East Towne Assisted Living

4815 N Sharon Amity Road

Charlotte, NC 28205

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August 25,2020

Attached is the plan of correction in reference to the Statement of Deficiencies for East Towne Assisted Living, regarding the death complaint survey. Which was completed on 7/15/2020.Please feel free to contact me at the number or email listed above.

Thank you,

Marsha Pope

Marsha Pope, Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060149	A. BUILDING: _____ B. WING _____	07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a complaint investigation and a COVID-19 Infection Control Survey with an onsite visit on 07/01/20, a desk review survey on 07/01/20 - 07/03/20, 07/06/20 - 07/10/20, 07/13/20 - 07/15/20 and a telephone exit on 07/15/20. The Mecklenburg County Department of Social Services initiated the Complaint Investigation on 06/30/20.	D 000	Responses to the cited deficienies do not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance by law.	
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to respond immediately and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #1) who had bleeding from a central venous catheter that became dislodged which required an immediate emergency response. Review of Resident #1's current FL2 dated 06/03/20 revealed:	D 271	10A NCAC 13F .0901(C) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff Shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedure Staff were trained 6/23/2020 and 6/30/2020 on policy and procedure of how to respond to an emergency situation. Staff will be trained at the time of hire on the policy and how to respond in an emergency situation. Emergency response drills will be conducted by a certified CPR instructor at least once a quater per shift for no less than the next year. Training on Residents Rights will be held on the next available date with the Ombudsman. Residents Rights training conducted by Ombudsman completed on 7/31/2020 with all staff. Facility will be in compliance by 8/14/2020.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha Pope | TITLE: Executive Director | (X6) DATE: 8/25/2020

Reviewed and accepted by Diana Spalding BSN, RN on 09/15/20. DMS

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D 271	Continued From page 1 -Diagnoses included diabetes mellitus II (DM II), a contagious blood borne pathogen, end stage renal failure (ESRF) and hyperkalemia (an elevated level of potassium in the blood). -There was documentation Resident #1 had a "port in the right upper chest". Review of Resident #1's Physician's Order Report dated 06/03/20 revealed Resident #1 was a "Full Code", (all interventions needed to get their heart started). Review of Resident #1's Face Sheet dated 05/27/20 revealed Resident #1 was listed as a "Full Code". Review of Resident #1's electronic medication administration record (eMAR) from 06/01/20-06/23/20 revealed: -The heading of the eMAR documented Resident #1's name. -In parenthesis, next to the resident's name, was written "Full Code" in bold letters. Review of the American Heart Association's definition of a "Full Code" revealed: -A full code means a person will allow all interventions needed to get their heart started. -This may include chest compressions and defibrillation to shock the heart out of a life threatening heart rhythm. -A full code means the individual is willing to allow any of the above measures. Review of the facility's Accident /Falls/Emergency and Fire Safety Policy revealed: -When an accident or emergency occurs, staff should: -Remain calm. Do not panic -Call for help.	D 271		

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D 271	Continued From page 2 -Evaluate the resident. -Call 911 -Determine if the resident was breathing, conscious and check for a pulse. -Administer cardiopulmonary resuscitation (CPR) if appropriate-check for Do Not Resuscitate (DNR status). -Administer first aide as appropriate. -Continue emergency intervention until EMS arrives. Review of the Emergency Medical Services (EMS) report for Resident #1 dated 06/23/20 revealed: -The facility called EMS at 6:11am. -The unit was dispatched to the facility and arrived at 6:16am. -EMS was dispatched to the facility for cardiac/respiratory arrest. -"There were several liters of blood puddled throughout the room." -"The patient's bed was soaked with blood, the patient was covered in blood, his wheelchair was soaked in blood, and there were several puddles in the room of congealed blood." -"It appeared the patient's port in his right upper chest was removed which caused severe bleeding." -"The patient was moved to the floor and CPR was administered." -"While performing CPR, blood spewed out of the chest area where the port was removed." -"Due to the severity of blood loss, EMS consulted the hospital physician to determine if resuscitative efforts should be continued, or if the patient should be pronounced deceased. -The physician felt it was appropriate to pronounce the patient deceased. -"The patient was pronounced deceased at 0629."	D 271		

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D 271	Continued From page 3	D 271		

Telephone interview with a first responder on 07/01/20 at 9:00am revealed:
-When he arrived on the scene, the Paramedics were going into the facility.
-Resident #1 was sitting in his wheel chair approximately 3 feet away from the bed, facing the door to his room.
-The staff were out in the hallway and did not have on gloves or gowns.
-There was blood on Resident #1, on his wheelchair as well as under the wheel chair and on his bed.
-The Paramedics had on gowns, gloves, mask, and goggles.

