Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | Hal089002 | A. BUILDING: _____ B. WING _____ | R-C 08/20/2019 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Tyrrell County Department of Social Services conducted a Follow-Up Survey and Complaint Investigation on 08/14/19 through 08/20/19. The complaint investigation was initiated by the Tyrrell County Department of Social Services on 07/11/19. | D 000 | Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report: the plan of correction is prepared solely as a matter of compliance with the State Law. | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>FOLLOW UP TO TYPE A1 VIOLATION<br><br>Based on these findings, the previous Type A1 Violation was not abated.<br><br>Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 2 sampled residents (#1, #7, #8, #11), who resided on the special care unit (SCU), including a resident (#8), who had diagnoses of vascular dementia and schizoaffective disorder, had been deemed incompetent and was unable to consent to a witnessed sexual encounter with a male | D 270 | Procedure establshed for any resident or visitor wishing to enter the secure care unit to include, but not limited to;<br>-Training provided on supervision of residents in common areas and rooms, authorized visitors and obligation to report on 9/12, 9/13, & 9/16.<br>-Sign in/out log reinstated for the memory care and assisted living. ED will monitor for to assure logs are in place and being utilized during daily routine rounds and observations.<br>-Employees were trained on this procedure to promote a safe and secure environment.<br>-All new employees will be trained on these procedures.<br><br>Chart audits completed to assure accurate guardian and/or power of attorney are noted in every resident chart. List is available at the nurses station for easy access to assure residents don't leave with unauthorized individualized and will be updated upon notification of a change in guardianship/POA.<br><br>Executive Director in coordination with the Resident Care Coordinator are responsible for monitoring compliance to assure the safety of the residents. | 9/17/19 ongoing<br><br>9/17/19<br><br>9/17/19 |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Corey Hinemon Executive Director 9-25-19



Plan of Correction reviewed and accepted 10/07/19.
Kathy Gray

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| D 270 | Continued From page 1<br>resident from assisted living (AL), and a resident (#7), who had a diagnosis of vascular dementia and was allowed to leave the SCU and the premises with a person who was banned from the facility; and 2 of 2 sampled residents (#11 and #1), who resided on the AL, including, a male resident (#11), who was allowed by staff to visit the SCU unsupervised with a resident who had a diagnosis of dementia, and a resident (#1), who had four falls within five days resulting in contusions to his scalp and leg.<br><br>The findings are:<br><br>1. Review of Resident #8's current FL-2 dated 12/28/18 revealed:<br>-Diagnoses included vascular dementia, schizoaffective disorder, hypertension, and gastroesophageal reflux disease.<br>-Recommended level of care was the Special Care Unit (SCU).<br>-Resident #8 was intermittently confused.<br>-Resident #8 required assistance with bathing and dressing.<br><br>Review of Resident #8's Resident Register revealed:<br>-Resident #8 was admitted on 11/02/17.<br>-Resident #8 had a guardian.<br>-Resident #8 had significant memory loss and had to be directed.<br>-The Resident Register was signed by the guardian.<br><br>Telephone interview with a court representative on 08/16/19 at 11:33am revealed Resident #8 had a guardian on file with the court system dated 10/01/10.<br><br>Review of Resident #8's legal documents | D 270 | Executive Director and Resident Care Coordinator will assure the list of guardians and POA remains accurate and accessible to employees.<br><br>Employees received training on proper notifcation of leadership regarding any significant incidents including, theft, fire, to include missing resident protocol and procedure. Procedure will be reviewed in all new hire orientation.<br><br>Incidents involving inappropriate behaviors will be investigated by the Care Manager and the Executive Director. All required reporting to the proper authorities, local DSS, Guardian/POA, RP, Families, Physician or other required agencies will be completed by the Executive Director and/or designee.<br><br>Executive Director will assure the secuirty of the community by protecting the entry codes from unauthorized visitors or residents who are cognitively impaired. Codes will be changed as deemed necessary to maintain the security and safety of the residents. | 9/17/19<br><br>9/17/19 ongoing<br><br>9/17/19 ongoing<br><br>9/17/19 ongoing |

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| D 270 | Continued From page 2<br>obtained from the court revealed:<br>-The court found clear, cogent, and convincing evidence Resident #8 was incompetent.<br>-Resident #8 was declared incompetent and her family member was named her guardian on 09/29/10.<br><br>Telephone interview with Resident #8's guardian on 08/15/19 at 3:59pm revealed:<br>-Resident #8's ability to "think for herself" was impaired.<br>-She had not been notified by the facility staff of any incidents related to Resident #8.<br>-She was Resident #8's legal guardian.<br>-She faxed Resident #8's guardianship papers to the facility when Resident #8 was admitted to the facility.<br><br>Interview with the facility's previous ED on 08/20/19 at 1:05pm revealed:<br>-The Business Office Manager (BOM) was responsible for obtaining copies of guardian paperwork.<br>-If the family did not provide the guardian paperwork, the BOM was responsible for following up with the family.<br>-She recalled Resident #8 being admitted.<br>-She knew the BOM and family had been doing a lot of faxing back and forth.<br>-She did not recall if Resident #8 had a guardian or not.<br>-She did not mark the responsible party information on the Resident Register until she was sure what was on file.<br>-She did not know why the guardian was marked on Resident #8's Resident Register.<br><br>Review of Resident #8's Special Care Unit Resident Profile dated 11/02/17 revealed:<br>-Resident #8 required assistance with bathing, | D 270 | All incidents/accidents are reviewed in the morning stand up meetings in detail by the Care Manager and the Executive Director. Each incident will be evaluated to assure immediate measures were taken to address the needs of the resident. Additional interventions will be introduced as necessary. 9/17/19 ongoing<br><br>Fall Management Program: Employees received training on the program to include, but not limited to assessment, identification, prevention, interventions, reporting,documented follow up, environmental and health factors.<br><br>Incident reports will be reviewed and included in the monthly fall management meetings to assure interventions are effective and address any areas of concern. Interventions may include, but not limited to PT/OT referrals, increased supervision, foot wear, clothing, environmental changes, collaboration with primary care physicians and medication reviews. Executive Director and Care Manager will communicate residents requiring increased supervision, any changes with interventions to appropriate staff and monitor program for compliance. 9/17/19 ongoing<br><br>The Divisional Team will monitor personal care and supervision and ongoing compliance to the plan set forth during site visits. 9/17/19 ongoing<br><br>Senior Level Management including Senior Vice Presidents will monitor community and divisional team to assure sustained compliance. 9/17/19 ongoing | |

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| D 270 | Continued From page 3<br>dressing, and grooming.<br>-Resident #8 required prompting with bladder and bowel.<br>-Resident #8 was independent with eating, walking and transferring.<br><br>Review of Resident #8's Care Plan dated 12/28/18 revealed:<br>-Resident #8 required extensive assistance with bathing. hanging and retrieving clothing, and applying and removing socks and shoes.<br>-Resident #8 required limited assistance with ambulating room to room, toileting, and cutting food.<br><br>Review of Resident #8's Quarterly Review and Care Plan Update Form dated 06/25/19 revealed:<br>-Assessed changes included Resident #8 was exit-seeking; intervention included staff to monitor.<br>-Cognitive impairment was mild-moderate.<br><br>Review of Resident #8's Primary Care Provider's (PCP) summary dated 03/06/19 revealed:<br>-This was an initial encounter with Resident #8.<br>-Staff reported to the PCP Resident #8 had been trying to get out of her bedroom window.<br><br>Review of Resident #8's PCP's summary dated 05/14/19 revealed:<br>-This was a follow-up encounter with Resident #8.<br>-Staff reported to the PCP Resident #8 had been having a lot of exit seeking behavior.<br>-Resident #8 was still trying to get out of the window.<br>-Staff had walked by Resident #8's room and found one foot outside the window.<br>-Resident #8 was started on Oxcarbazepine 150mg every 12 hours for behaviors.<br>(Oxcarbezepine is an antiseizure medication that | D 270 | | |

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| D 270 | Continued From page 4<br>can be used to treat bipolar conditions).<br><br>Review of Resident #8's PCP's summary dated 07/16/19 revealed:<br>-The PCP documented he saw Resident #8 on 07/16/19 secondary to Resident #8 exit seeking times three days.<br>-Staff reported Resident #8 had been trying to get out of the building for three days.<br>-Staff reported Resident #8 had gone into other residents' rooms and broken screens trying to get out; she also broke a window.<br>-Resident #8 told the PCP she was not okay, but she could not tell the PCP what was wrong.<br><br>Review of Care Notes for Resident #8 revealed:<br>-On 07/03/19, Resident #8 was reported to the Care Manager (CM) for having sex with another resident; Resident #8 initiated the sexual encounter and Resident #8's PCP was notified.<br>-On 07/13/19, Resident #8 went into another resident's room and kicked out the screen; resident was put on 15-minute checks.<br>-On 07/17/19, Resident #8 made several attempts to leave the facility. | D 270 | | |
| | Confidential interview with a staff revealed:<br>-This staff walked into Resident #8's room and found Resident #8 and a male resident having sex. (They did not recall the date).<br>-The male resident was lying on his back and Resident #8 was straddling the male resident.<br>-This staff walked out of the room and closed the door.<br>-This staff called for other staff to come and witness the sexual encounter.<br>-This staff did not know what to do, so they did not stop it.<br>-Resident #8 turned and looked at the staff and continued having sex. | | | |

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| D 270 | Continued From page 5<br>-Both Resident #8 and the male resident were spoken to by the Executive Director (ED) about the incident.<br><br>Confidential interview with a second staff revealed:<br>-Another staff called for other staff on the SCU to come to Resident #8's room.<br>-This staff witnessed Resident #8 on top of the male resident having sex.<br>-This staff closed the door to the resident's room.<br><br>Confidential interview with a third staff revealed:<br>-The sexual encounter happened between May 2019 and June 2019. (The staff were not sure of the day).<br>-The male resident went to the SCU because he had something to give to Resident #8.<br>-This staff did not think anything about it because the male resident always took snacks to Resident #8.<br>-This staff went looking for the male resident because he was taking too long, and staff found Resident #8 and the male resident having sex.<br>-The male resident went back to the AL and Resident #8 came out of her room, got a towel and bath cloth, and took a shower.<br>-It happened after 5:00pm because the ED and the CM were notified the next day of the incident.<br>-The ED stated, "staff were not supposed to let it happen."<br>-Since the incident the male resident was allowed in the SCU when there were activities, but he was always supervised.<br><br>Confidential interview with a fourth staff revealed:<br>-Residents could go to different units to visit friends, but a staff should always supervise.<br>-The male resident used to always visit Resident #8 and took her snacks. | D 270 | | |

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| D 270 | Continued From page 6<br>-Most of the time this staff would take the male resident to the SCU to take snacks, but some staff would let the male resident go to the SCU and "did not pay him any mind."<br>-Some staff said the male resident could go to the SCU, and some staff said he could not.<br>-This staff did not let the male resident go into the SCU alone because this staff knew the male resident was "fresh".<br>-The male resident was reported to management by several staff.<br>-Management was quick to say it was the "resident's right to have sex".<br>-This staff thought since one resident was on the SCU and the other on the AL, the male resident took advantage of Resident #8.<br><br>Confidential interview with a fifth staff revealed:<br>-A personal care aide (PCA) was laughing and joking about the sexual encounter on the SCU unit during the residents' lunch.<br>-This staff said the male resident and Resident #8 were caught having sex.<br>-This staff could not believe Resident #8 would do "anything like that."<br>-The ED stated, "the incident that happened was consensual between two residents".<br><br>Interview with Resident #8 on 08/15/19 at 5:05pm revealed:<br>-A male resident used to come visit her in her room, but now "I don't see him anymore."<br>-She engaged in sexual intercourse with the male resident one time (date unknown) and it was "an abomination to God."<br>-As a result of the sexual incident, the male resident could not come to her room.<br>-Staff knew; staff saw, "but they went the other way."<br>-She did not know who had seen her and the | D 270 | | |

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| D 270 | Continued From page 7<br>male resident engaging in sexual intercourse.<br>-No staff had talked to her about the incident.<br><br>Second interview with Resident #8 on 08/16/19 at 11:18am revealed:<br>-She did not know the male resident before she was admitted to the facility.<br>-Staff had taken her to the male resident's room three times, but she did not know when.<br>-She could not identify the staff who had taken her to the male resident's room.<br>-He walked to her room on his own.<br>-"I don't like him [the male resident]. He ain't [sic] my friend."<br><br>Interview with the male resident on 08/15/19 at 3:30pm revealed:<br>-He became friends with three [named] female residents from the SCU; he did not know the female residents prior to his admission into the facility.<br>-None of the female residents were his girlfriend and he did not have a "favorite" friend; they were all just his friends.<br>-About three to four months before the sexual encounter, staff brought Resident #8 over to his room on AL; he could not remember the staff names.<br>-Resident #8 had been brought to his room to visit five times; there was no "particular time of the day" Resident #8 was brought to visit with him.<br>-He and Resident #8 would sit in his room alone and talk; staff would be outside the door in the hallway.<br>-He and Resident #8 did not have sex when she would visit him in his room.<br>-He did not know before hand when Resident #8 would come to visit; if he was not in his room the staff would come get him to visit with Resident | D 270 | | |

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| D 270 | Continued From page 8<br>#8.<br>-He had only been into the SCU to attend church since the sexual encounter because church was held inside the SCU; he attended church services in the SCU last week.<br>-Resident #8 asked him three times on the day of the encounter if he would come to her room and have sex with her.<br>-He did not remember the date of the encounter.<br>-Resident #8 asked him if he wanted to go to her room with her and he asked her "For what?" and she told him "to have sex".<br>-Resident #8 "had been at me"; he had turned down her advances for the past year.<br>-On the day of the encounter Resident #8 said; "I want to [expletive] you"; he did not turn her down on that day.<br>-He only had sex with Resident #8 one time; he had not had sex with any other residents at the facility.<br>-He had a bad back, so during the sexual encounter, he sat on the bed and Resident #8 sat on top of him facing the wall.<br>-The sexual encounter happened between 7:30pm and 8:00pm.<br>-The entire encounter took about 20 minutes. | D 270 | | |
| | -He did not know if Resident #8 was happy or sad after the sexual encounter.<br>-Staff were in the hallway outside of Resident #8's room and were talking about the encounter when he came out of her room.<br>-He stayed on the SCU about five to ten minutes after the sexual encounter.<br>-He went back to his room, took a shower and went to sleep.<br>-There were three staff who encouraged him to "hook up" with Resident #8 prior to the encounter.<br>-Staff told him he could have "conjugal visits" with residents in the SCU, so he thought the sexual encounter was okay. | | | |

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| D 270 | Continued From page 9<br>-Staff "hooked up" him and Resident #8.<br>-Female staff came to him after the encounter, "joking and laughing" and made sexually inappropriate comments to him about the incident; he would not name the female staff but said they all still worked at the facility.<br>-The ED took him into the office about a week after his encounter with Resident #8 and to spoke to him about the "sexual affair" with Resident #8.<br>-The ED asked him if he had sex with Resident #8 and if the sex with Resident #8 was consensual; he told her "yes" because Resident #8 asked him to have sex with her.<br><br>Second interview with the male resident on 08/16/19 at 10:55am revealed:<br>-He thought staff brought Resident #8 to his room because they wanted her to be his girlfriend.<br>-Resident #8 wanted to come visit with him in his room; he never asked staff for her to come visit him.<br>-He told staff to stop bringing Resident #8 to his room; he could not remember the last time Resident #8 was in his room.<br>-He thought the first place he met Resident #8 was at church on the AL side of the facility; he could not remember when he met her or how long he had known her.<br>-He thought Resident #8 was in the SCU because of her mental health; something was wrong with her "upstairs".<br>-He knew Resident #8's mental state was not right because she would constantly get up and sit back down, walk over to the door or speak out and interrupt activities.<br>-The first time he met Resident #8 she hugged him; Resident #8 wanted to hug him every time she saw him, but he thought she smelled bad and musty, so he did not want to hug her anymore.<br>-Resident #8's hugs were friendly, and she did | D 270 | | |

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| D 270 | Continued From page 10<br>not hug other residents.<br>-Resident #8 would remember who he was when she saw him and would say hello to him by name.<br>-He never considered her his girlfriend; he never kissed her or held her hand.<br>-She always seemed to sit next to him during activities; they were paired together for an activity at the facility called "Prom", but he did not know who placed them together.<br>-Resident #8 tricked him into being her prom date.<br>-He told [named staff] that he did not want to be Resident #8's boyfriend and he did not want to be with Resident #8 sexually but the [named staff] did not listen to him.<br>-Resident #8's room was located passed the nurse's station; on the day of the sexual encounter he walked past the staff who were at the nurse's station on his way to Resident #8's room.<br>-Staff told him Resident #8 wanted him to call her; he used the phone at the nurse's station to call Resident #8 after the sexual encounter.<br>-Resident #8 asked how he was doing during the phone call; he only called her once.<br><br>Third interview with the male resident on 08/19/19 at 7:26pm revealed:<br>-He could not remember if someone gave him the code to the keypad or if he looked at the code while someone entered it into the keypad at the SCU door.<br>-He had the code to the keypad for about three months.<br>-He let a physician and a nurse into the SCU; the staff found out he let a physician and a nurse into the SCU.<br>-The staff reported to the ED that he had let the physician and the nurse into the SCU, and the code was changed; he was not given the new | D 270 | | |

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| D 270 | Continued From page 11<br>code and was told by the ED staff would have to let him into the SCU.<br>-He knew not to let residents from the SCU out of the door because it was memory care, but he did not know he could not let anyone into the SCU.<br>-After the sexual encounter with Resident #8, he was told he could go into the SCU if he was escorted by staff.<br>-Three weeks ago, he was told he was not allowed to go into any resident rooms while in the SCU; he could only be in the SCU hallway or go into the SCU for church and he needed to be escorted.<br>-Over the weekend of 08/17/19 he was told he could only go into the SCU for church; no one from the AL could visit in the SCU anymore.<br><br>Interview with the male resident's roommate on 0816/19 at 10:50am revealed:<br>-The male resident was a big flirt and "liked the ladies".<br>-Resident #8 was his roommate's girlfriend.<br>-Resident #8 came to visit his roommate two to three times a year; Resident #8 did not visit long with the male resident.<br>-Staff brought Resident #8 over to visit with the male resident; he did not remember the staff who brought the male resident over to visit.<br><br>Interview with the first PCA on 08/15/19 at 5:19pm revealed:<br>-AL residents did not come on the SCU.<br>-She did not let any AL residents on the SCU.<br>-She did not know of a policy in place allowing AL residents on the SCU.<br>-The SCU residents visited the AL for activities or to go to the vending machine.<br><br>Interview with a second PCA on 08/15/19 at 5:59pm revealed: | D 270 | | |

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| D 270 | Continued From page 12<br>-Residents from the SCU did not visit with AL residents in their rooms.<br>-The SCU residents left the unit to go to the library or vending machines.<br>-It had been at least two months since AL residents visited the SCU.<br>-As a SCU PCA she watched for injuries, changes in residents' behaviors, aggressiveness, crying and residents going into other residents' rooms.<br><br>Telephone interview with a third PCA on 08/20/19 at 9:26am revealed:<br>-She worked in both the SCU and the AL.<br>-She would take residents from the SCU outside of the building to get them out of the building for a while.<br>-She only took two or three residents at a time outside unless there was another staff available to take more residents outside.<br>-The residents in the SCU required more attention because they were incontinent and some of the residents needed assistance when transferring.<br>-Residents in the SCU had to be monitored more often than the AL residents; the SCU residents were checked every hour.<br>-The residents in the SCU were behind locked doors to keep them from going out of the building alone and getting hurt; one resident talked about going to a bridge, so she had to be in the SCU to protect her.<br>-Sometimes Resident #8 was in her right mind and sometimes she was not.<br>-She saw Resident #8 and the male resident talking but had never seen them hold hands, sitting together or kissing.<br>-Before the sexual encounter between Resident #8 and the male resident she was told by the ED that it was okay for residents to have sex | D 270 | | |

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| D 270 | Continued From page 13<br>because residents had rights.<br>-She took residents from the SCU to visit residents in the AL, go to the beauty shop on the AL, participate in activities and to get snacks out of the vending machines in the AL.<br>-When she took residents from the SCU to visit residents in the AL, she would leave the SCU residents alone in the residents rooms; she knew which residents were "okay" to leave alone in other residents rooms.<br>-She had never escorted or supervised any residents from the AL in the SCU.<br>-The male resident used to let himself into the SCU but that was stopped when the door code was changed, and he was not allowed to have the new door code.<br>-She did not know why the male resident was not allowed to have the new door code or when the code was changed but only staff had the code for the keypad at the door.<br>-Other staff had let the male resident into the SCU, but she had not let the male resident into the SCU; she had seen the male resident in the SCU only one or two times.<br>-Resident #8 would call to the AL and speak to the male resident on the phone and Resident #8 would ask to go over to the AL to see the male resident.<br>-She only took Resident #8 to the AL to go to the beauty shop to get her hair done or to take her to the snack machine.<br>-She saw the male resident and Resident #8 talking to each other at the nurse's station and she saw pictures of them at the "Prom" activity together.<br>-She heard Resident #8 and the male resident were caught having a sex; she did not remember who told her.<br>-She was told about the encounter between Resident #8 and the male resident the day it | D 270 | | |

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| D 270 | Continued From page 14 | D 270 | | |

happened, but it was after the encounter was over that she found out about it.
-She was in the SCU that day because she worked the morning shift, but she could not remember when the encounter happened; she thought sometime between May and June 2019.
-The ED never talked to her or asked her questions about the encounter.
-Staff were required to report everything concerning residents to the medication aide (MA) on duty and the MA reported to the ED.
-She spoke to Resident #8 after the encounter; she told Resident #8 sex was wrong because they were not married and told Resident #8 to go take a shower.
-Resident #8 would ask the male resident to bring her popcorn when he came to visit.
-She never watched the male resident when he went to visit with Resident #8 because she thought it was "okay" for the male resident to talk to Resident #8 alone.
-Something developed between the male resident and Resident #8 after the "Prom".
-It was the residents' rights to go from the SCU to the AL and back; "it is their home".
-It was "alright" for the residents from AL to go over to the SCU to watch television with the SCU residents; "it's not a threat because the residents know what they are doing".
-She asked Resident #8 if the male resident was her boyfriend and she said "No."
-She did not know who let the male resident in the SCU; she did not see him on a regular basis in the SCU.

