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
	HAL060142	A. BUILDING: _____ B. WING _____	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF HUNTERSVII	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on July 1, 2019-July 2, 2019.	D 000	Plan: The Executive Director 100% audit of existing team member health files to identify all current issues of non-compliance. All non-compliance regarding current team member T.B. screening testing will be corrected to include the appropriate testing for tuberculosis. The Executive Director with the assistance of the Regional Director of Operations will establish a system to ensure all new team member hired receive required T.B. testing upon hire	8/17/19
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 4 of 5 sampled staff (Staff A, C, D, and E) were tested for tuberculosis upon hire. The findings are: 1. Review of Staff A, a medication aide (MA)/Supervisor's personnel record revealed: -Staff A was hired on 10/23/18. -There was documentation of a first step tuberculosis (TB) skin test administered on 01/10/19, no results were documented. -There was documentation of a second step TB skin test administered on 01/29/19, no results were documented. -There was documentation of a TB skin test given	D 131	Monitoring System: The Regional Nurse, Regional Director of Operations and Director of Clinical Operations will review the records for new hires during facility visits to ensure ongoing compliances are maintained.	7/23/19 and ongoing

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 8/13/19

Karen Polce Reviewed and acknowledged 08/29/19

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D 131	Continued From page 1 on 07/01/19. Interview with the Administrative Assistant on 07/02/19 at 4:55pm revealed: -She was responsible for managing staff personnel records. -She did not know the time frames for when staff were supposed to receive their TB skin test. -She did not realize Staff A did not have results documented on the first and second TB skin test. -There was an audit of staff personnel records completed in May 2019. Interview on with the Administrator on 07/02/19 at 5:05pm revealed: -The Administrative Assistant was responsible for maintaining the staff personnel records. -She did not realize Staff A did not have results documented on the TB skin tests until an audit was completed on 06/10/19. -She had to get the Regional Registered Nurse to complete TB skin test. -She knew all staff needed a TB skin test upon hire. -The lack of having a nurse on staff prevented staff from getting a TB skin test upon hire. Attempted interview with Staff A on 07/02/19 at 5:00pm was unsuccessful. 2. Review of Staff C, a medication aide (MA)/Memory Care Coordinator's (MCC) personnel record revealed: -Staff C was hired on 04/23/19. -Staff C had a tuberculosis (TB) skin test placed on 06/10/19 and was read as negative on 06/13/19. -There was no documentation that Staff C had a TB skin test upon hire.	D 131		

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D 131	Continued From page 2 Interview with Staff C on 07/02/19 at 5:02pm revealed: -She did not have a TB test when she was hired in April 2019. -She came with a 2-step negative TB skin test from another facility. -The facility lost her TB skin test and she had to get another one in June 2019. -She did not know she had to get a new TB skin test completed upon hire. Interview with the Administrative Assistant on 07/02/19 at 4:55pm revealed: -She was responsible for managing staff personnel records. -She did not know the time frames for when staff were supposed to receive their TB skin test. -She did not realize Staff C did not have a first and second TB skin test administered upon hire. -There was an audit of staff personnel records completed in May 2019. Interview on with the Administrator on 07/02/19 at 5:05pm revealed: -The Administrative Assistant was responsible for maintaining the staff personnel records. -She did not realize Staff C did not have a valid TB skin test until an audit was completed on 06/10/19. -She knew all staff needed a TB skin test upon hire. -The lack of having a nurse on staff prevented staff from getting a TB skin test upon hire. 3. Review of Staff D, a medication aide's (MA) personnel record revealed: -Staff D was hired on 02/01/19. -There was no documentation of a tuberculosis (TB) skin test upon hire. -There was no documentation that a chest x-ray	D 131		

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D 131	Continued From page 3 was completed. Interview with Staff D on 07/02/19 at 5:02pm revealed: -She had a history of a positive TB skin test. -She provided a copy of her negative chest x-ray when she was first hired. -She was told by management that her chest x-ray was misplaced and requested that she bring in another copy. Interview with the Administrative Assistant on 07/02/19 at 4:55pm revealed: -She was responsible for managing staff personnel records. -She did not know the time frames for when staff were supposed to receive their TB skin test. -She did not realize Staff D did not have a TB skin test completed upon hire. -There was an audit of staff personnel records completed in May 2019. Interview on with the Administrator on 07/02/19 at 5:05pm revealed: -The Administrative Assistant was responsible for maintaining the staff personnel records. -She did not realize Staff D did not have a valid TB skin test until an audit was completed on 06/10/19. -She knew all staff needed a TB skin test upon hire. -The was waiting on Staff D to bring a copy of a negative chest x-ray. 4. Review of Staff E, a personal care aide's (PCA) personnel record revealed: -Staff A was hired on 05/31/19. -There was documentation of a first step tuberculosis (TB) skin test given on 07/01/19, no results were documented.	D 131		