Telephone interview with the Fire Chief on 07/01/20 at 9:10am revealed:
-He responded to a facility for a reported cardiac arrest.
-When he arrived on the scene the Paramedics had just entered the facility.
-The Paramedics were in full level 3 personal protective equipment (PPE), which included gown, gloves and goggles.
-The report he received was that CPR was not initiated by the facility staff prior to their arrival.
-There was an "excessive amount of blood" at the scene.
-The facility staff was not wearing gowns or gloves, just face masks.

Telephone interview with the first Medication Aide (MA) on 07/07/20 at 3:48pm revealed:
-She arrived for her shift at 5:00am on 06/23/20.
-She went into Resident #1's room around 6:00am to take his fingerstick blood sugar (FSBS) and administer his scheduled insulin.
- She observed Resident #1 sitting in his wheelchair with his head extended back. He did

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D 271	Continued From page 4 not have a shirt on. -There was blood all over him, the bed, the wheelchair and the floor. -The central venous catheter, inserted in his right upper chest, was fully dislodged and on the bed. -She called to him and he did not answer. -She took his radial pulse and she did not feel a pulse. -She yelled to the other MA to call 911 and told the personal care assistant (PCA) to wait at the door for the first responders. -She did not perform CPR because she could not locate any personal protective equipment (PPE). -She tried to get a sheet from the linen closet but it was locked and she did not have the key. -She did not know where to find PPE. -She thought the PPE might have been in the medication room, but she did not check. -The situation that morning was chaotic and traumatic. Telephone interview with a second MA on 07/07/20 at 4:10pm revealed: -She was the MA on the second shift, 7:00pm -7:00am, on 06/23/20. -She was providing personal care to residents and the first MA was administering medications and FSBS checks. -The first MA came running up the hall yelling, "he's dead, he's dead!". -She ran to the door of Resident #1's room and he was sitting in his wheelchair with his back to the door and his head hyper-extended. -The mattress was so soaked with blood it was sagging. -There was blood on the wheelchair and under the wheelchair. -She contacted 911. -She called the Administrator next who told the MAs to perform CPR on Resident #1.	D 271		

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D 271	Continued From page 5 -Due to Resident #1's diagnosis of a blood borne infection, the MAs did not want to perform CPR without PPE. -She did not know if there was PPE on the medication cart or the medication room. -She was looking for towels or linens to protect themselves so they could perform CPR. -While they were still looking for protection, the first responders arrived. Telephone interview with a third MA on 07/08/20 at 3:47pm revealed: -She worked the first shift as a MA. -When she was first hired and initially trained she was instructed the PPE gowns were located in the medication room and the gloves were on the medication carts. -The Administrator passed out the masks each shift and as needed. -At the end of each shift the MAs were responsible for re-stocking the medication carts with supplies, including PPE. Telephone interview with a fourth MA on 07/08/20 at 4:05pm revealed: -She worked first shift as a MA. -When they were trained earlier this year on the COVID 19 protocols, the Administrator informed the staff the protective gowns were in the medication room in a drawer. -Gloves are kept in the conference room and given to MAs to place on the medication carts and PCAs to place at the nurses station. -Masks were given to the staff each shift by the Administrator and as needed. Telephone interview with a PCA on 07/13/20 at 9:30am revealed: -PPE was kept at the nurses station (gowns and gloves).	D 271		

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D 271	Continued From page 6 -Masks were kept in the Administrators office and were given to the staff each shift or as needed. Telephone interview with the Administrator on 07/09/20 at 3:49pm revealed: -At approximately 6:19am, she received a call from the second MA informing her Resident #1 was unresponsive and bleeding. -She instructed the MA to perform CPR on Resident #1 until the first responders arrived. -When she arrived at the building at approximately 8:20am, she was told the MAs had not performed CPR while waiting for the medics to arrive. -The statement given by the first MA was that there was blood on the right side of Resident #1 and on his bed. There was no pulse and he was unresponsive. She did not initiate CPR because she did not have anything to protect herself. -The statement given by the second MA was that she told the first MA to start CPR. The first MA stated "There is blood everywhere!" The second MA tried to find towels to protect themselves. Before she could find any PPE the first responders arrived. -The Administrator and the Director of Operations checked the medication room, the nurses station and the conference room after the incident of 6/23/20. -There were gowns in the medication room, the nurses station and the medication carts. -There were gloves at the nurses station on both carts and in the conference room. -Masks were kept in good supply in the Administrators office, -She expected the CPR certified staff to perform CPR according to the facility's Accident /Falls/Emergency and Fire Safety Policy. Observation of the facility Personal Protective	D 271		