Interview with a medication aide (MA) on 08/15/19 at 6:30pm revealed she would not have expected or imagined Resident #8 would engage in sexual activity with another resident because she had never heard Resident #8 speak of sex

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| D 270 | Continued From page 15<br>and she had never seen Resident #8 flirt with anyone.<br><br>Interview with the Activities Director (AD) on 08/20/19 at 12:27pm revealed:<br>-He did not see anything negative to the SCU and the AL residents participating in joint activities because joint activities gave the residents the opportunity to see new faces; interaction was better for all the residents; combined activities were good for memory care residents because it triggered memories.<br>-He did not recognize a relationship between Resident #8 and the male resident; he did not see them hold hands and did not notice if they sat together during activities.<br><br>Interview with the CM on 08/15/19 at 5:11pm revealed:<br>-Resident #8 was "happy confused."<br>-One-minute Resident #8 knew what she was talking about and the next minute she did not.<br>-Residents had the right to have sex.<br>-If a resident was incompetent, they would reach out to the guardian.<br>-There was no protocol related to allowing residents from the AL to visit in the SCU and SCU residents to visit on the AL.<br>-If a resident from the SCU went to the AL, they were supervised.<br>-If a resident from AL went to the SCU, the AL resident was not supervised; the AL resident could visit anywhere in the SCU including a SCU residents' room.<br>-He expected SCU staff to make rounds every 30 minutes in the SCU.<br>-If a resident from AL wanted to visit in the SCU, he would assess why the resident wanted to visit, such as if they had a previous relationship such as roommates or knew each other. | D 270 | | |

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| D 270 | Continued From page 16<br>-He had verbally told staff residents from AL could visit residents in the SCU if they knew someone in the SCU.<br>-Someone told him two residents had sexual contact; he did not remember who told him or when.<br>-He reached out to the county representative to see what he needed to do as far as contacting Resident #8's family and physician.<br>-The county representative told him to verify with the PCP Resident #8 was competent, and if so, the family did not need to be contacted; the resident had the right to privacy.<br>-The county representative told him the facility staff could not stop an AL resident from visiting a resident in the SCU; the resident had the right to have visitors.<br>-He called Resident #8's PCP on 07/03/19 after he was told about the sexual encounter; Resident #8's PCP told him Resident #8 was competent to make the decision to have sex.<br>-The ED talked with Resident #8 and the male resident.<br>-He did not do an investigation related to the incident between Resident #8 and the male resident.<br><br>Interview with the ED on 08/15/19 at 6:04pm revealed:<br>-The facility did not have a policy related to residents having sexual contact with each other; "they had that right."<br>-If a resident had a guardian, they would reach out to the guardian for permission; if the guardian said "no" they would not allow sex to happen.<br>-Staff knew having sex was a resident's right.<br>-Some of the staff thought if a resident was in the SCU they could not have sex.<br>-If a resident in the SCU was competent and able to make that decision, they could. | D 270 | | |

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| D 270 | Continued From page 17<br>-A resident would be assessed by the PCP to determine if they were competent to make that decision.<br>-She talked to the county representative about the incident; the ombudsman said as long as the resident was competent, she could make that decision for herself.<br>-The county representative directed her to contact Resident #8's PCP and if he was okay with Resident #8 making that decision, it was considered consent.<br>-Resident #8's PCP gave verbal approval Resident #8 could make the decision to have sex.<br>-She did not recall if she had reached out to Resident #8's mental health provider (MHP).<br>-She did not know why Resident #8 was in the SCU.<br>-She knew to be in the SCU a resident had to have a diagnosis of dementia; dementia could affect one's cognitive ability.<br>-When she found out about the incident (the LHPS nurse reported the incident to her) she wanted to make sure staff knew it was not rape; it was consensual.<br>-Residents from AL were allowed to visit residents in the SCU; she thought they should be checked on "regularly" (she did not have a specific meaning to regularly).<br>-The county representative said residents in the SCU had the right to have visitors from AL.<br>-If Resident #8 left the SCU to visit a resident in the AL, she expected Resident #8 to be supervised at all times.<br>-If the staff did not know if the sexual act was consensual or not, she expected the staff to stop it.<br>-She could not remember if she had a staff meeting to discuss this with staff or not.<br>-She did not know if the PCP had checked either of the residents out after the sexual encounter. | D 270 | | |

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| D 270 | Continued From page 18<br>-She completed an incident report.<br>-She did not involve law enforcement because she thought the incident was consensual.<br>-She did not know if anyone had talked to staff about what to do if they saw a resident having sex.<br><br>Second telephone interview with the guardian for Resident #8 on 08/20/19 at 12:45pm revealed:<br>-A county staff had notified her of the incident between Resident #8 and a male resident on 08/20/19.<br>-The facility staff had not notified her of the incident between Resident #8 and the male resident.<br>-She did not think Resident #8 could have made that kind of decision.<br>-Before this incident, she had peace of mind knowing Resident #8 was safe and protected.<br>-She thought Resident #8 would be as well taken care of in the facility as she would have been at home.<br>-She had lost her sense of confidence.<br>-She was hoping something would be learned from this incident that would protect Resident #8 and other residents from this "ever happening again."<br><br>Telephone interview on 08/19/19 at 8:55am with the Physician who signed Resident #8's FL-2 dated 12/28/18 revealed:<br>-Resident #8 used very poor judgment.<br>-Resident #8 could not make the decision to have sex.<br>-Resident #8 having sex with a resident from AL was "significantly alarming."<br>-Resident #8 was in a locked unit because she needed supervision and her decisions were impaired.<br>-Allowing a resident from AL to visit a resident in | D 270 | | |

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| D 270 | Continued From page 19<br>SCU without supervision was not acceptable.<br><br>Telephone interview with the Registered Nurse (RN) for Resident #8's mental health provider on 08/19/19 at 1:07pm revealed:<br>-Resident #8 received a monthly injection for paranoid schizophrenia.<br>-The resident had been receiving mental health services for "a while"; she used to receive services in another town, prior to moving into the current facility.<br>-The RN was not aware of the incident that occurred between Resident #8 and a male resident.<br>-She saw Resident #8 last month (July 2019) and the resident never mentioned anything to her about the incident.<br>-The RN could not say for sure if Resident #8 would be able to give consent to have sexual intercourse or consent to anything related to her health care.<br>-She thought based on Resident #8's diagnoses of vascular dementia and paranoid schizophrenia, her decision making would be questionable.<br>-The RN did not think anyone would force Resident #8 to do anything she did not want to do.<br>-Overall, Resident #8 was not a happy person, based on the RN's history of providing services to the resident, and found it difficult to believe Resident #8 would have agreed to have sex.<br>-The RN could not understand how this incident could have occurred when Resident #8 was supposed to be living in a locked unit.<br>-The RN believed the incident happening was unacceptable and would have expected to have been notified by staff.<br><br>Telephone interview with a dietary aide on 07/19/19 at 9:10pm revealed: | D 270 | | |

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| D 270 | Continued From page 20<br>-Several staff were talking about the incident between Resident #8 and the male resident.<br>-The staff were laughing and said, "the male resident could have done more but he would have had a heart attack."<br>-It really bothered her that a resident in the SCU had sex with a resident in the AL.<br>-She was concerned because Resident #8 was "childlike" and at times did not even know where she was.<br><br>Telephone interview with the facility's previous ED on 08/16/19 at 1:05pm revealed:<br>-She was the interim ED until 07/10/19.<br>-She went with the current ED in July 2019 (she did not recall the exact date) to talk to Resident #8 about the sexual encounter.<br>-Resident #8 verbalized the sexual encounter was consensual.<br><br>2. Review of Resident #7's current FL-2 dated 12/28/18 revealed:<br>-Diagnoses included vascular dementia, hypertension, debility with falls, hypokalemia, and hyperlipidemia.<br>-Resident #7 was constantly confused.<br>-Resident #7 required assistance with bathing and dressing.<br>-Resident #7 wandered.<br>-Resident #7 was incontinent of bowel and bladder occasionally.<br><br>Review of Resident #7's Resident Register revealed:<br>-Resident #7 was admitted on 04/19/19.<br>-Resident #7 had significant memory loss and had to be directed.<br>-Resident #7 had a guardian.<br><br>Review of Resident #7's Special Care Unit (SCU) | D 270 | | |

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| D 270 | Continued From page 21<br><br>Resident Profile dated 04/19/19 revealed:<br>-Resident #7 required assistance with bathing, dressing, and grooming.<br>-Resident #7 required prompting with transferring and toileting.<br>-Resident #7 was independent with eating, orientation, and walking.<br><br>Review of Resident #7's Quarterly Review and Care Plan Update Form dated 06/25/19 revealed:<br>-Resident #7 required limited assistance with eating and toileting.<br>-Resident #7 required supervision with transferring.<br>-Resident #7 required extensive assistance with self-help abilities, bathing, dressing, and grooming.<br>-Cognitive impairment was listed as moderate to severe.<br><br>Review of a hospital discharge summary for Resident #7 dated 04/05/19 revealed the physician did not feel Resident #7 had the decision-making capacity and was not safe to live alone. | D 270 | | |
| | Review of Resident #7's care notes dated 05/16/19 revealed:<br>-At 6:16pm, a [named] visitor was at the facility and the guardian did not want the visitor to visit Resident #7.<br>-The visitor was not allowed to take Resident #7 out of the facility.<br>-The guardian believed the visitor was attempting to take Resident #7 back to another state.<br><br>Telephone interview with Resident #7's family member on 08/20/19 at 9:55am revealed:<br>-A visitor went to the facility, sometime in May 2019; he wanted to take Resident #7 out to eat. | | | |

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| D 270 | Continued From page 22<br>-The family was called by staff, and the staff was instructed not to allow Resident #7 to leave with the visitor.<br>-She was concerned the visitor would not bring Resident #7 back to the facility.<br>-She agreed to let the visitor visit Resident #7 since he was already at the facility, but was not allowed to take Resident #7 out of the facility.<br>-During the visit, the visitor tried to leave the facility with Resident #7 and the police were called.<br>-She was told by facility staff the visitor was banned from the facility. (They did not recall who they had spoken to).<br>-She asked the staff what they would do if the the visitor came back to the facility and they were told the facility staff would call 911. (They did not recall who they had spoken to).<br><br>Telephone interview with Resident #7's guardian on 08/20/19 at 3:34pm revealed:<br>-He told a lead staff on in May 2019 (he did not recall the name) the [named] visitor was not to visit Resident #7.<br>-The visitor came back to the facility with his power of attorney papers and was trying to use the papers to get in to see Resident #7.<br>-When the visitor was not allowed in, he caused a "ruckus" and the police were called to the facility.<br>-He did not recall the dates or times of the incident in May 2019.<br><br>Telephone interview with Resident #7's family member on 08/19/19 at 12:44pm revealed:<br>-Resident #7 knew the visitor prior to coming to live at the facility.<br>-The visitor made it seem like he was taking care of Resident #7 when they lived together in another state; however, he left her alone 95% of the time. | D 270 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| D 270 | Continued From page 23<br>-The visitor made it clear to Resident #7's family member he had no intentions of being Resident #7's caregiver on a daily basis.<br>-The family member was surprised the visitor showed up to see Resident #7 on 07/10/19; the family member thought he would have called to say he was coming so far to visit Resident #7.<br>-It was obvious to the family member the intent of the visitor on 07/10/19 was not acceptable.<br>-The resident was gone for ten days when the visitor was allowed to take her out of the SCU and leave the facility.<br>-When the resident was returned to her family, she was wearing the same clothes she left the facility in and had not bathed.<br>-The resident had not had her medications for the ten days she was gone with the visitor.<br>-Staff told the family member the visitor signed the visitor log, but the family member was not allowed to see the sign out log.<br><br>Second telephone interview with Resident #7's family member on 08/20/19 at 9:55am revealed:<br>-On 07/10/19, Resident #7 was having pain in her side and was taken to see the physician.<br>-She asked to be called with an update on Resident #7.<br>-At 6:23pm She still had not received a call, and they, therefore, called the facility.<br>-The staff she spoke to said Resident #7 had returned to the facility and she was doing fine.<br>-The following morning she received a call to ask if Resident #7 was with her and they said "no."<br>-The staff reported to her Resident #7 was not at dinner the evening before.<br>-The staff had to have known Resident #7 was not in the facility when she called at 6:23pm if Resident #7 had not been seen since dinner which was at 5:00pm.<br>-The staff did not tell her Resident #7 had not | D 270 | | |

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| D 270 | Continued From page 24<br>been seen at the facility since dinner on 07/10/19.<br>-She still could not believe it happened.<br><br>Telephone interview with Resident #7's guardian on 08/20/19 at 3:34pm revealed he was concerned Resident #7 did not have her medication for 10 days when the visitor was allowed to take her out of the SCU and leave the facility.<br><br>Telephone interview with the previous Executive Director (ED) 08/20/19 at 12:27pm revealed:<br>-A male visitor came to the facility to see Resident #7 on 05/21/19.<br>-The visitor did not have any legal paperwork when he came to the facility and was not allowed to come to the facility.<br>-Resident #7's guardian said the resident should never leave with the visitor because the visitor wanted to take the resident to another state.<br>-She, the current ED (who was in another position at the time), and another staff banned the visitor from coming to the facility because he wanted to remove Resident #7 from the facility.<br>-She "thoroughly" documented this occurrence in Resident #7's care notes.<br>-Increased supervision was described as checking on Resident #7 every 15 minutes and was implemented immediately following this incident.<br>-She did not know about police involvement related to the incident involving the visitor for Resident #7.<br><br>Interview with a previous interim ED on 08/20/19 at 12:55pm revealed:<br>-She was not present when a male visitor came to the facility to visit Resident #7.<br>-She was the acting ED at that time.<br>-She could not remember which ED was at the | D 270 | | |

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| D 270 | Continued From page 25<br>facility.<br>-The visitor wanted to take Resident #7 off the premises.<br>-Resident #7's family member said the visitor could visit but could not take Resident #7 off the premises.<br>-Staff was to inform the visitor he could not remove Resident #7 from the building.<br>-She did not remember if the police were called to the facility.<br>-When individuals were banned from the facility, she expected notices to be placed to inform staff.<br>-She did not know if a notice was placed in Resident #7's room or record.<br><br>Review of police reports from May 2019 revealed there was no report Resident #7's visitor had been escorted from the facility with police involvement.<br><br>Interview with a personal care aide (PCA) on 07/11/19 at 3:27 PM revealed:<br>-Resident #7 had gone to the hospital, but came back on 07/10/19 around 4:30pm-4:40pm.<br>-The transporter brought Resident #7 back to the SCU.<br>- Several minutes after Resident #7 arrived back from the hospital she saw a visitor standing in the doorway of Resident #7's room; the PCA had never seen him before.<br>-The next time she saw Resident #7 and the visitor, they were by the SCU door; another staff was coming into the SCU and let Resident #7 and the visitor out of the unit.<br>-At dinner, staff asked where Resident #7 was and the PCA told the staff "she left with that man."<br>-Her shift was over at 7:00pm.<br>-When she returned at 7:00am on 07/11/19, she went into Resident #7's room to get her up for breakfast; Resident #7 was not in her room. | D 270 | | |

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| D 270 | Continued From page 26<br>-She asked other staff on her shift had they seen Resident #7 and the response was "no".<br>-The night shift medication aide (MA) and a PCA told her Resident #7 was still at the hospital.<br>-The MA stated Resident #7 was sent out on first shift on 07/10/19 but did not come back on the night shift.<br>-She made the ED and Care Manager (CM) aware Resident #7 was missing from the facility.<br>-The ED stated, "why did you all let Resident #7 out, she cannot go with that man."<br>-She was not aware Resident #7 could not leave with the visitor.<br>-Management staff had let Resident #7 leave with him for Resident #7's birthday in June 2019.<br>-Power of Attorney (POA) information was not in Resident #7's record until after the incident.<br>-There was no policy to inform staff of who could or could not leave the facility and who they could or could not leave with.<br>-The ED and CM contacted local law enforcement on 07/11/19.<br><br>Interview with a second PCA on 07/11/19 at 4:05pm revealed:<br>-She had never worked with Resident #7 one on one but had encountered her in the common area on the SCU.<br>-She had ever seen the visitor before and had never seen any of Resident #7's family.<br>-When she was coming back from getting laundry for the SCU, Resident #7 and the visitor were standing at the SCU door waiting to be let out.<br>-She let Resident #7 and the visitor out of the unit.<br>-She asked if they were leaving and the visitor stated "yes".<br>-She asked that he sign the sign-in/out book and she let Resident #7 and the visitor out the front door. | D 270 | | |

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| D 270 | Continued From page 27<br>-She was never made aware that Resident #7 could not leave with her "boyfriend."<br>-She was made aware of Resident #7's elopement when she returned to work.<br><br>Interviews with a third PCA on 08/14/19 at 5:02am and 6:21am revealed:<br>-Upon starting shift, rounds were made; the PCA who was leaving and the PCA who was coming on shift went room to room to make sure each resident was there and did not need personal care.<br>-There was no information relayed about Resident #7 from first shift to second/third shift.<br>-When she went to do rounds, Resident #7 was not in her room; the PCA was not startled because several residents from the SCU went into each other's rooms and would sit and talk before bed.<br>-When she realized Resident #7 was not in another resident's room, she made the MA aware.<br>-The MA checked the file to see if Resident #7 was out with family or the hospital; it was documented Resident #7 had returned from the hospital around 4:00pm.<br>-She was not sure what time they started searching for Resident #7.<br>-She and a MA searched every resident room for Resident #7.<br>-The entire building was searched for Resident #7, but she was not found.<br>-The MA contacted the CM and made him aware Resident #7 was not in the building.<br>-She alerted the morning shift Resident #7 was not in the building and staff from the 7:00am-7:00pm shift stated someone checked Resident #7 out of the facility.<br>-At first she was not told Resident #7 was out of the facility, but later she was told Resident #7 was | D 270 | | |

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| D 270 | Continued From page 28<br>gone with family.<br>-Second shift left the unit when third shift arrived on the unit; no one reported Resident #7 was gone with family.<br>-She did not know Resident #7 was missing until the next morning.<br><br>Interview with the Transporter/PCA on 07/11/19 at 2:45pm revealed:<br>-She knew Resident #7 could not leave the facility with her "boyfriend" because the previous ED made staff aware of the situation.<br>-She went to get Resident #7 dressed for the day and Resident #7 was complaining of chest pain on 07/10/19.<br>-She told the MA; Resident #7 was sent to the hospital around 10:00am by emergency medical services (EMS).<br>-Around 3:30pm she was transporting another resident from a medical appointment and stopped by the hospital to check on Resident #7; she was ready for discharge, so she transported her back to the facility.<br>-Resident #7 returned to facility around 4:30pm.<br>-She escorted Resident #7 back to the SCU and gave the discharge summary to a [named] MA.<br>-She did not find out Resident #7 was missing until the next day (07/11/19) when she returned to work.<br>-She was asked if Resident #7 returned to the facility from the hospital on 07/10/19 and she said "yes."<br>-The ED and CM searched the building, inside and out.<br>-The ED contacted local law enforcement.<br><br>Interview with a MA on 07/11/19 at 4:25pm revealed:<br>-She was administering morning medications in the dining area and she was looking for Resident | D 270 | | |

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| D 270 | Continued From page 29<br>#7 to administer her morning medications.<br>-When she realized Resident #7 was not in the dining room, she asked PCAs where Resident #7 was; both PCAs stated: "in her room".<br>-She asked if Resident #7 was coming to eat breakfast; one PCA stated she would go and see.<br>-The PCA came back into the dining area and stated Resident #7 was not in her room.<br>-The transporter brought Resident #7 back from the hospital.<br>-Staff searched the building for Resident #7 and informed the ED and CM.<br>-The ED and CM contacted local law enforcement.<br><br>Interview with a second MA on 08/14/19 at 5:45am revealed:<br>-When shift began they were to count medication and tell who was here and who was not.<br>-A [named] MA reported Resident #7 was out with family.<br>-Prior to Resident #7 leaving with family, she was sent to the hospital; after Resident #7 returned back to the facility Resident #7 left with family.<br>-When checks were done, a PCA stated Resident #7 was not back and the MA told the PCA Resident #7 was out with family.<br>-In the morning on 07/11/19, shift report was given from her to another MA and in the report she documented Resident #7 was still out with family.<br>-She knew who the visitor was because he had been escorted out of the building by the previous ED.<br>-When she came back to the facility on 07/12/19 she was notified Resident #7 was missing.<br><br>Interview with a third MA on 07/24/19 at 11:10am revealed:<br>-She let Resident #7's "boyfriend" into the facility | D 270 | | |

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| D 270 | Continued From page 30<br><br>around Resident #7's birthday June 2019.<br>-It was not until he had visited that she was told by the transporter Resident #7's "boyfriend" could not visit the resident.<br>-She sent Resident #7 to the hospital on 07/10/19 because the transporter/PCA said Resident #7 was complaining of chest pain; the ED told the MA to send Resident #7 to the hospital.<br>-EMS transported Resident #7 to the local hospital around 10:00am.<br>-On 07/11/19, she asked a PCA if Resident #7 was back, and the PCAsaid no.<br>-There was no policy for signing a resident out.<br><br>Interview with the Housekeeper Manager on 07/11/19 at 1:50pm revealed:<br>-Staff was discussing Resident #7 had been gone since 07/10/19.<br>-A PCA went to get Resident #7 up for breakfast and Resident #7 was not in her room.<br>-Staff started searching the building and outside for Resident #7 but were unable to locate Resident #7.<br>-The Housekeeper Manager said he would not be surprised if her "boyfriend" did not have her because there was an incident in May 2019 where the "boyfriend" tried to take Resident #7, but management interjected; the "boyfriend" was asked to leave by management.<br>-The "boyfriend" showed management his POA papers for Resident #7 and management informed the "boyfriend" guardianship overruled POA papers.<br>-The "boyfriend" had talked about taking Resident #7 back to another state.<br><br>Review of Resident #7's care notes dated 07/10/19 revealed:<br>-At 12:38pm, Resident #7 complained of chest pain; Resident #7's blood pressure was 179/90. | D 270 | | |

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| D 270 | Continued From page 31<br>-Resident #7 left the facility via emergency medical services (EMS) at 11:45am.<br>-Resident #7 returned to the facility at 4:38pm.<br><br>Review of a police report dated 07/11/19 at 8:55am revealed:<br>-The CM contacted the police department to file a missing person report.<br>-Resident #7 was signed out by visitor.<br>-Resident #7 was last seen at 7:00pm on 07/10/19.<br><br>Review of the sign-in and out log dated 07/10/19-07/11/19 revealed Resident #7 was not signed out of the facility.<br><br>Interview with Resident #7's guardian on 07/11/2019 at 2:20pm revealed:<br>-He was made aware of Resident #7's elopement at 9:00am on 07/11/19 by the CM.<br>-He contacted the facility on 07/10/19 around 6:00pm to get an update about Resident #7's hospital visit and the MA reported that Resident #7 was fine and labs came back good.<br>-Resident #7 was not even in the building when he called and spoke to the MA on 07/10/19.<br>-Staff were aware Resident #7 could not leave the facility with anyone and law enforcement was called on at least one occasion before this incident to escort the visitor off the premises.<br>-This incident was unacceptable.<br><br>Interview with the CM on 07/11/2019 at 4:51pm revealed:<br>-The ED notified him the morning 07/11/19 of Resident #7 being missing.<br>-There was some confusion as to who Resident #7 left the facility with.<br>-He contacted Resident #7's guardian to see if Resident #7 left the facility with him. | D 270 | | |

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| D 270 | Continued From page 32<br>-The guardian had "no clue" Resident #7 was not at the facility.<br>-The guardian was very concerned and angry.<br>-Staff thought Resident #7 was still at the hospital.<br>-He made the guardian aware of the elopement and the steps taken to find Resident #7.<br>-The local law enforcement had been contacted and a picture of Resident #7 was provided.<br>-The local county department of social services (DSS) were contacted, and several policies were being implemented.<br>-Policies had been in place; they just had not been implemented.<br><br>Interview with the ED on 07/11/19 at 5:30pm revealed:<br>-She contacted local law enforcement and local DSS Resident #7 was taken from the facility by a "boyfriend" and a silver alert was issued.<br>-She was not notified Resident #7 was missing from the facility until 07/11/19 when she arrived to work.<br>-The CM contacted Resident #7's guardian.<br>-A PCA told her Resident # 7 left the facility around 5:15pm-5:20pm on 07/10/19 with a visitor but was unsure of who the visitor was.<br>-She was aware Resident #7's "boyfriend" was not allowed to visit or take Resident #7 out of the facility.<br><br>3. Review of Resident #11's current FL-2 dated 03/20/19 revealed:<br>-Diagnoses included dementia with arthrodesis, spinal senosis cervical, schizophrenia, chronic obstructive pulmonary disease, hypertension and hyperlipidemia.<br>-He was semi-ambulatory with the need for a rollator. | D 270 | | |

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| D 270 | Continued From page 33<br><br>Review of Resident #11's care plan dated 07/26/19 revealed:<br>-His ambulation was limited.<br>-Resident #11 required ambulation with aide or device(s): walker/rollator.<br>-Resident #11 required some assistance with activities of daily living.<br><br>Interview with Resident #11 on 08/15/19 at 3:30pm revealed:<br>-He did not want to be with Resident #8 but "push came to shove, and it came down to sex".<br>-Prior to the sexual encounter, the staff would talk about sex with him and flirt and he would flirt with them.<br>-The ED had spoken to him about his inappropriate behavior and flirting with staff prior to the sexual encounter, but he could not remember the date.<br>-He attended church services on the special care unit (SCU) last week.<br>-He used to be allowed to go unsupervised into the SCU, but he was stopped about a week and a half ago when the Executive Director (ED) told him he must be escorted when he went to the SCU.<br>-The ED told him he could not go back into the SCU because the residents were in memory care.<br>-The ED told him it was a mistake to have sex with the female resident and it could not happen again.<br>-He did not think anything was wrong with having sex with the resident.<br>-No one would take him to the SCU; he would go to the SCU by himself; he went every day to visit and take snacks to his friends.<br>-He used to have the code to the keypad at the SCU door, but the facility staff changed the code in December 2018. | D 270 | | |

