervision (Type A1	D912		

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D912	Continued From page 123 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 6 sampled residents related to one resident who had a fall and was not administered an anticonvulsant as ordered (Resident #12), one who antiviral medication was not available for administration for 14 days (Resident #9), and one resident with orders for labwork not being drawn (Resident#6). [Refer to Tag 0273 10A NCAC .0902(b) Health Care (Type A1 Violation)]. 5. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for supervision, health care referral and follow-up, medication administration, medication storage, administration of control substances, adult care homes infection prevention, resident rights, resident record, resident contract, resident assessment, resident care plan, special care unit disclosure, admission to the special care unit, special care unit profile, testing for tuberculosis, other staff qualifications, competency validation for licensed health professional support tasks (LHPS), special care unit (SCU) training, and cardio-pulmonary resuscitation. [Refer to tag 980 G.S. 131D-25 Implementation (Type A1 Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to assure 5 of 6 sampled residents (#3, #5, #9, #12, #13, and #17) were administered medications as ordered by a licensed prescribing practitioner related to lorazepam not administered as ordered (Resident #3), missing multiple doses of Genvoya, sulfamethoxazole, and lorazepam (Resident #9),	D912		

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D912	Continued From page 124 Depakote not administered as ordered (Resident #12), Norco not administered as ordered (Resident #13), and administering sodium polystyrene sulfate (Resident #17). [Refer to tag 338 10A NCAC 13F .1004 Medication Administration (Type A2 Violation)]. 7. Based on record reviews and interviews, the facility failed to ensure 3 of 6 sampled staff member (Staff A, B and E) had completed a course on Cardio-Pulmonary resuscitation (CPR) and choking management within the past 24 months. [Refer to tag 167 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation (Type B Violation)]. 8. Based on observation, interviews, and record review the facility failed to assure 1 of 5 sampled resident's (Resident #9) had a physician's order, a pre-admission screening for appropriate placement, and a disclosure regarding policies and procedures in the Special Care Unit (SCU). [Refer to tag 463 10A NCAC 13F .1306 Admission To The Special Care Unit (Type B Violation)]. 9. Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff A) assigned to the Special Care Unit (SCU) had completed 20 hours of training, specific to the needs of the residents in the SCU within the first six months of employment 3 of 3 sampled staff (Staffs A, B, and C) completed 6 hours of training within the first week of employment. [Refer to tag 468 10A NCAC 13F .1309 (1) Special Care Unit Staff Orientation and Training (Type B Violation)]. 10. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the	D912		

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D912	Continued From page 125 federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 4 of 5 sampled diabetic residents (Residents #1, #14, #15, and #16) with orders for blood sugar monitoring resulting in shared use of glucometers.[Refer to tag 932 G.S. 131D-4.4A (a) Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are free of neglect and physical abuse in compliance with federal and state laws and rules and regulations related to supervision of residents in the Special Care Unit (SCU) in regards to elopement, sexual assault and residents engaging in sexual activity with known diagnosis of communicable disease, health care referral and follow-up related to a SCU resident with changes in condition not being sent out to be evaluated in the Emergency Department (ED) and later that day found unresponsive in his room, a resident in the SCU going 3 weeks without an autoimmune medication with no notification to the medical providers resulting in the chance for a higher viral load, regarding testing for a sexually transmitted disease (STD) after a resident was sexually assaulted in the	D914		

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D914	Continued From page 126 SCU, failed to administer medications as ordered by a licensed prescribing practitioner related to missing multiple doses of Genvoya an autoimmune medication, failed to ensure staff members had completed a course on Cardio-Pulmonary resuscitation (CPR) and choking management performing CPR which was unsuccessful, and the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained resulting in neglect and abuse to the residents in the SCU. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 7 sampled residents who resided in the Special Care Unit (SCU) as evidenced by two residents, both of whom had a diagnoses of dementia and one who had a diagnosis of a communicable disease and were known by staff to engage in sexual activity (#9 and #10), Resident (#6) with dementia and sexually aggressive behaviors who assaulted multiple residents, including Resident (#8), and two residents with a history of elopements (Residents #6 and #8). [Refer to Tag 0270 10A NCAC .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 6 sampled residents related to one resident who had a fall and was not administered an anticonvulsant as ordered (Resident #12), one who antiviral medication was not available for administration for 14 days (Resident #9), and one resident with orders for labwork not being drawn (Resident #6). [Refer to Tag 0273 10A NCAC	D914		