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D 271	Continued From page 7 Equipment on 07/01/20 at 12:45pm revealed: -There were 5 plastic packages containing 5 disposable gowns located at the Nurse's Station, in the top drawer of the desk. -There were 15 plastic packages containing 5 disposable gowns located in the medication room, in the top drawer and second drawer of the cabinet. -There were 10 unopened boxes of gloves, assorted sizes, located in the medication room, in the top drawer of the cabinet. -There was 1 unopened package containing 5 disposable gowns and 3 boxes of gloves located in the bottom drawer of each of the 2 medication carts. Review of the personnel files on 07/01/20 at 4:22pm revealed: -The first MA was CPR certified on 04/04/19 with an expiration date of 04/30/21. -The second MA was CPR certified on 07/29/19 with no expiration date listed. Telephone interview with the Regional LHPS RN on 07/10/20 at 9:20am revealed: -She arrived at the facility on 06/23/20 at approximately 9:30am for a scheduled training. -The two MAs were visibly shaken by the incident. -They had panicked and all they could say was there was blood everywhere. -She asked why they did not perform CPR on Resident #1, they both said "we did not do CPR because there was blood everywhere". Review of the Health Care Personnel Registry Summary report dated 06/25/20 revealed: -The staff member present on 06/23/20 during Resident #1's cardiac event refused to initiate CPR despite the resident being a full code and being instructed to initiate CPR (by the	D 271		

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D 271	Continued From page 8 Administrator). -Staff member stated she refused to initiate CPR due to Resident #1's diagnosis of a contagious blood borne pathogen, and she did not have anything to protect herself. -During the investigation, the facility noted adequate PPE located throughout the facility. The staff failed to respond in accordance with the facility's policy and procedures to provide cardiopulmonary resuscitation (CPR) to Resident #1 who was found unresponsive and bleeding in his room and was a "full code". The facility's policy was to perform CPR whenever a resident was found unresponsive, without a pulse and/or not breathing until EMS arrived. The CPR certified staff failed to perform CPR for Resident #1, as directed by their Administrator, when he was found in his room unresponsive and without a pulse. Resident #1 was pronounced dead shortly after the first responders arrived. This failure resulted in serious neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/ 20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 14, 2020.	D 271		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preperation and administration of medications, prescriptions and non presciptions, and non treatments by staff are in accordance with: (1) orders by a licensed prescribing practioner which are maintained in the residents records and (2) rules in this section and the facility's policies and procedures.	

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D 358	Continued From page 9 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents, related to medications for a contagious blood borne pathogen, hypertension, a blood thinner, elevated levels of potassium, fast acting insulin to lower blood sugar before meals and daily blood pressure checks with parameters (Resident #1); and related to blood pressure medications and blood pressure checks with parameters, medications used to prevent blood clots, medications used to lower blood sugars and medications used to lower high phosphorus levels in patients on dialysis (Resident #2). The findings are: 1. Review of Resident #2's current FL2 dated 04/01/20 revealed diagnoses included diabetes, diabetic chronic kidney disease, end stage renal failure, pulmonary embolism, bilateral below the knee amputation with prosthesis, hypertension, blind in the left eye, obstructive sleep apnea and hypertension. a. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for Eliquis (a medication used to to lower the risk of a stroke or blood clot) 5mg two times a day at 6:00am and 8:00pm.	D 358	DRC and Ed will conduct an inservice on correct Medication Administration documentation for MA including terminology was completed by 7/17/2020. DRC and RCM will perform an immediate cart audit and review of all MARS on 7/16/2020 and 7/17/2020 DRC and RCM will perform Med Pass Observations All MA will be revaluated by an RN completed on 7/28/2020 All MA will have training on the 5 and 10 hour Med Aide Training will be assigned FELS training completed on 7/20/2020 Facility will be in compliance by 8/14/2020	

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D 358	Continued From page 10 Review of Resident #2's May 2020 eMAR revealed: -There was an entry for Eliquis 5mg scheduled for administration at 6:00am and 8:00pm and documented as not administered, "gone to dialysis" on 05/01/20 at 6:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 6:00am, "resident unavailable" on 05/06/20, 05/13/20, 05/20/20, 05/22/20, 05/25/20, 05/27/20 and 05/29/20 at 6:00am, "refused" on 05/15/20 at 6:00am. -The Eliquis was documented as not administered 11 out of 62 opportunities. Review of Resident #2's June 2020 eMAR revealed: -There was an entry for Eliquis 5mg scheduled for administration at 6:00am and 8:00pm and documented as not administered, "dialysis" on 06/15/20 at 6:00am, "refused going to dialysis" on 06/22/20, at 6:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/06/20, 06/10/20, 06/12/20, 06/17/20 and 06/19/20 at 6:00am, "assisting resident" on 06/09/20 at 6:00am. -The Eliquis was documented as not administered 10 out of 60 opportunities. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/20 at 10:00am revealed: -Resident #2 was on a monthly cycle fill for medications that were scheduled. These medications were automatically sent to the facility on a specific date each month. -Eliquis 5mg two times a day, 28 tablets were filled on 07/06/20 and 28 tablets were sent out on 07/20/20. -If Resident #2 did not receive Eliquis as prescribed over a longer period than a few days, the potential for blood clotting would increase and	D 358		