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| | Ha1089002 | A. BUILDING: _____ B. WING _____ | R-C 08/20/2019 |

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| D 270 | Continued From page 34<br>-Staff would let him in when he wanted to be let into the SCU.<br>-He was told by the ED he must escorted when he went to the SCU.<br>-He used to go to the SCU every day to take snacks and to visit his friends; he visited five resident in the SCU.<br><br>A second interview with Resident #11 on 08/16/19 at 10:55am revealed:<br>-He thought the female resident was in the SCU because of her mental health.<br>-He gave the ED and Care Manager (CM) the names of the staff who peaked in on him and the resident.<br>-He visited with other residents on the SCU.<br>-Staff let him onto the SCU.<br><br>Interview with Resident #11's roommate on 08/16/19 at 10:50am revealed:<br>-Staff brought the female resident over to visit with Resident #11.<br>-He did not know if staff remained in Resident #11 room's during the visit.<br>-The female resident did not visit long with Resident #11.<br><br>Interview with the Licensed Health Professional Support (LHPS) Nurse on 08/15/19 at 6:30 pm revealed:<br>-She had let Resident #11 into the SCU for an activity, but she did not know when or how often.<br>-On another occasion (date/time unknown), she redirected Resident #11 away from the SCU entry door because there was not an activity taking place, "so he didn't need to be in there."<br><br>Interview with the CM on 08/15/19 at 5:11pm revealed:<br>-Resident #11 could not function on his own | D 270 | | |

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| D 270 | Continued From page 35<br>outside of the facility.<br>-Resident #11 required assistance with his bathing and dressing.<br>-Resident #11 had made inappropriate comments to several staff members (he did not recall the date).<br>-Resident #11 had been talked to for making inappropriate comments to staff.<br><br>Telephone interview with the facility's previous ED on 08/20/19 at 9:21am revealed:<br>-She was the interim ED until 07/10/19.<br>-She went with the current ED in July 2019 (she did not recall the exact date) to talk to Resident #11 about the sexual encounter.<br>-Resident #11 verbalized the sexual encounter was consensual.<br><br>Interview with the ED on 08/20/19 at 12:27pm revealed:<br>-Three-four weeks ago a female resident in AL had reported the male resident making "kissy faces" at the resident.<br>-She talked to the male resident and told him he could not do that; the male resident said he would stop.<br>-She did not tell the staff to do anything different related to supervising the male resident.<br>-Staff had talked with her about the male resident's behavior approximately 2-4 weeks ago; she talked to him and told him he could not do that.<br>-She did not see anything with the male resident that would be of harm to anyone; he was not someone who would force himself on anyone.<br><br>Interview with the facility's second previous ED on 08/20/19 at 1:05pm revealed:<br>-She had not talked to Resident #11 about his behavior prior to the incident related to the sexual | D 270 | | |

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| D 270 | Continued From page 36<br>encounter with the female resident.<br>-Resident #11 had made comments to her such as if she was wearing a dress he would tell her her legs looked nice.<br><br>4. Review of Resident #1's current FL-2 dated 08/06/19 revealed:<br>-Resident #1's level of care was for assisted living.<br>-Resident #1 was intermittently disoriented and ambulatory.<br>-There was an order for oxygen at 2 liters per minute continuous.<br><br>Review of Resident #1's care plan dated 08/06/19 revealed:<br>-Resident #1 ambulated independently.<br>-Resident #1 used oxygen.<br>-Resident #1 was oriented but forgetful and needed reminders.<br>-Resident #1 transferred independently.<br><br>Review of Resident #1's Licensed Health Professional Support evaluation dated 07/02/19 revealed:<br>-Resident #1 did not use assistive devices to ambulate.<br>-Resident #1 was assessed to ambulate in the hallway without difficulty with oxygen tank.<br>-Resident #1 was cautioned to watch the oxygen tubing when ambulating to decrease his falls risk.<br><br>Review of Resident #1's accident/incident report dated 08/10/19 revealed:<br>-Resident #1 was in his bathroom and fell attempting to get off of the toilet.<br>-Resident #1 had a bruise to his right upper thigh and no first aid was given.<br>-Resident #1 was alert and oriented. | D 270 | | |

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| D 270 | Continued From page 37<br><br>-Resident #1's physician was notified.<br>-Resident #1 was placed on 72 hours monitoring from 08/10/19 to 08/13/19 for bruising, change in mental status/condition, pain or other injuries related to fall.<br>-The falls prevention program was initiated for Resident #1.<br>-Resident #1 was not transported to the hospital on 08/10/19.<br><br>Interview with the Care Manager (CM) who completed the accident/incident report for 08/10/19 on 08/16/19 at 8:36 am revealed Resident #1 had fallen recently and was placed on 72 hours monitoring status after his 08/10/19 fall, which included the resident having their vital signs checked and a note written by the Medication Aide (MA) about the resident per shift.<br><br>Review of Resident #1's progress notes dated 08/10/19 revealed:<br>-At 7:30 am, Resident #1 reported slipping over the trash can in his bathroom, had a little pain, and will continue to monitor.<br>-At 12:15 pm, Resident #1 came to the medication aide (MA), reported falling during the night, which caused a bruise on his right thigh where it hit the trashcan and he requested pain medication; staff continued to monitor him.<br>-There were no other interventions for increasing supervision or falls prevention noted.<br><br>Review of Resident #1's accident/incident report dated 08/11/19 revealed:<br>-Resident #1 was sent to the hospital because he was not able to see.<br>-Resident #1 was transported via emergency management services (EMS).<br>-Resident #1's physician was notified. | D 270 | | |

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| D 270 | Continued From page 38<br><br>Interview with the CM who completed the accident/incident report for 08/11/19 on 08/16/19 at 8:36 am revealed:<br>-Resident #1 was placed on 72 hours monitor status after his 08/10/19 fall and it was continued after the 08/11/19 hospital visit.<br>-There was no increased supervision initiated for Resident #1 after he returned from the emergency room (ER) on 08/11/19.<br><br>Review of Resident #1's progress notes dated 08/11/19 revealed:<br>-At 10:45 am, Resident #1 told the MA he had blood in his urine.<br>-Resident #1 was asked if he would like to be seen in the emergency room and he refused.<br>-Resident #1's physician was notified, and a urinalysis was ordered.<br>-At 6:02 pm, Resident #1 requested to go to the hospital due to loosing his vision and shaking.<br>-Resident was transported to the hospital.<br>-At 10:44 pm, Resident #1 returned from the local hospital.<br>-There were no interventions for increasing supervision or falls prevention documented.<br><br>Review of Resident #1's hospital discharge summary dated 08/11/19 revealed:<br>-Resident #1's discharge diagnoses were initial encounter fall, contusion of scalp, contusion of left lower extremity, neck sprain and unspecified chest pain.<br>-Resident #1's discharge instruction was to follow up with primary care physician to discuss chest pain, Tylenol (used to treat pain and fever) if needed, and home medications as before.<br><br>Review of Resident #1's accident/incident report dated 08/13/19 revealed:<br>-Resident #1 fell in his room and did not have an | D 270 | | |

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| D 270 | Continued From page 39<br>injury.<br>-Resident #1 reported he tripped over something and he felt like his head was bleeding.<br>-Resident #1 was not transported to the hospital and his physician was notified.<br>-Resident #1 was placed on monitoring status for 72 hours from 08/13/19 to 08/16/19 due to bruising, change in mental status/condition, pain or other injuries related to fall.<br><br>Interview with the CM who completed the accident/incident report for 08/13/19 on 08/16/19 at 8:36 am revealed:<br>-Resident #1 saw his physician on 08/13/19 when he fell, and the resident had complaints of lower extremity weakness.<br>-Resident #1's physician ordered an magnetic resonance imaging (MRI) of the spine and had concerns the resident had a neurological disorder.<br>-Resident #1 was on 72 hour monitoring and no other interventions were done for increased supervision or falls prevention.<br><br>Review of Resident #1's progress notes dated 08/13/19 revealed:<br>-At 4:57 pm, Resident #1 was found on the floor and reported that he tripped over something and felt like his head was bleeding.<br>-Resident #1's vital signs were checked, and he was helped off of the floor.<br>-There was no documentation of any interventions to prevent Resident #1 from falling.<br><br>Review of Resident #1's accident/incident reports dated 08/14/19 at 10:30 am revealed:<br>-Resident #1 had an unwitnessed fall in his bedroom without injury.<br>-Resident #1 was not transported to the hospital and his physician was notified. | D 270 | | |

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| D 270 | Continued From page 40<br>-There was documentation that Resident #1 would follow-up with his physician on the physician's next site visit.<br>-There was documentation that Resident #1 was placed on 72 hours monitoring status from 08/14/19 to 08/17/19 for bruising, change in mental status/condition, pain or other injuries related to fall.<br><br>Interview with the MA who completed the accident/incident report for 08/14/19 at 10:30 am on 08/15/19 at 4:08 pm revealed:<br>-Resident #1 fell on 08/14/19 moving around in his room and he told the CM that he was not injured.<br>-When Resident #1 fell later on 08/14/19, he was found by the CM who assessed the resident and sent him out to the hospital.<br>-There was an order for a walker for Resident #1 on 08/14/19 after he returned from the hospital and he was placed on 72-hour monitoring status.<br>-Resident #1 was previously on 72-hour monitoring status, and he was continued on the 72 hour monitoring after the 08/14/19 falls.<br>-When a resident was placed on 72 hours monitoring status, the MA took the resident's vital signs each shift, wrote a shift note about the resident in the computerized progress notes and there were no other interventions involved with the 72 hours monitoring.<br><br>Review of Resident #1's accident/incident reports dated 08/14/19 at 3:56 pm revealed:<br>-Resident #1 had an unwitnessed fall without injury in his room trying to get up to ambulate to the bathroom.<br>-Resident #1 was transported to the local hospital via EMS.<br>-Resident #1's physician was notified.<br>-There was documentation that Resident #1 was | D 270 | | |

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| D 270 | Continued From page 41<br>placed on 72 hours monitoring status for bruising, change in mental status/condition, pain or other injuries related to fall.<br>-There was no documentation of interventions to prevent Resident #1 from falling.<br><br>Interview with the CM who completed the accident/incident report for 08/14/19 at 3:56 pm on 08/16/19 at 8:36 am revealed:<br>-Resident #1 went to the hospital after falling on 08/14/19 and an order for a walker was obtained.<br>-Resident #1 initially refused the walker but he spoke with the resident at length to encourage him to use the walker.<br>-The walker was ordered to help to prevent Resident #1 from falling.<br>-He told staff about the walker and to assist Resident #1 with walking on 08/15/19.<br>-He told Resident #1 to use the call bell to call staff for assistance getting to the bathroom.<br>-Staff were told about the changes with Resident #1 by word of mouth.<br>-There was no increased supervision or falls prevention initiated for Resident #1.<br><br>Review of Resident #1's progress notes dated 08/14/19 revealed:<br>-At 11:51 am, Resident #1 told the CM he fell without injury that morning and did not tell staff.<br>-At 4:05 pm, Resident #1 was seen lying on the floor and reported he slipped on water.<br>-Resident #1's physician was notified and requested Resident #1 be sent to the hospital due to Resident #1's difficulty walking.<br>-Resident #1 was transported to local hospital via EMS.<br>-At 9:30 pm, Resident #1 returned from the local hospital and was placed on magnesium oxide (used to treat magnesium deficiency) due to diagnosis of hypomagnesemia. | D 270 | | |

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| D 270 | Continued From page 42<br><br>Review of Resident #1's hospital discharge summary dated 08/14/19 revealed:<br>-Resident #1's diagnoses at discharge were accidental fall, acute pain of right shoulder, ataxia, and hyponatremia.<br>-An order for a walker was given for Resident #1.<br>-An order for a MRI of the spine was given for Resident #1.<br>-Resident #1's computed tomography (CT) for the head and spine were negative for acute changes or abnormalities.<br>-Resident #1's x-rays of the shoulder and lumbar spine noted degenerative changes but no dislocations.<br><br>Interview with Resident #1 on 08/15/19 at 8:51 am revealed:<br>-He had fallen once in his bedroom, once in the laundry room and he had fallen just trying to make it to the bathroom to urinate.<br>-He had difficulty standing at times because he did not have much strength in his legs.<br>-He had received a walker from his church and started using it on 08/15/19, the day after he returned from the hospital.<br>-He fell three times on 08/14/19 and it was embarrassing to fall because he was not able to hold his urine anymore until reaching the toilet.<br>-Staff helped him off the floor two times on 08/14/19 and he was able to get himself up on the third fall.<br>-It took him 20 minutes to get off the floor the third time, he was not able to reach the call bell because of his location in his room.<br>-His physician ordered the walker and magnesium because his magnesium level was low at the hospital.<br>-He had a "bad heart" and has had several tests for his heart. | D 270 | | |

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| D 270 | Continued From page 43<br>-He had been sent to the hospital a couple of times due to fall but more due to his heart condition.<br>-He started falling in the month of August 2019 and three months before he was dancing.<br>-He had been instructed by the CM to "not fall", use the walker, and use his oxygen.<br>-The last time he went to the hospital was the night of 08/14/19.<br>-Staff had not told him of interventions to prevent him from falling after the 08/10/19 and 08/13/19 falls.<br>-The walker was given to him to use after the 08/14/19 falls.<br>-There were no other interventions shared with him after the 08/14/19 falls.<br><br>Interview with a representative at Resident #1's physician's office on 08/15/19 at 11:33 am revealed:<br>-The physician last saw Resident #1 on 08/13/19 after the resident was sent to the emergency room (ER) on 08/11/19.<br>-The physician noted that he was aware of Resident #1's contusion of the scalp.<br>-There were no notes concerning interventions after the 08/10/19 and 08/13/19 fall.<br>-There were no other notes concerning interventions or orders to prevent Resident #1 from falling after the 08/14/19 falls.<br><br>Interview with the same MA on 08/15/19 at 4:08 pm revealed:<br>-There were no instructions from the C or Resident #1's physician to increase supervision for Resident #1 after the 08/10/19 and 08/13/19 falls.<br>-Resident #1 was not on every 15 minutes checks and the personal care aides (PCAs) checked Resident #1 every 2 hours. | D 270 | | |

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| D 270 | Continued From page 44<br>-The only new intervention after the 08/14/19 falls was a walker was provided for the resident.<br>-There was no increased supervision for Resident #1 after the four falls.<br><br>Interview with a PCA on 08/15/19 at 9:53 revealed:<br>-She had not known Resident #1 to fall previously, but he fell on 08/14/19.<br>-Resident #1 was assisted by the CM to get up from the floor.<br>-She was trained by another PCA and told to do rounds every two hours.<br>-She walked the hallways more than every 2 hours and checked on residents.<br>-She had not been told to check Resident #1 more frequently by anyone.<br>-She had not been told to do anything different for Resident #1.<br>-Resident #1 did not have a floor mat, chair alarm, bed alarm, nor was he on frequent checks.<br>-She had seen Resident #1 use his oxygen carrier when he walked.<br>-There was no increased supervision after Resident #1 fell on 08/14/19.<br><br>Interview with another PCA on 08/15/19 at 10:01 am revealed:<br>-Resident #1 seemed like he was not himself the last few days, his walking pace was slower than usual.<br>-She knew Resident #1 fell last week 08/10/19.<br>-She had observed Resident #1 using a walker on 08/15/19 but this was new.<br>-He had to be reminded to wear his oxygen.<br>-She had not been told to check Resident #1 more frequently and he did not have any new equipment except for the walker.<br>-There was no increased supervision for Resident #1 after he fell. | D 270 | | |

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| D 270 | Continued From page 45<br><br>Interview with the CM on 08/15/19 at 5:29 pm revealed:<br>-There was no written policy concerning supervision.<br>-Residents were checked every hour on the assisted living side.<br><br>Second Interview with the CM on 08/16/19 at 8:36 am revealed:<br>-Resident #1's care plan was done on 08/06/19 and a new one was pending because of Resident #1's changes with mobility.<br>-Resident #1 was on 72-hour monitor status, but he was not on more frequent checks.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:40 am revealed:<br>-Residents were placed on increased supervision when necessary and the amount of time for the frequent checks was determined by the MAs or the CM.<br>-Residents were placed on increased supervision also based on the mechanism of their fall.<br>-She did not know what was put into place for Resident #1 but she knew he was sent to the hospital because of a fall.<br>-She expected the responsibility of increased supervision of a resident to be a shared responsibility.<br>-She was informed of all falls during the morning stand-up meeting each day, but she did not know what was put into place to prevent Resident #1 from falling.<br><br>The facility failed to supervise residents in accordance with their current symptoms, behaviors, care plans, and assessed needs resulting in Resident #8, who had a diagnosis of | D 270 | | |

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| TYRRELL HOUSE | 950 HWY 64 EAST COLUMBIA, NC 27925 |

| (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 |
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| D 270 | Continued From page 46<br>vascular dementia, resided in the special care unit (SCU) and who had been declared incompetent was left unsupervised in her room with a male resident (#11) from the assisted living who had unrestricted access to SCU, resulting in the residents having sex while staff witnessed; Resident #7, who resided in the SCU, being taken from the facility by a "boyfriend," who was not allowed to leave the facility with the resident, and was taken out of state without her medication and personal care for 10 days; and Resident #1 falling four times within five days while on 72 hour monitoring, resulting in contusions of the scalp and left lower extremity. This failure resulted in serious neglect and physical harm to the residents, and constitutes an Unabated Type A1 Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/15/19 for this violation. | D 270 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. | D 276 | | |

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| D 276 | Continued From page 47 | D 276 | | |
| | This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to implement a physician's order for 1 of 5 sampled residents (Resident #2) who was ordered to wear compression hose.<br><br>The findings are:<br><br>Review of the current FL2 for Resident #2 dated 03/29/19 revealed diagnoses included schizoaffective disorder, bipolar type, hyperlipidemia, diabetes mellitus and hypertension.<br><br>Review of Resident's #2 physician's order dated 05/14/19, revealed an order for compression hose to apply at 8:00am and remove at 8:00pm.<br><br>Interview with Resident #2 on 08/14/19 at 9:08 am revealed:<br>-Resident #2 did not wear compression hose because the hose "were to hard put on."<br>-She had not worn the hose for over 2 months.<br>-She asked for assistance from staff with putting on the hose.<br>-Staff did not assist with putting on the hose.<br><br>Second interview with Resident #2 on 08/15/19 at 9:40 am revealed:<br>-She had put on the compression hose without staff assistance around 5:30am.<br>-She had a "hard time" getting the compression hose on.<br>-Staff had not checked to see if the compression hose were on. | | Chart audits conducted to assure physcian orders are processed and carried out accordingly.<br><br>Weekly chart audits of a sample set will be conducted to assure sustained compliance. Audits will be performed by the Care Manager in coordination with the Executive Director.<br><br>The identified Care Manager has been re-trained on the order processing system and the required follow up to assure continuity of care and services.<br><br>All nursing staff were inserviced on application of TED or compression hose. The Med Aide is responsible for assuring the hose are placed on resident daily and removed at night as ordered. The Care Manager will monitor weekly to ensure compliance. | 9/17/19<br><br>9/17/19<br><br>9/17/19<br><br>9/17/19 |

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| D 276 | Continued From page 48<br><br>Review of Resident #2's Medication Administration Record (MAR) on revealed:<br>-There was an entry where staff initialed for putting on the compression hose on 08/13/19.<br>-There was not an entry of staff initials for putting on the compression hose for the morning of 08/14/19.<br><br>Observation of Resident #2 on 08/14/19 at 9:10am revealed:<br>-Resident #2 was not wearing the compression hose.<br>-She had difficulty putting on the compression hose.<br>-She placed the compression hose on right leg.<br>-She was not able to place the compression hose on the left leg.<br><br>Interview with two Personal Care Aides (PCA) on 08/15/19 at 9:44am revealed:<br>-They assisted Resident #2 when needed.<br>-They did not know Resident #2 needed to wear compression hose.<br><br>Interview with a third PCA on 08/16/19 at 8:25 am revealed she did not know Resident #2 needed to wear compression hose daily.<br><br>Interview with a Medication Aide (MA) on 08/16/19 at 8:30 am revealed:<br>-Resident #2 had an order for compression hose to wear from 8:00am to 8:00pm daily.<br>-She had not assisted Resident #2 in putting on the compression hose because the resident was up and dressed prior to the 7:00am shift.<br>-She had checked to see if Resident #2 had on the compression hose during morning med pass.<br>-She did not know Resident #2 had difficulty putting on the compression hose.<br>-She did not know Resident #2 had not worn the | D 276 | Executive Director and or designee will check for compliance during rounds while observing the care and services of the residents. | 9/17/19 ongoing |

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| D 276 | Continued From page 49<br>compression hose.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/16/19 at 8:37am revealed:<br>-All residents had a "Who am I Sheet" placed on the back of their doors that noted their activities of daily living.<br>-The PCAs had access to residents' records.<br>-The PCAs could have assisted with placing on compression hose.<br>-MAs were responsible for putting on compression hose.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 8:51 am revealed:<br>-PCAs assisted with bathing, grooming and toileting.<br>-PCAs had access to residents' records.<br>-PCAs were trained on LHPS tasks.<br>-PCAs could assist with putting on compression hose.<br>-MAs were responsible for checking to assure compression hose were on residents.<br>-She was not aware Resident #2 had not been wearing the compression hose.<br><br>Attempted telephone interview with the LHPS Nurse on 08//19/19 at 10:20am was unsuccessful. | D 276 | | |
| D 282 | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. | D 282 | | |

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| D 282 | Continued From page 50<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to assure the kitchen and walk-in refrigerator were clean and free of contamination including buildup on the shelves and walls and uncovered food in the refrigerator and buildup on the hot food serving table.<br><br>The findings are:<br><br>Observation of the walk-in refrigerator on 08/15/19 at 10:17am revealed:<br>-There was a black and white spotted buildup on two walls in the walk-in refrigerator in the kitchen.<br>-There was a white buildup on the storage shelves; there were paper labels on the shelves that had a black spotted buildup.<br>-There were canned apples in thirty small bowls on trays in the walk-in refrigerator that were not dated, labeled or covered.<br><br>Observation of the hot food serving table on 08/15/19 at 10:23am revealed:<br>-There was dirty water in the inside of the hot holding wells and there was a buildup of white and pink scales.<br>-There was a sticky brownish yellow film on the lids to the food serving table.<br><br>Observation of the kitchen on 08/15/19 at 10:45am revealed there was no evidence of a cleaning assignment list or cleaning schedule for staff to follow posted in the kitchen.<br><br>Interview with the cook on 08/15/19 at 10:05am revealed:<br>-She did not have a cleaning assignment list or cleaning schedule to follow; she cleaned as she | D 282 | Dietary staff were trained on the cleaning schedule and check list which was implemented pn 8/16/19. This is monitored by the Dietary Manager in coordination with the Executive Director.<br><br>Executive Director will monitor for compliance by observations during rounds in the dietary departments. Executive Director will review the cleaning check list and address any concerns with the dietary personnel and the dietary manager. | 9/17/19<br><br>9/17/19 &ongoing |

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| D 282 | Continued From page 51<br>worked and deep cleaned equipment when she had time.<br>-When she saw equipment needed cleaning, she would clean it; sometimes the dietary manager (DM) would ask her to deep clean a certain piece of equipment.<br>-She knew the shelves in the walk-in refrigerator were wiped clean once a week before the food delivery came in; she saw the buildup on the walls, and she meant to clean it off but forgot.<br>-She did not know who put the uncovered canned apples in the walk-in refrigerator, but staff knew better than to put food in the walk-in refrigerator without a date and uncovered.<br><br>Interview with the DM on 08/15/19 at 10:25am revealed:<br>-The hot food serving table was wiped clean once a day and deep cleaned once a week or when it was dirty.<br>-The lids on the hot food serving table were only cleaned when they touched the food or got food on them.<br>-The water inside the hot food serving table wells was only drained once a week; when the water was drained out the kitchen staff would use soap and water to scrub the wells clean.<br>-The shelves to the walk-in refrigerator were wiped down once a week in preparation for the weekly food delivery.<br>-She did not know the last time the shelves or the walls in the walk-in refrigerator had been deep cleaned; she was not aware of the buildup on the walls or the shelves, but she was aware of the dirty paper tags on the shelves.<br>-The bowls of canned apples should have been covered and dated before they were placed in the walk-in refrigerator by the kitchen staff.<br>-All staff had been instructed to date, label and cover food before placing it in the walk-in | D 282 | | |