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D914	Continued From page 127 .0902(b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure 5 of 6 sampled residents (#3, #5, #9, #12, #13, and #17) were administered medications as ordered by a licensed prescribing practitioner related to lorazepam not administered as ordered (Resident #3), missing multiple doses of Genvoya, sulfamethoxazole, and lorazepam (Resident #9), Depakote not administered as ordered (Resident #12), Norco not administered as ordered (Resident #13), and administering sodium polystyrene sulfate (Resident #17). [Refer to tag 338 10A NCAC 13F .1004 Medication Administration (Type A2 Violation)]. 4. Based on record reviews and interviews, the facility failed to ensure 3 of 6 sampled staff member (Staff A, B and E) had completed a course on Cardio-Pulmonary resuscitation (CPR) and choking management within the past 24 months. [Refer to tag 167 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for supervision, health care referral and follow-up, medication administration, medication storage, administration of control substances, adult care homes infection prevention, resident rights, resident record, resident contract, resident assessment, resident care plan, special care unit disclosure, admission to the special care unit, special care unit profile, testing for tuberculosis, other staff qualifications, competency validation for licensed health	D914			

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D914	Continued From page 128 professional support tasks (LHPS), special care unit (SCU) training, and cardio-pulmonary resuscitation. [Refer to tag 980 G.S. 131D-25 Implementation (Type A1 Violation)].	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or	D932		

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D932	Continued From page 129 dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 4 of 5 sampled diabetic residents (#1, 14, 15, and #16) with orders for blood sugar monitoring resulting in shared glucometers. The findings are: Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed: -Blood glucose monitoring devices (glucometers) should not be shared between residents. -If the glucometer is to be used for more than one	D932			

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D932	Continued From page 130 person, it should be cleaned and disinfected per the manufacturer's instructions. -If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the cleaning and disinfection instructions for the Brand A glucometer revealed: -If the glucometer was to be used on multiple patients, cleaning and disinfecting with an Environmental Protection Agency (EPA) approved disinfecting solution should be done between patients. -Disinfecting would remove most, but not all possible infectious agents from the meter. -The surface of the glucometer must remain wet for the contact time listed on the disinfecting wipes instructions. Review of the cleaning and disinfection instructions for the Brand B glucometer revealed the glucometer was intended to be used by a single person and should not be shared. Observation of medication cart A on the assisted living hall on 02/18/19 at 9:30am revealed: -On cart A, there were five glucometer cases labeled with resident's names with glucometers inside the case. -There was one empty glucometer case. -There was an unlabeled glucometer case stored with the labeled glucometers. Observation of mediation cart B on the assisted living hall on 02/18/19 at 9:45am revealed: -There were six glucometers labeled with resident's names with a piece of tap on the back of the glucometer. -The resident's name was unidentifiable on two of six of the glucometers.	D932		

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D932	Continued From page 131 Review of the history in an unidentifiable Brand A glucometer located in medication cart B on 02/18/19 at 1:16pm revealed: -The date and time were correct when the glucometer was turned on. -The most recent finger stick blood sugar (FSBS) recorded in the glucometer's history dated 02/18 at 7:14am was 115. The next FSBS recorded in the glucometer's history dated 02/18 at 7:12am was 131. -The first reading in the glucometer matched the FSBS reading documented on Resident #1's February, 2019 electronic Medication Administration record (eMAR) at 6:30am. The next reading matched the FSBS reading documented on Resident #15's February, 2019 eMAR at 6:30am. Review of the history in an unlabeled Brand B glucometer identified by the medication aide (MA) as a "back up" glucometer located in medication cart A on 02/18/19 at 9:59am revealed: -The date and time were correct when the glucometer was turned on. -FSBS results in the glucometer's history included 12/14 at 5:46am as 164 and at 12/14 at 5:48am as 157. -There were seven FSBS results in the history dated 12/14 from 5:07 to 5:48am as follows a reading at 5:48am of 56, 5:44am of 83, 5:42am of 73, 5:32am of 240, 5:26am of 175, 5:19am of 262, and at 5:07am of 146. -Results from the glucometer matched the FSBS reading documented on Resident #14's December, 2018 eMAR for 12/14/18 at 6:30am and the FSBS reading documented on Resident #16's December, 2018 eMAR for 12/14/18 at 6:30am.	D932			