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D 358	Continued From page 11 could cause damage to the new Arteriovenous Fistula (AVF, is an abnormal connection between the artery and a vein, used as a dialysis access port). Telephone interview with Resident #2's Cardiovascular Surgeon on 07/10/20 at 11:32am and 07/14/20 at 1:04pm revealed: -Resident #2 received a right upper chest AVF on 06/30/20 as a "last resort" for his dialysis access port. -Resident #2 had a left chest wall perma-cath (a catheter placed through a vein into or near the right atrium and used for dialysis in an emergency or permanent until a device is ready to use) after multiple failed accesses were placed. -The perma-cath was placed September 2019. b. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for Metoprolol (a medication used to lower blood pressure) 25mg 2 times a day on Monday, Wednesday and Fridays, (hold for a systolic blood pressure less than 110 and a pulse of less than 60) at 6:00am and 8:00pm. Review of Resident #2's May 2020 eMAR revealed: -There was an entry for metoprolol 25mg scheduled for administration at 6:00am and 8:00pm documented as not administered, "gone to dialysis" on 05/01/20 at 6:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 6:00am, "resident unavailable" on 05/06/20, 05/13/20, 05/20/20, 05/22/20, 05/25/20, 05/27/20 and 05/29/20 at 6:00am, "refused" on 05/15/20 at 6:00am. -The metoprolol was documented as not administered 11 out of 62 opportunities.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 Review of Resident #2's June 2020 eMAR revealed: -There was an entry for metoprolol 25mg scheduled for administration at 6:00am and 8:00pm documented as not administered, "dialysis" on 06/01/20 at 6:00am, "refused going to dialysis" on 06/22/20 at 6:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/08/20, 06/10/20, 06/12/20, 06/17/20 and 06/19/20 at 6:00am, "refused" on 06/29/20 at 6:00am. The metoprolol was documented as not administered 10 out of 60 opportunities. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/20 at 10:00am revealed: -Resident #2 was on a monthly cycle fill for medications that were scheduled. These medications were automatically sent to the facility on a specific date each month. -Metoprolol 25mg twice daily, 28 tablets were filled on 07/06/20 and 14 tablets were sent on 07/20/20. -If Resident #2 did not receive his Metoprolol to lower his blood pressure, as prescribed, it could cause the blood pressure to increase and could cause rebound hypertension (blood pressure rises) and an increase in pulse rate, heart attack or stroke. c. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for clonidine HCL (a medication used to lower blood pressure) 0.2mg three times a day, on Monday, Wednesday and Friday 05/01/20 - 05/06/20, then stop, (hold for a systolic blood pressure less than 110 and a pulse of less than 60) at 6:00am, 2:00pm and 8:00pm. Review of Resident #2's May 2020 eMAR revealed:	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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D 358	Continued From page 13 -There was an entry for clonidine HCL 0.2mg three times a day 05/01/20 - 05/06/20, on Monday, Wednesday and Fridays, then stop, scheduled for administration at 6:00am, 2:00pm and 8:00pm documented as not administered, "gone to dialysis" on 05/01/20 at 6:00am, "refused going to dialysis" on 05/04/20, at 6:00am, "resident unavailable" on 05/06/20 at 6:00am and "other" on 05/04/20 at 2:00pm. -The clonidine HCL was documented as not administered 4 out of 9 opportunities. d. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for sevelamer carbonate (a medication used to lower high phosphorus levels in patients who are on dialysis due to severe kidney disease) 800mg, take 3 tablets (2400mg) with meals at 7:00am, 12:00pm and 5:00pm. Review of Resident #2's May 2020 eMAR revealed: -There was an entry for sevelamer carbonate 800mg, take 3 tablets (2400mg) with meals scheduled for administration at 7:00am, 12:00pm and 5:00pm documented as not administered, "gone to dialysis" on 05/01/20 at 7:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 7:00am, "resident unavailable" on 05/06/20, 05/13/20, 05/20/20, 05/22/20, 05/25/20, 05/27/20 and 05/29/20 at 7:00am, "refused" on 05/15/20 at 7:00am. -The sevelamer carbonate was documented as not administered 11 out of 93 opportunities. Review of Resident #2's June 2020 eMAR revealed: -There was an entry for sevelamer carbonate 800mg, take 3 tablets (2400mg) with meals scheduled for administration at 7:00am, 12:00pm	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4816 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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and 5:00pm documented as not administered, "unavailable resident (out of facility) "OOF" on 06/11/20 at 12:00pm, 06/24/20, 06/29/20 at 8:00am and 06/29/20 at 6:00pm "refused " on 06/28/20 at 8:00am, 06/29/20, at 12:00pm and 06/30/20 at 8:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/08/20, 06/10/20, at 7:00am, and "resident unavailable treatment" on 06/26/20 at 8:00am.
-The sevelamer carbonate was documented as not administered 12 out of 90 opportunities.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/20 at 10:00am revealed:
-Resident #2 was on a monthly cycle fill for medications that were scheduled. These medications were automatically sent to the facility on a specific date each month.
-Sevelamer carbonate 800mg, take 3 tablets (2400mg) with meals, 252 tablets were filled on 07/06/20 and 126 tablets were sent out on 07/20/20.
-If Resident #2 did not receive the sevelamer carbonate as prescribed, it could lead to increased levels of phosphorus in the body which could increase the risk of heart attack.

