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	HAL029001	A. BUILDING: _____ B. WING _____	10/28/2019

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BROOKSTONE RETIREMENT CENTER	2968 OLD SALISBURY ROAD LEXINGTON, NC 27295

(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 Davidson County Department of Social Services conducted an annual survey on October 23, 24, 25 and 28, 2019.	D 000		
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 record reviews and interviews, the facility failed to assure 2 of 6 sampled staff (Staff A, Staff B) were tested for Tuberculosis disease (TB) upon hire. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired on 07/08/19 as a medication aide (MA). -There was documentation of a TB test administered on 07/29/19 and read on 07/31/19 with negative results. -There was a second test administered on 08/19/19 and read on 8/21/19 with negative results. Interview with Staff A on 10/28/19 at 11:00 am	D 131		

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D 131	Continued From page 1 revealed: -She was not aware she needed TB testing done upon hire. -The facility management was responsible for assuring her TB testing was done upon hire. Refer to interview with the Resident Care Coordinator on 10/25/19 at 11:45 am. Refer to interview with the Administrator on 10/25/19 at 11:50 am. 2. Review of Staff B's personnel record revealed: -She was hired on 02/25/19 as a personal care aide. -There was documentation of a TB skin test administered on 03/12/19 and read on 03/14/19 with negative results. -There was documentation of a second TB skin test administered on 04/10/19 and read on 04/12/19 with negative results.. Interview with Staff B on 10/28/19 at 3:20 pm was unsuccessful. Refer to interview with the Resident Care Coordinator on 10/25/19 at 11:45 am. Refer to interview with the Administrator on 10/25/19 at 11:50 am. _____ Interview with the Resident Care Coordinator (RCC) on 10/25/19 at 11:45 am revealed: -The Director of Nursing (DON) was in charge of administering the TB test for staff, but he had been at another facility for several weeks. -They had to wait for another registered nurse to do the TB testing for staff. -Her understanding was as long as the first TB	D 131		

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D 131	Continued From page 2 testing for staff was done in the first week or two of employment it was okay. Interview with the DON on 10/25/19 at 11:50 am revealed: -He usually provided the TB testing for staff to save the staff the money for the test, but he was working at a sister facility when Staff A and Staff B were hired. -Another nurse administered the TB tests to Staff A and Staff B.	D 131		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 7 sampled residents (#5) residing in the special care unit (SCU), having repeated falls and requiring hip replacement surgery. The findings are:	D 270		

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Review of Resident #5's current FL-2 dated 07/24/19 revealed:
-Diagnoses included Alzheimer's disease, hypertension, hyponatremia and tobacco use.
-The resident had wandering behaviors.
-The resident resided on the Special Care Unit (SCU).

Review of Resident #5's Care Plan dated 08/14/19 revealed:
-The resident had wandering behaviors and needed a safe and secure environment.
-The resident used a rollator (rolling walker) for ambulation.
-The resident was confused and forgetful.
-The resident's cognitive abilities affected his ability to perform activities of daily living (ADLs).
-The resident needed assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring.
-There was no documentation of a history of falls.

Review of Resident #5's Incident/Accident report dated 07/01/19 at 12:00 am revealed:
-Resident #5 sat on the edge of (his) mattress and slid onto the floor.
-A small laceration on his neck and under his left ear was noticed.
-Range of motion (ROM) was performed and vital signs were taken.
-"No complaints of pain were noted at the moment".

Review of the electronic medication administration record (e-MAR) Nurse's Comments documentation dated 07/02/19 at 6:27 am revealed:
-At 12:00 am, Resident #5 sat on the edge of mattress and slid onto the floor; while on the floor he moved his head and a small laceration was

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noticed on his neck and under his left ear.
-ROM and vital signs within normal limits; no complaints of pain at the moment.
-There was no documentation of increased supervision.

Review of Resident #5's Incident/Accident report dated 07/07/19 at 8:31 pm revealed:
-Resident #5 was trying to go to the bathroom in his room when he lost balance with his walker.
-There were no complaints of pain and no signs of injury.
-ROM was performed and vital signs were taken.

Review of the Nurse's Comments documentation on the e-MAR dated 07/07/19 at 8:44 pm revealed:
-Resident #5 fell last night while trying to go to the bathroom.
-"No signs of injury at this time."
-There was no documentation of increased supervision.

Review of Resident #5's Incident/Accident report dated 08/16/19 at 6:25 pm revealed:
-Resident #5 fell out of bed, his last finger on his left hand could not move.
-The resident was sent to the hospital.

Review of the e-MAR Nurse's Comments documentation dated 08/16/19 at 6:57 pm revealed:
-Resident #5 fell out of bed; he could not move the last finger on his left hand.
-The resident was sent to a local hospital.
-There was no documentation of increased supervision.

Review of Resident #5's medical records, from a local medical center, dated 08/16/19 revealed:

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D 270	Continued From page 5 -Resident #5 was found on floor, had rolled out of bed; it was unknown how long he had been on the ground. -His little and ring finger on his left hand were contracted. -There was an abrasion on the ring finger. -Resident #5 was diagnosed with acute cystitis, fall, contracture of left hand. -Resident #5 was discharged on 08/18/19. Review of Resident #5's Incident/Accident report dated 08/22/19 at 11:18 pm revealed: -Resident #5 was in his room and fell. -He had a skin tear on his left jaw, a skin tear on his lower back, and a skin tear on his left hand, pinky finger. -Resident #5's vital signs were taken. Review of the Nurse's Comments documentation on the e-MAR dated 08/22/19 at 4:31 pm revealed: -Resident #5 fell in his room. -Resident #5 had a skin tear on his left jaw, a skin tear on his lower back, and a skin tear on his left hand pinky. -There was no documentation of increased supervision. Review of the Nurse's Comments documentation on the e-MAR dated 09/19/19 at 3:41 pm revealed: -Resident #5 said "his bones had been hurting for a long time". -Resident #5's primary care provider (PCP) was contacted to have an x-ray for Resident #5. Review of Resident #5's Incident/Accident report dated 09/21/19 at 11:40 pm revealed: -Resident #5 was walking out of his bathroom, lost balance and fell on his bottom on the floor.	D 270		