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D932	Continued From page 132 Interview with a first shift medication aide (MA) on 02/18/19 at 11:51am revealed: -She had worked in the facility since October or November, 2018 and had always shared glucometers. -She did not remember who told her it was okay to share glucometers between residents. -Medication cart B had two glucometers that most MAs used on the cart to check FSBS. -She used a sanitary wipe to clean each glucometer before and after use. -After she wiped the glucometer, she would immediately put it back in the medication cart or check another FSBS for the next resident. Interview with another first shift MA on 02/18/19 at 11:08am revealed she cleaned each glucometer with alcohol wipe after use and would check another resident's FSBS. Interview with a second shift MA on 02/18/19 at 4:17pm revealed she had always used the same glucometer to check FSBS for multiple residents. Review of the Facility Infection Control Protocol did not contain information regarding procedure for checking FSBS or the use of glucometers. 1. Review of Resident #1's current FL2 dated 01/14/19 revealed: -Diagnosis included diabetes. -There was an order to check finger stick blood sugar (FSBS) twice daily before breakfast and dinner. Observation of Resident #1's Brand A glucometer revealed: -The glucometer was not working properly and would not turn on. -The glucometer was labeled with Resident's #1's	D932		

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NAME OF PROVIDER OR SUPPLIER AURORA OF STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1902 ORA DRIVE STATESVILLE, NC 28625		
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D932	Continued From page 133 name on a piece of tape on the back of the glucometer. Review of Resident #1's January, 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry to check FSBS twice daily scheduled for 6:30am and 4:30pm. -FSBS readings were documented twice daily from 01/15/19 to 01/31/19 and ranged from 88 to 136. Review of Resident #1's February, 2019 eMAR revealed: -There was a computer generated entry to check FSBS twice daily scheduled for 6:30am and 4:30pm. -FSBS readings were documented twice daily from 02/01/19 to 02/18/19 and ranged from 74 to 152. Interview with Resident #1 on 02/20/19 at 10:15am revealed: -The MAs checked her blood sugar twice daily. -She did not know her glucometer was not working and did not know what glucometer they were using to check her FSBS. Refer to the telephone interview with the Nurse Consultant on 02/18/19 at 3:35pm. Refer to the telephone interview with the Pharmacist Consultant from the facility's contracted pharmacy on 02/19/19 at 10:35am. Refer to the interview with the Resident Care Coordinator (RCC) on 02/18/19 at 12:57pm. Refer to the telephone interview with the facility's	D932			

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D932	Continued From page 134 contracted licensed Nurse Practitioner (NP) on 02/19/19 at 4:45pm. Refer to the interview with the Administrator on 02/18/19 at 11:30am. 2. Review of Resident #14's current FL2 dated 01/13/18 revealed a diagnosis of hypertension. Review of Resident #14's physician's orders dated 01/22/19 revealed: -Diagnoses included diabetes, cognitive dysfunction, and chronic pain. -There was a physician's order to check finger stick blood sugar (FSBS) once daily. Review of Resident #14's record revealed a physician's order dated 02/05/19 to discontinue FSBS checks when the resident was readmitted to the facility from the hospital. Review of Resident #14's Brand A glucometer's history on 02/18/19 at 10:25am revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #14's December 2018, January 2019, and February 2019 eMAR. Example of inconsistencies were as follows: -The glucometer was located in medication cart A and was labeled with Resident #14's name on a piece of tape on the back of the glucometer. -The date and time were not correct when the glucometer was turned on; the glucometer displayed 04/01 with no specified year and 12:37pm. -The last FSBS readings were recorded on 01/12 at 6:54pm as 82, 6:49pm as 129, and 6:47pm as 205. -There were no FSBS readings recorded in Resident #14's glucometer in the last 3 months.	D932			