e. Review of Resident #2's current FL2 dated 04/01/20 revealed an order to check a finger stick blood sugar (FSBS) and record two times a day at 6:00am and 8:00pm.

Review of Resident #2's May 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a entry for a finger stick blood sugar (FSBS) scheduled to be obtained at 6:00am and 8:00pm.
-The FSBS was documented as not obtained,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15 "gone to dialysis" on 05/01/20 at 6:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 6:00am, "resident unavailable" on 05/06/20, 05/13/20, 05/20/20, 05/22/20, 05/25/20, 05/27/20 and 05/29/20 at 6:00am, "refused" on 05/15/20 at 6:00am. -A FSBS was documented as not obtained 11 out of 62 opportunities. Review of Resident #2's June 2020 eMAR revealed: -There was a entry for a FSBS scheduled to be obtained at 6:00am and 8:00pm -The FSBS was documented as not obtained, "dialysis" on 06/01/20, and 06/15/20 at 6:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/08/20, 06/10/20, 06/12/20, 06/17/20, 06/19/20, "going to dialysis" on 06/22/20 at 6:00am and 05/29/20 at 6:00am, "assisting resident" on 06/09/20 at 6:00am. The documentation was blank 06/23/20 - 06/30/20, at 6:00am and 8:00pm. A FSBS was documented as not obtained 26 out of 60 opportunities. f. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for Dialyvite (a dialysis multivitamin) 1mg every day for end stage renal disease, at 6:00am. Review of Resident #2's May 2020 eMAR revealed: -There was an entry for Dialyvite 1mg every day scheduled for administration at 6:00am and documented as not administered, "gone to dialysis" on 05/01/20 at 6:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 6:00am, "resident unavailable" on 05/06/20, 05/13/20, 05/20/20, 05/22/20, 05/25/20, 05/27/20 and 05/29/20 at 6:00am, "refused" on 05/15/20 at	D 358		

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6:00am.
-The Dialyvite was documented as not administered 11 out of 31 opportunities.

Review of Resident #2's June 2020 eMAR revealed:
-There was an entry for Dialyvite 1mg scheduled for administration at 6:00am and documented as not administered, "dialysis" on 06/15/20 at 6:00am, "refused going to dialysis" on 06/22/20 at 6:00am, "assisting resident" on 06/09/20 at 6:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/08/20, 06/10/20, 06/12/20, 06/17/20 and 06/19/20 at 6:00am.
-The Dialyvite was documented as not administered 10 out of 30 opportunities.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/20 at 10:00am revealed:
-Resident #2 was on a monthly cycle fill for medications that were scheduled. These medications were automatically sent to the facility on a specific date each month.
-Dialyvite 1mg every day, 28 tablets were filled on 07/06/20 and 14 tablets were sent out on 07/20/20.

g. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for Tradjenta (is a medication used to lower blood sugars) 5mg every day at 6:00am.