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D 270	Continued From page 6 -He had no complaint of pain. -There was a small abrasion on his right elbow. Review of the Nurse's Comments documentation on the e-MAR dated 09/21/19 at 11:00 pm revealed: -Resident #5 was walking out from his bathroom to go lay in his bed and lost balance. -Resident #5 fell on his bottom on the floor. -The resident had no complaint of pain, but had a small laceration on his right elbow. Review of the Nurse's Comments documentation on the e-MAR dated 09/23/19 at 11:00 pm revealed: -A portable x-ray for hip and pelvis was done for Resident #5 at 8:00 pm. -The SCU MA called the PCP to read the results of the x-ray. -The PCP referred Resident #5 to an Orthopedic physician for an x-ray consult/appointment. -After reading the x-ray results, the Orthopedic physician immediately referred Resident #5 to the local medical center. Review of Resident #5's medical records, from a local medical center dated 09/26/19 revealed: -The patient had a mechanical fall when walking on 09/21/19, complained of hip pain after the fall. -The orthopedic surgeon called the primary physician and referred him to the emergency department. -Resident #5 was diagnosed with a closed fracture of left hip, fall, closed displaced fracture of left femoral neck and was admitted for inpatient management of hip fracture with surgery. -Resident #5 was discharged to a rehabilitation facility on 10/01/19.	D 270		

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D 270	Continued From page 7 Interview with a special care unit (SCU) personal care aide (PCA) on 10/28/19 at 10:40 am revealed: -She worked in the SCU for the last 5 weeks. -When she first starting working, Resident #5 could stand on his own. -She did not see him fall, but he would say his legs hurt and he could hardly walk. -She had not been asked to increase Resident #5's supervision by performing more frequent monitoring. -She was not aware of a falls policy for resident supervision. Interview with another SCU PCA on 10/28/19 at 10:50 am revealed: -When a resident had a fall, she would follow the medication aide's instructions and monitor the resident by "keeping an eye on them" as staff worked. -Observations of residents were done during rounds at shift changes. -Sometimes staff would do 15 minute checks for residents who were a fall risk; the MA would determine how long the 15 minute checks were to be done. -The checks were to be documented on a paper posted at the nurse's desk. -When she walked by a resident was on 15 minute checks, she would stop by the desk and sign her initials on the paper indicating that she checked on that resident. -If a resident had a second fall, they could get an order for a lap belt. -If a resident had more falls, the process was the same, 15 minute checks as determined by the MA. -She assisted Resident #5 by giving him a bath and helping him to get dressed. - Resident #5 used a walker and she sometimes	D 270		

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walked with him to the dining room.
-He did not complain of pain, but walked very slowly.
-She had not been told to make 15 minute checks for supervision for Resident #5.

Interview with a third SCU PCA on 10/28/19 at 11:15 am revealed:
-The medication aide (MA) would tell the PCAs if a resident was a fall risk.
-The PCA was not told of any supervision plan to be put into place before or after a resident had a fall.
-She did what she personally thought she should do for Resident #5 and keep the environment clear so there would not be any obstructions for the resident to trip over.
-Sometimes 15 minute checks were done for residents with falls; the 15 minute checks would continue as long as the MA determined, they could last for hours or up to a couple of days and sometimes "a couple more."
-She did not remember having training for residents with falls.
-She did not know of a facility policy for resident falls or for the prevention of resident falls.
-She was not instructed to increase supervision for Resident #5.

Interview with the SCU MA on 10/28/19 at 4:18 pm revealed:
-After a resident had a fall, incident reports were completed, the resident's power of attorney (POA) and their physician were notified.
-Staff would watch the resident to see how they walked.
-Sometimes residents were put on 15 minute checks for 3 days up to a week.
-If a resident had a second fall, physical therapy might be requested.

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D 270	Continued From page 9 -For the third or more falls staff would call the resident's family to determine what they wanted the facility to do for the resident's reoccurring falls. -On 07/01/19, Resident #5 slid off of his bed and onto the floor; he had a small laceration on his neck and under his left ear. -On 07/07/19, Resident #5 fell while trying to go to the bathroom; there were no signs of injury. -On 08/16/19, Resident #5 fell out of bed and could not move his left hand, last finger. - On 08/22/19, Resident #5 fell in his room, had a skin tear on his left jaw, left lower back, and left hand, last finger. -On 09/21/19, Resident #5 was walking out of his bathroom, lost balance and fell onto his bottom onto the floor. -Resident #5 sustained a small laceration on his right elbow. -She was responsible for documentation for Resident #5 in the e-MAR Nurses Comments. -The plan for supervision for Resident #5 was documented in the e-MAR Nurses Comments. Interview with the Special Care Unit Manager (SCUM) on 10/28/19 at 4:58 pm revealed: -Residents known to be a falls risk were placed on every 15 minutes checks for 3 days "to see how they do and if their shoes fit". -Staff would walk with the resident to assist with ambulation to the bathroom. -If a resident had a fall, there was not much staff could do except the 15 minutes checks. -Staff would alternate doing observations of a resident due to having to take care of other residents. -Whichever staff was in the area of the resident to be watched would do the 15 minutes checks. -Besides doing the 15 minute checks, staff checked on residents during every 2 hour rounds.	D 270		