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D932	Continued From page 135 Review of Resident #14's December 2018, January 2019, and February 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry to check FSBS daily scheduled at 6:30am. -FSBS readings were documented daily on eMAR except when Resident #14 was out of the facility from 02/01/19 to 02/04/19. -Resident #14's FSBS's were discontinued on 02/05/19. Interview with Resident #14 on 02/20/19 at 12:35pm revealed facility staff was checking his FSBS but he did not know how often and when. Refer to the telephone interview with the Nurse Consultant on 02/18/19 at 3:35pm. Refer to the telephone interview with the Pharmacist Consultant from the facility's contracted pharmacy on 02/19/19 at 10:35am. Refer to the interview with the Resident Care Coordinator (RCC) on 02/18/19 at 12:57pm. Refer to the telephone interview with the facility's contracted licensed Nurse Practitioner (NP) on 02/19/19 at 4:45pm. Refer to the interview with the Administrator on 02/18/19 at 11:30am. 3. Review of Resident #15's current FL2 dated 07/31/18 revealed: -Diagnoses included diabetes and hypertension. -There was an order to check finger stick blood sugar (FSBS) once daily in the morning.	D932		

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D932	Continued From page 136 Review of Resident #15's glucometer's history on 02/18/19 at 10:25am revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #15's December 2018, January 2019, and February 2019 eMAR. Example of inconsistencies were as follows: -Resident #15's glucometer was located in medication cart B and was labeled with Resident #15's name. -The date and time were not correct when the glucometer was turned on and displayed 04/01 with no specified year and 12:44am. -The last recorded FSBS reading was documented on 01/05 at 1:23am as 119. -There were no FSBS readings were recorded in Resident #15's glucometer in the last 3 months. Review of Resident #15's December 2018, January 2019, and February 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry to check FSBS daily scheduled at 6:30am. -FSBS readings were documented daily on eMAR. Based on observations, interviews, and record reviews, it was determined Resident #15 was not interviewable. Refer to the telephone interview with the Nurse Consultant on 02/18/19 at 3:35pm. Refer to the telephone interview with the Pharmacist Consultant from the facility's contracted pharmacy on 02/19/19 at 10:35am. Refer to the interview with the Resident Care Coordinator (RCC) on 02/18/19 at 12:57pm.	D932		

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D932	Continued From page 137 Refer to the telephone interview with the facility's contracted licensed Nurse Practitioner (NP) on 02/19/19 at 4:45pm. Refer to the interview with the Administrator on 02/18/19 at 11:30am. 4. Review of Resident #16's current FL2 dated 01/23/19 revealed: -Diagnoses included schizoaffective disorder, hypertension, and anxiety. -There was an order to check finger stick blood sugar (FSBS) 4 times daily before meals and at bedtime. Review of Resident #16's Brand A glucometer's history on 02/18/19 at 10:25am revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #16's February 2019 eMAR. Example of inconsistencies were as follows: -Resident #16's glucometer was located in medication cart A and was labeled with Resident #16's name on a piece of tape on the back of the glucometer. -The date and time were not correct when the glucometer was turned on and displayed 03/31 with unspecified year and 8:15pm. -The last FSBS reading was recorded on 3/26 at 7:49am as 269. -There was only one FSBS reading in Resident #16's glucometer history for February, 2019. -This reading did not match any FSBS readings documented on Resident #16's February, 2019 eMAR. -The previous FSBS reading was recorded on 01/31 at 6:48am as 123. Review of Resident #16's February electronic	D932			