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| D 282 | Continued From page 52<br><br>refrigerator.<br>-She did not have a cleaning schedule or cleaning assignment list for the kitchen staff to follow.<br>-When she saw equipment needed to be deep cleaned, she would verbally ask the staff to clean the equipment.<br>-She did not document the completed cleaning.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:50am revealed:<br>-She walked through the kitchen "every other week or so"; she did not remember the last time she walked through the kitchen.<br>-She did not have a check off list she referred to when she walked through the kitchen; she just looked at the equipment for cleanliness and looked for dating and labeling.<br>-The DM did not provide her with a check off list or a cleaning assignment list of equipment from the kitchen.<br>-She expected all food to be covered, dated and labeled when it was placed into the walk-in refrigerator.<br>-She did not know the last time the walls and shelves in the walk-in refrigerator had been deep cleaned.<br>-She expected the hot food serving table to be wiped cleaned after every meal and to be deep cleaned once a week; she expected the lids to be removed and cleaned after every meal.<br>-A DM from another facility had visited and trained the current DM and the kitchen staff on dating, labeling, covering of food and cleaning the equipment. | D 282 | | |
| D 312 | 10A NCAC 13F .0904(f)(2) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service | D 312 | | |

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| D 312 | Continued From page 53<br>(f) Individual Feeding Assistance in Adult Care Homes:<br>(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to provide assistance with meals in an unhurried manner that promoted dignity and respect for 1 of 5 sampled residents (#5), who was dependent on staff for assistance with feeding.<br><br>The findings are:<br><br>Review of Resident #5's current FL-2 dated 02/05/19 revealed:<br>-Diagnoses included Alzheimer's disease, pre-renal, high blood pressure, and a vitamin D deficiency.<br>-She was constantly disoriented.<br>-She required assistance with feeding.<br>-The resident's diet order was regular diet with chopped meats.<br><br>Review of Resident #5's Licensed Health Professional Support (LHPS) dated 07/22/19 revealed:<br>-Diagnoses included Alzheimer's disease, pre-renal, acute tubular necrosis, degenerative joint disease, syncope, peptic ulcer, gastrointestinal bleed, and a vitamin D deficiency.<br>-Resident #5's diet was chopped meats.<br>-Feeding techniques for residents with swallowing problems was listed as an LHPS task.<br>-The resident required total care and feeding assistance from staff. | D 312 | All staff were trained on proper feeding techniques to include feeding assistance in an unhurried environment to assure a pleasurable dining experience. Training provided by a Registered Nurse on 9-12, 9-13, & 9-16-19.<br><br>An assigned manager or designee will be present in the dining area to monitor meals. During, weekends, a Manager on Duty will observe meals during on duty assignment.<br><br>Executive Director will monitor meals weekly to assure compliance and a resident right to an unhurried dining experience.<br><br>Divisional Team will monitor Nutrition and Food Service during site visits and follow up with Executive Director to address any concerns. | 9/20/19<br><br>9/20/19 & ongoing<br><br>9/20/19 ongoing<br><br>9/20/19 |

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| D 312 | Continued From page 54<br><br>Observation of Resident #5 on 08/14/19 from 7:39am to 7:58am revealed:<br>-She was in a wheelchair and seated at a table with three other residents.<br>-A personal care aide (PCA) sat next to her in a dining room chair and proceeded to feed the resident.<br>-The resident was served scrambled eggs, grits, a hash brown patty, orange juice and water.<br>-The PCA stirred the grits and the scrambled eggs together and began to feed Resident #5.<br>-The PCA cut the hash brown patty into six pieces and used a large table spoon to feed the resident.<br>-The PCA put a large portion of the egg and grits mixture on the spoon.<br>-The PCA put the large portions of food into Resident #5's mouth all at once.<br>-The PCA finished feeding Resident #5 in ten minutes.<br>-Resident #5 ate 100% of her meal.<br><br>Observation of Resident #5 on 08/14/19 from 12:00pm to 12:15 pm revealed:<br>-The resident was seated in her wheelchair, in the dining room, at a table with three other residents.<br>-The same PCA that fed her at breakfast sat next to Resident #5 and fed her lunch.<br>-Resident #5 was served chicken tortellini with spinach and diced fresh tomatoes in Alfredo sauce, sautéed squash with onions, a cookie, iced tea and water.<br>-The PCA used a large spoon to feed Resident #5 her food.<br>-The PCA put large portions of the chicken tortellini on the spoon and then blew on the food to cool it down; after the PCA blew on the food, the PCA put the large portion into Resident #5's mouth all at once.<br>-The PCA pushed the pieces of diced tomatoes to | D 312 | Senior Level Management including Senior Vice Presidents will monitor and observe for compliance during site visits to assure compliance. | 9/20/19 ongoing |

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| D 312 | Continued From page 55<br>the side of the plate and did not feed them to Resident #5.<br>-It took the PCA fifteen minutes to feed Resident #5 her lunch.<br>-Resident #5 ate 75% of her meal.<br><br>Based on observations, interviews and record reviews it was determined Resident #4 was not interviewable.<br><br>Interview with the PCA on 08/16/19 at 8:20am revealed:<br>-She had fed Resident #5 breakfast that morning.<br>-She was taught how to feed residents as part of her orientation when she was hired in June 2019.<br>-She was told to sit next to the resident so she would be eye to eye with the resident she was feeding.<br>-Her training did not include observation of her while she fed a resident.<br>-She knew to keep the food separate and not mix it together even though it was not part of her training.<br>-She was not told how much food to put on the utensil; she did not put more food than she would feed her child.<br>-She was not trained to tell Resident #5 what was on the plate and the fork before she fed the resident, but she did it anyway.<br>-When she would feed Resident #5, it usually took Resident #5 30 minutes to eat.<br>-She was not assigned to feed Resident #5; the PCAs just took turns when they fed her.<br><br>Attempted interview with a second PCA on 08/16/19 at 8:30am was unsuccessful.<br><br>Attempted interview with the LHPS nurse on 08/16/19 at 12:30pm was unsuccessful. | D 312 | | |

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| D 312 | Continued From page 56<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:50am revealed:<br>-The staff were trained in how to feed residents as part of their skills for LHPS check off by the LHPS nurse.<br>-She did not know what the feeding assistance training involved because she had never been through the training herself.<br>-She thought the feeding assistance training taught the PCA to sit at eye level with the resident, cut food up if needed and to take your time while the PCA fed the resident.<br>-It would not be acceptable to mix foods together.<br>-She was not sure about the amount of food to put on the spoon or fork to feed a resident; she thought it should be the same bite size as for herself.<br>-She thought 15 minutes was not enough time to properly feed a resident.<br>-She had observed residents being feed by PCAs in the dining rooms during meals and did not have concerns with the feed assistance training or the feeding of residents by the PCAs. | D 312 | | |
| D 321 | 10A NCAC 13F .0906(a) Other Resident Care And Services | D 321 | | |
| | 10A NCAC 13F .0906 Other Resident Care And Services<br>(a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, | | | |

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| D 321 | Continued From page 57<br>public systems, volunteer programs, family members as well as facility vehicles.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to provide transportation back to the facility after an Emergency Department (ED) visit in a reasonable amount of time for 2 of 3 sampled residents (#1, #10) who were transported to the ED via Emergency Medical Services (EMS).<br><br>The findings are:<br>1. Review of Resident #1's current FL-2 dated 08/06/19 revealed:<br>-Diagnoses included altered mental status, chronic obstructive pulmonary disease, and dementia.<br>-Resident #1 was intermittently disoriented and ambulatory.<br><br>Review of Resident #1's record revealed:<br>-There was a hospital discharge summary for 06/28/19.<br>-There was a hospital visit on 07/10/19 for a magnetic resonance imaging (MRI) of the spine, on 07/16/19 for an echocardiogram and on 07/18/19 for right lower extremity venous study.<br>-There was a hospital discharge summary for 07/15/19, 07/29/19, 08/11/19, and 08/14/19.<br><br>Interview with Resident #1 on 08/15/19 at 9:04 am revealed:<br>-He had been sent to the hospital for his heart condition many times and a few times for falls.<br>-The staff came to pick him up unless he went out of state for a psychiatric appointment.<br>-The facility arranged for a taxi cab to bring him back to the facility for the past two visits out of state. | D 321 | Training was provided on transportation referencing requirement for transport services to and from appointments and medical facilities. on 9-12, 9-13, & 9-16-19.<br><br>A designated transport person has been assigned for each shift and noted on the daily assignment sheet to assure proper transport and pick up.<br><br>Executive Director and/or Resident Care Coordinator will follow up prior to the close of business on the status of any resident who has not returned from any medical appointment or emergency room visit. | 9/20/19<br><br>9/20/19<br><br>9/20/19 |

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| D 321 | Continued From page 58<br>-His average wait time after an emergency room visit was two hours.<br>-He felt the problem was the facility needed two vans and the one van used by the facility staff had high mileage.<br>-The van was used to take residents to appointments and pick them up after the appointment.<br>-While waiting to be picked up from the hospital, he had read books, looked at television, or read the bible until facility staff arrived.<br>-He was always hungry while waiting to be picked up.<br>-He was patient, so it did not bother him too bad to wait.<br>-When he had complaints about transportation, he told the Executive Director (ED).<br>-He told the ED staff who picked him up on 08/12/19 stopped several times to look at new trucks, and to shop for a backpack, lotion and perfume.<br><br>Telephone interview with a Social Worker (SW) at the local hospital on 08/20/19 at 9:37 am revealed:<br>-There were three incidents when Resident #1 was not picked up by the facility staff in a timely manner.<br>-On 06/28/19 at 8:00 pm, Resident #1 was seen in the emergency room (ER) and was cleared to return on 06/29/19 at 1:00 am.<br>-The facility was called by the ER nurse at 1:37 am and staff were informed Resident #1 was ready to be picked up.<br>-The facility staff called back at 1:54 am and stated they were not able to pick up the resident due to staffing.<br>-At 6:30 am, on 06/29/19, staff from the facility came to pick up Resident #1 but forgot to bring his oxygen tank. | D 321 | | |

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| D 321 | Continued From page 59<br>-The staff returned on 06/29/19 at 9:10 am and picked up Resident #1 with his oxygen tank, 8 hours after discharge.<br>-On 07/15/19, Resident #1 was discharged and staff at the facility reported at 8:43 pm someone was on the way to pick up Resident #1.<br>-At 10:24 pm staff from the facility arrived without Resident #1's oxygen tank and the nurse documented telling staff who answered the phone to bring an oxygen tank for Resident #1.<br>-The staff returned to the facility to get Resident #1's oxygen tank and came back to pick up Resident #1 on 07/16/19 at 12:17 am.<br>-On 08/11/19, Resident #1 was discharged from the hospital and the ER secretary called the facility to request transport at 7:07 pm and was told no one was available to pick up the resident by staff.<br>-A staff called back and stated they were trying to arrange transport for Resident #1.<br>-The hospital secretary called back and was hung up on twice.<br>-The hospital secretary spoke with staff at 8:42 pm and was told staff was on the way.<br>-Resident #1 was picked up at 8:58 pm with his oxygen tank. | D 321 | | |
| | Interview with the Transporter on 08/16/19 at 11:49 am revealed:<br>-She did not pick up Resident #1 after their ER visits in August 2019.<br>-She transported Resident #1 on 08/12/19 for his appointment and he asked to stop at a local retail store and restaurant.<br>-Resident #1 wanted to use the restroom and get food to eat.<br><br>Interview with a second shift Personal Care Aide (PCA) on 08/19/19 at 7:20 pm revealed:<br>-She took Resident #1's oxygen tank whenever | | | |

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| D 321 | Continued From page 60<br>she picked him up.<br>-She last picked him up on 08/14/19 and Resident #1 slept during the ride back to the facility.<br><br>Refer to the interview with the Transporter on 08/07/19 at 11:06 am.<br><br>Refer to the interview with the Care Manager CM on 08/07/19 at 4:57 pm.<br><br>Refer to the interview with the ED on 08/07/19 at 5:30 pm<br><br>Refer to interview with the Transporter on 08/16/19 at 11:49 am.<br><br>Refer to interview with a second shift PCA on 08/19/19 at 7:20 pm.<br><br>Refer to interview with the ED on 08/20/19 at 10:31 am.<br><br>2. Review of Resident #10's current FL-2 dated 06/18/19 revealed diagnoses included diabetes mellitus, gastro-esophageal reflux disease, hyperlipidemia, vitamin B12 deficiency, tremors, asthma, osteoporosis, tobacco use.<br><br>Review of Resident #10's record revealed there was a hospital discharge summary for a hospitalization on 06/20/19, 06/28/19, and 07/17/19.<br><br>Interview with Resident #9's guardian on 08/20/19 at 10:30am revealed:<br>-Resident #9 was transported by Emergency Medical Services (EMS) to the hospital.<br>-She was not aware Resident #9 had been left at the emergency department after being | D 321 | | |

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| D 321 | Continued From page 61<br>discharged for hours.<br>-She had concerns about the facility not being consistent with returning phone calls or when she went to the facility there was no staff to be found to answer questions or concerns.<br><br>Telephone interview with a Social Worker (SW) at the local hospital on 08/20/19 at 9:45 am revealed:<br>-On 08/03/19, Resident #10 was discharged from the hospital and a nurse called report to the facility staff at 9:11 pm.<br>-The staff who took report stated they would be able to provide transport for Resident #10.<br>-At 10:12 pm, staff called the hospital and stated they could not pick up the resident and he would have to stay there until morning.<br>-The ER nurse called back to the facility, informed staff it was not appropriate for him to remain in the ER overnight and gave the staff transport company names that could be used to transport the resident back to the facility.<br>-On 08/04/19 at 12:50 am staff came to pick up Resident #10.<br>-She had not spoken with anyone at the facility about the transporting of residents after discharge.<br>-Resident #10 was admitted to the local hospital on 08/08/19 and discharged on 08/13/19 to long term care.<br>-He was admitted secondary to falling at the facility but his discharge diagnosis was stroke with right sided weakness.<br><br>Refer to the interview with the Transporter on 08/07/19 at 11:06 am<br><br>Refer to the interview with the CM on 08/07/19 at 4:57 pm. | D 321 | | |

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| D 321 | Continued From page 62<br>Refer to the interview with the ED on 08/07/19 at 5:30 pm<br><br>Refer to interview with the Transporter on 08/16/19 at 11:49 am.<br><br>Refer to interview with second shift PCA on 08/19/19 at 7:20 pm.<br><br>Refer to interview with Executive Director (ED) on 08/20/19 at 10:31 am.<br><br>Interview with the Transporter on 08/07/19 at 11:06am revealed:<br>-Only staff that had extensive Department of Motor Vehicle (DMV) screening were allowed to drive the facility van.<br>-It had to be after 5pm that residents were not being picked up from the hospital because she always went to get residents that were discharged.<br>-Medication Aides (MA) were in charge of selecting a staff on second and third shift to pick residents up from the hospital.<br>-If no one was cleared on second or third shift to drive the van, the MA should contact the Care Manager (CM) or Executive Director (ED) for assistance.<br>-She had been given the task from the ED to select several staff and submit names to the home office to have DMV screening done so there would be a staff on every shift that could operate the van.<br><br>Interview with the CM on 08/07/19 at 4:57pm revealed:<br>-The staff at the facility were responsible for getting residents back to the facility after being discharged from the emergency department. | D 321 | | |

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| D 321 | Continued From page 63<br>-Only staff who had DMV screening could operate the facility vehicle.<br>-He was not aware of residents not being picked up from the emergency department after 5 pm and having to sit for hours waiting.<br>-The MA on second and third shift was in charge of assuring residents were transported back from the ED after being discharged after normal business hours and weekends.<br>-The ED had started a policy where at least one staff on each shift was cleared to drive the facility vehicle to pick residents up from the emergency department after being discharged.<br><br>Interview with the ED on 08/07/19 at 5:30pm revealed:<br>-The facility staff should pick residents up from the emergency department who were transported by EMS.<br>-If no one was available, the CM or Transporter were to be contacted to assist with getting residents back from the emergency department.<br>-She was not aware of residents being left for hours after being discharged from the emergency department.<br>-Only staff that had been cleared through the home office could drive the facility van.<br>-She had implemented a policy that allowed for at least one staff per shift to drive the facility vehicle.<br>-If a resident was not ambulatory, EMS would transport the resident back to the facility.<br>-Another option was to utilize a taxi service to pick residents up from the hospital after being discharged and bring them to the facility at no expense to the resident.<br><br>Interview with the Transporter on 08/16/19 at 11:49 am revealed:<br>-She worked from 8:00 am to 5:00 pm.<br>-During her work hours, she transported residents | D 321 | | |

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| D 321 | Continued From page 64<br><br>to appointments and picked the residents up from their appointments or after residents were released from the hospital.<br>-She did not transport residents to the hospital after injuries or accidents.<br>-The facility only had one vehicle at this time.<br>-There was a car log that she had to complete each time she drove the facility van.<br>-Staff on the evening and night shift did not have to complete the document.<br>-The facility van had a monitoring system on it so that the ED knew the location of the facility van.<br><br>Interview with a second shift Personal Care Aide (PCA) on 08/19/19 at 7:20pm revealed:<br>-She was the staff who transported residents at night from the hospital.<br>-She started transporting residents two weeks ago for second shift, 3:00pm to 11:00pm.<br>-She was approached by the ED, who asked her to complete a form and show her driver's license.<br>-She did not know who the other transporters may be and she did not ask.<br>-If the hospital called to report a resident was ready to be picked up, a MA would tell her.<br>-She would complete the task she was doing at the moment she was notified and tell the MA prior to leaving the facility.<br>-She did not complete any documentation when she picked up residents from the hospital.<br><br>Interview with the ED on 08/20/19 at 10:31am revealed:<br>-She had added more drivers to the transportation list, about two weeks ago.<br>-She added four to five drivers to the list so that there were one or two drivers on each shift.<br>-She had not spoken with anyone at the local hospital about the transport of residents after discharge. | D 321 | | |

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| D 321 | Continued From page 65<br>-She thought someone from the local hospital would have reached out to her with their concerns.<br>-She thought a reasonable wait time for residents discharged from the local hospital was 1 to 1 1/2 hours. | D 321 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to protect 1 of 1 sampled residents (#8) from exploitation, who had a diagnosis of vascular dementia, was adjudicated incompetent and resided in the special care unit (SCU), by allowing a male resident to visit her unsupervised in the resident's room resulting in a sexual encounter between the two residents.<br><br>The findings are:<br><br>Review of Resident #8's current FL-2 dated 12/28/18 revealed:<br>-Diagnoses included vascular dementia, schizoaffective disorder, hypertension, and gastroesophageal reflux disease.<br>-Recommended level of care was the Special Care Unit (SCU).<br>-Resident #8 was intermittently confused.<br>-Resident #8 required assistance with bathing | D 338 | Resident Rights training was provided by the regional ombudsman on 9-13 & 9-16-19.<br><br>Procedure establshed for any resident or visitor wishing to enter the secure care unit to include, but not limited to;<br>-Training provided on supervision of residents in common areas and rooms, authorized visitors and obligation to report on 9/12, 9/13, & 9/16.<br>-Sign in/out log reinstated for the memory care and assisted living. ED will monitor for to assure logs are in place and being utilized during daily routine rounds and observations.<br>-Employees were trained on this procedure to promote a safe and secure environment.<br>-All new employees will be trained on these procedures. | 9/17/19<br><br>9/17/19 Ongoing |

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| D 338 | Continued From page 66<br>and dressing.<br><br>Review of Resident #8's Resident Register revealed:<br>-Resident #8 was admitted on 11/02/17.<br>-Resident #8 had a guardian.<br>-Resident #8 had significant memory loss and had to be directed.<br>-The Resident Register was signed by the guardian.<br><br>Review of Resident #8's Special Care Unit Resident Profile dated 11/02/17 revealed:<br>-Resident #8 required assistance with bathing, dressing, and grooming.<br>-Resident #8 required prompting with bladder and bowel.<br>-Resident #8 was independent with eating, walking and transferring.<br><br>Review of Resident #8's Care Plan dated 12/28/18 revealed:<br>-Resident #8 required extensive assistance with bathing. hanging and retrieving clothing, and applying and removing socks and shoes.<br>-Resident #8 required limited assistance with ambulating room to room, toileting, and cutting food.<br><br>Review of Resident #8's Quarterly Review and Care Plan Update Form dated 06/25/19 revealed:<br>-Assessed changes included Resident #8 was exit-seeking; intervention included staff to monitor.<br>-Cognitive impairment was mild-moderate.<br><br>Review of Resident #8's legal documents obtained from the court revealed:<br>-The court found clear, cogent, and convincing evidence Resident #8 was incompetent. | D 338 | Employees received training on proper notifcation of leadership regarding any significant incidents including, theft, fire, to include missing resident protocol and procedure. Procedure will be reviewed in all new hire orientation.<br><br>Incidents involving inappropriate behaviors will be investigated by the Care Manager and the Executive Director. All required reporting to the proper authorities, local DSS, Guardian/POA, RP, Families, Physician or other required agencies will be completed by the Executive Director and/or designee.<br><br>Executive Director in coordination with the Resident Care Coordinator are responsible for monitoring compliance to assure the safety of the residents.<br><br>The Divisional Team will monitor resident rights and ongoing compliance to the plan set forth during site visits.<br><br>Senior Level Management including Senior Vice Presidents will monitor community and divisional team to assure sustained compliance. | 9/17/19 ongoing<br><br>9/17/19 Ongoing<br><br>9/17/19<br><br>9/17/19<br><br>9/17/19 ongoing |

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| D 338 | Continued From page 67<br>-Resident #8 was declared incompetent and her family member was named her guardian on 09/29/10.<br><br>Telephone interview with the previous Executive Director (ED) on 08/20/19 at 12:27pm revealed:<br>-The documents required when residents were admitted to the SCU included copies of guardianship paperwork, copies of all insurance cards, a medication list, and contact information.<br>-The guardian needed to be someone who had a close, familiar relationship with the resident.<br>-If a resident had a legal guardian, the resident, guardian, and Care Manager (CM) needed to be present during the admission process.<br>-Copies of the guardianship documents were filed in two places, the resident's record and the Business Office Manager (BOM's) office.<br>-She was not the ED when Resident #8 was admitted to the facility.<br>-She did not complete Resident #8's admission paperwork.<br>-Resident #8 did not have a guardian.<br>-Resident #8's family member was to be called for information regarding the resident.<br><br>Interview with a second previous ED on 08/20/19 at 12:55pm revealed:<br>-When a resident, who had a guardian, was admitted, copies of guardianship documents were placed in the resident's record and in the BOM office.<br>-The BOM followed up if guardianship documents were not provided during the admission process.<br>-She was assisted by the previous BOM when Resident #8 was admitted.<br>-The previous BOM completed the Resident Register.<br>-Resident #8's Resident Register indicated she had a guardian but guardianship documents were | D 338 | | |

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| D 338 | Continued From page 68<br>not received for Resident #8.<br>-She would not indicate on the Resident Register a resident had a guardian until the guardianship papers had been received.<br>-She knew the BOM and family had been doing a lot of faxing back and forth.<br>-The BOM was responsible for following up with document requests.<br>-Residents from AL were allowed to visit the SCU when she was the ED.<br><br>Confidential interview with a staff revealed:<br>-This staff walked into Resident #8's room and found Resident #8 and a male resident having sex.<br>-The male resident was lying on his back and Resident #8 was straddling the male resident.<br>-This staff walked out of the room and closed the door.<br>-This staff called for other staff to come and witness the sexual encounter.<br>-This staff did not know what to do, so they did not stop it.<br>-Resident #8 turned and looked at the staff and continued having sex.<br>-Several minutes later, the male resident passed the nurse's station and made inappropriate comments about the incident.<br><br>Confidential interview with a second staff revealed:<br>-Another staff called for other staff on the SCU to come to Resident #8's room.<br>-This staff witnessed Resident #8 on top of the male resident having sex.<br>-This staff closed the door.<br><br>Confidential interview with a third staff revealed:<br>-This sexual encounter happened between May 2019 and June 2019. | D 338 | | |