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D 270	Continued From page 10 -"There was no documentation of the 2 hour checks anywhere, it was up to the MA to see that they were done." -Resident #5 was monitored for falls by watching him and assisting with activities of daily living (ADLs). -After Resident #5 fell on 07/01/19 and 07/07/19, he was put on every 15 minutes checks. -The MAs would instruct the PCAs when to do the 15 minute checks. -There was no documentation of the 15 minute checks being done. -After Resident #5 fell on 08/16/19 and went to the hospital; the primary care provider said "the resident looked normal" and his medications were evaluated. -There was no documentation of the 15 minute checks being done for Resident #5. -After Resident #5 fell on 08/22/19, 15 minute checks were started and ended on 08/30/19. -An order for a physical therapy evaluation for Resident #5 was requested and approved on 08/22/19. -Resident #5 fell on the floor on his bottom on 09/21/19; he had no complaint of pain. -The PCP on call made a referral for Resident #5 to see an orthopedic physician. -A portable x-ray was done, the results sent to the orthopedic physician, and Resident #5 was sent to the emergency department (ED) of a local hospital. -The facility did not have a policy for the supervision of residents having a risk for falls. Review on 10/28/19 of submitted "Every 15 Minute Checks" log documentation, received on 10/28/19, for Resident #5 revealed there were initialed 15 minute checks for the dates of 08/23/19 through 08/27/19.	D 270		

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D 270	Continued From page 11 Review of e-MAR Nurses Comments documentation from 07/02/19 to 09/23/19 revealed there was no documentation of increased supervision for Resident #5 for falls. Interview with Resident #5's Guardian on 10/18/19 at 12:00 pm revealed: -She visited Resident #5 once a week, the days and times varied. -There was never a discussion with facility staff about what to put in place to prevent Resident #5 from falling. -She had not been asked by the SCU MA about putting changes in place for supervising Resident #5. -She did not see any documentation changes in Resident #5"s Care Plan for falls or prevention of falls. -She gave permission for Resident #5 to have physical therapy (PT) on 08/26/19. -She visited Resident #5 on Monday (09/23/19) after his fall the night before. -Resident #5 was seated in a wheel chair because he could not walk. -The SCU MA told her the PCP would be called to have an x-ray done for Resident #5. -Resident #5's PCP reviewed the x-ray and requested an orthopedic appointment for the resident. -The orthopedic physician reviewed the results of the x-ray and made a referral for Resident #5 to be transported to the local hospital immediately. -She was contacted by the hospital, on 09/23/29, to give consent for Resident #5 to have hip replacement surgery. Interview with the PCP's office nurse on 10/28/19 at 2:30 pm revealed: -Resident #5 was seen on 08/21/19 for a follow-up after a fall.	D 270		

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D 270	Continued From page 12 -On 9/23/19, a hip and pelvis x-ray was ordered for Resident #5 after having a fall. -There was no documentation of fall prevention precautions, in the physician's notes, for Resident #5. -When asked by his nurse, the physician replied he "expected facility staff to closely supervise Resident #5 for gait and balance". Interview with the Administrator on 10/28/19 at 5:30 pm revealed: - Resident #5's incident reports were not given to her for review. -Any actions taken for supervision for Resident #5 should have been documented in the e-MAR Nurses Comments and Care Plan. -Staff should have called Resident #5's physician to get an order for a lap belt and 15 minute checks should continue for residents with falls. -Staff needed more training on residents having falls. Observation of Resident #5 on 10/24/19 at 5:30 pm revealed the resident returned to the facility from the rehabilitation facility by the emergency medical service (EMS). _____ The facility failed to provide supervision to Resident #5 who resided on the SCU and had a recent history of falls. This failure resulted in injuries which included a closed fracture of the left hip and a closed displaced fracture of the left femoral neck which required surgery. This failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 10/25/19. CORRECTION DATE FOR THE TYPE A1	D 270		

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D 270	Continued From page 13 VIOLATION SHALL NOT EXCEED NOVEMBER 27, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 7 sampled residents (Resident #1) related to scheduled medications not administered on dialysis days, a phosphorus lowering medication, a high blood pressure medication, a heart medication, and ophthalmic drops. The findings are: Review of Resident #1's current FL-2 dated 01/08/19 revealed diagnoses included acute kidney injury, iron deficiency anemia due to chronic blood loss, Stage 4 kidney disease, essential hypertension, and Type 2 diabetes with chronic kidney disease, with long term current use of insulin. Review of Resident #1's discharge summary	D 273		

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dated 10/14/19 revealed the resident was admitted to a local hospital on 10/09/19 for worsening renal insufficiency and volume overload secondary to renal failure. The resident was started on hemodialysis and discharged from the hospital with instructions to continue hemodialysis on a Monday, Wednesday, and Friday schedule.

a. Review of Resident #1's current discharge summary dated 10/14/19 revealed there was an order for calcium acetate (used to prevent high blood phosphate levels for people on dialysis) 667 mg take 2 tablets three times a day with meals.

Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed:
-There was an entry for calcium acetate 667 mg take 2 tablets three times a day with meals and scheduled for at 8:00 am, 12:00 pm, and 5:00 pm daily.
-Calcium acetate 667 mg tablets were not documented as administered at 12:00 pm on 10/16/19, 10/18/19, 10/21/19, 10/23/19, and 10/25/19 with documentation the resident was on leave of absence (LOA).

Refer to the interview with Resident #1 on 10/28/19 at 8:30 am.

Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am.

Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am.