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D932	Continued From page 138 Medication Administration Record (eMAR) revealed: -There was a computer generated entry to check FSBS before meals and at bedtime scheduled at 6:30am, 11:30am, 4:30pm, and 9:00pm. -FSBS readings were documented four times daily from 02/01/19 to 02/17/19 and ranged from 111 to 425 except for 4 times where it was documented Resident #16 refused. Based on observations, interviews, and record reviews, it was determined Resident #16 was not interviewable. Refer to the telephone interview with the Nurse Consultant on 02/18/19 at 3:35pm. Refer to the telephone interview with the Pharmacist Consultant from the facility's contracted pharmacy on 02/19/19 at 10:35am. Refer to the interview with the Resident Care Coordinator (RCC) on 02/18/19 at 12:57pm. Refer to the telephone interview with the facility's contracted licensed Nurse Practitioner (NP) on 02/19/19 at 4:45pm. Refer to the interview with the Administrator on 02/18/19 at 11:30am. _____ Telephone interview with the Nurse Consultant on 02/18/19 at 3:35pm revealed: -She was an employee of the facility until November, 2018. -She was responsible for providing infection control training to the facility staff during new employee orientation. -The infection control training included twenty to	D932		

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D932	Continued From page 139 thirty minutes of diabetic training. -Diabetic training included what diabetes was and the causes of the disease, covered different types of insulin, and how to properly use and clean a glucometer. -It was the facility policy for each resident to have their own glucometer. -The MAs were responsible to make sure each resident had their own glucometer. -The MAs were responsible for disinfecting each glucometer after use by washing the glucometer with a disinfecting wipe and let the glucometer air dry for several minutes. Telephone interview with the Pharmacist Consultant from the facility's contracted pharmacy on 02/19/19 at 10:35am revealed: -She was responsible for training the medication aides (MA) including infection control training since the pharmacy started providing medications to facility in November, 2018. -She trained facility staff to only use one glucometer per resident to prevent the spread of diseases. -She stressed if glucometers were shared then they had to be cleaned properly. -The glucometers had to be wiped with a disinfectant wipe before and after use. -The MA must wait and let the disinfectant air dry for 2 to 5 minutes from the glucometer before checking another resident's FSBS. Interview with the Resident Care Coordinator (RCC) on 02/18/19 at 12:57pm revealed: -Each resident should have their own glucometer to have their FSBS checked. -The MAs were responsible for notifying her if a glucometer was not working properly. -If the MAs had to use the same glucometer for different residents then the glucometer must be	D932			

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D932	Continued From page 140 cleaned between residents. -The MAs were responsible for proper disinfecting technique. -The glucometer should be cleaned with a sanitary wipe or alcohol wipe. -The MA should wait 10 to 15 minutes between checking FSBS on another resident with the same glucometer. -She did not audit the glucometers or monitor the MAs checking FSBS. Telephone interview with the facility's contracted licensed Nurse Practitioner (NP) on 02/19/19 at 4:45pm revealed: -The facility should not share glucometers between residents. -Each resident should have their own glucometer. -Sharing glucometers increases the risk of spreading infections between residents. Interview with the Administrator on 02/18/19 at 11:30am revealed: -She knew every resident did not have their own glucometer. -The facility had always shared glucometers between residents. -The MAs were responsible for using proper disinfecting techniques to clean the glucometers between residents. -She did not know what proper disinfecting techniques should be used on the glucometers. -She did not know how the MAs were disinfecting the glucometers. -The Nurse Consultant was responsible for training staff on how to use and clean the glucometers. _____ The facility failed to implement infection control procedures consistent with the federal Center for	D932			

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D932	Continued From page 141 Disease Control (CDC) guidelines for finger stick blood sugar checks. The facility's failure placed the residents at risk to possible exposure and transmission of blood borne pathogens by sharing of glucometers for Residents #1, #14, #15, and #16. This failure was detrimental to the health, safety and welfare of the residents receiving FSBS checks and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/18/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 8, 2019.	D932		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for supervision, health care referral and follow-up, medication administration,	D980		