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D 131	Continued From page 4 -There was no documentation of a TB skin test given upon hire. Interview with the Administrative Assistant on 07/02/19 at 4:55pm revealed: -She was responsible for managing staff personnel records. -She did not know the time frames for when staff were supposed to receive their TB skin test. -There was no nurse available to administer the TB skin test when Staff E was hired. - When the regional nurse came the TB skin test was administered. Interview on with the Administrator on 07/02/19 at 5:05pm revealed: -The Administrative Assistant was responsible for maintaining the staff personnel records. -She did not realize Staff E did not have a valid TB skin test until an audit was completed on 06/10/19. -She knew all staff needed a TB skin test upon hire. -The lack of having a nurse on staff prevented staff from getting a TB skin test upon hire. Attempted interview with Staff E on 07/02/19 at 5:30pm was unsuccessful.	D 131		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver,	D 167	Plan: The Regional Nurse will assist the Resident Care Director to identify CPR classes to ensure access for any Supervisor in Charge not currently CPR certified becomes CPR certified before the end of August. Additional team member will also be sent for CPR certification to have excess staff trained. Team Members who are CPR certified will have an (*) beside their name on the schedule for easy identification to ensure at least one CPR certified team member present per shift.	8/15/19

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D 167	Continued From page 5 provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management for 14 of 50 shifts sampled in June 2019 and July 2019. The findings are: Review of the master schedule, time reports, and current CPR certification for all employees revealed: -The facility had 3 shifts: first shift was from 7:00am to 3:00pm, second shift was from 3:00pm to 11:00 pm and third shift was from 11:00pm to 7:00am. -There was no staff scheduled on second shift, who had been trained on CPR for 3 shifts including 06/16/19, 06/29/19, and 06/30/19. -There was no staff scheduled on third shift, who had been trained on CPR on for 11 shifts including 06/17/19-06/28/19. Interview with the Administrator on 07/02/19 at 5:10pm revealed:	D 167	Monitoring System: The Regional Director of Operations and Director of Clinical Operations will perform random review of the posted schedule with verification of the CPR certification in the team member's personnel file.	7/23/19 and ongoing

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D 167	Continued From page 6 -She required the medication aides (MAs)/supervisors to be CPR certified. -There was a turnover in staff and some shifts were not covered with staff who were CPR certified. -She developed the schedule based on the staff to resident ratio. -She did not require the personal care aides (PCAs) to be CPR certified. -She could not provide any other CPR certification for staff. -She tried to get coverage for the dates that a CPR certified staff was unavailable, but she did not have anyone. -She did not have her CPR certification and therefore could not assist. -She notified her corporate office; however, no assistance was provided. Review of Staff D's personnel record revealed: -Staff D was hired as a medication aide (MA)/supervisor on 02/01/19. -There was no documentation of Staff D having training on CPR. Review of the staff schedule and personnel records revealed: -Staff D worked second shift on 06/16/19. -No other staff on duty with Staff D on 06/16/19 (from 2:33pm-11:46pm) had training on CPR. -Staff D worked second shift on 06/29/19. -No other staff on duty with Staff D on 06/29/19 (from 3:12pm-11:06pm), had training on CPR. -Staff D worked second shift on 06/30/19. -No other staff on duty with Staff D on 06/30/19 (from 3:13pm-10:58pm) had training on CPR. -Staff D worked third shift on 06/21/19. -No other staff on duty with Staff D on 06/21/19 (from 11:19pm-7:02am) had training on CPR. -Staff D worked third shift on 06/24/19.	D 167		

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D 167	Continued From page 7 -No other staff on duty with Staff D on 06/24/19 (from 9:18pm-7:10am) had training on CPR. -Staff D worked third shift on 06/26/19. -No other staff on duty with Staff D on 06/26/19 (from 11:31pm-7:12am) had training on CPR. Interview with Staff D on 07/02/19 at 5:07pm revealed: -She was previously CPR certified and it "just expired". -She would need a refresher course to be able to perform CPR. -She was informed of a CPR class that she could take soon. -She had worked some shifts in the building with no other staff that had CPR. -No residents required CPR during the shifts that she worked. Interview with the Administrator on 07/02/19 at 5:05pm revealed: -She had Staff D scheduled for a CPR class two weeks ago, but she was unable to attend. -She tried to get coverage for the dates that a CPR certified staff was unavailable, but she did not have anyone. -She did not have her CPR certification and therefore could not assist. -She notified her corporate office; however, no assistance was provided. -She was responsible for reviewing the schedule and ensuring that someone was CPR certified on each shift. The facility failed to assure there was one staff member on duty in the facility at all times who had completed a course on CPR and choking management within the last 24 months. The facility's failure was detrimental to the health and safety of the residents in the event of an	D 167		