Refer to the interview with the Resident Care

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D 273	Continued From page 15 Coordinator (RCC) on 10/28/19 at 3:00 pm. Refer to the interview with the Administrator on 10/28/19 at 3:05 pm. b. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order for clonidine 0.2 mg (used to treat high blood pressure) one tablet three times a day. Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed: -There was an entry for clonidine 0.2 mg one tablet three times a day and scheduled at 8:00 am, 12:00 pm, and 8:00 pm. -Clonidine 0.2 mg tablets were not documented as administered at 12:00 pm on 10/16/19, 10/18/19, 10/21/19, 10/23/19, and 10/25/19 with documentation the resident was on leave of absence (LOA). Refer to the interview with Resident #1 on 10/28/19 at 8:30 am. Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am. Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm. Refer to the interview with the Administrator on 10/28/19 at 3:05 pm. c. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order for	D 273		

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isosorbide dinitrate 40 mg (used to treat decreased heart blood supply) three times a day.

Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed:
-There was an entry for isosorbide dinitrate tablets 40mg three times a day and scheduled at 8:00 am, 12:00 pm, and 8:00 pm.
-Isosorbide dinitrate 40 mg was not documented as administered at 12:00 pm on 10/16/19, 10/18/19, 10/21/19, 10/23/19, and 10/25/19 with documentation the resident was on leave of absence (LOA).

Refer to the interview with Resident #1 on 10/28/19 at 8:30 am.

Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am.

Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm.

Refer to the interview with the Administrator on 10/28/19 at 3:05 pm.

d. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order for Refresh 1% ophthalmic drops (used to dry, irritated eyes) 4 times a day.

Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed:
-There was an entry for Refresh 1% ophthalmic

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drops 4 times a day and scheduled at 8:00 am, 12:00 pm, 5:00 pm, and 9:00 pm.
-Refresh 1% ophthalmic drops were not documented as administered at 12:00 pm on 10/16/19, 10/18/19, 10/21/19, 10/23/19, and 10/25/19 with documentation the resident was on leave of absence (LOA).

Refer to the interview with Resident #1 on 10/28/19 at 8:30 am.

Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am.

Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm.

Refer to the interview with the Administrator on 10/28/19 at 3:05 pm.

e. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order to start ketorolac 0.5% ophthalmic drops (used to treat itchy, irritated eyes) 4 times a day for 5 days.

Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed:
-There was an entry for ketorolac 0.5% ophthalmic drops 4 times a day for 5 days and scheduled at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm.
-Ketorolac ophthalmic drops were not documented as administered at 12:00 pm on 10/16/19, 10/18/19, and 10/20/19 with documentation the resident was on leave of

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D 273	Continued From page 18 absence (LOA). Interview with Resident #1 on 10/28/19 at 10:50 am revealed he was ordered ketorolac drops after his hospitalization in October 2019 because his eyes were swollen, irritated, and itchy when he went to the hospital. Refer to the interview with Resident #1 on 10/28/19 at 8:30 am. Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am. Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm. Refer to the interview with the Administrator on 10/28/19 at 3:05 pm. f. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order to start Neosporin ophthalmic drops (used to treat irritated, draining eyes) 4 times a day for 5 days. Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed: -There was an entry for Neosporin ophthalmic drops 4 times a day for 5 days and scheduled at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. -Neosporin ophthalmic drops were not documented as administered for 2 of 20 scheduled doses from 10/15/19 to 10/20/19. -Neosporin ophthalmic drops were not documented as administered at 12:00 pm on	D 273		

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D 273	Continued From page 19 10/16/19 and 10/18/19 with documentation the resident was on leave of absence (LOA). Interview with Resident #1 on 10/28/19 at 10:50 am revealed he was ordered Neosporin eye drops after the hospitalization in October 2019 because his eyes were swollen, irritated, and itchy when he went to the hospital. Refer to the interview with Resident #1 on 10/28/19 at 8:30 am. Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am. Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm. Refer to the interview with the Administrator on 10/28/19 at 3:05 pm. Interview with Resident #1 on 10/28/19 at 8:30 am revealed: -He went to dialysis on Monday, Wednesday, and Friday starting after he came from the hospital on 10/15/19. -He routinely left for dialysis at 10:15 am and returned to the facility around 5:15 pm. -He received his medications scheduled before he went to dialysis and medications scheduled after he returned from dialysis. -He did not receive medications scheduled for administration at 12:00 pm on dialysis days (Monday, Wednesday, or Friday). Interview with the physician's assistant (PA) at	D 273		

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Resident #1's primary care providers's (PCP) office on 10/28/19 at 10:50 am revealed:
-She did not know Resident #1 was not administered medications on dialysis days.
-She knew dialysis started on 10/16/19, but she had not been informed Resident #1 did not receive 12:00 pm medications on dialysis days.
-She would expect the facility to inform her so she could evaluate whether there should be changes to the times of administration or if the medication's doses scheduled for dialysis days could be held.

Interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am revealed:
-Resident #1 did not take medication with him to dialysis.
-The local dialysis clinic did not administer medications unless ordered by the dialysis practitioner.
-She did not send his medications with him to dialysis.
-She had not informed the RCC or prescriber that Resident #1 was not receiving medications at 12:00 pm on dialysis days because the resident had not been on dialysis very long and she just had not thought to let them know.

Interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm revealed:
-MA staff had not told her about Resident #1 being at dialysis when scheduled medications were due to be administered.
-The MAs or the RCC would be responsible to contact the physician's assistant (PA) at Resident #1's primary care providers's (PCP) office regarding how medications scheduled for administration at 12:00 pm on dialysis days should be handled.
-She had not contacted Resident #1's PA

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D 273	Continued From page 21 regarding Resident #1 not be administered 12:00 pm medications on dialysis days. Interview with the Administrator on 10/28/19 at 3:05 pm revealed: -The RCC was responsible to assure MA staff were administering medications as ordered and notifying the PCP for missed medications on dialysis days. -She knew at one time residents took medications to dialysis for administration while at dialysis. -She did not know the local dialysis did not currently administer residents' medications.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the	D 280		

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D 280	Continued From page 22 resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure a Registered Nurse (RN) completed an on-site Licensed Health Professional Support (LHPS) evaluation and assessment within thirty days and quarterly for 1 of 2 sampled residents (Resident #6) who had an order for a restraint to prevent falls while in bed. The findings are: Review of Resident #6's current FL-2 dated 12/11/18 revealed diagnoses included Alzheimer's dementia with behavioral disturbances, type 2 diabetes mellitus with stage 3 chronic kidney disease, vitamin d deficiency, anemia of chronic disease and enterocutaneous fistula. Review of Resident #6's physician's order dated 05/22/19 revealed there was an order for bedrails to prevent falls. Review of Resident #6's physician's order dated 08/14/19 revealed there was an order for bedrails to prevent falls. Review of Resident #6's LHPS assessment dated 04/18/19 revealed there was no LHPS task completed for restraint use. Review of Resident #6's current LHPS	D 280		

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D 280	Continued From page 23 assessment dated 07/01/19 revealed there was no LHPS task completed for restraint use. Observation of Resident #6's bedroom on 10/23/19 at 11:10 am revealed there were ¾ siderails attached to both sides of her bed in a downward position. Observation of Resident #6's bedroom on 10/25/19 at 10:45 am revealed: -There were ¾ siderails attached to both sides of her bed in an upward position. -Resident #6 was lying in the bed on her back. Telephone interview with the LHPS nurse on 10/25/19 at 1:54 pm revealed: -It was the LHPS nurse expectation the staff inform the nurse of any new task or discontinued tasks for Resident #6. -The LHPS nurse expectation was for staff to review the LHPS review for Resident #6. -There was a place on the LHPS review for the staff to sign and date and to confirm if information needed to be added or deleted from the LHPS review for Resident #6. -The staff should have notified the LHPS nurse Resident #6 had an order for restraint use while in bed. Interview with the Interim Special Care Unit Coordinator (SCUC) on 10/25/19 at 3:39 pm revealed: -The staff was responsible for giving Resident #6's record to the LHPS nurse. -It was the LHPS's nurse responsibility to interview the staff and Resident #6 about the LHPS tasks for the resident. -The staff who signed and dated the LHPS review for Resident #6 were saying the LHPS review was accurate.	D 280		

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D 280	Continued From page 24 -The task for restraints should have been added to the LHPS review for 07/11/19. -The previous SCUC signed and dated the LHPS evaluation, but she no longer worked at the facility as of 10/19/19. Interview with the Administrator on 10/25/19 at 3:50 pm revealed: -A personal care aide (PCA) went with the LHPS nurse to do the assessment for Resident #6. -When a staff signed the LHPS review for Resident #6, they were confirming the LHPS review was correct for Resident #6. -The task for restraint use should have been added to the LHPS review for 07/11/19. -The LHPS nurse was given a list of residents with LHPS tasks. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.	D 280		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the air vents in the kitchen areas were clean and free of contamination related to dusty and rusty air vents blowing in the 3-door reach in cooler, ice	D 282		

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D 282	Continued From page 25 machine, ice scoop, shelf with stored dishes and coffee preparation area. The findings are: Observation of the kitchen area on 10/24/19 at 3:50 pm - 4:10 pm revealed: -There was a 3-door reach in cooler with three circular air vents with dust blowing over the food in the cooler. -There was an ice scoop lying on the ice machine with the handle hanging slightly over the edge of the front of the ice machine. -There was a dusty air vent on the right side of the ice machine. -There were two rusty and dusty air vents blowing over the shelf with stored dishes. -There were 2-sets of 4 rusty and dusty air vents blowing air over the coffee preparation area. Interview with the cook on 10/24/19 at 4:10 pm revealed: -She was responsible for cooking, stocking supplies, sweeping and mopping the floor. -It was not her responsibility to clean the air vents in the kitchen. -She did not know who was responsible for cleaning the air vents in the kitchen. -She did not know who put the ice scoop on top of the ice machine. -She removed the ice scoop from the top of the ice machine and washed it. -The ice scoop should have been stored in a container on the side of the ice machine. Interview with the Dietary Manager (DM)/Administrator on 10/25/19 at 3:30 pm: -She did not know the air vents in the 3-door reach in cooler were dusty. -She did not know the ice scoop was lying on the	D 282		

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D 282	Continued From page 26 top of the ice machine. -The ice scoop should have been stored in a container and not lying on the top of the ice machine. -The DM did not know the air vents over the shelf with stored dishes, and the coffee preparation area were dusty and rusty. -There was a dietary aide (DA) who worked from 8:00 am -2:00 pm who was responsible for cleaning the kitchen. -The DA was responsible for making her own cleaning schedule in the kitchen area. -The DA was responsible for making sure the kitchen area was clean. -If the DA saw something needed to be cleaned, she should clean the area. -The air vents should have been cleaned by the DA. Telephone interview with the DA on 10/25/19 at 4:24 pm revealed: -The DA vacuumed the outside of the air vents, but she did not take the air vents apart. -She did not remember the last time she vacuumed or dusted the air vents. -She had reported to the previous DM over a year ago about the air vents being rusty in the kitchen. -She cleaned the ice machine last week. -The DA worked from 8:00 am-2:00 pm Monday-Friday, and she was responsible for cleaning the kitchen area. -She did not do the same cleaning in the kitchen area every week -She worked around the other dietary staff's schedule. -She did not keep a cleaning log.	D 282		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 27 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 2 of 7 residents (#3 and #10) observed during the medication pass related to an oral inhaler, eye drops and insulin; and 1 of 7 sampled residents (#1) for record review related to not administering doses of blood pressure medications, eye drops, and a phosphorus lowering medication on dialysis days. The findings are: The medication error rate was 11% as evidenced by 3 errors of 27 opportunities observed during the 8:00 am medication pass on 10/24/19. 1. Review of Resident #10's current FL2 dated 06/11/19 revealed diagnoses included Alzheimer's Dementia, chronic obstructive pulmonary disease (a disease that blocks airways making it difficult to breath) and essential hypertension. a. Review of Resident #10's current FL2 dated 06/11/19 revealed there was an order for Zaditor ophthalmic solution (an antihistamine eye drop), instill 1 drop in the right eye twice a day.	D 358		