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D980	Continued From page 142 administration of a control substance, adult care homes infection prevention, resident rights, resident record, resident contract, resident assessment, resident care plan, special care unit disclosure, admission to the special care unit, special care unit profile, staff testing for tuberculosis, other staff qualifications, competency validation for licensed health professional support tasks (LHPS), special care unit (SCU) training, and cardio-pulmonary resuscitation. The findings are: Interview with a resident's legal guardian on 02/18/19 at 3:47pm revealed: -She visited her client two times a month. -She did not think staffing was adequate in the facility, "Sometimes I walk in and see no one in the facility." -She relied on the facility to monitor the resident [her client] and provide supervision. -The facility never had enough staff to meet the needs of the residents. -"I am not sure what is going on here." -She did not think the outside smoking area on the Special Care Unit (SCU) was secured and safe for the SCU residents to go in and out of. -There had been multiple turn-over in staff and management in the past year. Telephone interview with a family member on 02/18/19 at 6:20pm revealed: -She visited her family member two times a week. -She did not think the staff communicated with her concerning her family member's care. -One time she thought she had smelled "weed" in the facility. -The facility needed management, she could never find management on the weekends.	D980		

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D980	Continued From page 143 -The facility had a lot of turn-over in staff. -The new staff did not know the residents and what they required for personal care. -Her family member needed assistance and had to wait a long time for staff to help. -Because she complained the Administrator was trying to "get my family member out of the facility." -The facility was always short staffed when she looked for staff she could never find them. -She had spoken to the Administrator several times, "I don't think she liked being confronted about not having enough staff." -She had also left several phone messages for the Administrator regarding her family member status, the Administrator had not returned her phone call as of 02/18/19. Confidential telephone interviews with facility staff revealed: -"I had to work by myself on the SCU for 2 nights, the RCC was on the floor but did nothing to provide care to the 21 residents". -The staff called out all the time. -"You cannot provide proper care to the residents because there is not enough staff. -The Administrator was aware a resident in the SCU would get out on the SCU and go into her office. -The Administrator had known the resident's on the assisted living side were propping the outside court yard door open with a rock. -The Administrator had known family members in the facility had the "key pad code" to enter into the SCU. -The Administrator provided condoms to a resident in the SCU to engage in sex with another resident in the SCU. -The Administrator does not care what happened in the SCU.	D980		

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D980	Continued From page 144 -There is no communications with the Administrator and the clinical staff. -Staff will not talk because "They are afraid of losing their jobs." Interview with the SCU RCC on 02/18/19 at 10:45am revealed: -There had been a lot of staff turnover in the SCU since she had been employed with this facility. -She had been trained on the facility's policies and procedures, but was not aware of all the policies. -She had known a resident on the SCU had been admitted to the facility about 6 weeks and did not have a record, "only a few papers held together with a paper clip." -Documentation were missing from the residents' records because, "staff were not documenting like they should." -The nurse was responsible for auditing eMARs to assure orders were correct. -She had not seen the facility nurse since she had been at the facility. -She had not audited any eMARs because she had been "too overwhelmed." -The RCC reported to the Administrator. Interview with the Administrator on 02/21/19 at 9:10am revealed: -She had obtained her administer license in January 15, 2019. -She was responsible for day to day operations of the facility. -She had an open door policy for staff to communicate with her on any issues. -She was aware staff complained about not enough staff on the SCU. -She had provided condoms to residents in the SCU to engage in sexual activity with on e known resident with a communicable disease.	D980		