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D 167	Continued From page 8 emergency requiring CPR. This non-compliance constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/02/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 16, 2019.	D 167		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up with the licensed physicians for 2 of 6 residents related to contacting the mental health provider for documented behaviors which were unsafe and to verify behavior medications (Resident #7) and failed to follow-up with the physician regarding a prescription for a pain medication (Resident #3). The findings are:	D 273	Plan: In-services of resident care staff will be conducted regarding information to report to the Resident Care Director and how to ensure the appropriate referral and follow up occurs when resident needs are identified. The Resident Care Director and/or Regional Nurse will review the progress notes daily (M-F) for all residents to ensure appropriate referral ad follow up has occurred. Should any issues be identified requiring additional assessment, referral or follow up, actions will be taken as warranted to meet resident's health care needs. Monitoring System: The Regional Director of Operations and Director of Clinical Operation will perform random review of resident progress notes during facility visits to identify any potential areas wherein appropriate referral and follow up did not occur. Additional actions will be taken as warranted and additional training will be provided if the need is identified.	8/17/19 7/23/19

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D 273	Continued From page 9 1. Review of Resident #7's FL2 dated 03/06/19 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbances. -He was ambulatory with wandering behavior. a. Review of Resident #7's Progress Notes revealed: -On 03/07/19 at 7:00pm, the second shift supervisor documented, "Resident (#7) became very combative, he was chasing a PCA (personal care aide) down the hallway with a glass duck from the kitchen." "...he was very combative and throwing things around." -On 03/08/19 at 9:35am, the Resident Care Director (RCD) documented, " Received a call from the supervisor regarding patient (Resident #7) was being difficult with the staff-resisting care and trying to throw things." -On 03/08/19 at 5:00pm, the second shift supervisor documented, " the resident (#7) was combative and walking around hallways trying to get out and taking things out of people's rooms." -On 03/11/19, a third shift supervisor documented, Resident #7 was "attempting to hit women residents and women employees, resident was running behind PCA with an object in his hand. Resident is highly combative and wont go to sleep". -On 03/13/19 at 6:00am, the third shift supervisor documented "The resident (#7) insisted on laying on the room floor and bathroom floor. When trying to assist with helping him off the floor, resident gets extremely combative." -There is no documentation Resident #7's primary care physician (PCP) or mental health provider had been contacted regarding this behavior.	D 273		

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D 273	Continued From page 10 Interview with the medication aide (MA) on 07/01/19 at 3:30pm revealed: -Resident #7 was very combative. -The staff were unable to "calm him down." -His significant other visited daily and verbalized the need for Resident #7 to have "one on one " care. -The staff could not provide one on one care to Resident #7 - "We had other residents to care for." Interview with a PCA on 07/01/19 at 3:50pm revealed: -Resident #7's significant other did not want the MAs to administer any medications to him when he was having behaviors. -He would run all over the facility. -Because he would run so fast, he would sometimes fall. -His behaviors were very different from the other dementia residents. Telephone interview with a MA on 07/01/19 at 4:05pm revealed: -She spoke with the Administrator and the Resident Care Coordinator (RCC) regarding the resident's combative behavior. -She also spoke to the Administrator and RCC regarding Resident #7's significant other demanding the MAs not to administer scheduled behavior medications. -Resident #7 was very combative, especially after his significant other left the facility. -He would "hit the staff, punch us and push us." -Resident #7's roommate became agitated with Resident #7's behavior and had to be moved to another room. -The women residents were afraid of Resident #7. -"He would go in their rooms at night when they	D 273		

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D 273	Continued From page 11 were sleeping and get in their face." Telephone interview with the second shift supervisor on 07/01/19 at 8:59pm revealed: -Resident #7 flooded 2 residents rooms by leaving the water running in their sinks. -He never slept at night-always wandered in resident's rooms or ran in the halls. -We were instructed to "keep an eye on him" from the administrator and the RCC. -No other interventions were implemented. -The RCC was responsible for contacting the physician. Telephone interview with a third shift PCA on 07/02/19 at 4:45pm revealed: -Resident #7 was abusive to staff, he would hit staff. -Resident #7 would run down the hall hitting anyone in the hall. -He would rip the tablecloths off the dining room tables. -The female residents were intimidated by him. -The MAs had informed the RCC. Interview with the Administrator on 07/02/19 at 3:20pm revealed: -It was the responsibility of the MAs and supervisors to follow up with the physician for any issues that needed their attention. -The RCC was also responsible for following up with the physician, but there had not always been an RCC in the building. -It was the MAs responsibility to read the progress notes from the previous shift and follow up with the physician or family member if needed, in the absence of the RCC. -She knew Resident #7 had behaviors, but she thought it was the approach of certain staff that contributed to the behaviors.	D 273		