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|---|---|
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| D 338 | Continued From page 69<br>-The male resident went to the SCU because he had snacks to give to Resident #8.<br>-This staff did not think anything about it because the male resident always took snacks to Resident #8.<br>-This staff went looking for the male resident because he was taking too long coming back from Resident #8's room, and staff found Resident #8 and the male resident having sex.<br>-By the time other staff went to witness the sexual encounter, the male resident was coming out of the room.<br>-The male resident went back to the AL side and Resident #8 came out of her room, got a towel and bath cloth, and took a shower.<br>-It happened after 5:00pm because the ED and the CM were notified the next day of the incident.<br>-The ED stated, "staff were not supposed to let it happen."<br><br>Confidential interview with a fourth staff revealed:<br>-The male resident used to always visit Resident #8 and took her snacks.<br>-Most of the time staff would take the male resident to SCU to take snacks, but some staff would let the male resident go to the SCU and "did not pay him any mind."<br>-Some staff said the male resident could go to the SCU, and some staff said he could not.<br>-This staff did not let the male resident go into the SCU alone because they knew the male resident was "fresh."<br>-This staff thought since Resident #8 was on the SCU and the male resident on the AL, the male resident took advantage of Resident #8.<br><br>Confidential interview with a fifth staff revealed:<br>-A personal care aide (PCA) was laughing and joking about the sexual encounter on the SCU unit during the residents' lunch. | D 338 | | |

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| D 338 | Continued From page 70<br>-The male resident and Resident #8 were caught having sex.<br>-This staff could not believe Resident #8 would do "anything like that."<br>-The ED stated, "the incident that happened was consensual between two residents".<br><br>Telephone interview with Resident #8's guardian on 08/15/19 at 3:59pm revealed:<br>-Resident #8's ability to "think for herself" was impaired.<br>-She had not been notified by the facility staff of any incidents related to Resident #8.<br>-She was Resident #8's legal guardian.<br><br>Interview with the male resident on 08/15/19 at 3:30pm revealed:<br>-Staff brought Resident #8 over to his room to visit.<br>-Staff did not remain in the room during Resident #8 visits; they waited in the hallway.<br>-Resident #8 visited him on the AL at least three times in the past year.<br>-He used to be allowed to go unsupervised into the SCU, but he was stopped about a week and a half ago; he was told by the ED he must be escorted when he went to the SCU.<br>-The ED told him he could not go back into the SCU because the residents were in memory care.<br>-Resident #8's room was passed the nurse's station.<br>-Staff had been seated at the nurse's station when he went to Resident #8's room.<br>-Three staff watched he and Resident #8 engaging in sex.<br>-One at a time three different staff opened the door to Resident #8's room and looked into the room while he and Resident #8 were engaged in intercourse; one staff asked; "What are y 'all doing?". | D 338 | | |

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| D 338 | Continued From page 71<br>- "They (the staff) were having fun with what we were doing."<br>-The sexual encounter lasted for twenty minutes.<br>-The three staff laughed and joked with him about getting an erection with Resident #8.<br>-The sexual encounter was his first time having sex with anyone at the facility.<br>-Staff were in the hallway outside of Resident #8's room and were talking about the encounter when he came out of her room.<br>-The ED asked him if he had sex with Resident #8 and if the sex with Resident #8 from the SCU was consensual; he told her "yes" because Resident #8 asked him to have sex with her.<br>-The ED told him the encounter was a mistake and it could not happen again.<br>-He did not know if Resident #8 was happy or sad.<br>-He would not name the staff that encouraged him to have a relationship with Resident #8 and he would not name the three staff that opened the door while he was in Resident #8's room.<br>-He did not think anything "was wrong with it" but staff told him it was wrong because it was memory care; he realized that he could not do that anymore.<br><br>Second interview with the male resident on 08/16/19 at 10:55am revealed:<br>-He thought Resident #8 was in the SCU because of her mental health; something was wrong with her "upstairs".<br>-He knew Resident #8's mental state was not right because she would constantly get up and sit back down, walk over to the door or speak out and interrupt activities.<br>-He was not sure if the staff wanted Resident #8 to be his girlfriend, but they would tell him they would make a "good couple".<br>-A [named] staff told him there was nothing wrong | D 338 | | |

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| D 338 | Continued From page 72<br><br>with Resident #8 being his girlfriend because they would make a good couple; the same staff told him it was okay to have sex with Resident #8.<br>-He told the staff he did not want to be Resident #8's boyfriend and he did not want to be with Resident #8 sexually but the staff did not listen to him.<br>-Resident #8 would remember who he was when she saw him and would say hello to him by name.<br>-He gave the ED and the CM the names of the staff who peaked in on him and Resident #8 on 08/15/19.<br><br>Interview with Resident #8 on 08/15/19 at 5:05pm revealed:<br>-A male resident used to come visit her in her room, but now "I don't see him anymore."<br>-She engaged in sexual intercourse with the male resident one time (date unknown) and it was "an abomination to God."<br>-As a result of the sexual incident, the male resident could not come to her room.<br>-Staff knew; staff saw, "but they went the other way."<br>-She did not know who had seen her and the male resident engaging in sexual intercourse.<br>-No staff had talked to her about the incident.<br><br>Second interview with Resident #8 on 08/16/19 at 11:18am revealed:<br>-She did not know the male resident before she was admitted to the facility.<br>-Staff had taken her to the male resident's room three times, but she did not know when.<br>-She could not identify the staff who had taken her to the male resident's room.<br>-He walked to her room on his own.<br>-"I don't like him [the male resident]. He ain't [sic] my friend." | D 338 | | |

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| D 338 | Continued From page 73<br><br>Interview with a PCA on 08/19/19 at 7:25pm revealed:<br>-Resident #8 was on 15-minute checks for elopement precautions.<br>-AL residents could not go into the SCU; the SCU and the AL residents got together for scheduled activities only.<br>-Resident #8 was friends with the male resident on the AL unit.<br>-The male resident was friendly and talked with staff while he was getting his medication.<br>-Resident #8 and the male resident sat together and talked at church.<br>-In July 2019, while talking with three staff, she learned that Resident #8 and the male resident had engaged in sexual intercourse.<br>-She did not know the date of the incident, but knew she did not work that night.<br>-Management did not provide training about sexual activity between residents; she was told to "let them finish" if she witnessed sexual activity between residents, but could not recall who told her this.<br><br>Interview with a second PCA on 08/19/19 at 8:48pm revealed:<br>-The ED, BOM, CM, and Activity Director told her residents from AL could not come into SCU (date unknown).<br>-She had not seen AL residents trying to come onto the SCU.<br>-She had not seen the male resident in the SCU.<br>-She had not taken Resident #8 to the AL unit.<br>-While she was in training, another PCA told her residents were not allowed to have sex, but she was not told how to respond if she saw residents having sex.<br>-She would get a manager or Medication Aide (MA) if she saw residents having sex. | D 338 | | |

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| D 338 | Continued From page 74<br><br>Interview with a third PCA on 08/15/19 at 5:43pm revealed:<br>-She would stop any witnessed inappropriate encounter between residents.<br>-Resident #8 was "in and out".<br>-Resident #8's long term memory was good but short-term memory was not good.<br>-Resident #8 tried to escape by telling staff "I want to go out".<br><br>Interview with the Licensed Health Professional Support (LHPS) Nurse on 08/15/19 at 6:30pm revealed:<br>-Resident #8's cognitive ability "comes and goes" and was hard to pinpoint.<br>-Resident #8 appeared "dazed" at times and at other times could answer questions appropriately.<br>-In mid-July, 2019, a Dietary Aide (DA), whose name she did not know, asked her if the male resident could keep going into the SCU.<br>-The DA informed her that Resident #8 had engaged in sexual intercourse with the male resident.<br>-She did not know the date the incident occurred.<br>-She "immediately" reported this information to the ED.<br>-After she spoke with the ED, she told the CM about the incident.<br>-After she reported the incident, she "trusted it was being handled."<br>-Her understanding of the policy regarding sexual intercourse between residents was if the residents were competent to make decisions, "they could have privacy to have relations."<br><br>Telephone interview with the DA on 07/19/19 at 9:10pm revealed:<br>-Several staff were talking about the incident between Resident #8 and the male resident.<br>-The staff were laughing and said, "the male | D 338 | | |

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| D 338 | Continued From page 75<br>resident could have done more but he would have had a heart attack."<br>-It really bothered her that a resident in the SCU had sex with a resident in the AL.<br>-She was concerned because Resident #8 was "childlike" and at times did not even know where she was.<br><br>Telephone interview with a PCA on 08/20/19 at 9:26am revealed:<br>-She worked in both the SCU and the AL.<br>-The residents in the SCU required more attention because they were incontinent, and some of the residents needed assistance when transferring.<br>-Residents in the SCU had to be monitored more often than the AL residents; the SCU residents were checked every hour.<br>-The residents in the SCU were behind locked doors to keep them from going out of the building alone and getting hurt; one resident talked about going to a bridge, so she had to be in the SCU to protect her.<br>-Sometimes Resident #8 was in her right mind and sometimes she was not.<br>-She saw Resident #8 and the male resident talking but had never seen them hold hands, sitting together or kissing.<br>-She never asked Resident #8 if she and the male resident were boyfriend and girlfriend.<br>-She was told by the ED it was okay for residents to have sex because residents had rights.<br>-She never told any residents it was okay to have sex.<br>-After Resident #8 and the male resident had the sexual encounter, the ED and the CM told the staff the residents "did not need to be having sex with each other".<br>-A nurse came to the facility and taught the staff "about dementia and residents do not have the | D 338 | | |

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| D 338 | Continued From page 76<br>right to have sex"; she could not remember when this was.<br><br>Interview with a MA on 08/15/19 at 6:30pm revealed:<br>-She had not been trained what to do if she encountered two residents engaging in sexual activity; she would close the door and give the residents privacy.<br>-The male resident was the only resident she knew who visited the SCU from the AL.<br>-She would not have expected or imagined that kind of behavior from Resident #8 because she had never heard Resident #8 speak of sex and she had never seen Resident #8 flirt with anyone.<br><br>Second telephone interview with the guardian for Resident #8 on 08/20/19 at 12:45pm revealed:<br>-A county staff had notified her of the incident between Resident #8 and a male resident on 08/20/19.<br>-The facility staff had not notified her of the incident between Resident #8 and the male resident.<br>-She did not think Resident #8 could have made that kind of decision.<br>-Before this incident she had peace of mind knowing Resident #8 was safe and protected.<br>-She thought Resident #8 would be as well taken care of in the facility as she would have been at home.<br>-She had lost her sense of confidence.<br>-She was hoping something would be learned from this incident that would protect Resident #8 and other residents from this "ever happening again."<br><br>Telephone interview on 08/19/19 at 8:55am with the physician who signed Resident #8's FL-2 dated 12/28/18 revealed: | D 338 | | |

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| D 338 | Continued From page 77<br><br>-Resident #8 used very poor judgment.<br>-Resident #8 could not make the decision to have sex.<br>-Resident #8 having sex with a resident from the assisted living (AL) was "significantly alarming."<br><br>Telephone interview with the Registered Nurse (RN) for Resident #8's mental health provider (MHP) on 08/19/19 at 1:07pm revealed:<br>-The RN was not aware of the incident that occurred between Resident #8 and a male resident.<br>-She thought based on Resident #8's diagnoses of vascular dementia and paranoid schizophrenia, her decision making would be questionable.<br>-Overall, Resident #8 was not a happy person, based on the RN's history of providing services to the resident, and found it difficult to believe Resident #8 would have agreed to have sex.<br>-The RN could not understand how this incident could have occurred when Resident #8 was supposed to be living in a locked unit.<br>-The RN believed the incident happening was unacceptable and would have expected to have been notified by staff. | D 338 | | |
| | Interview with the CM on 08/15/19 at 5:11pm revealed:<br>-"Residents have the right to have sex".<br>-If a resident was incompetent, they would reach out to the guardian.<br>-If a resident from the SCU went to the AL, they were supervised.<br>-If a resident from AL went to the SCU, the AL resident was not supervised; the AL resident could visit anywhere in the SCU, including a resident's room.<br>-If a resident from AL wanted to visit in the SCU, he would assess why the resident wanted to visit, such as if they had a previous relationship such | | | |

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| D 338 | Continued From page 78<br><br>as roommates or knew each other.<br>-He had verbally told staff residents from AL could visit residents in the SCU if they knew someone in the SCU.<br>-Someone told him two residents had sexual contact; he did not remember who told him or when.<br>-He reached out to the county representative to see what he needed to do as far as contacting Resident #8's family and physician.<br>-The county representative told him to verify with the Primary Care Provider (PCP) Resident #8 was competent, and if so, the family did not need to be contacted.<br>-The county representative told him the facility staff could not stop an AL resident from visiting a resident in the SCU; the residents had the right to have visitors.<br>-Resident #8's PCP told the CM Resident #8 was competent to make the decision to have sex.<br><br>Interview with the ED on 08/15/19 at 6:04pm revealed:<br>-The facility did not have a policy related to residents having sexual contact with each other; "they had that right."<br>-If a resident had a guardian, they would reach out to the guardian for permission; if the guardian said "no" they would not allow sex to happen.<br>-Staff knew having sex was a resident's right.<br>-Some of the staff thought if a resident was in the SCU, they could not have sex.<br>-If a resident in the SCU was competent and able to make that decision, they could.<br>-A resident would be assessed by the PCP to determine if they were competent to make that decision.<br>-She talked to the county representative about the incident; the county representative said as long as the resident was competent, Resident #8 | D 338 | | |

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| D 338 | Continued From page 79<br>could make that decision for herself.<br>-The county representative directed her to contact Resident #8's PCP and if he was okay with Resident #8 making that decision, it was considered consent.<br>-Resident #8's PCP gave verbal approval Resident #8 could make the decision to have sex.<br>-She did not recall if she had reached out to Resident #8's MHP.<br>-She did not know why Resident #8 was in the SCU.<br>-She knew to be in the SCU a resident had to have a diagnosis of dementia.<br>-Dementia could affect one's cognitive ability.<br>-When she found out about the incident (the LHPS nurse reported the incident to her) she wanted to make sure staff knew it was not rape; it was consensual.<br><br>The facility failed to protect 1 of 1 sampled residents (#8) who had been declared incompetent and was left unsupervised with a male resident; the male resident had sex with Resident #8 while in the Special Care Unit (SCU); staff witnessed and mocked the residents after the sexual encounter occurred , laughed with other staff about the sexual encounter and did not stop the residents from having sex. The facility's failure resulted in serious neglect to Resident #8 and constitutes an Type A2 Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/15/19 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2019. | D 338 | | |

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| D 358 | Continued From page 80 | D 358 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures. | D 358 | | |
| | This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE B VIOLATION.<br><br>Based on these findings, the previous Type B Violation was not abated.<br><br>Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents observed during the medication pass including an error with eye drops (#6); and 3 of 8 residents sampled for record review (#3, #4, #5) including errors with an antihypertensive medication, a blood thinner and a stool softener (#3); a pain medication (#4); a blood pressure medication and a medication used to treat anemia (#5). | | Medication adies received training on the six rights of medication administration, medication ordering process and order processing system on 8-14-19 by registered nurse. 9/17/19<br><br>Medication aides received training on medication cart audit process, order processing system, and medication administration system on 8/29/19. Training provided by the Resident Care Coordinator. 9/17/19<br><br>All medication aides were recredentialed using the medication skills validation form by a Registered Nurse. 9/17/19 | |

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| D 358 | Continued From page 81<br><br>The findings are:<br><br>1. The medication pass error rate was 6.8% (percent) as evidenced by the observation of 2 errors of 29 opportunities during the 8:00 am medication passes on 08/14/19 and 08/15/19.<br><br>Review of Resident #6's current FL-2 dated 07/09/19 revealed diagnoses included vascular dementia, alcohol abuse, type 2 diabetes, major depression disorder.<br><br>Review of Resident #6's eye surgeon orders dated 07/18/19 revealed:<br>-Resident #6's surgery date was 08/08/19.<br>-There was a medication order for Ketorolac 0.5% (used to decrease inflammation and pain) one drop in the right eye four times daily for four weeks after surgery.<br>-There was a medication order for ciprofloxacin 0.3% (used to treat infection) one drop in the right eye four times daily for seven days after surgery.<br>-There was a medication order for prednisolone 1% (used to treat inflammatory conditions) one drop in the right eye four times daily for seven days; then three times daily for seven days; then twice daily for seven days; then once daily for seven days; then stop.<br><br>Review of "Before Cataract Surgery Instructions" from the eye surgeon revealed there were instructions to wait at least five minutes between two different drops.<br><br>Review of "After Cataract Surgery Instructions" from the eye surgeon revealed there were instructions at the top of the sheet to continue the drops used before surgery. | D 358 | Medication pass observations will be conducted weekly by a Registered Nurse or qualified designee for 4 weeks, then monthly for 2 months, then quarterly thereafter. 9/17/19<br><br>Medication cart audits will be conducted weekly and reviewed by the care manager to assure compliance. 9/17/19<br><br>Medication order processing system and medication compliance will be reviewed by the Executive Director at stand up meetings in coordination with the Resident Care Coordinator to assure medications are available and administered as ordered. 9/17/19<br><br>Divisional Teams will review process to assure compliance with the Executive Director during site visits. 9/17/19<br><br>Senior Management Personnel to include Senior Vice Presidents will review medication administration process and procedures during site visits and review compliance with Executive Director. 9/17/19 | |

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| D 358 | Continued From page 82<br><br>Observation of the medication pass on 08/14/19 at 8:00 am revealed:<br>-The Medication Aide (MA) gathered her supplies, gloves, tissue, and three eyes drop bottles for Resident #6.<br>-Resident #6 was sitting on a couch in his room.<br>-The MA washed her hands, placed the gloves on her hands, and requested the resident lean his head back.<br>-Resident #6 received one drop of prednisolone 1% in the right eye at 8:09 am.<br>-Resident #6 received one drop of ciprofloxacin 0.3% in the right eye at 8:10 am.<br>-Resident #6 received one drop of Ketorolac 0.5 % in the right eye at 8:12 am.<br>-The MA did not wait five minutes between each eye drop before administering the next one.<br><br>Review of Resident #6's August 2019 electronic medication administration record (eMAR) revealed:<br>-There was an entry for ciprofloxacin 0.3% ophthalmic drops instill one drop four times daily after surgery, scheduled for 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm.<br>-There were no instructions to wait five minutes when administering more than one eye drop.<br>-There was an entry for Ketorolac 0.5% ophthalmic drops instill one drop in right eye four times daily for four weeks after surgery, scheduled for 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm.<br>-There were no instructions to wait five minutes when administering more than one eye drop.<br>-There was an entry for prednisolone 1% ophthalmic drops instill one drop in the right eye four times daily for seven days after surgery, scheduled for 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm.<br>-There were no instructions to wait five minutes | D 358 | | |

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| D 358 | Continued From page 83<br>when administering more than one eye drop.<br>-There was an entry for prednisolone 1% ophthalmic drops instill one drop in right eye four times daily, scheduled for 9:00 am, 1:00 pm, 5:00 pm and 9:00 pm.<br>-There was no intructions to wait five minutes when administering more than one eye drop.<br><br>Interview with Resident #6 on 08/15/19 at 3:29 pm revealed:<br>-He had cataract removal surgery on the right eye one week ago, 08/08/19.<br>-He saw the eye surgeon the day after surgery, 08/09/19.<br>-When he came back from the eye appointment on 08/09/19 his eye drops had arrived at the facility.<br><br>Interview with a representative from Resident #6's eye surgeon's office on 08/20/19 at 8:51 am revealed:<br>-Resident #6 cataract removal was on 08/08/19 on the right eye and he was seen by the eye surgeon the day after surgery on 08/09/19.<br>-Resident #6 had three eye drops ordered post-operatively, prednisolone 1%, ciprofloxacin 0.3%, and Ketorolac 0.5%.<br>-The office staff provide a detailed post-operative instruction sheet that includes instructions for administering the eye drops.<br>-The instructions included waiting five minutes if administering more than one eye drop.<br>-The effect of not waiting five minutes between eye drops was that it washed away the eye drop administered prior to the next one.<br>-Another effect of not waiting five minutes between eye drops was that the benefits of the medication such as anti-inflammation, less pain and infection prevention would be decreased. | D 358 | | |

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| D 358 | Continued From page 84<br><br>Interview with medication aide (MA) who administered Resident #6's eye drops during the medication pass observation on 08/14/19 at 10:35 am revealed:<br>-When she administered eye drops, she first washed her hands, gathered her supplies (which were the medication, gloves, and tissues), told the resident what medication she needed to administer, placed the gloves on, positioned the resident so that their head was leaned back, pulled down the lower eye lid and placed one drop in the eye.<br>-She waited 3 to 5 minutes if she gave more than one eye drop.<br>-She knew she did not wait the 3 to 5 minutes when she administered Resident #6 eye drops.<br>-She was not prepared on 08/14/19 because she left her watch at home and did not think to use the clock on her phone.<br>-The CM did not tell her about the surgical instructions to wait five minutes between each eye drop, she knew already that she should wait that length of time between each eye drop.<br>-She was also observed by the Licensed Health Professional Support nurse administering oral, topical, and eye drop medications on five occasions since starting at the facility three months ago.<br><br>Interview with the Care Manager (CM) on 08/16/19 at 8:36 am revealed:<br>-He was responsible for reviewing the post-operative order and told MAs about any specific orders for residents after surgery.<br>-The MA who administered the eye drops to Resident #6 had received training from the LHPS nurse in July 2019.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:00 am revealed: | D 358 | | |

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| D 358 | Continued From page 85<br>-The CM was responsible for medication administration and reported any medication administration problems to her at the stand-up meetings or throughout the day.<br>-The employee involved with the medication error was counseled by the CM.<br>-She was made aware by staff of Resident #6's eye drops given within the wrong intervals of each other.<br>-She expected the CM to know the post-operative orders and medication instructions.<br>-She expected the CM to share the post-operative information with staff and ensure any special instructions were placed in the computer system under the resident's profile.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the the interview with the Care Manager (CM) on 08/15/19 at 8:36am and 12:13pm.<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br>2. Review of Resident #3's current FL-2 dated 03/16/19 revealed diagnoses included vascular dementia, hypertension, diabetes, gastro-esophageal reflux disease (GERD), irritable bowel syndrome with constipation, seizures, and hypothyroid.<br><br>Review of a hospice comprehensive assessment | D 358 | | |

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| D 358 | Continued From page 86<br>and plan of care revealed Resident #3 was admitted to hospice services on 02/22/19.<br><br>a. Review of Resident #3's physician's orders dated 03/16/19 revealed an order for Clonidine HCL 0.1mg take one tablet twice daily. (Clonidine is used to treat high blood pressure).<br><br>Review of a Physician's order dated 04/10/19 revealed an order to increase Resident #3's Clonidine to 0.2mg twice daily.<br><br>Review of Resident #3's June 2019, July 2019, and August 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an order to check Resident #8's blood pressure weekly.<br>-Resident #3's blood pressure ranged from 122/78-174/98.<br><br>Review of Resident #3's June 2019, July 2019, and August 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Clonidine 0.2mg twice daily with scheduled administration times as 8:00am and 8:00pm.<br>-Clonidine was documented as unavailable on 06/17/18 at 8:00pm.<br>-Thirty-five doses of Clonidine were documented as administered from 06/18/19 at 8:00am through 07/05/19 at 8:00pm; it was documented as unavailable for administration on 07/05/19 at 8:00am.<br>-Clonidine was documented as unavailable for administration on 07/06/19 at 8:00am and 8:00pm.<br>-Thirty-four doses of Clonidine were documented as administered from 07/07/19 at 8:00am through 07/23/19 at 8:00pm.<br>-Resident #3 missed 15 doses of Clonidine out of | D 358 | | |