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D980	Continued From page 145 -The RCC on the AL and the SCU were responsible for the weekly staff schedule. -She worked from 9:00am to 5:00pm at the facility five days a week. -She was on call twenty-four/seven and staff had her personal telephone number. -The PCAs should notify the MAs with any resident concerns. -The MAs should notify the RCC. Interview with the former administrator on 02/22/19 at 8:24am revealed: -She did not know her licenses were posted in the facility. -She had worked with the current Administrator on several occasions, the last time she was in the facility was in January 2019. -The Administrator could reach out to her anytime to obtain advice. -The current Administrator was in charge of day to day operations in the facility. -The Administrator had contacted her on 02/21/19 regarding the survey. -The Administrator had not requested she be presence in the facility during the survey. -She did not know in the SCU a resident had multiple falls with changes in condition for several days, then found on the floor in his room unresponsive, CPR was attempted, resident died in the facility, another resident in the SCU diagnosed with dementia being sexually assaulted by another resident in the SCU, a resident in the SCU with a diagnosis of dementia was provided condoms by the Administrator without professional education on sexual transmitted diseases prior to engaging in sexual behavior with another resident in the SCU who was confirmed on his FL2 to have diagnosis which included human immunodeficiency virus (HIV), hepatitis B, history of hepatitis C.	D980			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 146 -The Administrator had been "running the facility for a bit." -The facility had gone through several administrator in the past 2 years. Non-compliance was identified at violation level in the following rule areas: 1. Based on interviews and record reviews, the facility failed to assure five of six sampled staff (Staff A, B, C, D and E) were tested for tuberculosis (TB) disease upon hire. [Refer to Tag 132 10A NCAC 13F .0406 Test For Tuberculosis. (Unabated Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 7 sampled staff (Staff B and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256.[Refer to tag 137 10A NCAC 13F .0407(a) (5) Other Staff Qualifications (Unabated Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 7 sampled residents who resided in the Special Care Unit (SCU) as evidenced by two residents, both of whom had a diagnoses of dementia and one who had a diagnosis of a communicable disease and were known by staff to engage in sexual activity (#9 and #10), Resident (#6) with dementia and sexually aggressive behaviors who assaulted multiple residents, including Resident (#8), and two residents with a history of elopements (Residents #6 and #8). [Refer to Tag 0270 10A NCAC .0901(b) Personal Care and Supervision (Type A1 Violation)].	D980		

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D980	Continued From page 147 4. Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 6 sampled residents related to one resident who had a fall and was not administered an anticonvulsant as ordered (Resident #12), one who antiviral medication was not available for administration for 14 days (Resident #9), and one resident with orders for labwork not being drawn (Resident#6). [Refer to Tag 0273 10A NCAC .0902(b) Health Care (Type A1 Violation)]. 5. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for supervision, health care referral and follow-up, medication administration, medication storage, administration of control substances, adult care homes infection prevention, resident rights, resident record, resident contract, resident assessment, resident care plan, special care unit disclosure, admission to the special care unit, special care unit profile, testing for tuberculosis, other staff qualifications, competency validation for licensed health professional support tasks (LHPS), special care unit (SCU) training, and cardio-pulmonary resuscitation. [Refer to tag 980 G.S. 131D-25 Implementation (Type A1 Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to assure 5 of 6 sampled residents (#3, #5, #9, #12, #13, and #17) were administered medications as ordered by a licensed prescribing practitioner related to lorazepam not administered as ordered (Resident #3), missing multiple doses of Genvoya, sulfamethoxazole, and lorazepam (Resident #9), Depakote not administered as ordered (Resident #12), Norco not administered as ordered	D980		

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D980	Continued From page 148 (Resident #13), and administering sodium polystyrene sulfate (Resident #17). [Refer to tag 338 10A NCAC 13F .1004 Medication Administration (Type A2 Violation)]. 7. Based on record reviews and interviews, the facility failed to ensure 3 of 6 sampled staff member (Staff A, B and E) had completed a course on Cardio-Pulmonary resuscitation (CPR) and choking management within the past 24 months. [Refer to tag 167 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation (Type B Violation)]. 8. Based on observation, interviews, and record review the facility failed to assure 1 of 5 sampled resident's (Resident #9) had a physician's order, a pre-admission screening for appropriate placement, and a disclosure regarding policies and procedures in the Special Care Unit (SCU). [Refer to tag 463 10A NCAC 13F .1306 Admission To The Special Care Unit (Type B Violation)]. 9. Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff A) assigned to the Special Care Unit (SCU) had completed 20 hours of training, specific to the needs of the residents in the SCU within the first six months of employment 3 of 3 sampled staff (Staffs A, B, and C) completed 6 hours of training within the first week of employment. [Refer to tag 468 10A NCAC 13F .1309 (1) Special Care Unit Staff Orientation and Training (Type B Violation)]. 10. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection	D980		