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D 273	Continued From page 12 -The RCC had tried to get in touch with Resident #7's primary care physician (PCP) for medication clarification but was unsuccessful. -She did not know Resident #7 was being seen by a mental health provider who prescribed his behavior medications. -There was no documentation staff had attempted to contact the mental health provider or the PCP for Resident #7. -She did not know of any attempts by staff to contact the mental health provider for Resident #7's behaviors. Interview with the Regional Registered Nurse (RN) on 07/02/19 at 2:50pm revealed: -If a resident was exhibiting behaviors, the physician should be notified and a request for as needed (PRN) medications. -If there was an immediate safety concern, the resident should be sent out to be evaluated at the hospital. -Resident #7's behaviors noted in the progress notes should have been addressed by the RCC or Resident Care Director (RCD). -The behaviors should have been reported to the physician, "the ball was dropped." -Currently neither the RCC or RCD position was occupied. Interview with the nurse assisting Resident #7's mental health provider on 07/02/19 at 11:25am revealed: -Resident #7 had been seen by the mental health provider in the past few months for behaviors. -The facility had not notified the provider Resident #7 was exhibiting combative behaviors. Review on 07/02/19 of the facility protocol for "Emergency Procedures in the Event of Aggressive, Wandering or Combative behavior	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060142	A. BUILDING: _____ B. WING _____	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF HUNTERSVII	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13 revealed: -If staff attempted to calm the individual, removed potential causes of aggression, refocused and/or redirected the resident, and the aggressive behavior was not alleviated, and administration of any as needed (PRN) medication as prescribed by the physician was included...., the physician should be contacted. -If at any point the resident becomes combative, and it was deemed the demonstrated behavior could not safely be managed without placing others at risk or harm, the caregiver should call 911 for immediate assistance, and the physician should be contacted ...". Attempted telephone interview with the PCP on 07/01/19 at 2:30pm was unsuccessful. Attempted telephone interview with the RCC on 07/02/19 at 11:00am was unsuccessful. Attempted telephone interview with the Power of Attorney (POA) on 07/02/19 at was unsuccessful. b. Review of Resident #7's FL2 dated 03/06/19 revealed: -The admission date at the current facility was 03/07/19. -There was an order for Risperdal 0.25mg one tablet in the morning and two tablets at 9:00pm daily. Review of the March 2019 electronic medication administration record (eMAR) from 03/08/19 through 03/16/19 revealed: -There was an entry for Risperdal 0.25mg one tablet daily at 8:00am. -Risperdal 0.25mg was documented as administered daily at 8:00am from 03/08/19-03/15/19.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF HUNTERSVIL	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

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D 273	Continued From page 14 -There was an entry for Risperdal 0.25mg take 2 tablets (0.5mg) every evening at 9:00pm. -Risperdal 0.5mg was documented as administered daily at 9:00pm from 03/08/19-03/13/19. -There was documentation the Risperdal 0.5mg at 9:00pm was held per family request on 03/14/19. Telephone interview with the first shift medication aide (MA) on 07/01/19 at 4:05pm revealed: -Resident #7 was accompanied by his significant other when he arrived at the facility. -She visited every day and stayed most of the day. -Resident #7 was very combative, but he would take his medications when the MA administered them. -His significant other would always question the MA as to what medications were being administered to the resident. -The significant other never mentioned to the MA that any of the medications were incorrect. Confidential telephone interview with an employee revealed: -Resident #7 would never sleep at night; he wandered or ran around the special care unit (SCU) all evening. -His significant other would stay very late in the evening, sometimes until 11pm. -She asked that we not administer the evening dose of Risperdal. -The significant other thought the medication should not be on his medication profile. -First the significant other stated the medication would make him sleepy. -Then the significant other stated the medication made him "hyper". -The MAs told the significant other they had an	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARILLON ASSISTED LIVING OF HUNTERSVII	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

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D 273	Continued From page 15 order to administer the medication and until it was discontinued they would have to administer the Risperdal. -It was the responsibility of the RCC or the RCD to follow up with the physician to clarify medication orders. -The significant other also voiced her concerns to the RCC regarding the Risperdal order. -She did not see a change in the Risperdal order before Resident #7 went to the hospital. Interview with the Administrator on 07/02/19 at 3:20pm revealed: -Resident #7's significant other reported to her the Risperdal was a medication he should not be administered. He had a reaction to the medication, and it made him hyperactive. -She did not know why the Risperdal was on the current FL2 signed by a different physician in her primary care physician's office. -The FL2 from his previous facility did not include Risperdal. -The Administrator reiterated the MAs had to administer the medications as ordered. -She encouraged the significant other to get a clarification order from her primary care physician. -In the absence of the RCC or RCD, the supervisor or MAs could request a verification on medications or treatments from the physicians. "I have told them this several times." -The RCC, RCD or MAs should be following up with the physicians when needed. -The MAs should have verified this order with the physician if the RCC did not. Interview with the mental health provider's nurse on at revealed: -Resident #7 was a client of the mental health provider and was being seen for behaviors	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 16 related to his diagnosis. -The mental health provider prescribed the medications for the Resident #7's behaviors. -The records for Resident #7 indicated he had a reaction to Risperdal according to his significant other. -There was no record the mental health provider had prescribed the Risperdal. -His significant other had requested the Risperdal be discontinued on 03/14/19. -The mental health provider gave the significant other the discontinue order for Risperdal on 03/14/19. Review of the progress notes for 03/15/19 documented Resident #7 had a fall and was sent to the hospital. Resident #7 did not return to the facility. Attempted telephone interview with the primary care physician on 07/01/19 at 2:30pm was unsuccessful. Attempted telephone interview with the significant other on 07/02/19 at 4:22pm was unsuccessful. 2. Review of Resident #3's current FL2 dated 03/08/19 revealed: -Diagnoses included Parkinson's disease, lupus, osteoarthritis, peripheral neuropathy. -There was an order for Norco 5-325mg (used to treat pain) one to two tablets every six hours as needed for pain. Review of the May 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Norco 5-325mg one tablet every six hours for pain "hard copy prescription required".	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 17 -There were no documented administrations of Norco from 05/01/19-05/31/19. Review of the June 2019 eMAR revealed: -There was an entry for Norco 5-325mg one tablet every six hours for pain "hard copy prescription required". -There were no documented administrations of Norco from 06/01/19-06/30/19. Review of Resident #3's "Resident Progress Notes" revealed: -There was an entry dated 06/30/19 at 2:30pm which documented, "resident has been complaining of back pain, was given Tylenol, waiting for hard script from his doctor, resident to be monitored". -There was a second entry dated 06/30/19 written during the 3pm-11pm shift that stated, "resident complained of pain, he wanted his hydrocodone because it was more effective". Review of Resident #3's medications available for administration on 07/02/19 at 11:52am revealed Norco 5-325mg was unavailable for administration. Telephone interview with a representative at the contracted pharmacy on 07/02/19 at 12:12pm revealed: -The pharmacy received an order for Norco 5-325mg on 03/27/19. -A representative notified the facility when the order was received that a hard copy of the prescription was needed before the medication could be filled. -The medication was placed on the eMAR and indicated that a hard copy of the prescription was needed. -All controlled substances required a hard copy of	D 273		