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| D 358 | Continued From page 87<br>75 opportunities.<br><br>Observation of Resident #3's medications on hand on 08/14/19 at 10:07am revealed:<br>-There was a bubble pack of thirty Clonidine 0.2mg dispensed on 08/09/19.<br>-Nine tablets had been administered; twenty-one tablets were available to be administered.<br><br>Review of pharmacy dispensing records for Resident #3's Clonidine revealed:<br>-Thirty tablets were dispensed on 06/17/19.<br>-Thirty tablets were dispensed on 07/06/19.<br>-Thirty tablets were dispensed on 07/24/19 and 08/09/19.<br><br>Interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am revealed:<br>-Medications were filled on a monthly cycle except hospice patients.<br>-Hospice patients medications had to be requested; the medications were filled for a 15-day supply.<br>-The facility staff would need to request a refill either in the eMAR system electronically or pull the sticker off the medication and fax the refill request to the pharmacy.<br>-If the refill request came in before noon it would be sent out to the facility the same day; after noon it would go out the next day.<br><br>Interview with Resident #3's hospice nurse on 08/15/19 at 9:30am revealed:<br>-She was concerned Resident #3 had missed doses of Clonidine because he was at risk of having a stroke.<br>-She knew one of the other hospice nurses had made an unscheduled visit because they had been called when Resident #3's blood pressure | D 358 | | |

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| D 358 | Continued From page 88<br><br>was high.<br>-The other hospice nurse asked if Resident #3 had taken his blood pressure medication and it had not been administered because it was not available. (She was not sure of the date or which medication.).<br>-She knew Resident #3 had an incident where his blood pressure was high and emergency medical services (EMS) were called out; Resident #3 was not transported to the hospital.<br><br>Review of EMS report dated 07/08/19 revealed:<br>-EMS was called to the facility for Resident #3 for possible stroke.<br>-Vitals were obtained and Resident #3 was assessed; Resident #3's blood pressure was 149/81.<br>-Resident #3 improved during the assessment and was not transported.<br><br>Review of Resident #3's care note dated 07/08/19 revealed:<br>-At 7:00am the hospice nurse was called due to Resident #3 experiencing stroke like symptoms.<br>-EMS was called and when EMS arrived Resident #3 had become more alert.<br>-There were no documented vitals.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed:<br>-She did not recall Resident #3 missing doses of Clonidine.<br>-When she was administering medication, she pulled all of Resident #3's medications out of the medication cart.<br>-She then went down the list, found the tablet, popped it out, hit "prep" on the eMAR and went to the next medication.<br>-Once all of Resident #3's medication had been administered she would be able to sign off at one | D 358 | | |

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| D 358 | Continued From page 89<br>time on all the medication that had been "prepped."<br>-She would not document a medication had been "prepped" if the medication was not available.<br>-She would never "prep" a tablet if the tablet was not available.<br>-She did not know why her initials were documented as administering a medication when it was not available.<br><br>Telephone interview with Resident #3's primary care provider (PCP) on 08/16/19 at 11:23am revealed:<br>-Clonidine was ordered for Resident #3 due to blood pressure concerns.<br>-He had increased Resident #3's Clonidine about a month ago because Resident #3's blood pressure was not controlled.<br>-He expected Resident #3's Clonidine to be administered as ordered because it was a preventive medication for blood pressure and if it was not administered correctly Resident #3's blood pressure would increase.<br>-Resident #3 was at risk of having a stroke if his blood pressure medication was not administered as ordered.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed:<br>-He was aware Resident #3 had missed doses of Clonidine; he recalled it was on a Saturday.<br>-He reached out to Resident #3's hospice nurse because the prescription did not have refills.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed she was not aware Resident #3's Clonidine was not administered as ordered.<br><br>Based on observations, interview and record | D 358 | | |

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| D 358 | Continued From page 90<br>review, Resident #6 was not interviewable.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the the interview with the Care Manager (CM) on 08/15/19 at 8:36am.<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br><br>b. Review of Physician's order dated 05/02/19 revealed an order to discontinue Resident #3's Docusate Sodium and start Senna one tablet twice daily. (Senna is a laxative.).<br><br>Review of Resident #3's June 2019, July 2019, and August 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Senna 8.6mg twice daily with scheduled administration times as 8:00am and 8:00pm.<br>-Senna was documented as unavailable on 06/17/19 at 8:00pm and 06/18/19 at 8:00am.<br>-Seventy-nine doses of Senna were documented as administered from 06/18/19 at 8:00pm through 07/27/19 at 8:00pm.<br>-Thirty-four doses of Senna were documented as administered from 07/28/19 at 8:00am through 08/13/19 at 8:00pm.<br>-Resident #3 missed 51 doses of Senna out of 82 opportunities. | D 358 | | |

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| D 358 | Continued From page 91<br><br>Review of pharmacy dispensing records for Resident #3's Senna revealed:<br>-Thirty tablets were dispensed on 06/17/19.<br>-Thirty tablets were dispensed on 07/28/19.<br>-Thirty tablets were dispensed on 08/09/19.<br>-There were no other dispensing records for Senna for July 2019.<br><br>Observation of Resident #3's medications on hand on 08/14/19 at 10:07am revealed:<br>-There was a bubble pack of thirty Senna dispensed on 05/02/19; twenty-nine tablets had been administered; one tablet was available to be administered.<br>-There was a second bubble pack of thirty Senna dispensed on 07/28/19; twelve tablets were available to be administered.<br>-There was a third bubble pack of thirty Senna dispensed on 08/09/19; thirty tablets were available to be administered.<br><br>Interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am revealed:<br>-Medications were filled on a monthly cycle except hospice patients.<br>-Hospice patients medications had to be requested; the medications were filled for a 15-day supply.<br>-The facility staff would need to request a refill either in the eMAR system electronically or pull the sticker off the medication and fax the refill request to the pharmacy.<br>-If the refill request came in before noon it would be sent out to the facility the same day; after noon it would go out the next day.<br><br>Interview with Resident #3's hospice nurse on 08/15/19 at 9:30am revealed: | D 358 | | |

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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 |
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| D 358 | Continued From page 92<br>-She was concerned Resident #3 had missed doses of Senna because he had a history of constipation.<br>-Resident #3's Senna was changed from as needed (prn) to scheduled, because constipation had been a problem.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed:<br>-She did not recall Resident #3 missing doses of Senna.<br>-Resident #3 had not had any problems with constipation.<br>-She did not know why her initials were documented as administering a medication when it was not available.<br><br>Telephone interview with the primary care provider (PCP) on 08/16/19 at 11:23am revealed:<br>-Senna was ordered for Resident #3 due to a history of constipation.<br>-Resident #3 was at end-of-life and was not moving around a lot which increased his risk of constipation.<br>-Resident #3 was not able to tell anyone if he experienced discomfort related to constipation.<br>-Senna was necessary to promote bowel movements.<br>-He expected Senna to be administered as ordered.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed he was not aware Resident #3's Senna was not administered as ordered.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed she was not aware Resident #3's Senna was not administered as ordered. | D 358 | | |

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| D 358 | Continued From page 93<br><br>Based on observations, interview and record review, Resident #6 was not interviewable.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the interview with the Care Manager (CM) on 08/15/19 at 8:36am.<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br><br>c. Review of Resident #3's physician's orders dated 03/16/19 revealed an order for Hydralazine HCL 50mg take one tablet twice a day. (Hydralazine is used to treat high blood pressure.).<br><br>Review of Physician's order dated 04/22/19 revealed an order to increase Resident #3's Hydralazine 50mg to three times daily.<br><br>Review of Resident #3's June 2019, July 2019, and August 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an order to check Resident #8's blood pressure weekly.<br>-Resident #3's blood pressure ranged from 122/78-174/98.<br><br>Review of Resident #3's June 2019 and July | D 358 | | |

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| D 358 | Continued From page 94<br><br>2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Hydralazine 50mg three times daily with scheduled administration time as 8:00am, 2:00pm, and 8:00pm.<br>-Hydralazine was documented as unavailable on 06/17/29 at 8:00pm and 2:00pm.<br>-Fifty-two doses of Hydralazine were documented as administered from 06/17/19 at 8:00pm and 07/04/19 at 8:00pm.<br>-Hydralazine was documented as unavailable 07/08/19 at 8:00am and 2:00pm.<br>-Five-five doses of Hydralazine were documented as administered from 07/08/19-07/26/19 at 8:00pm.<br>-Hydralazine was documented as unavailable 07/27/19 at 8:00pm.<br>-Fifty-one doses of Hydralazine were documented as administered on 07/28/19 at 8:00am through 08/13/19 at 8:00pm.<br>-Resident #3 missed 39 doses of Hydralazine out of 171 opportunities.<br><br>Review of pharmacy dispensing records for Resident #3's Hydralazine revealed:<br>-Forty-five tablets were dispensed on 06/17/19.<br>-Forty-five tablets were dispensed on 07/08/19.<br>-Forty-five tablets were dispensed on 07/27/19.<br>-Forty-five tablets were dispensed on 08/14/19.<br><br>Observation of Resident #3's medications on hand on 08/14/19 at 10:07am revealed there was a bubble pack of thirty Hydralazine dispensed on 08/14/19; thirty tablets were available to be administered.<br><br>Interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am revealed: | D 358 | | |

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| D 358 | Continued From page 95<br><br>-Medications were filled on a monthly cycle except hospice patients.<br>-Hospice patients medications had to be requested; the medications were filled for a 15-day supply.<br>-The facility staff would need to request a refill either in the eMAR system electronically or pull the sticker off the medication and fax the refill request to the pharmacy.<br>-If the refill request came in before noon it would be sent out to the facility the same day; after noon it would go out the next day.<br><br>Review of EMS report dated 07/08/19 revealed:<br>-EMS was called to the facility for Resident #3 for possible stroke.<br>-Vitals were obtained and Resident #3 was assessed; Resident #3's blood pressure was 149/81.<br>-Resident #3 improved during the assessment and was not transported.<br><br>Review of Resident #3's care note dated 07/08/19 revealed:<br>-At 7:00am the hospice nurse was called due to Resident #3 experiencing stroke like symptoms.<br>-EMS was called and when EMS arrived Resident #3 had become more alert.<br>-There were no documented vitals.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed:<br>-She did not recall Resident #3 missing doses of Hydralazine.<br>-She did not know why her initials were documented as administering a medication when it was not available.<br><br>Telephone interview with Resident #3's primary care provider (PCP) on 08/16/19 at 11:23am | D 358 | | |

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| D 358 | Continued From page 96<br>revealed:<br>-Hydralazine was ordered for Resident #3 due to blood pressure concerns.<br>-He had increased Resident #3's Hydralazine because Resident #3's blood pressure was not controlled.<br>-He expected Resident #3's Hydralazine to be administered as ordered because it was a preventive medication for blood pressure and if it was not administered correctly Resident #3's blood pressure would increase.<br>-Resident #3 was at risk of having a stroke if his blood pressure medication was not administered as ordered.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed:<br>-He knew Resident #3 had missed doses of Hydralazine.<br>-He recalled talking to Resident #3's hospice nurse about getting the medication reordered.<br>-He did not recall when he had talked to Resident #3's hospice nurse.<br>-He had physician's orders resigned on all the residents, so the pharmacy was able to refill medication as needed.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed she was not aware Resident #3's Hydralazine was not administered as ordered.<br><br>Based on observations, interview and record review, Resident #6 was not interviewable.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with the pharmacy | D 358 | | |

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| D 358 | Continued From page 97<br>consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the interview with the Care Manager (CM) on 08/15/19 at 8:36am.<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br><br>d. Review of Resident #3's physician's orders dated 03/16/19 revealed an order for Aspirin 81mg take one tablet daily. (Aspirin is used as a blood thinner.).<br><br>Review of Resident #3's July 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Aspirin 81mg daily with scheduled administration time as 8:00am.<br>-Aspirin was documented as unavailable on 07/05/19, 07/06/19, 07/13/19-07/25/19.<br>-Aspirin was documented as administered on 07/07/19-07/12/19.<br>-Resident #3 missed 21 doses of Aspirin out of 31 opportunities.<br><br>Review of dispensing records for Resident #3's Aspirin revealed:<br>-Fifteen tablets were dispensed on 06/04/19.<br>-Fifteen tablets were dispensed on 06/17/19<br>-Fifteen tablets were dispensed on 07/25/19.<br>-Fifteen tablets were dispensed on 08/09/19.<br>-There were no other dispensing records for Aspirin for July 2019.<br><br>Observation of Resident #3's medications on | D 358 | | |

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| D 358 | Continued From page 98<br><br>hand on 08/14/19 at 10:07am revealed there was a bubble pack of fifteen Aspirin dispensed on 08/09/19; eleven tablets were available to be administered.<br><br>Interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am revealed:<br>-Medications were filled on a monthly cycle except hospice patients.<br>-Hospice patients medications had to be requested; the medications were filled for a 15-day supply.<br>-The facility staff would need to request a refill either in the eMAR system electronically or pull the sticker off the medication and fax the refill request to the pharmacy.<br>-If the refill request came in before noon it would be sent out to the facility the same day; after noon it would go out the next day.<br><br>Interview with Resident #3's hospice nurse on 08/15/19 at 9:30am revealed she was concerned Resident #3 had missed doses of Aspirin because he was at risk of having a stroke.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed:<br>-Resident #3 had missed taking Aspirin "it had been a while, though."<br>-She did not recall why Aspirin was not refilled.<br><br>Telephone interview with Resident #3's primary care provider (PCP) on 08/16/19 at 11:23am revealed:<br>-Resident #3 had a history of heart failure.<br>-Aspirin was ordered for Resident #3 as a preventive medication.<br>-He expected Resident #3's Aspirin to be administered as ordered because it was a | D 358 | | |

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| D 358 | Continued From page 99<br>preventive medication and Resident #3 was at risk of having a heart attack.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed:<br>-He was aware Resident #3 missed doses of Aspirin.<br>-He thought the missed doses of Aspirin were because there were no refills.<br>-He had physician's orders resigned on all the residents, so the pharmacy was able to refill medication as needed.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed:<br>-She was aware Resident #3's Aspirin was not administered as ordered.<br>-She did not know how long Resident #3's Aspirin was not administered as ordered.<br><br>Based on observations, interview and record review, Resident #6 was not interviewable.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the telephone interview with a second MA on 08/15/19 at 12:08pm.<br><br>Refer to the interview with the Care Manager (CM) on 08/15/19 at 8:36am. | D 358 | | |

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| D 358 | Continued From page 100<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br><br>e. Review of Resident #3's physician's orders dated 03/16/19 revealed an order for Esomeprazole Magnesium 20mg take one tablet every other day. (Esomeprazole Magnesium is used to treat gastro-esophageal reflux disease.).<br><br>Review of Resident #3's June 2019 and July 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Esomeprazole Magnesium every other day with scheduled administration time as 6:00am.<br>-Thirteen tablets of Esomeprazole were documented as administered every other day from 06/03/19-06/25/19 and 07/05/19.<br>-Esomeprazole was documented as unavailable 06/27/19, 06/29/19, 07/01/19 and 07/03/19.<br>-Nineteen tablets were documented as administered every other day from 07/07/19-08/13/19.<br>-Resident #3 missed 13 doses of Esomeprazole out of 29 opportunities.<br><br>Review of dispensing records for Resident #3's Esomeprazole revealed:<br>-Eight tablets were dispensed on 06/01/19.<br>-Fifteen tablets were dispensed on 07/06/19.<br>-Eight tablets were dispensed on 08/16/19.<br>-There were no other dispensing records for Esomeprazole for June 2019 or July 2019.<br><br>Observation of Resident #3's medications on hand on 08/14/19 at 10:07am revealed:<br>-There was a bubble pack of fifteen Esomeprazole 20mg dispensed on 07/06/19.<br>-Fourteen tablets had been administered; one tablet was available to be administered. | D 358 | | |

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| D 358 | Continued From page 101<br><br>Interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am revealed:<br>-Medications were filled on a monthly cycle except hospice patients.<br>-Hospice patients medications had to be requested; the medications were filled for a 15-day supply.<br>-The facility staff would need to request a refill either in the eMAR system electronically or pull the sticker off the medication and fax the refill request to the pharmacy.<br>-If the refill request came in before noon it would be sent out to the facility the same day; after noon it would go out the next day.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed:<br>-She did not recall Resident #3 missing doses of Esomeprazole.<br>-Resident #3 had not complained of heartburn; she had not noticed Resident #3 burping.<br><br>Telephone interview with Resident #3's primary care provider (PCP) on 08/16/19 at 11:23am revealed:<br>-Esomeprazole was ordered for heartburn.<br>-He expected Resident #3's Esomeprazole to be administered as ordered because it was being used as a preventive medication because Resident #3 took medications like aspirin that could irritate the stomach.<br>-Resident #3 could be experiencing discomfort if Esomeprazole was not administered as ordered and would not be able to tell anyone.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed he was not aware Resident #3's Esomeprazole was not | D 358 | | |

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| D 358 | Continued From page 102<br>administered as ordered.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed she was not aware Resident #3's Esomeprazole was not administered as ordered.<br><br>Based on observations, interview and record review, Resident #6 was not interviewable.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the interview with the Care Manager (CM) on 08/15/19 at 8:36am and 12:13pm.<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br>Review of Resident #4's current FL-2 dated 05/07/19 revealed:<br>-Diagnoses included vascular dementia, frontal temporal degeneration, hypothyroidism, osteoporosis, and back pain.<br>-There was an order for acetaminophen 325 milligrams (mg) take two tablets twice a day for generalized pain. (Acetaminophen is used to relieve minor aches and pains).<br><br>Review of Resident #4's July 2019 electronic medication administration records (eMARs) revealed:<br>-There was an entry for acetaminophen 325 mg | D 358 | | |

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| D 358 | Continued From page 103<br>take two tabs (650 mg) twice daily, scheduled 8:00am and 8:00pm for generalized pain.<br>-There was no documentation Resident #4 received acetaminophen at 8:00am on 07/21/19 through the 8:00am on 07/25/19, for a total of nine missed doses.<br>-There was documentation in the eMAR notes as acetaminophen was not administered because it was not available.<br><br>Observation of Resident #4's medications on hand on 08/14/19 at 11:05am revealed:<br>-There were three punch cards of acetaminophen.<br>-One punch card was dispensed on 07/25/19 and contained 16 of 30 tablets.<br>-Another punch card was dispensed on 08/09/19 and contained 24 of 30 tablets.<br>-A third punch card was dispensed on 08/09/19 and contained 30 of 30 tablets.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/14/19 at 11:43am revealed:<br>-Since Resident #4 was a hospice patient, the pharmacy dispensed two-week refills.<br>-Two punch cards, each containing 30 tablets, were dispensed on 07/25/19.<br>-Two punch cards, each containing 30 tablets, were dispensed on 08/09/19.<br>-The overage of medication on hand pointed to a medication error.<br><br>Interview with Resident #4's hospice nurse on 08/15/19 at 8:35am revealed:<br>-Resident #4 was noncommunicative; therefore, the acetaminophen was a scheduled medication.<br>-Resident #4 had rubbed her knees in the past two months, and the nurse interpreted it as a sign of pain. | D 358 | | |

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| D 358 | Continued From page 104<br><br>Interview with Personal Care Aide (PCA) on 08/15/19 at 12:20pm revealed:<br>-Resident #4 sometimes grimaced when she was being transferred by the PCAs.<br>-The last time Resident #4 grimaced while being transferred was less than a week ago.<br><br>Interview with Resident #4's hospice physician on 08/16/19 at 11:35am revealed:<br>-Resident #4 was prescribed acetaminophen for generalized pain.<br>-Resident #4's acetaminophen was scheduled because she was nonverbal and could not request pain medication.<br><br>Based on observations, interviews and record review, it was determined Resident #4 was not interviewable.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the the interview with the Care Manager (CM) on 08/15/19 at 8:36am and 12:13pm.<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br>4. Review of Resident #5's current FL-2 dated 02/05/19 revealed diagnoses included Alzheimer's disease, high blood pressure, and a vitamin D deficiency. | D 358 | | |

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| D 358 | Continued From page 105<br><br>a. Review of Resident #5's physicians order dated 02/05/19 revealed there was an order for amlodipine besylate 10mg take once daily (amlodipine besylate is used to treat high blood pressure).<br><br>Review of Resident #5's June 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry for amlodipine 10mg take once daily scheduled for 8:00am.<br>-Amlodipine was documented as administered every day in June 2019.<br><br>Review of Resident #5's July 2019 eMAR revealed:<br>-There was an entry for amlodipine 10mg take once daily scheduled for 8:00am.<br>-Amlodipine was documented as administered every day in July 2019.<br><br>Review of Resident #5's August 2019 eMAR revealed:<br>-There was an entry for amlodipine 10mg take once daily scheduled for 8:00am.<br>-Amlodipine was documented as administered every day in August 2019.<br><br>Observation of Resident #5's medications on hand on 08/14/19 at 10:15am revealed:<br>-There was a bubble package of thirty amlodipine dispensed on 07/25/19.<br>-Ten tablets had been administered and twenty were still in the package and available to be administered.<br><br>Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable. | D 358 | | |

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| D 358 | Continued From page 106<br><br>Telephone interview with a representative from the contracted pharmacy on 08/14/19 at 11:46am revealed:<br>-Thirty doses of amlodipine 10mg take once daily was dispensed on 05/26/19, 06/25/19, and 07/25/19.<br>-The amlodipine 10mg administered once a day was to keep Resident #5's blood pressure at a constant level; missed doses of amlodipine could cause elevated blood pressure levels and put the resident at increased risk of heart attack or stroke.<br><br>Telephone interview with a representative from Resident #5's primary care physician (PCP) on 08/16/19 at 8:50am revealed:<br>-Amlodipine was ordered due to high blood pressure.<br>-The facility staff should have notified the physician when a resident missed or refused a dose of any medication; there were no notes from the facility in Resident #5's record concerning medication.<br>-She did not know what the outcome of missed medication or when too much medication was administered.<br><br>Attempted telephone interview with Resident #5's PCP on 08/15/19 at 12:00pm was unsuccessful.<br><br>Interview with the Medication Aide (MA) on 08/14/19 and 08/15/19 at 10:40am and 11:35am revealed:<br>-Scheduled medication was automatically dispensed from the pharmacy before the current bubble package ran out.<br>-New medication bubble packages were started the day after they were dispensed from the pharmacy. | D 358 | | |

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| D 358 | Continued From page 107<br>-Sometimes there would be extra or left-over pills because a resident would refuse medication; when there were still pills in a package, she would use the package until the pills were gone before starting the newly dispensed bubble pack.<br>-Resident #5 usually did not refuse her medication so there were no unused pills from month to month; refusals were documented in the eMAR.<br>-She did not understand why there would be extra pills or not enough pills.<br><br>Interview with the Executive Director on 08/16/19 at 9:10am revealed the MAs should be documenting when a resident refused a medication or when a medication was not administered; she could not answer why Resident #5 had extra amlodipine tablets.<br><br>Interview with the Care Manager (CM) on 08/14/19 and 08/16/19 at 10:45 and 12:15pm revealed:<br>-He conducted medication audits once a week by comparing the medication on the cart, eMAR and physician's orders; he randomly selected which residents to audit.<br>-He looked to make sure the eMAR and the medication label matched and were accurate with the orders; he did not count pills.<br>-When he found a discrepancy, he would contact the physician and the pharmacy.<br>-The pharmacy entered orders into the eMAR.<br>-The MAs typically did not do cart or medication audits.<br>-The MAs should always document on the eMAR when a resident refused a medication or when a medication was not administered.<br>-He did not know why Resident #5 had extra amlodipine tablets. | D 358 | | |