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D980	Continued From page 149 control procedures for the use of glucometers for 4 of 5 sampled diabetic residents (Residents #1, #14, #15, and #16) with orders for blood sugar monitoring resulting in shared use of glucometers.[Refer to tag 932 G.S. 131D-4.4A (a) Adult Care Home Infection Prevention Requirements (Type B Violation)]. 11. Based on observation, interviews and record reviews, the facility failed to ensure 4 of 6 sampled staff (Staff B, C, D and, F) were competency validated by a registered nurse with return demonstration prior to performing Licensed Health Professional Support tasks. [Refer to tag 161 10A NCAC 13F .0504(a) Competency Validation For Licensed Health Professional Support Task]. 12. Based on interviews, and record review the facility failed to initiate and complete a resident record including a resident contract for 1 of 6 sampled residents (Resident #9). [Refer to tag 243 10A NCAC 13F .0704(a) (1) Resident Contract, Information on Home and Resident Register]. 13. Based on observation, interviews, and record review the facility failed to initiate an initial assessment within 30 days of admission for 1 of 6 sampled residents (Resident #9). [Refer to tag 254 10A NCAC 13F .0801 (b) Resident Assessment]. 14. Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 1 of 1 residents sampled (Resident #13) who were prescribed controlled substances including Hydrocodone. [Refer to tag	D980		

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D980	Continued From page 150 392 10A NCAC 13F .1008 Controlled Substances.] 15. Based on observations, record reviews and interviews, the facility failed to assure resident records were maintained in an orderly manner for 1 of 9 sampled residents (#9). [Refer to tag 433 10A NCAC 13F .1201(a) Resident Records]. 16. Based on observation, interviews, and record review the facility failed to assure 1 of 5 sampled residents (Resident #9) had a care plan based on the resident profile, developed in conjunction with the resident assessment, within 30 days following admission. [Refer to tag 464 10A NCAC 13F .1307 (1) Special Care Unit Resident Profile & Care Plan]. The Administrator failure to assure responsibility for the overall operation of the facility resulted in significant noncompliance with state rules and regulations related to supervision in regards Resident #8's elopement from a locked Special Care Unit (SCU) found by a visitor leaving the facility while the staff in the SCU unaware of her whereabouts, health care referral and follow up regarding physician notification Resident #9 who had a diagnosis of communicable diseases engaging in oral sex and sexual intercourse with another resident both residing the SCU without notification to the medical providers or the guardians, the Administrator providing condoms to the residents without professional education of the communicable disease process, Resident #9 was not administered the medication Genvoya an autoimmune medication for 3 weeks resulting in the chance for a higher viral load, Resident #12 with multiple falls in the SCU with documentation of change in condition without notifying the medical providers and was later found	D980			

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D980	Continued From page 151 unresponsive on the floor required CPR and pronounced dead by the EMS, the medical providers not aware of missed mediations for several residents #12, #17, and #9) residing in the SCU, control substance not accounted for, sharing glucometers without the proper disinfection prevention measures, resident rights to be free of abuse and neglect related to resident in the SCU, Resident #9 in the SCU without an order to be admitted to the SCU without a resident record, resident assessment, care plan, resident contract, SCU disclosure, or the SCU profile, assuring staff testing for TB upon hire, obtaining a HCPR check prior to hiring staff, competency validation LHPS skills for clinical staff, SCU training and CPR training for staff one of whom performed CPR without documentation of completing a certified class on CPR. This failure to assure responsibility for the overall operation, administration, management and supervision of the facility resulted in serious physical harm and neglect of other residents and constitutes a Type A1 Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 02/21/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 24, 2019.	D980		