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D 273	Continued From page 18 the prescription. -The hard copy prescription was had not been received, therefore the medication was never filled. Interview with Resident #3 on 07/02/19 at 11:13am revealed: -He had been complaining of pain "over the past week". -He was given tylenol for the pain because the Norco was not available. -The tylenol was not effective at managing his pain. Interview with a first shift medication aide (MA) on 07/02/19 at 11:48am revealed: -Resident #3 had requested Norco 5-325mg recently and she faxed a request to the pharmacy to be filled. -She spoke to the nurse at Resident #3's physician's office "last week" and the medication was not delivered. -She did not know why the medication was not delivered yet. -She had not requested a hard copy of the prescription prior to "last week". -She did not know why a hard copy of the prescription was not requested when the order was initially received. Interview with a second shift MA on 07/02/19 at 4:40pm revealed: -Resident #3 needed Norco 5-325mg as he was complaining of pain and the tylenol was not helping. -The resident requested Norco and she put a note in the progress notes so that management could follow-up. -She did not know Norco was not available.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 19 Interview with the nurse for the primary care provider (PCP) on 07/02/19 at 1:27pm revealed: -The Norco 5-325mg was ordered to treat pain. -The office received a request for a hard copy of the Norco prescription on 06/30/19. -There was no request for a hard copy prescription for Norco prior to 06/30/19. -The physician expected the facility to request a prescription when the prescription was initially ordered. Interview with the Regional Nurse on 07/02/19 at 4:25pm revealed: -The Resident Care Director (RCD)/Resident Care Coordinator (RCC) were responsible for ensuring medications were ordered when a resident was admitted to the facility. -The had several RCCs/RCDs since March 2019 and was not sure who was in place at the time. -The RCC or RCD should have contacted the PCP for a hard copy prescription of the Norco 5-325mg when Resident #3 was admitted. -She did not know why the hard script was not requested. Interview with the Administrator on 07/02/19 at 3:15pm revealed: -She did not know Resident #3's Norco 5-325mg was not available for administration. -The MAs/supervisors would be responsible for contacting the physician for a hard copy of the prescription. -If the RCC or RCD was not available the MA/supervisor was responsible for following up with the physician. --- The failure of the facility to assure referral and follow-up to the primary care physician for a resident exhibiting unsafe behaviors in a special care unit, and failing to clarify a behavior	D 273		

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D 273	Continued From page 20 medication with the prescribing physician (Resident #7) and failed to follow-up with the physcian regarding a prescription for a pain medication (Resident #3). This failure of the facility was detrimental to the health, safety and welfare for the residents and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 07/02/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 16, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 2 of 5	D 276		

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D 276	Continued From page 21 sampled residents (Resident #2 and Resident #5) with an order for urinalysis to rule out urinary tract infections.. The findings are: 1. Review of Resident #2's current FL2 dated 12/04/18 revealed: -Resident #2 had diagnoses of dementia with behavioral disturbances, hypercholesterolemia, atrial fibrillation, dysphagia, and muscle weakness. -Resident #2 was incontinent of bowel and bladder. -Resident #2 required a special care unit (SCU) level of care. Review of Resident #2's current Care Plan dated 01/22/19 revealed she required "extensive assistance" with toileting and transferring. Review of Resident #2's record revealed: -There was a signed physician's order sheet dated 06/12/19 to "obtain urine sample today please and contact for pick up" and "Macrobid 100mg twice daily by mouth for 5 days." Review of Resident #2's Progress Notes revealed there was no documentation in Resident #2's progress notes regarding a urinalysis (UA) being ordered or attempts to collect a urine sample. Review of Resident #2's June 2019 electronic Medication Administration Records (eMAR) from 06/13/19 through 06/17/19 revealed: -There was an entry for Macrobid 100mg, administered twice daily, at 8:00am and 8:00pm. -Macrobid was documented as administered twice daily, at 8:00am and 8:00pm on 06/13/19 through 06/17/19.	D 276		