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| D 358 | Continued From page 108<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with the Care Manager (CM) on 08/15/19 at 8:36am.<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br><br>Based on review of eMARs, observation of medications on hand and dispense dates from the pharmacy only ten amlodipine tablets should have been available to be administered, therefore Resident #5 was not administered ten doses of amlodipine tablets out of twenty opportunities.<br><br>b. Review of Resident #5's physicians order dated 02/05/19 revealed there was an order for ferrous sulfate (ferrous sulfate is used to treat iron deficiency) 325mg take twice a day.<br><br>Review of Resident #5's June 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry for ferrous sulfate 325mg take twice daily scheduled for 8:00am and 8:00pm.<br>-Ferrous sulfate was documented as administered every day in June 2019.<br><br>Review of Resident #5's July 2019 eMAR revealed: | D 358 | | |

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| D 358 | Continued From page 109<br>-There was an entry for ferrous sulfate 325 mg take twice daily scheduled for 8:00am and 8:00pm.<br>-Ferrous sulfate was documented as administered every day in July 2019.<br><br>Review of Resident #5's August 2019 eMAR revealed:<br>-There was an entry for ferrous sulfate 325 mg take twice daily scheduled for 8:00am and 8:00pm.<br>-Ferrous sulfate was documented as refused on 08/03/19 and 08/13/19 at 8:00pm in August 2019.<br><br>Observation of Resident #5's medication on hand on 08/14/19 at 10:15am revealed:<br>-There was a bubble package of 30 ferrous sulfate tablets dispensed on 07/25/19.<br>-The bubble package was numbered one of two packages and was the only package available for dispensing; 60 tablets total were dispensed on 07/25/19 between two packages.<br>-The package still had twelve tablets available for dispensing; there should have been 23 tablets available for dispensing.<br><br>Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable.<br><br>Telephone Interview with a representative from the contracted pharmacy on 08/14/19 at 11:46am revealed:<br>-Sixty doses of ferrous sulfate 325mg take twice daily was dispensed on 05/26/19, 06/25/19, and 07/25/19.<br>-Ferrous sulfate is used to treat iron deficiency and too ferrous sulfate much could cause constipation and eventually damage organs. | D 358 | | |

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| D 358 | Continued From page 110<br><br>Telephone interview with a representative from Resident #5's primary care physician (PCP) on 08/16/19 at 8:50am revealed:<br>-She did not know why the ferrous sulfate was ordered for Resident #5.<br>-The facility staff should have notified the physician when a resident missed or refused a dose of any medication; there were no notes from the facility in Resident #5's record concerning medication.<br>-She did not know what the outcome of missed medication or when too much medication was administered.<br><br>Attempted telephone interview with Resident #5's PCP on 08/15/19 at 12:00pm was unsuccessful.<br><br>Interview with the Care Manager (CM) on 08/14/19 and 08/16/19 at 10:45 and 12:15pm revealed:<br>-He conducted medication audits once a week by comparing the medication on the cart, eMAR and physician's orders; he randomly selected which residents to audit.<br>-He looked to make sure the eMAR and the medication label matched and were accurate with the orders; he did not count pills.<br>-When he found a discrepancy, he would contact the physician and the pharmacy.<br>-The pharmacy entered orders into the eMAR.<br>-The MAs typically did not do cart or medication audits.<br>-The MAs should always document on the eMAR when a resident refused a medication or when a medication was not administered.<br>-He did not know why Resident #5 had missing ferrous sulfate tablets; sometimes the MAs would borrow medication from one resident to the other, but it should not happen too often and should be documented. | D 358 | | |

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| D 358 | Continued From page 111<br><br>Interview with the Executive Director on 08/16/19 at 9:10am revealed:<br>-The MAs should be documenting when a resident refused a medication or when a medication was not administered.<br>-The MAs might have borrowed the ferrous sulfate from Resident #5 for other residents; she did not have an explanation for the missing ferrous sulfate.<br>-She did not know if borrowing medication from one resident for another was common practice; if it was a common practice, she did not see a problem with it because it was better than having a resident miss medication.<br>-When medication was borrowed from Resident #5 it needed to be documented so the borrowed medication could be returned.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am.<br><br>Refer to the interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am.<br><br>Refer to the interview with a Medication Aide (MA) on 08/15/19 at 11:42am.<br><br>Refer to the the interview with the Care Manager (CM) on 08/15/19 at 8:36am and 12:13pm.<br><br>Refer to the interview with the Executive Director (ED) on 08/16/19 at 9:11am.<br><br>Based on review of eMARs, observation of medications on hand and dispense dates from the pharmacy there should have been twenty three ferrous sulfate tablets available to be | D 358 | | |

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| D 358 | Continued From page 112<br>administered to Resident #5; there were only twelve tables available to administer to Resident #5.<br><br>Interview with a representative from the facility's contracted pharmacy on 08/14/19 at 8:31am revealed:<br>-Medications were filled on a monthly cycle.<br>-Medications on cycle refill did not need to be requested; they were filled automatically.<br>-As needed medication (prn) had to be requested to be refilled; refill requests could be faxed in or done electronically in the eMAR.<br><br>Interview with the pharmacy consultant from the facility's contracted pharmacy on 08/16/19 at 11:12am revealed:<br>-Her pharmacy reviews focused on the clinical aspect.<br>-She did not look at medications on hand unless it was a high-risk medication.<br>-An example of a high-risk medication would be a blood thinner.<br>-She looked at labs to make sure medications did not need to be changed.<br>-She looked to make sure doses were appropriate and at the appropriateness of the medication.<br>-She did not look at the eMARs.<br>-If a medication was documented that it had been administered, the pharmacy consultants accepted that.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 11:42am revealed:<br>-She audited the medication cart weekly; the last audit was on 08/14/19.<br>-Audit tasks included reconciling the physician orders with the eMAR, counting medications, and faxing refill requests to the pharmacy. | D 358 | | |

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| D 358 | Continued From page 113<br><br>Interviews with the Care Manager (CM) on 08/15/19 at 8:36am and 12:13pm revealed:<br>-Medications were filled on a monthly cycle.<br>-If a medication was filled early, it would fall off the cycle and would not automatically be refilled.<br>-There had been a problem with medications running out of refills, so he had new physicians' orders completed on all residents to eliminate that issue; missed medication because of refills had improved because of this.<br>-He pulled the compliance report daily; it showed if medications were missed and the reason so he could address it immediately.<br>-He expected medications to be administered timely, per regulation, and proper protocol.<br>-The facility followed state policies and rules regarding medication administration.<br>-He and the MA were responsible for weekly cart audits which include reviewing out of date medications and noting medications that needed to be ordered; the last audit was completed 08/08/19.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed:<br>-The Care Manager (CM) was responsible for overseeing everything related to medications.<br>-The CM discussed medication issues at stand-up report daily; he also went to her with any concerns about specific medication issues.<br>-When there were problems with medications she and the CM came up with an immediate plan.<br>-Ordering medication was the responsibility of the medication aides but ultimately was the CM's responsibility.<br>-The backup pharmacy was a local pharmacy and had limited hours.<br>-An error report was completed as needed.<br>-The physician would be notified, the staff would | D 358 | | |

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| D 358 | Continued From page 114<br>be spoken to, and a solution to the error would be discussed.<br>-She expected staff to notify the physician when medication was not available.<br>-The CM and MA were responsible for reordering refills in a timely manner.<br>-She thought medications were ordered when there were ten doses left.<br>-MAs performed audits, which included counting pills and comparing with the previous audit.<br>-She did not know if MAs recognized overages.<br>-She did not know if extra medications were kept in the medication cart.<br><br>The facility failed to assure medications were administered as ordered to four residents, including an error with an eye drops ordered after cataract surgery (#6); an antihypertensive medication and blood thinner for Resident #3 who was at risk of a stroke and a stool softener for a hospice patient who was unable to verbalize discomfort associated with constipation; a scheduled pain medication for a hospice patient that was not able to verbalize when she was in pain (#4); and a blood pressure medication for a resident (#5) which could lead to elevated blood pressure. This failure resulted in a substantial risk for harm and neglect of the resident which constitutes an Unabated Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/14/19 for this violation. | D 358 | | |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration | D 367 | | |

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| D 367 | Continued From page 115<br>record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 2 of 8 residents sampled (#3 and #5) including inaccurate documentation of medication to prevent blood clots and heart disease, blood pressure medication and stool softener (#3); and medications used to treat blood pressure and anemia (#5).<br><br>The findings are: | D 367 | Medication pass observations will be conducted weekly by a Registered Nurse or qualified designee for 4 weeks, then monthly for 2 months, then quarterly thereafter.<br><br>The Care Manager and/or designee will monitor daily to ensure medications are available and documented appropriately as given.<br><br>Cart audits will be conducted weekly on each medication cart to ensure all medications are available as ordered and any discrepancies will be corrected. These will be reviewed by the Care Manager and comparisons of medicaiton count will be completed. Med Techs were trained on proper procedure for ordering medications that are unavailable to ensure timely delivery. | 9/17/19 & ongoing<br><br>9/17/19 & ongoing<br><br>9/17/19 & ongoing |

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| D 367 | Continued From page 116<br><br>1. Review of Resident #3's current FL-2 dated 03/16/19 revealed diagnoses included vascular dementia, hypertension, diabetes, gastro-esophageal reflux disease (GERD), irritable bowel syndrome with constipation, seizures, and hypothyroid<br><br>a. Review of Resident #3's physician's orders dated 03/16/19 revealed an order for Clonidine HCL 0.1mg take one tablet twice daily. (Clonidine is used to treat high blood pressure.).<br><br>Review of Physician's order dated 04/10/19 revealed an order to increase Resident #3's Clonidine to 0.2mg twice daily.<br><br>Review of Resident #3's June 2019, July 2019, and August 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Clonidine 0.2mg twice daily with scheduled administration time as 8:00am and 8:00pm.<br>-Clonidine was documented as unavailable on 06/17/18 at 8:00pm.<br>-Thirty-five doses of Clonidine were documented as administered from 06/18/19 at 8:00am through 07/05/19 at 8:00pm; it was documented as unavailable on 07/05/19 at 8:00am.<br>-Clonidine was documented as unavailable on 07/06/19 at 8:00am and 8:00pm.<br>-Thirty-four doses of Clonidine were documented as administered from 07/07/19 at 8:00am through 07/23/19 at 8:00pm.<br><br>Review of dispensing records for Resident #3's Clonidine revealed:<br>-Thirty tablets were dispensed on 06/17/19.<br>-Thirty tablets were dispensed on 07/06/19.<br>-Thirty tablets were dispensed on 07/24/19 and 08/09/19. | D 367 | Medication aides were re-trained on cart auditing process, order processing system, documentation, and medication administration system on 8-29-19.<br><br>Medication aides were revalidated by a Registered Nurse to assure proper techniques, medication administration procedures including education on blood pressure medications, anticoagulants, stool softeners and anemia.<br><br>Executive Director and/or Care Manager will review the order processing system and medication compliance during stand up meeting to assure medications are re-ordered and available for administration.<br><br>Divisional Teams will monitor and review compliance during site visits and review with the Executive Director.<br><br>Senior Level Management Personnel including Senior Vice Presidents will monitor systems, tools and processes to assure compliance in medication administration. | 9/17/19<br><br>9/17/19<br><br>9/17/19<br><br>9/17/19<br><br>9/17/19 |

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| D 367 | Continued From page 117<br><br>Based on review of Resident #3 eMARs, medications on hand and pharmacy dispensing records Resident #3 missed 15 doses of Clonodine; 9 of 15 doses were documented as administered when the medication was not available.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed she did not know why her initials showed she had administered a medication when it was not available.<br><br>Interview with a second MA on 08/20/19 at 3:00pm revealed:<br>-She could not explain why her initials were documented on the eMAR as administered when the medication was not available; if she documented she administered the medication then she administered the medication.<br>-She would not document medication was administered if she did not administer it.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed:<br>-He was aware Resident #3 had missed doses of Clonidine; he recalled it was on a Saturday.<br>-He was not aware MAs had documented administering medication when it was not available.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed she was not aware Resident #3's Clonidine was documented as administered when the medication was not available to be administered; MAs should not document the medication had been administered if it was not available.<br><br>Based on observations, interview and record | D 367 | | |

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| D 367 | Continued From page 118<br>review it was determined Resident #3 was not interviewable.<br><br>b. Review of Resident #3's Physician's order dated 05/02/19 revealed an order to start Senna one tablet twice daily (Senna is a laxative).<br><br>Review of Resident #3's June 2019, July 2019, and August 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Senna 8.6mg twice daily with scheduled administration time as 8:00am and 8:00pm.<br>-Senna was documented as unavailable on 06/17/19 at 8:00pm and 06/18/19 at 8:00am.<br>-Seventy-nine doses of Senna were documented as administered from 06/18/19 at 8:00pm through 07/27/19 at 8:00pm.<br>-Thirty-four doses of Senna were documented as administered from 07/28/19 at 8:00am through 08/13/19 at 8:00pm.<br><br>Review of dispensing records for Resident #3's Senna revealed:<br>-Thirty tablets were dispensed on 06/17/19.<br>-Thirty tablets were dispensed on 07/28/19.<br>-Thirty tablets were dispensed on 08/09/19.<br>-There were no other dispensing records for Senna for July 2019.<br><br>Observation of Resident #3's medications on hand on 08/14/19 at 10:07am revealed:<br>-There was a bubble pack of thirty Senna dispensed on 05/02/19; twenty-nine tablets had been administered; one tablet was available to be administered.<br>-There was a bubble pack of thirty Senna dispensed on 07/28/19; twelve tablets were available to be administered.<br>-There was a bubble pack of thirty Senna | D 367 | | |

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| D 367 | Continued From page 119<br>dispensed on 08/09/19; thirty tablets were available to be administered.<br><br>Based on review of Resident #3 eMARs, medications on hand and pharmacy dispensing records Resident #3 missed 51 doses of Senna; 51 of 51 missed doses were documented as administered when the medication was not available.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed she did not know why her initials showed she had administered a medication when it was not available.<br><br>Interview with a second MA on 08/20/19 at 3:00pm revealed:<br>-She could not explain why her initials were documented on the eMAR as administered when the medication was not available; if she documented she administered the medication then she administered the medication.<br>-She would not document medication was administered if she did not administer it.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed he was not aware Resident #3's Senna was documented as administered when it was not available.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed she was not aware Resident #3's Senna was documented as administered when the medication was not available to be administered; MAs should not document the medication had been administered if it was not available.<br><br>Based on observations, interview and record review it was determined Resident #3 was not | D 367 | | |

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| D 367 | Continued From page 120<br>interviewable.<br><br>c. Review of Resident #3's physician's orders dated 03/16/19 revealed an order for Hydralazine HCL 50mg take one tablet twice a day. (Hydralazine is used to treat high blood pressure.).<br><br>Review of Physician's order dated 04/22/19 revealed an order to increase Resident #3's Hydralazine 50mg to three times daily.<br><br>Review of Resident #3's June 2019, July 2019 and August 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Hydralazine 50mg three times daily with scheduled administration time as 8:00am, 2:00pm, and 8:00pm.<br>-Hydralazine was documented as unavailable on 06/17/29 at 2:00pm.<br>-Fifty-two doses of Hydralazine were documented as administered from 06/17/19 at 8:00pm and 07/04/19 at 8:00pm.<br>-Hydralazine was documented as unavailable 07/08/19 at 8:00am and 2:00pm.<br>-Five-five doses of Hydralazine were documented as administered from 07/08/19 at 8:00pm-07/26/19 at 8:00pm.<br>-Hydralazine was documented as unavailable 07/27/19 at 8:00pm.<br>-Fifty-one doses of Hydralazine were documented as administered on 07/28/19 at 8:00am through 08/13/19 at 8:00pm.<br><br>Review of dispensing records for Resident #3's Hydralazine revealed:<br>-Forty-five tablets were dispensed on 06/17/19.<br>-Forty-five tablets were dispensed on 07/08/19.<br>-Forty-five tablets were dispensed on 07/27/19. | D 367 | | |

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| D 367 | Continued From page 121<br>-Forty-five tablets were dispensed on 08/14/19.<br><br>Observation of Resident #3's medications on hand on 08/14/19 at 10:07am revealed there was a bubble pack of thirty Hydralazine dispensed on 08/14/19; thirty tablets were available to be administered.<br><br>Based on review of Resident #3 eMARs, medications on hand and pharmacy dispensing records Resident #3 missed 39 doses of Hydrazaline; 23 of 39 doses were documented as adminsitered when the medication was not available.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed she did not know why her initials showed she had administered a medication when it was not available.<br><br>Interview with a second MA on 08/20/19 at 3:00pm revealed:<br>-She could not explain why her initials were documented on the eMAR as administered when the medication was not available; if she documented she administered the medication then she administered the medication.<br>-She would not document medication was administered if she did not administer it.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed he was not aware Resident #3's Hydrazaline was documented as administered when it was not available.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed she was not aware Resident #3's Hydrazidine was documented as administered when the medication was not available to be administered; MAs should not | D 367 | | |

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| D 367 | Continued From page 122<br>document the medication had been administered if it was not available.<br><br>Based on observations, interview and record review it was determined Resident #3 was not interviewable.<br><br>d. Review of Resident #3's physician's orders dated 03/16/19 revealed an order for Esomeprazole Magnesium 20mg take one tablet every other day. (Esomeprazole Magnesium is used to treat GERD).<br><br>Review of Resident #3's June 2019 and July 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry to administer Esomeprazole Magnesium every other day with scheduled administration time as 6:00am.<br>-Thirteen tablets of Esomeprazole were documented as administered every other day from 06/03/19-06/25/19 and 07/05/19.<br>-Esomeprazole was documented as unavailable 06/27/19, 06/29/19, 07/01/19 and 07/03/19.<br>-Nineteen tablets were documented as administered every other day from 07/07/19-08/13/19.<br><br>Review of dispensing records for Resident #3's Esomeprazole revealed:<br>-Eight tablets were dispensed on 06/01/19.<br>-Fifteen tablets were dispensed on 07/06/19.<br>-Eight tablets were dispensed on 08/16/19.<br>-There were no other dispensing records for Esomeprazole for June 2019 or July 2019.<br><br>Observation of Resident #3's medications on hand on 08/14/19 at 10:07am revealed:<br>-There was a bubble pack of fifteen Esomeprazole 20mg dispensed on 07/06/19. | D 367 | | |

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| D 367 | Continued From page 123<br>-Fourteen tablets had been administered; one tablet was available to be administered.<br><br>Based on review of Resident #3 eMARs, medications on hand and pharmacy dispensing records Resident #3 missed 13 doses of Esomeprazole; 8 of 13 doses were documented as administered when the medication was not available.<br><br>Interview with a Medication Aide (MA) on 08/15/19 at 9:03am revealed she did not know why her initials showed she had administered a medication when it was not available.<br><br>Interview with the Care Manager (CM) on 08/15/19 at 8:36am revealed he was not aware Resident #3's Esemprazole was documented as administered when it was not available.<br><br>Interview with the Executive Director (ED) on 08/16/19 at 9:11am revealed she was not aware Resident #3's Esomeprazole was documented as administered when the medication was not available to be administered; MAs should not document the medication had been administered if it was not available.<br><br>Based on observations, interview and record review it was determined Resident #3 was not interviewable.<br><br>2. Review of Resident #5's current FL-2 dated 02/05/19 revealed diagnoses included Alzheimer's disease, pre-renal, high blood pressure, and a vitamin D deficiency.<br><br>Review of Resident #5's physicians order dated 02/05/19 revealed there was an order for amlodipine besylate (amlodipine besylate is used | D 367 | | |

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| D 367 | Continued From page 124<br>to treat high blood pressure) 10mg take once daily.<br><br>Review of Resident #5's June 2019 and July electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry for amlodipine 10mg take once daily scheduled for 8:00am.<br>-Amlodipine was documented as administered daily from 06/01/19 through 06/30/19 and 07/01/19 through 07/31/19.<br><br>Review of Resident #5's August 2019 eMAR revealed:<br>-There was an entry for amlodipine 10mg take once daily scheduled for 8:00am.<br>-Amlodipine was documented as administered daily from 08/01/19 through 08/13/19.<br><br>Observation of Resident #5's medications on hand on 08/14/19 at 10:15am revealed:<br>-There was a bubble package of thirty amlodipine dispensed on 07/25/19.<br>-Ten tablets had been administered and twenty were still in the package and available to be administered.<br>-According to the eMAR there should have been only ten tablets available for administering.<br><br>Interview with a Medication Aide (MA) on 08/14/19 and 08/15/19 at 10:40am and 11:35am revealed resident refusals for medication or missed administration of medications should be documented in the eMAR as refusaled or missed administrations.<br><br>Interview with a second MA on 08/15/19 at 5:10pm revealed she documented on the eMAR when a resident was out of the facility, missed medication or refused medication; she could not | D 367 | | |

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| D 367 | Continued From page 125<br>explain why amlodipine was documented on the eMAR as administered daily when there were ten tablets that had not been administered but documented as administered.<br><br>Interview with the Resident Care Director (RCD) on 08/14/19 and 08/16/19 at 10:45 and 12:15pm revealed:<br>-The MAs should always document on the eMAR when a resident refused a medication or when administration of a medication is missed.<br>-He had no idea why Resident #5 had extra ten amlodipine tablets when the eMAR showed documentation of administration and no missed or refused medication.<br><br>Interview with the Executive Director on 08/16/19 at 9:10am revealed the MAs should havedocumented when a resident refused a medication or when administration of medication was missed; she could not answer why Resident #5 had extra amlodipine tablets when the eMAR had documentation of daily administration of the amlodipine tablets. | D 367 | | |
| D 453 | 10A NCAC 13F .1212(d) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. | D 453 | All staff were retrained on 09/12/19, 09/13/19 and 09/16/19 on reporting of incidents and accidents by a Registered Nurse.<br><br>An audit ws completed on 09/13/19 on all resident records to identify RP/POA/Guardian to ensure proper legal documents are located in the charts.<br><br>The ED will monitor weekly to enusre compliance and make sure the list is up to date. The ED will ensure all new staff is trained and comply with this rule. | 9/17/19 & ongoing<br><br>9/17/19<br><br>9/17/19 & ongoing |

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| D 453 | Continued From page 126<br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on interviews and record reviews, the facility failed to immediately notify the local county Department of Social Services (DSS) for 1 of 1 sampled residents (Resident #8), who had been neglected and exploited by staff.<br><br>The findings are:<br><br>Review of Resident #8's current FL-2 dated 12/28/18 revealed:<br>-Diagnoses included Vascular Dementia, schizoaffective disorder, hypertension, and gastroesophageal reflux disease.<br>-Resident #8 was intermittently confused.<br>-Resident #8 required assistance with bathing and dressing.<br><br>Review of Resident #8's Resident Register revealed:<br>-Resident #8 had significant memory loss and had to be directed.<br>-Resident #8 had a guardian.<br><br>Review of Resident #8's Quarterly Review and Care Plan Update Form dated 06/25/19 revealed:<br>-Assessed changes included Resident #8 had exit-seeking behaviors; intervention included staff to monitor the resident.<br>-Cognitive impairment was mild-moderate.<br><br>Review of Resident #8's court documents obtained from the court on 08/18/19 revealed Resident #8 was declared incompetent and her family member was named her guardian on 09/29/10 in one county and 10/01/10 in an adjoining county. | D 453 | Chart audits were completed on 9.-3-19 to assure that all residents had accurate Guardian POA, Responsible Party, and Family contact information to protect the safety of the resident.<br><br>The ED/CM will monitor and be responsible for assuring that all required reporting to proper authorities, local DSS, Guardian/POA, RP, Families, Physician or other required agencies.<br><br>Management will discuss all incident and accident reports in the daily morning meeting to ensure appropriate action is taken to provide a safe environment for residents. Resident service plans will be updated will necessary interventions. | 9/17/19<br><br>9/17/19 & ongoing<br><br>9/17/19 & ongoing |