Review of Resident #2's May 2020 eMAR revealed:
-There was an entry for Tradjenta 5mg scheduled for administration at 6:00am and documented as not administered, "gone to dialysis" on 05/01/20 at 6:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 6:00am, "resident

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D 358	Continued From page 17 unavailable" on 05/06/20, 05/13/20, 05/20/20, 05/22/20, 05/25/20, 05/27/20 and 05/29/20 at 6:00am, "refused" on 05/15/20 at 6:00am. -The Tradjenta was documented as not administered 11 out of 31 opportunities. Review of Resident #2's June 2020 eMAR revealed: -There was an entry for Tradjenta 5mg scheduled for administration at 6:00am documented as not administered, "dialysis" on 06/15/20 at 6:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 6:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/08/20, 06/10/20, 06/12/20, 06/17/20 and 06/19/20 at 6:00am, "assisting resident" on 06/09/20 at 6:00am, "refused going to dialysis" on 06/22/20 at 6:00am. -The Tradjenta was documented as not administered 12 out of 30 opportunities. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/20 at 10:00am revealed: -Resident #2 was on a monthly cycle fill for medications that were scheduled. These medications were automatically sent to the facility on a specific date each month. -Tradjenta 5mg every day, 28 tablets were filled on 07/06/20 and 14 tablets were sent out on 07/20/20. -If Resident #2 did not receive the Tradjenta as ordered, it could cause his blood sugars to increase. h. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for Vitamin D3 (a medication used to help the body absorb calcium and phosphorus) 125mcg every day at 6:00am. Review of Resident #2's May 2020 eMAR	D 358		

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revealed:
-There was an entry for Vitamin D3 5000 units scheduled for administration at 6:00am documented as not administered, "gone to dialysis" on 05/01/20 at 6:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 6:00am, "resident unavailable" on 05/06/20, 05/13/20, 05/20/20, 05/22/20, 05/25/20, 05/27/20 and 05/29/20 at 6:00am, "refused" on 05/15/20 at 6:00am.
The Vitamin D3 was documented as not administered 11 out of 31 opportunities.

Review of Resident #2's June 2020 eMAR revealed:
-There was an entry for Vitamin D3 5000 units scheduled for administration at 6:00am documented as not administered, "dialysis" on 06/15/20 at 6:00am, "refused going to dialysis" on 06/22/20, at 6:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/08/20, 06/10/20, 06/12/20, 06/17/20 and 06/19/20 at 6:00am, "assisting resident on 06/09/20 at 6:00am.
-The Vitamin D3 was documented as not administered 10 out of 30 opportunities.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/20 at 10:00am revealed:
-Resident #2 was on a monthly cycle fill for medications that were scheduled. These medications were automatically sent to the facility on a specific date each month.
-Vitamin D3 5000 units every day, 28 tablets were filled on 07/06/20 and 14 tablets were sent out on 07/20/20.

Telephone interview with the first medication aide (MA) on 07/08/20 at 2:03pm revealed:
-Resident #2 was at the front door waiting for his

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ride to dialysis before she got to his hall to administer morning medications.
-She did not administer any morning medications to Resident #2 on the days he left for dialysis treatment.
-There was no directive on the eMAR to do anything different on the days Resident #2 went out to dialysis.
-She did not know if Resident #2 received his morning medications when he returned from dialysis.

Telephone interview with a second MA on 07/08/20 at 2:33pm revealed:
-Resident #2 refused to take his morning medications on dialysis days.
-She would always ask him if he wanted to take his medications while he was waiting for his ride to the treatment center.
-He preferred not to take any medication before his dialysis treatment.
-She did not administer morning medications to Resident #2 on the mornings he went to dialysis.
-She was not working when Resident #2 returned from dialysis and she did not know if he was administered his morning medications when he returned from dialysis.

Telephone interview with the nurse practitioner (NP) on 07/08/20 at 4:44pm revealed:
-Resident #2 had informed the NP that he did not want to take his medications before dialysis but the NP did not know Resident #2 did not receive them at all.
-He should have received them when he returned from dialysis or the facility should have had the times of administration changed.
-The NP expected to be notified when a resident was not receiving their medications.
-He could have adjusted the medication

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D 358	Continued From page 20 administration schedule to accommodate Resident #2's dialysis treatment. Refer to telephone interview with the Administrator on 07/09/20 at 3:49pm. Refer to telephone interview with a medication aide (MA) on 07/08/20 at 2:03pm. Refer to telephone interview with a second MA on 07/08/20 at 2:33pm. Refer to telephone interview with a third MA on 07/08/20 at 3:47pm. 2. Review of Resident #1's current FL2 dated 06/03/20 revealed: -Diagnoses included diabetes mellitus II (DM II), a contagious blood borne pathogen, end stage renal failure (ESRF) and hyperkalemia. -There was documentation Resident #1 had a "port in the right upper chest". a. Review of Resident #1's signed Physician Order Report dated 06/03/20 revealed there was an order for abacavir 300mg, two tablets (600 mg) once daily, used to treat the progression of a contagious blood borne pathogen. Review of Resident #1's June 2020 electronic administration record (eMAR) from 06/01/20 through 06/22/20 revealed: -There was a computer generated entry for abacavir 300mg, 2 tablets (600mg) daily scheduled to be administered at 8:30am. - Abacavir 600mg was not documented as administered on 06/02/20, 06/06/20, 06/10/20, 06/11/20, 06/16/20, 06/18/20, and 06/20/20. -The reason documented on the eMAR by the medication aides (MAs) was "out of the facility" (OOF).	D 358		