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D 276	Continued From page 22 Interview with Resident #2's physician on 07/02/19 at 9:15am revealed: -She assessed Resident #2 on 06/12/19 for a potential urinary tract infection (UTI). -At the time of the assessment, she ordered a urine sample to be collected the same day, and for the facility to call the office for pick up once the sample had been collected. -On 06/12/19, she also prophylactically ordered Macrobid 100mg to be administered twice daily. -The physician's office had never received a call to pick up Resident #2's urine sample, and no sample had been received by their office. -She saw Resident #2 a week later for a follow-up appointment and described Resident #2 as being "back to baseline" so she felt that if she had a UTI, it had resolved. -It had been a challenge to get lab work completed by the facility in a timely manner when she ordered any labs for residents. -In order to assure labs were completed, she would have to tell the staff that she needed it completed the same day and "really stress this." -She could not leave a written order in the Resident Care Director's (RCD's) office and assume that the orders would be carried out. -Recently, she had several orders for labs that had not been carried out, even after she had stressed the importance of the labs being completed quickly. -Her expectation was that when she wrote orders for labs, that the facility carry out the orders promptly. Confidential interview with an employee revealed: -It was "pretty easy" to collect urine samples from Resident #2 because she still used the toilet, and a sample could be collected in a "catch hat." -No one had told her a urine sample was needed	D 276		

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D 276	Continued From page 23 for Resident #2 in the past month. -The information should have been documented in the "shift notes" for the MAs to convey to the personal care assistants (PCAs). -The PCAs or the MAs would have been responsible for collecting the urine sample. Confidential interview with another employee revealed: -She thought she recalled Resident #2 had a recent order for a urine sample to be collected, but she was not certain if it was ever obtained. -She had not collected a urine sample from Resident #2. Refer to interview with a Regional RN on 07/02/19 at 2:50pm. Refer to interview with the Administrator on 07/02/19 at 3:10pm. Refer to interview with the Memory Care Coordinator (MCC) on 07/02/19 at 3:45pm. Refer to confidential interview with a second employee. 2. Review of Resident #5's current FL2 dated 05/20/19 revealed: -Resident #5's diagnoses included cognitive dysfunction, hypothyroidism, hypercholesterolemia, hearing loss and vitamin D deficiency. -Resident #5 was continent of bowel and bladder. -Resident #5 required a special care unit (SCU) level of care. Review of Resident #5's current Care Plan dated 02/01/19 revealed she required "limited assistance" with documentation "supervise/assist	D 276		

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D 276	Continued From page 24 as needed" regarding toileting, and that she could transfer with "supervision." Review of Resident #5's physician's orders revealed: -There was an order dated 06/11/19 for a urinalysis (UA) to be completed for Resident #5. -There was a physician's order dated 06/12/19 for a UA to be completed for Resident #5. Review of Resident #5's progress notes revealed there was no documentation regarding a UA being requested or attempts to collect a urine sample. Interview with Resident #5's physician on 07/02/19 at 9:15am revealed: -She saw resident #5 on 06/12/19 for symptoms of a urinary tract infection (UTI). -She ordered a UA to be completed for Resident #5 and also ordered Macrobid 100mg to be administered for 5 days prophylactically. -She ordered an antibiotic to be started immediately, prior to having the results from the UA, for Resident #5. -Resident #5 had a history of UTI's which strongly correlated with falls. -She was unable to follow-up with Resident #5 a week after initially seeing her and ordering a UA because Resident #5 was sent out as a result of a fall on 06/13/19 and did not return to the facility. -It had been a challenge to get lab work completed by the facility in a timely manner when she ordered any labs for residents. -Recently, she had several orders for labs that had not been carried out, even after she had stressed the importance of the labs being completed quickly. -Her expectation was that when she wrote orders for labs, that the facility carry out the orders	D 276		

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D 276	Continued From page 25 promptly. Review of the hospital discharge summary documentation dated 06/20/19 revealed: -Documentation from Resident #5's emergency department visit on 06/13/19 noted there was "no evidence of a UTI." -Resident #5 was diagnosed with a pathological fracture of right hip due to osteoporosis. -Resident #5 was discharged to a skilled nursing facility. Confidential interview with an employee revealed: -She recalled Resident #5 had some behavior changes prior to her fall and being sent out and that she had been complaining of not feeling well, which was uncharacteristic for her. -She had collected a urine sample from Resident #5 a few months ago but was not aware of a recent order to collect a urine sample. Refer to confidential interview with a second employee. Refer to interview with a Regional RN on 07/02/19 at 2:50pm. Refer to interview with the Administrator on 07/02/19 at 3:10pm. Refer to interview with the Memory Care Coordinator (MCC) on 07/02/19 at 3:45pm. _____ Interview with the Administrator on 07/02/19 at 3:10pm revealed: -She read the progress notes book each morning. -If anything documented in the progress notes required follow-up with a physician, she would ensure the supervisor or MA followed up with the	D 276		