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| D 453 | Continued From page 127<br><br>Confidential interview with a staff revealed:<br>-This staff walked into Resident #8's room and found Resident #8 and a male resident having sexual intercourse.<br>-The male resident was lying on his back and Resident #8 was straddling the male resident.<br>-This staff walked out of the room and closed the door.<br>-This staff called for other staff to come and witness the sexual encounter.<br>-This staff did not know what to do, so staff did not stop it.<br>-Both Resident #8 and the male resident were spoken to by the Executive Director (ED) after the situation occurred.<br><br>Confidential interview with a second staff revealed:<br>-Another staff called for staff on the SCU to come to Resident #8's room.<br>-This staff witnessed Resident #8 on top of the male resident having sexuL intercourse.<br>-This staff closed the door.<br><br>Confidential interview with a third staff revealed:<br>-The sexual encounter happened between May 2019 and June 2019. (The staff were not sure of the day).<br>-The male resident went to the SCU because he had something to give to Resident #8.<br>-This staff did not think anything about it because the male resident always took snacks.<br>-This staff went looking for the male resident because he was taking too long, and staff found Resident #8 and the male resident having sex.<br>-By the time other staff went to witness the sexual encounter, the male resident was coming out of the room.<br>-The male resident went back to the AL side and Resident #8 came out of her room, got a towel | D 453 | | |

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| D 453 | Continued From page 128<br>and bath cloth, and took a shower.<br>-It happened after 5:00pm because the ED and the Care Manager (CM) were notified the next day of the incident.<br>-The ED stated, "staff were not supposed to let it happen."<br><br>Confidential interview with another staff revealed:<br>-A personal care aide (PCA) laughing and joking about the sexual encounter on the SCU unit during the residents' lunch.<br>-This staff said the male resident and Resident #8 were caught having sex.<br>-This staff could not believe Resident #8 would do "anything like that."<br>-The ED stated, "the incident that happened was consensual between two residents".<br><br>Interview with Resident #8 on 08/15/19 at 5:05pm revealed:<br>-A male resident used to come visit her in her room, but now "I don't see him anymore."<br>-She engaged in sexual intercourse with the male resident one time (date unknown) and it was "an abomination to God."<br>-As a result of the sexual incident, the male resident could not come to her room.<br>-Staff knew; staff saw the sexual incident.<br>-She did not know who had seen her and the male resident engaging in sexual intercourse.<br>-No staff had talked to her about the incident.<br><br>Second interview with Resident #8 on 08/16/19 at 11:18am revealed:<br>-She did not know the male resident before she was admitted to the facility.<br>-Staff had taken her to the male resident's room three times, but she did not know when.<br>-She could not identify the staff who had taken her to the male resident's room. | D 453 | | |

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| D 453 | Continued From page 129<br>-The male resident walked to her room on his own.<br>-"I don't like him [the male resident]. He ain't [sic] my friend."<br><br>Review of Incident and Accident Reports for Resident #8 and the male resident from 06/01/19-08/1319 revealed there was no Incident and Accident report completed for the sexual assault of Resident #8.<br><br>Telephone interview with the Physician who signed Resident #8's FL-2 dated 12/28/18 on 08/19/19 at 8:55am revealed:<br>-Resident #8 used very poor judgment.<br>-Resident #8 could not make the decision to have sex.<br>-Resident #8 having sex with a resident from AL was "significantly alarming."<br>-Resident #8 was in a SCU because she needed supervision.<br>-Resident #8 was in a SCU unit because her decisions were impaired.<br>-Allowing a resident from AL to visit a resident in SCU without supervision was not acceptable. | D 453 | | |
| | Telephone interview with the Registered Nurse (RN) for Resident #8's mental health provider on 08/19/19 at 1:07pm revealed:<br>-Resident #8 received a monthly injection for paranoid schizophrenia.<br>-The resident had been receiving mental health services for "a while"; she used to receive services in another town, prior to moving into the current facility.<br>-The RN was not aware of the incident that occurred between Resident #8 and a male resident.<br>-She saw Resident #8 last month (July 2019) and the resident never mentioned anything to her | | | |

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| D 453 | Continued From page 130<br>about the incident.<br>-The RN could not say for sure if Resident #8 would be able to give consent to have sexual intercourse or consent to anything related to her health care.<br>-She thought based on Resident #8's diagnoses of vascular dementia and paranoid schizophrenia, her decision making would be questionable.<br>-The RN did not think anyone would force Resident #8 to do anything she did not want to do.<br>-Basedon the RN's history of providing services to the resident, she found it difficult to believe Resident #8 would have agreed to have sex.<br>-The RN could not understand how this incident could have occurred when Resident #8 was supposed to be living in a SCU.<br><br>Interview with the CM on 08/15/19 at 5:11pm revealed:<br>-He did not do an incident report.<br>-Someone told him two-residents had sexual contact; he did not remember who told him or when.<br>-Resident #8 was a "happy confused."<br>-One-minute Resident #8 knew what she was talking about and the next minute she did not.<br>-Residents had the right to have sex.<br>-If a resident was incompetent, they would reach out to the guardian.<br>-Resident #8's PCP told him Resident #8 was competent to make the decision to have sex.<br>-The Executive Director (ED) talked with Resident #8 and the male resident.<br>-He did not do an investigation related to the incident between Resident #8 and a [named] male resident.<br><br>Interview with the ED on 08/15/19 at 6:04pm revealed: | D 453 | | |

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| D 453 | Continued From page 131<br>-An incident report was done when a resident had an accident or an incident.<br>-The facility did not have a policy related to residents having sexual contact with each other.<br>-She completed an incident report.<br>-She did not involve law enforcement because she thought the incident was consensual.<br><br>Second interview with the ED on 08/15/19 at 6:47pm revealed she did not have an incident report; she was mistaken when she said earlier an incident report had been completed.<br><br>Telephone interview with a county representative on 08/16/19 at 1:35pm revealed:<br>-She advised the facility to contact the department of social services (DSS); because there was potential for resident to resident abuse.<br>-She let the facility know they needed to act to protect the resident.<br><br>Telephone interview with dietary staff on 08/19/19 at 9:10pm revealed:<br>-She over-heard several staff members talking about the incident between Resident #8 and a male resident.<br>-She was concerned because Resident #8 was "childlike" and at times did not even know where she was.<br><br>Interview with the ED on 08/20/19 at 10:31 am revealed:<br>-She nor any other staff had notified the police concerning the sexual encounter that occurred between Resident #8 and a male resident.<br>-She was not told to complete an incident report or to contact the DSS.<br>-Staff received training on about reporting any incident or unusual occurrence to her or the CM so that an incident report could be completed. | D 453 | | |

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| D 453 | Continued From page 132<br><br>Interview with a corporate staff on 08/20/19 at 12:20pm revealed:<br>-An police report was not needed because the sexual encounter was consensual.<br>-They did not know Resident #8 had a guardian.<br>-If Resident #8 had a guardian, they "dropped the ball."<br><br>Based on record reviews and interviews, the facility staff did not notify law enforcement or DSS after the two residents had sexual intercourse.<br><br>The facility failed to immediately notify the county Department of Social Services and the local law enforcement as required by law of any alleged sexual abuse of a resident. This failure resulted in substantial risk for harm and neglect of the resident which constitutes a Type A2 Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/19 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2019. | D 453 | | |
| D 469 | 10A NCAC 13F .1310 Other Applicable Rules For Special Care Units<br><br>10A NCAC 13F .1310 Other Applicable Rules For Special Care<br><br>In addition to specific rules pertaining to special care units for residents in this Section, such units shall also meet all other applicable requirements governing the operation of adult care homes as | D 469 | All staff were trained on 09/12/19, 09/13/19 and 09/16/19 on supervision of residents<br><br>Any AL resident visiting or attending an activity on the SCU will be supervised in an open common area. Any SCU resident will be supervised when leaving the SCU area at all times.<br><br>The ED/CM will monitor randomly during activities to ensure supervision is done. | |

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| D 469 | Continued From page 133<br>set forth in this Subchapter.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to implement policies and procedures for the special care unit (SCU) that promoted a safe, secure and consistent environment resulting in staff allowing a male resident from the assisted living (AL) unsupervised visitation to a female resident on the SCU, who had diagnoses of vascular dementia and schizoaffective disorder, had been ajudicated incompetent, and was unable to consent to a sexual encounter with the male resident; and another resident (#7), who resided on the SCU and had a diagnosis of vascular dementia, being allowed to leave the SCU and facility with a visitor, who had been previously banned from the facility. The findings are:<br><br>1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 2 sampled residents (#1, #7, #8, #11), who resided on the special care unit (SCU), including a resident (#8), who had diagnoses of vascular dementia and schizoaffective disorder, had been deemed incompetent and was unable to consent to a witnessed sexual encounter with a male resident from assisted living (AL), and a resident (#7), who had a diagnosis of vascular dementia and was allowed to leave the SCU and the premises with a person who was banned from the facility; and 2 of 2 sampled residents (#11 and | D 469 | Procedure establshed for any resident or visitor wishing to enter the secure care unit to include, but not limited to;<br>-Training provided on supervision of residents in common areas and rooms, authorized visitors and obligation to report on 9/12, 9/13, & 9/16.<br>-Sign in/out log reinstated for the memory care and assisted living. ED will monitor for to assure logs are in place and being utilized during daily routine rounds and observations.<br>-Employees were trained on this procedure to promote a safe and secure environment.<br>-All new employees will be trained on these procedures.<br><br>Training was provided on the requirement for supervision while protecting resident rights to assure the safety of all residents on 9-12-9-13 & 9-16-19. New employees will be trained on supervision during orientation.<br><br>The Divisional Team will monitor personal care and supervision and ongoing compliance to the plan set forth during site visits.<br><br>Senior Level Management including Senior Vice Presidents will monitor community and divisional team to assure sustained compliance. | 9/17/19 Ongoing<br><br>9/17/19<br><br>9/17/19 ongoing<br><br>9/17/19 ongoing |

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| D 469 | Continued From page 134<br>#1), who resided on the AL, including, a male resident (#11), who was allowed by staff to visit the SCU unsupervised with a resident who had a diagnosis of dementia, and a resident (#1), who had four falls within five days resulting in contusions to his scalp and leg. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated Type A1 Violation)].<br><br>2. Based on observations, interviews, and record reviews, the facility failed to protect 1 of 1 sampled residents (#8) from exploitation, who had a diagnosis of vascular dementia, was adjudicated incompetent and resided in the special care unit (SCU), by allowing a male resident to visit her unsupervised in the resident's room resulting in a sexual encounter between the two residents. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].<br><br>3. 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, residents' rights, medication administration, reporting of accidents and incidents, other care and services, and nutrition and food service. [Refer to Tag 980 G. S. 131D-25 Implementation (Type Unabated A1 Violation)].<br><br>4. Based on interviews and record reviews, the facility failed to immediately notify the local county Department of Social Services (DSS) for 1 of 1 sampled residents (Resident #8), who had been neglected and exploited by staff. [Refer to Tag 0453 10A NCAC 13F .1212(d) Reporting of Accidents and Incidents (Type A2 Violation)]. | D 469 | Refer to Tag 270 for additional corrective action for Personal Care and Supervision.<br><br>Refer to Tag 338 for additional corrective actions for Resident Rights.<br><br>Refer to TAg 980 for additional corrective actions for Implementation.<br><br>Refer to Tag 453 for additional corrective actions for accidents and incidents. | |

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| D 469 | Continued From page 135<br>The facility failed to implement policies and procedures for the SCU that promoted a safe, secure and consistent environment resulted in Resident #8, who was ajudicated incompetent, being exploited by staff, who willingly allowed a male resident from AL unsupervised visitation with Resident #8 and have sexual intercourse while staff observed and Resident #7, who also resided on the SCU, being allowed to leave the SCU and facility with a visitor, who had been previously banned from the facility, and was located in another state after being without personal care or medications for ten days. This failure resulted in serious neglect to the residents on the SCU, and constitutes a Type A1 Violation.<br><br>Plans of Protection were provided in the above rule areas.<br><br>THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2019. | D 469 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record | D912 | Resident Rights training provided by regional ombudsman on 9-13-19 and 9-16-19. | 9/17/19 |

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| D912 | Continued From page 136<br>reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration.<br><br>The findings are:<br><br>Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents observed during the medication pass including an error with eye drops (#6); and 3 of 8 residents sampled for record review (#3, #4, #5) including errors with an antihypertensive medication, a blood thinner and a stool softener (#3); a pain medication (#4); a blood pressure medication and a medication used to treat anemia (#5). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)]. | D912 | Refer to Tag 358 for additional corrective actions for medication administration. | |
| D914 | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, implementation and reporting of accidents and | D914 | | |

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| D914 | Continued From page 137<br>incidents.<br><br>The findings are:<br><br>1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 2 sampled residents (#1, #7, #8, #11), who resided on the special care unit (SCU), including a resident (#8), who had diagnoses of vascular dementia and schizoaffective disorder, had been deemed incompetent and was unable to consent to a witnessed sexual encounter with a male resident from assisted living (AL), and a resident (#7), who had a diagnosis of vascular dementia and was allowed to leave the SCU and the premises with a person who was banned from the facility; and 2 of 2 sampled residents (#11 and #1), who resided on the AL, including, a male resident (#11), who was allowed by staff to visit the SCU unsupervised with a resident who had a diagnosis of dementia, and a resident (#1), who had four falls within five days resulting in contusions to his scalp and leg. [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated Type A1 Violation)].<br><br>2. Based on observations, interviews, and record reviews, the facility failed to protect 1 of 1 sampled residents (#8) from exploitation, who had a diagnosis of vascular dementia, was adjudicated Incompetent and resided in the special care unit (SCU), by allowing a male resident to visit her unsupervised in the resident's room resulting in a sexual encounter between the two residents. [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].<br><br>3. Based on observations, interviews, and record | D914 | Resident Rights training provided by the regional ombudsman on 9-13-19 and 9-16-19.<br><br>Refer to Tag 270 for additional corrective actions for personal care and supervision.<br><br>Refer to Tag 338 for additional corrective actions for Resident Rights. | 9/17/19 |

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| D914 | Continued From page 138<br>reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for supervision, health care, residents' rights, medication administration, reporting of accidents and incidents, other care and services, and nutrition and food service. [Refer to Tag 980 G.S.131D-25 Implementation (Unabated Type A1 Violation)].<br><br>4. Based on observations, interviews and record reviews, the facility failed to implement policies and procedures for the special care unit (SCU) that promoted a safe, secure and consistent environment resulting in staff allowing a male resident from the assisted living (AL) unsupervised visitation to a female resident on the SCU, who had diagnoses of vascular dementia and schizoaffective disorder, had been ajudicated incompetent, and was unable to consent to a sexual relationship with the male resident; and another resident (#7), who resided on the SCU and had a diagnosis of vascular dementia, being allowed to leave the SCU and facility with a visitor, who had been previously banned from the facility by management staff. [Refer to Tag 0469 10A NCAC 13F. 1310 Other Applicable Rules for Special Care Units (Type A1 Violation)].<br><br>5. Based on interviews and record reviews, the facility failed to immediately notify the local county Department of Social Services (DSS) for 1 of 1 sampled residents (Resident #8), who had been neglected and exploited by staff. [Refer to Tag 0453 10A NCAC 13F .1212(d) Reporting of Accidents and Incidents (Type A2 Violation)]. | D914 | Refer to Tag 980 for additional corrective actions for Implementation.<br><br>Refer to Tag 469 for additional corrective action for applicable rules for special care units.<br><br>Refer to Tag 453 for additional corrective action for accidents and incidents. | |

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| D980 | Continued From page 139 | D980 | | |
| D980 | G.S. § 131D-25 Implementation<br><br>G.S. 131D-25 Implementation<br><br>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.<br><br>This Rule is not met as evidenced by:<br>FOLLOW UP TO TYPE A1 VIOLATION<br><br>Based on these findings, the previous Type A1 Violation was not abated.<br><br>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, residents' rights, medication administration, reporting of accidents and incidents, other care and services, and nutrition and food service.<br><br>The findings are:<br><br>Interview with the Executive Director (ED).Administrator on 08/15/19 at 6:22 pm revealed the Care Manager (CM) was responsible for medication administration oversight and processes.<br><br>Interview with the ED/Administrator on 08/16/19 at 9:00 am revealed:<br>-Both she and the CM were jointly responsible for personal care and supervision.<br>-She, the Medication Aides (MAs), and CM were responsible for medication administration within | D980 | Responsibilities of the administrator to adhere to the NC Adult Care Licensure Rules in coordination witht the NC General Statue 131D have been reviewed and discussed with the Executive Director by the Divsional Team. 9/17/19<br><br>Systems, tools and processes have been reviewed with the Executive Director, Resident Care Coordinator and the Dietary Manager to assure understanding and knowledge of these procedures. 9/17/19 | |

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| D980 | Continued From page 140<br>the facility.<br>-The CM was more responsible for health care because he made rounds with the physicians, reviewed the physician orders and reports, ensured appointments were made for residents, reviewed progress notes and notified physician about residents' condition.<br>-She and the CM had daily meetings to discuss any concerns identified in the residents' progress notes and discuss what would be done to address the concerns.<br>-The CM reviewed the shift reports, incident reports, and medication administration compliance report.<br>-She made rounds 3 to 4 times per day on each unit (Assisted Living and Special Care Unit).<br>-When she made rounds, she walked through each unit, prompted staff to make rounds on residents, and report any issues concerning the residents.<br>-She was responsible for dietary services and had implemented a manager being present during meal service to immediately address any resident concerns in July 2019.<br>-She had attended resident counsel meetings and the last meeting she attended was in July 2019.<br>-She was responsible and completed the Health Care Personnel Registry notifications and five-day investigations.<br>-She had the LHPS nurse conducted Resident Rights inservices and she had scheduled a class with the Ombudsman on Friday, 08/23/19.<br>-The CM developed the guardian list; she was not sure how he determined who had a guardian and who did not.<br>-To alleviate residents waiting at the hospital for hours for transportation to arrive, she added more drivers to the transportation list.<br>-She had not contacted the local hospital to discuss their concerns with residents being | D980 | Executive Director will utlilize and monitor all systems in coordination with department leaders to achieve and maintain compliance. These systems will be reviewed by the Executive Director during meetings & daily rounds, observations, data collection, documentation review, incident report reviews,audits, transportation calendar,open discussions, staff meetings, and stand up meetings with department leaders. 9/17/19<br><br>Divsional Vice President of Operations and the Divisional Team will review systems, tools and processes during site visits to assure continued compliance. 9/17/19<br><br>Senior Leadership including Senior Vice Presidents will follow up with the Divisional VPO and Divsional Teams for status reports. Senior Leadership will monitor systems, tools and processes to assure compliance durign site visits. 9/17/19 | |

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| D980 | Continued From page 141<br>picked up after discharge from the hospital.<br>-She allowed Assisted Living (AL) residents to visit the Special Care Unit (SCU) prior two residents having sexual intercourse.<br>-She stopped residents' visitation from one unit to the other on 08/15/19 and she had to contact her management for the development of a long-term plan.<br>-Residents were able to receive visitors from outside the facility but now they requested all visitors sign the visitation book.<br>-If there was a visitor at the door after dark or after business hours and the staff could not identify the person the door did not have to be opened.<br>-Staff implemented a form with residents' family of who were allowed to visit residents and this was started last week.<br>-Prior to Resident #7 leaving with a visitor, staff were told to verify with the power of attorney before a resident was taken out of the facility.<br>-There was no facility policy for visitation.<br><br>Noncompliance was identified in the following rule areas: | D980 | | |
| | 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 2 sampled residents (#1, #7, #8, #11), who resided on the special care unit (SCU), including a resident (#8), who had diagnoses of vascular dementia and schizoaffective disorder, had been deemed incompetent and was unable to consent to a witnessed sexual encounter with a male resident from assisted living (AL), and a resident (#7), who had a diagnosis of vascular dementia and was allowed to leave the SCU and the premises with a person who was banned from the | | | |

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| D980 | Continued From page 142<br>facility; and 2 of 2 sampled residents (#11 and #1), who resided on the AL, including, a male resident (#11), who was allowed by staff to visit the SCU unsupervised with a resident who had a diagnosis of dementia, and a resident (#1), who had four falls within five days resulting in contusions to his scalp and leg. [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated Type A1 Violation)].<br><br>2. Based on observations, interviews, and record reviews, the facility failed to protect 1 of 1 sampled residents (#8) from exploitation, who had a diagnosis of vascular dementia, was adjudicated incompetent and resided in the special care unit (SCU), by allowing a male resident to visit her unsupervised in the resident's room resulting in a sexual encounter between the two residents. [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].<br><br>3. Based on observations, interviews and record reviews, the facility failed to implement policies and procedures for the special care unit (SCU) that promoted a safe, secure and consistent environment resulting in staff allowing a male resident from the assisted living (AL) unsupervised visitation to a female resident on the SCU, who had diagnoses of vascular dementia and schizoaffective disorder, had been ajudicated incompetent, and was unable to consent to a sexual relationship with the male resident; and another resident (#7), who resided on the SCU and had a diagnosis of vascular dementia, being allowed to leave the SCU and facility with a visitor, who had been previously banned from the facility by management staff. [Refer to Tag 0469 10A NCAC 13F. 1310 Other Applicable Rules for Special Care Units (Type A1 Violation)]. | D980 | Refer to Tag 270 for additional corrective actions for personal care and supervision.<br><br>Refer to Tag 338 for additional corrective actions for resident rights.<br><br>Refer to Tag 469 for additional corrective actions applicable rules for special care units. | |

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| D980 | Continued From page 143<br><br>4. Based on interviews and record reviews, the facility failed to immediately notify the local county Department of Social Services (DSS) for 1 of 1 sampled residents (Resident #8), who had been neglected and exploited by staff. [Refer to Tag 0453 10A NCAC 13F .1212(d) Reporting of Accidents and Incidents (Type A2 Violation)].<br><br>4. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents observed during the medication pass including an error with eye drops (#6); and 3 of 8 residents sampled for record review (#3, #4, #5) including errors with an antihypertensive medication, a blood thinner and a stool softener (#3); a pain medication (#4); a blood pressure medication and a medication used to treat anemia (#5). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].<br><br>5. Based on interviews and record reviews, the facility failed to provide transportation back to the facility after an Emergency Department (ED) visit in a reasonable amount of time for 2 of 3 sampled residents (#1, #10) who were transported to the ED via Emergency Medical Services (EMS). [Refer to Tag 0321 10A NCAC 13F .0906(a) Other Care and Services].<br><br>6. Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 2 of 8 residents sampled (#3 and #5) including inaccurate documentation of medication to prevent blood clots and heart disease, blood pressure medication and stool softener (#3); and medications used to treat blood pressure and | D980 | Refer to Tag 453 for additional corrective actions for reporting of accident and incidents.<br><br>Refer to Tag 358 for additional corrective actions for medication administration.<br><br>Refer to Tag 321 for additional corrective actions for emergency medical services. | |

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| D980 | Continued From page 144<br>anemia (#5). [Refer to Tag 0367 10A NCAC 13F .1004(j) Medication Administration].<br><br>7. Based on observations, interviews and record reviews, the facility failed to provide assistance with meals in an unhurried manner that promoted dignity and respect for 1 of 5 sampled residents (#5), who was dependent on staff for assistance with feeding. [Refer to Tag 0312 10A NCAC 13F .0904(f)(2) Nutrition and Food Service].<br><br>8. Based on observations, record reviews and interviews, the facility failed to assure the kitchen and walk-in refrigerator were clean and free of contamination including buildup on the shelves and walls and uncovered food in the refrigerator and buildup on the hot food serving table. [Refer to Tag 0282 10A NCAC 13F .0904(a)(1) Nutrition and Food Service].<br><br>9. Based on observations, interviews, and record reviews, the facility failed to implement procedures as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #2) who was ordered to wear compression hose.. [Refer to Tag 0276 10A NCAC 13F .0902(c) Health Care].<br><br>The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing supervision, personal care and supervision, residents' rights, medication administration, and other resident services related to transportation. The Administrator's failure resulted in a resident, who resided on the special care unit and was adjudicated incompetent being sexually assaulted by another resident; and another resident, who resided on the special care unit, being allowed to leave the | D980 | Refer to Tag 312 for additional corrective actions for nutrition and food services.<br><br>Refer to Tag 282 for additional corrective actions for nutrition and food services.<br><br>Refer to Tag 276 for additional corrective actions for health care. | |

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| D980 | Continued From page 145<br>facility with a visitor, who had previously been banned from taking the resident out of the facility. This failure resulted in serious neglect to the residents which constitutes a Type A1 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/19 for this violation. | D980 | | |