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D 358	Continued From page 21 -Abacavir was documented as not administered 7 out of 22 opportunities. Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/20 at 2:41pm revealed: -The pharmacy staff filled Resident #1's medications upon admission on 05/27/20. -Resident #1 was on a monthly automatic fill for medications that were scheduled. These medications were sent on a specific date each month. -As needed (PRN) medications and insulin were filled as needed. -Abacavir 300mg, two tablets (600 mg) daily, 56 tablets were filled on 05/27/20, and 28 tablets on 06/17/20. -If Resident #1 did not receive abacavir for a few days there would be no acute symptoms. If he did not receive the medication as prescribed over a longer period of time, than a few days, he would develop an increased resistance to the medication. Telephone interview with Resident #1's nurse practitioner (NP) on 07/08/20 at 4:44pm revealed: - Resident #1's antiviral medication for a contagious blood borne pathogen had to be administered consistently to be effective. -He would expect the medication times to be changed to the afternoon, and administered when Resident #1 returned from dialysis. -He would expect to be notified if a resident was not receiving their scheduled medications for any reason. b. Review of Resident #1's signed Physician Order Report dated 06/03/20 revealed there was an order for clopidogrel 75mg, one tablet daily, used to prevent blood clots.	D 358		

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Review of Resident #1's June 2020 eMAR from 06/01/20 through 06/22/20 revealed:
-There was a computer generated entry for clopidogrel 75mg daily, scheduled to be administered at 8:30am.
-Clopidogrel was not documented as administered on 06/02/20, 06/06/20, 06/10/20, 06/11/20, 06/16/20, 06/18/20, and 06/20/20.
-The reason documented on the eMAR by the MAs was "out of the facility (OOF).
-Clopidogrel was documented as not administered 7 out of 22 opportunities.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/20 at 2:41pm revealed:
-Clopidogrel 75mg daily, 28 tablets were filled on 05/27/20 and 14 tablets were filled on 06/17/20.
-If Resident #1 did not receive clopidogrel over a few days, there would be no acute symptoms. If he did not receive the medication as prescribed over a longer period than a few days, the potential for blood clotting would increase.

Telephone interview with Resident #1's NP on 07/08/20 at 4:44pm revealed:
-Since Resident #1 had an upper right chest central venous catheter, he was at risk of clotting if he did not receive his blood thinner regularly.
-He would expect the medication times to be changed to the afternoon, and administered when Resident #1 returned from dialysis.
-He would expect to be notified if a resident was not receiving their scheduled medications for any reason.

c. Review of Resident #1's signed Physician Order Report dated 06/03/20 revealed there was an order for Tivicay 50mg, one tablet daily, used

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D 358	Continued From page 23 to treat the progression of a blood borne pathogen. Review of Resident #1's June 2020 eMAR from 06/01/20 through 06/22/20 revealed: -There was a computer generated entry for Tivicay 50mg daily, scheduled to be administered at 8:30am. -Tivicay was not documented as administered on 06/02/20, 06/06/20, 06/10/20, 06/11/20, 06/16/20, 06/18/20, and 06/20/20. -The reason documented on the eMAR by the MAs was "OOF" (out of the facility). -Tivicay was documented as not administered 7 out of 22 opportunities. Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/20 at 2:41pm revealed: -Tivicay 50mg daily, 28 tablets were sent on 05/27/20 and 14 tablets were sent on 06/17/20. -If Resident #1 did not receive Tivicay for a few days there would be no acute symptoms. If he did not receive the medication as prescribed over a longer period of time, than a few days, he would develop an increased resistance to the medication. Telephone interview with Resident #1's NP on 07/08/20 at 4:44pm revealed: -Resident #1's antiviral medications for a contagious blood borne pathogen had to be administered consistently to be effective. -He would expect the medication times to be changed to the afternoon, and administered when Resident #1 returned from dialysis. -He would expect to be notified if a resident was not receiving their scheduled medications for any reason.	D 358		

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d. Review of Resident #1's signed Physician Order Report dated 06/03/20 revealed there was an order for metoprolol tartrate 25mg, one half tablet (12.5mg) every 12 hours, used to treat hypertension.