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D 276	Continued From page 26 physician regarding the concern. -Although the facility had been without a Resident Care Director (RCD) and a Resident Care Coordinator (RCC) intermittently for several months, the supervisors were all aware that they had the authority and responsibility to contact any resident's physician when needed. -Orders were usually received via fax in the upstairs RCD office. -Since the RCD position had been vacant recently, all MAs, supervisors, as well as the MCC were responsible for checking the fax throughout the day to assure no orders were missed, and they were sent to the pharmacy for delivery. -There was no clear time frame in the facility's policy regarding how many attempts should be made to collect a urine sample prior to notifying the physician that one could not be obtained. Interview with the Memory Care Coordinator (MCC) on 07/02/19 at 3:45pm revealed: -When staff had a concern that a resident may have a UTI, they were supposed to tell the supervisor or the MCC. -The supervisor or MCC notified the physician via fax their concerns and requested an order for a UA to be completed. -Staff should have been documenting any behavior changes in the progress notes. -The supervisor and/or MCC should have been documenting any communication with physicians regarding requests for UAs in the progress notes, as well as any unsuccessful attempts to collect a urine sample. -Staff had not been documenting these activities as they should have recently. -Either she or the MAs were responsible for attempting to obtain urine samples for residents in the SCU.	D 276		

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D 276	Continued From page 27 -She tried to ensure any samples for UAs were collected within 24 hours of receiving the order, but she and the MAs may continue to attempt to collect a sample up to 3 days before notifying the physician of the unsuccessful attempts. -Sometimes staff were unable to collect a urine sample after multiple attempts. When this occurred, they were to notify her so that she could notify the MD of the unsuccessful attempts. -Usually when she notified physicians of unsuccessful attempts to collect a urine sample, they would go ahead and write an order for an antibiotic to treat the resident prophylactically. Confidential interview with a second employee revealed: -When staff were concerned that a resident may have a UTI, they were to inform the MA or supervisor of their observations, which should be documented by the MA or supervisor in the resident's progress notes. -The MA or supervisor should notify the physician of the concerns and request a UA to be completed. -The Administrator or Regional Registered Nurse (RN) reads through the progress notes for each resident daily, and they were supposed to follow-up to assure an order had been obtained from the physician to collect a urine sample. -Either the MA or the MCC were responsible for collecting urine samples from residents once an order for a UA had been received by a resident's physician. -Sometimes it was challenging to catch a "clean sample" from residents in the SCU, especially those who were incontinent and wore briefs. -She usually made "2 or 3" attempts to collect a urine sample before notifying the MCC or resident care director (RCD) that she was unable to collect a sample.	D 276		

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D 276	Continued From page 28 -When a urine sample was unable to be obtained, each attempt was to be documented in the progress notes and the RCD, MCC, or Regional RN should be notified so that they could follow up with the physician Interview with a Regional RN on 07/02/19 at 2:50pm revealed: -When staff observed behavior changes or had concerns a resident may possibly have a UTI, the RCD or Resident Care Coordinator (RCC) should be notified. -The RCD or RCC was responsible for communicating with the physician to obtain an order for a UA. -The supervisor was responsible for documenting the changes in the resident's progress notes. -MAs were responsible for collecting UAs via a "swab". -The expectation was that a UA should be completed as soon as possible but no more than 24 hours of the order being received. -If staff were unable to collect a sample from a resident, the physician should be notified after 24 hours of attempting so that a different option to collect a sample could be considered. -When staff unsuccessfully attempted to collect a UA, this should be documented in the progress notes. -She was aware that staff had not been documenting unsuccessful attempts to obtain UAs from residents and had also not been documenting communication with physicians when staff were unable to obtain a sample. - There had been a lot of turnover in the RCD's and RCC's position and they had been vacant for the past 3 weeks. - In the absence of an RCD and RCC, the Administrator was responsible for assuring physician's orders were implemented.	D 276		

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D 276	Continued From page 29 -The Administrator could also request support from the corporate office. - She had been assisting intermittently in the facility while there was a vacancy in the RCD position. -She had been attempting to be in the facility 3 days per week for the past 3 weeks .	D 276		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure activities were carried out as scheduled during 5 of 5 observations. Review of the July activity calendar revealed: -On 07/01/19 scheduled activities included: 9:30am ball toss, 10:00am finish the phrase, 10:30am baking surprise, 11:00am sing along, 2:00pm stretch it out, 3:00pm bible trivia, 6:00pm word search and 7:00pm devotions. -On 07/02/19 scheduled activities included: 9:30am horseshoe toss, 10:00am name 5, 10:30am baking brownies, 11:00am hand spa, 2:00pm stretch it out, 3:00pm cranium crunches,	D 315	Plan: The Garden Place Coordinator will ensure activities are conducted in the Special Care Unit as identified on the daily activity calendar. Should the Garden Place Coordinator be absent the Supervisor in Charge will be responsible for assigning the activity tasks to ensure the activities occur as scheduled. Monitoring System: The Executive Director and/or Regional Director will perform routine walk through evaluations of the programming in the Special Care Unit to ensure activities are occurring as scheduled.	7/23/19 7/23/19