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D 358	Continued From page 28 Review of Resident #10's electronic medication administration record (eMAR) for October 2019 revealed there was an electronic entry for Zaditor ophthalmic solution, instill 1 drop in the right eye twice a day at 9:00 am and 9:00 pm. Observations during the morning medication pass on 10/24/19 at 8:44 am revealed: -The medication aide (MA) explained to Resident #10 that it was time for her eye drops. -The MA tilted the resident's head back and placed two drops of Zaditor into the right eye. -While the MA administered the eye drops, she touched the tip of the dropper bottle to the resident's eye lid. Interview with the MA on 10/24/19 at 2:30 pm revealed: -She was not aware she had administered 2 drops of Zalitor to Resident #10's right eye. -She did not realize the dropper touched Resident #10's eye when she was applying the medication. Interview with the Memory Care Director (MCD) on 10/24/19 at 4:58 pm revealed: -The MA should administer medications as ordered. -The MCD did not know the medication aide had administered 2 drops to Resident #10. -The MCD had observed staff administering medications occasionally, but she had not seen the MA administer medications recently. Telephone interview with a pharmacist at the facility's providing pharmacy on 10/28/19 at 11:00 am revealed when eye drops were administered, the tip of the dropper bottle must not touch any surface to prevent contamination of the medication.	D 358		

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D 358	Continued From page 29 Based on record review, and observation of Resident #10 on 10/24/19, it was determined the resident was not interviewable. b. Review of Resident #10's current FL2 dated 06/11/19 revealed an order for Spiriva Respimat 1.25mcg, inhale 2 puffs once daily for chronic obstructive pulmonary disease (Spiriva is used to dilate airways of the lungs). Review of Resident #10's eMAR for October 2019 revealed there was an electronic entry for Spiriva Respimat 1.25mcg, inhale 2 puffs once daily for chronic obstructive pulmonary disease to be administered at 9:00am. Observation during the morning medication pass on 10/24/19 at 8:47 am revealed: -The MA prepared the hand-held inhaler, depressed the button and waved the inhaler in a circular pattern approximately 4 inches from the resident's nose and face while she discharged the medication. -The MA followed the same procedure as she administered the second dose. -The MA was not observed giving instructions for breathing to the resident, no attempt to place the inhaler in the resident's mouth. Interview with the MA on 10/24/19 at 2:30 pm revealed: -She had observed another MA administer hand-held inhalers to residents who could not follow instructions by waving the inhaler in circular motions in front of the resident. -The second MA not longer worked at the facility. Telephone interview with a pharmacist at the facility's providing pharmacy on 10/28/19 at 11:00	D 358		

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pm revealed:
-The instructions included with the Spiriva Respimat inhaler directed the user to tightly seal lips around mouthpiece of inhaler during use.
-The method used by the MA to administer the medication would not assure the complete dose was inhaled by the resident.
-By not receiving her Spiriva, symptoms of chronic obstructive airway disease could be exacerbated.

Interview with the Memory Care Director (MCD) on 10/24/19 at 4:58 pm revealed:
-The MCD did not know the medication aide had administered Spiriva by waving the inhaler in front of the resident's face.
-The MCD had observed staff administering medications occasionally, but she had not seen the MA administer Spiriva to Resident #10 by waving the inhaler in front of the resident's face.

Based on record review, and observations of Resident #10 on 10/24/19, it was determined the resident was not interviewable.

2. Review of Resident #3's current FL2 dated 11/01/18 revealed:
-Diagnoses included dementia and insulin dependent diabetes mellitus.
-There was an order for fingerstick blood sugars (FSBS) before meals with sliding scale coverage with Novolog Flexpen insulin.

Review of Resident #3's electronic medication administration record (eMAR) for October 2019 revealed:
-There was an electronic entry for Novolog Flexpen insulin, inject 10 units subcutaneously before each meal scheduled at 8:00am, 12:00pm and 4:00pm.

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D 358	Continued From page 31 -There was an electronic entry for FSBS three times a day scheduled at 8:00 am, 12:00 pm and 4:00 pm with Novolog Flexpen insulin per sliding scale instructions. -There were instructions to prime the Novolog Flexpen with 2 units prior to each use (required to assure that full dose of insulin is administered by clearing any air from the insulin pen). Observation of the medication pass on 10/24/19 at 11:40 am revealed: -The MA performed a FSBS on Resident #3 and the result was 123. -The MA prepared the Novolog Flex pen to inject 10 units of insulin per routine orders. -The MA was not observed priming the Novolog Flex pen with 2 units. -After the insulin was injected into Resident #3, the MA was observed counting to three rapidly and withdrawing the insulin pen needle from injection site. -No insulin was observed leaking from Resident #3's skin. Interview with the AL/MA on 11/24/19 at 11:41 am revealed: -She was not aware she omitted the air shot. -She did not know she should hold the syringe in place for a slow count of 6 after the insulin dose was administered through the pen. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/28/19 at 11:00 pm revealed: -Instructions included with the Novolog Flexpen instructs that an "air shot" should be performed by holding the insulin pen upright, tap with fingernail to move possible air bubbles to the top of the insulin cartridge. Dial 2 units on meter and depress injector button. Observe for insulin at	D 358		

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end of needle, if not seen repeat.
-Once selected dosage is injected, wait until the dosage meter returned to zero and slowly count to six before withdrawing the needle from the injection site.
-These instructions assure the correct dosage of insulin was administered.

Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 4:58 pm revealed:
-The MAs have been checked off for insulin pen usage.
-The MA should administer medications as ordered.

Based on record review, and observation of Resident #10 on 10/24/19, it was determined the resident was not interviewable.

3. Review of Resident #1's current FL-2 dated 01/08/19 revealed diagnoses included acute kidney injury, iron deficiency anemia due to chronic blood loss, Stage 4 kidney disease, essential hypertension, and Type 2 diabetes with chronic kidney disease, with long term current use of insulin.

Review of Resident #1's discharge summary dated 10/14/19 revealed the resident was admitted to a local hospital on 10/09/19 for worsening renal insufficiency and volume overload secondary to renal failure. The resident was started on hemodialysis and discharged from the hospital with instructions to continue hemodialysis on Monday, Wednesday, and Friday schedule.

a. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order for calcium acetate (used as a phosphorus lowering

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medication) 667 mg take 2 tablets three times a day with meals.

Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed:
-There was an entry for calcium acetate 667 mg take 2 tablets three times a day with meals.
-Calcium acetate 667 mg tablets were scheduled for administration on the eMAR at 8:00 am, 12:00 pm, and 5:00 pm daily from 10/15/19 at 8:00 am to 10/28/19.
-Calcium acetate 667 mg tablets were not administered at 12:00 pm on 10/16/19, 10/18/19, 10/21/19, 10/23/19, and 10/25/19 with documentation the resident was on leave of absence (LOA).
-Calcium acetate 667 mg tablets were documented as not administered for 5 of 39 scheduled doses from 10/15/19 to 10/27/19.

Refer to the interview with Resident #1 on 10/28/19 at 8:30 am.

Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am.

Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm.

Refer to the interview with the Administrator on 10/28/19 at 3:05 pm.

b. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order for clonidine 0.2 mg (used to treat high blood

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D 358	Continued From page 34 pressure) one tablet three times a day. Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed: -Resident #1's blood pressure values ranged from 160/90 to 130/80. -There was an entry for clonidine 0.2 mg one tablet three times a day. -Clonidine 0.2 mg tablets were scheduled on the eMAR for administration at 8:00 am, 12:00 pm, and 8:00 pm daily from 10/15/19 at 8:00 am to 10/28/19. - Clonidine 0.2 mg tablets were not administered at 12:00 pm on 10/16/19, 10/18/19, 10/21/19, 10/23/19, and 10/25/19 with documentation the resident was on leave of absence (LOA). -Clonidine 0.2 mg tablets were documented as not administered for 5 of 39 scheduled doses from 10/15/19 to 10/27/19. Refer to the interview with Resident #1 on 10/28/19 at 8:30 am. Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am. Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm. Refer to the interview with the Administrator on 10/28/19 at 3:05 pm. c. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order for isosorbide dinitrate 40 mg (used to treat	D 358		

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D 358	Continued From page 35 decreased heart blood supply) three times a day. Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed: -There was an entry for isosorbide dinitrate tablets 40mg three times a day. -Isosorbide dinitrate tablets were scheduled on the eMAR for administration at 8:00 am, 12:00 pm, and 8:00 pm daily from 10/15/19 at 8:00 am to 10/28/19. -Isosorbide dinitrate 40 mg was not administered at 12:00 pm on 10/16/19, 10/18/19, 10/21/19, 10/23/19, and 10/25/19 with documentation the resident was on leave of absence (LOA). -Isosorbide dinitrate 40 mg dose was documented as not administered for 5 of 39 scheduled doses from 10/15/19 to 10/27/19. Refer to the interview with Resident #1 on 10/28/19 at 8:30 am. Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am. Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm. Refer to the interview with the Administrator on 10/28/19 at 3:05 pm. d. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order for Refresh 1% ophthalmic drops (used to dry, irritated eyes) 4 times a day.	D 358		

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Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed:
-There was an entry for Refresh 1% ophthalmic drops 4 times a day.
-Refresh 1% ophthalmic drops were scheduled on the eMAR at 8:00 am, 12:00 pm, 5:00 pm, and 9:00 pm from 10/15/19 to 10/27/19.
-Refresh 1% ophthalmic drops were not administered at 12:00 pm on 10/16/19, 10/18/19, 10/21/19, 10/23/19, and 10/25/19 with documentation the resident was on leave of absence (LOA).
-Refresh 1% ophthalmic drops were documented as not administered for 5 of 52 scheduled doses from 10/15/19 to 10/27/19.

Refer to the interview with Resident #1 on 10/28/19 at 8:30 am.

Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am.

Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm.

Refer to the interview with the Administrator on 10/28/19 at 3:05 pm.

e. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order to start ketorolac 0.5% ophthalmic drops (used to treat itchy, irritated eyes) 4 times a day for 5 days.

Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019

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D 358	Continued From page 37 revealed: -There was an entry for ketorolac 0.5% ophthalmic drops 4 times a day for 5 days. -Ketorolac ophthalmic drops were scheduled on the eMAR at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm from 4:00 pm on 10/15/19 to 4:00 pm on 10/20/19. -Ketorolac ophthalmic drops were not administered at 12:00 pm on 10/16/19, 10/18/19, and 10/20/19 with documentation the resident was on leave of absence (LOA). -Ketorolac ophthalmic drops were documented as not administered for 3 of 20 scheduled doses from 10/15/19 to 10/20/19. Interview with Resident #1 on 10/28/19 at 8:30 am revealed: -He was ordered ketorolac drops after his hospitalization in October 2019 because his eyes were swollen, irritated, and itchy when he went to the hospital. -He received ketorolac eye drops before he went to dialysis and after he returned. Refer to the interview with Resident #1 on 10/28/19 at 8:30 am. Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am. Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm. Refer to the interview with the Administrator on 10/28/19 at 3:05 pm.	D 358		

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D 358	Continued From page 38 f. Review of Resident #1's current discharge summary dated 10/14/19 revealed an order to start Neosporin ophthalmic drops (used to treat irritated, draining eyes) 4 times a day for 5 days. Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed: -There was an entry for Neosporin ophthalmic drops 4 times a day for 5 days. -Neosporin ophthalmic drops were scheduled on the eMAR at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm from 12:00 pm on 10/15/19 to 8:00 am on 10/20/19. -Neosporin ophthalmic drops were not administered at 12:00 pm on 10/16/19 and 10/18/19 with documentation the resident was on leave of absence (LOA). -Neosporin ophthalmic drops were documented as not administered for 2 of 20 scheduled doses from 10/15/19 to 10/20/19. Interview with Resident #1 on 10/28/19 at 8:30 am revealed: -He was ordered Neosporin eye drops after the hospitalization in October 2019 because his eyes were swollen, irritated, and itchy when he went to the hospital. -He received Neosporin eye drops before he went to dialysis and after he returned. Refer to the interview with Resident #1 on 10/28/19 at 8:30 am. Refer to the interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am. Refer to the interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am.	D 358		

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D 358	Continued From page 39 Refer to the interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm. Refer to the interview with the Administrator on 10/28/19 at 3:05 pm. _____ Interview with Resident #1 on 10/28/19 at 8:30 am revealed: -He went to dialysis on Monday, Wednesday, and Friday starting after he came from the hospital October 15, 2019. -He routinely left for dialysis at 10:15 am and returned to the facility around 5:15 pm. -He did not receive medications scheduled for administration at 12:00 pm on dialysis days (Monday, Wednesday, or Friday). -He received his medications scheduled before he went to dialysis and medications scheduled after he returned from dialysis. -Most dialysis days he received his medications scheduled for dinner (5:00 pm) when he got back to the facility. Interview with Resident #1's primary care Physician's Assistant (PA) on 10/28/19 at 10:50 am revealed: -She did not know Resident #1 was missing medication administration on dialysis days. -She knew dialysis started 10/16/19 but she had not been informed Resident #1 did not receive 12:00 pm medications on dialysis days. -She would expect the facility to inform her so she could evaluate whether there should be changes to the times of administration or if the medications doses scheduled for dialysis days could be held. Interview with a dayshift medication aide (MA) on 10/28/19 at 11:40 am revealed: -She routinely worked the dayshift which was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029001	A. BUILDING: _____ B. WING _____	10/28/2019

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D 358	Continued From page 40 currently 7:00 am to 7:00 pm. -Resident #1 started dialysis on 10/16/19 with Monday, Wednesday, and Friday as scheduled days. -Resident #1 did not take medication with him to dialysis. -The local dialysis unit does not administer medications unless ordered by the facility practitioner. -She marked Resident #1's medication as not administered on dialysis days because he let the facility around 10:15 am and returned around 5:15 pm. -She did not send his medications with him to dialysis. -She had not informed the RCC or prescriber that Resident #1 was not receiving medications at 12:00 pm on dialysis days because the resident had not been on dialysis very long and she just had not thought to let them know. Interview with the Resident Care Coordinator (RCC) on 10/28/19 at 3:00 pm revealed: -Medication aides were responsible to administer medications as ordered. -MA staff had not told her about Resident #1 being at dialysis when scheduled medications were due to be administered. -The MAs or the RCC would be responsible to contact Resident #1's prescriber regarding how medications scheduled for administration at 12:00 pm on dialysis days should be handled. -She had a system in place to run reports for missed medications, if the medications were not administered and not documented; however, she did not audit residents' records for medications missed and documented as on leave of absence. -She would review the facility's policy for missed medications with the MA staff, including residents being at appointments at scheduled time for	D 358		

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D 358	Continued From page 41 medications. Interview with the Administrator on 10/28/19 at 3:05 pm revealed: -The RCC was responsible to assure MA staff were administering medications as ordered. -She knew at one time residents took medications to dialysis for administration while at dialysis. -She did not know the local dialysis did not currently administer residents' medications.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in	D 468		

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D 468	Continued From page 42 Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff B), assigned to the Special Care Unit (SCU), completed 20 hours of training within the first 6 months in addition to the initial 6 hours of training the first week of employment specific to the population being served. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 02/25/19 as a personal care aide on the SCU. -There was no documentation of 6 hours of training for the first week of employment in the SCU. Attempted interview on 10/28 19 at 3:20 pm with Staff B was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 10/28/19 at 2:40 pm and at 3:25 pm revealed: -Staff B did not receive 6 hours of training within the first week of training. -Staff B completed 20 hours of training on 06/12/19. Attempted interview on 10/28/19 at 3:30 pm with	D 468		

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D 468	Continued From page 43 the Administrator was unsuccessful.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure every resident received care and services which were adequate, appropriate, and in compliance with relevant state rules and regulations for supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 7 sampled residents (#5) residing in the SCU, having repeated falls and requiring hip replacement surgery.[Refer to Tag D 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D912		