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D 315	Continued From page 30 6:00pm Jenna, and 7:00pm devotions. Observations of the special care unit (SCU) on 07/01/19 revealed: -Between 9:00am and 10:30am, no activities were occurring in the SCU. Several residents were sitting in the common area with the television turned on. -At 3:20pm, no activity was occurring in the SCU. Several residents were sitting in the common area with the television turned on, and several other residents were gathered near the entrance to the SCU. Interview with the memory care coordinator (MCC) on 07/01/19 at 3:41pm revealed: -A musical guest had just left the SCU. The guest had been playing guitar for the residents near the entrance to the SCU. The musical guest was not listed on the activity calendar. -Staff had attempted bible trivia at 3:00pm, but activities such as this often did not last very long in the SCU. Most residents were not able to participate, or lost interest very quickly. -There were only 2 or 3 residents who could actively participate in bible trivia. -The staff often modified activities that some residents could not participate in to something they could enjoy, for instance, "bible trivia" would become "bible devotion" for some residents. Observations of the SCU on 07/02/19 between 10:00-10:30am and 3:00pm revealed: -At 10:00am, no activities were observed in the SCU. Several residents were sitting in the common area with the television turned on. -At 10:30am, staff were observed at the craft table working with residents to decorate door hangers for the upcoming Independence Day holiday.	D 315		

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D 315	Continued From page 31 -At 3:00pm, no activities were observed in the SCU. Several residents were sitting in the common area. Interview with a family member of a resident on the SCU on 07/01/19 at 9:45am revealed: -Most times when she visited the facility residents were not actively engaged in any activities. -She usually observed most residents to be sitting or "parked" in the common area in front of the television. -She often looked at the activity calendar and observed that the scheduled activities for the day and time she was visiting the facility were not occurring as scheduled. Interview with the Activities Director on 07/02/19 at 1:35pm revealed: -The MCC was responsible for carrying out activities as scheduled in the SCU. -She and the MCC worked together to develop the activity calendar for the SCU. -Activities in the SCU could be challenging sometimes because residents had shorter attention spans and would often "get up and walk away." -She "only had 15 residents" on the assisted living side for which she was responsible and she visited those residents daily. Confidential interview with a PCA revealed: -Activities were conducted in the SCU at 9:00am, 2:00pm, and 7:00pm. -Staff conducted activities according to the posted schedule. -While staff attempted to implement the scheduled activities, sometimes residents were not interested, or could not engage in the scheduled activities. When this occurred, staff would always try "something else that they know	D 315		

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D 315	Continued From page 32 the residents would enjoy" such as listening to music, dancing, or other things. -The MCC was responsible for assuring activities were carried out in the SCU, and assured needs supplies are available for activities. -She had never been directed to document which residents participated in scheduled activities. -Sometimes the facility was short staffed and they "did the best they could, but sometimes activities were not completed as scheduled." -Sometimes it was difficult to conduct activities in the afternoon because several residents would experience "sundown symptoms" which would take away staff that were supposed to be conducting activities, to address individual resident's needs at that moment. Interview with MCC on 07/01/19 at 3:41pm revealed: -She was hired in May as the MCC for the SCU. -Since the census in the SCU had dropped below the number which required a MCC to be on staff, she had been scheduled as the medication aide (MA) for the whole building (both assisted living and SCU) frequently over the past several weeks. -Since she had been working in the MA role more often for about the past 3 weeks, she had been unable to fulfill some of her MCC responsibilities, such as assuring activities were being carried out as scheduled. -When she was passing medications in the SCU, she would try to engage with the residents in the SCU as much as possible while and directed the SCU staff to implement the activities. -Staff had not been documenting for at least 3 weeks what the residents had participated in for scheduled activities. Interview with the Administrator on 07/02/19 at 3:10pm revealed:	D 315		

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D 315	Continued From page 33 -The MCC was responsible for assuring activities are carried out as scheduled in the SCU. - Each resident was supposed to have a monthly calendar on which the staff were supposed to highlight the activities in which the resident participated each day. -She had observed on many occasions that activities were not always carried out in the SCU as scheduled when she would visit the unit. -She had verbally counseled the MCC that it was her responsibility to ensure activities were carried out as scheduled in the SCU. -The MCC had been working as a MA for the whole building recently, so she was not as available to monitor activities in the SCU. -The activity director for the assisted living side of the facility did not have any assigned responsibilities regarding implementing activities in the SCU.	D 315		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure each resident received care and services that were adequate, appropriate, and in compliance with relevant	D912		

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D912	Continued From page 34 federal and state laws and rules and regulations related to physician referral and follw up. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for 2 of 6 residents related to documented unsafe behaviors and contacting the mental health provider to verify behavior medications (Resident #7) and failed to follow-up with the physcian regarding a prescription for a pain medication (Resident #3). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care Referral and Follow Up (Type B Violation)].	D912		