Review of Resident #1's June 2020 eMAR from 06/01/20 through 06/22/20 revealed:
-There was a computer generated entry for metoprolol tartrate 12.5mg scheduled to be administered twice daily at 8:30am and 8:30pm.
-Metoprolol tartrate was not documented as administered on 06/02/20, 06/06/20, 06/10/20, 06/11/20, 06/16/20, 06/18/20, and 06/20/20.
-The reason documented on the eMAR by the MAs was "OOF" (out of the facility).
-Metoprolol was documented as not administered 7 out of 22 opportunities.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/20 at 2:41pm revealed:
-Metoprolol tartrate 12.5mg twice daily, 28 tablets were filled on 05/27/20 and 14 tablets were sent on 06/17/20.
-Resident #1 could experience rebound hypertension (a rise in blood pressure) and an increase in pulse rate if the medication was stopped or lowered.

Telephone interview with Resident #1's NP on 07/08/20 at 4:44pm revealed:
-He was concerned Resident #1 was not administered metoprolol on dialysis days.
-Resident #1 could spike a blood pressure of 180 or above.
-If that happened frequently over a 2 month period, he could be in danger of having a stroke.

e. Review of Resident #1's signed Physician

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D 358	Continued From page 25 Order Report dated 06/03/20 revealed there was an order for Renagel 800mg, one tablet three times a day with meals, used to treat an increase of potassium in the blood (hyperkalemia). Review of Resident #1's June 2020 eMAR from 06/01/20 through 06/22/20 revealed: -There was a computer generated entry for Renagel 800mg, one tablet three times a day with meals, scheduled to be administered at 7:00am, 12:00pm and 5:00pm. - Renagel was not documented as administered on 06/02/20, 06/06/20, 06/10/20, 06/11/20, 06/16/20, 06/18/20, and 06/20/20. -The reason documented on the eMAR by the MAs was "OOF" (out of facility). -Renagel was documented as not administered 7 out of 22 opportunities. Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/20 at 2:41pm revealed Renegal 800mg, one tablet three times daily, 84 tablets were sent on 05/27/20 and 42 tablets were sent on 06/17/20. f. Review of Resident #1's signed Physician Order Report dated 06/03/20 revealed there was an order for blood pressure checks daily. If systolic blood pressure was greater than 160 administer clonidine 0.6mg as needed (prn) every 6 hours. Review of Resident #1's June 2020 eMAR from 06/01/20 through 06/22/20 revealed: -There was a computer generated entry for blood pressure checks once a day scheduled between 7:00am and 3:00pm. If the systolic blood pressure was greater than 160, administer clonidine 0.6mg every 6 hours prn. -Blood pressure checks were not documented as	D 358		

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completed on 06/02/20, 06/06/20, 06/10/20, 06/11/20, 06/16/20, 06/18/20, and 06/20/20.
-The reason documented on the eMAR by the MAs was "OOF" (out of the facility).
-The blood pressure checks were documented as not administered 7 out of 22 opportunities.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/20 at 2:41pm revealed clonidine 0.6mg prn for blood pressure greater than 160, thirty tablets were sent on 05/27/20.

Telephone interview with Resident #1's NP on 07/08/20 at 4:44pm revealed:
-He was concerned Resident #1 was not having his blood pressure taken on dialysis days.
-Resident #1 could spike a blood pressure of 180 or above.
-Over time, elevated blood pressure could cause the resident to have a stroke.

g. Review of Resident #1's signed Physician Order Report dated 06/03/20 revealed there was an order for Humulin R (Regular) U-100 insulin, inject 5 units before each meal, used to treat elevated blood sugar. Hold the insulin if the fingerstick blood sugar (FSBS) was less than 70 and notify the physician if FSBS was greater than 400.

Review of Resident #1's June 2020 eMAR from 06/01/20 through 06/13/20 revealed:
-There was a computer generated entry for Humulin R U-100 inject 5 units before each meal scheduled to be administered at 6:30am, 11:30am and 4:30pm. Hold if FSBS was less than 70 and notify the physician if FSBS was greater than 400.
-Humulin 5 units was not administered at

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11:30am on 06/02/20, 06/04/20, 06/06/20, 06/10/20, 06/11/20, and 06/12/20.
-The reason documented on the eMAR by the MAs was "OOF" (out of the facility).
-Humulin R 5 units was documented as not administered 6 out of 13 opportunities at 11:30am.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 07/09/20 at 2:41pm revealed:
-Resident #1 was on a monthly automatic fill for medications that were scheduled.
-Insulin and PRN medications were filled by the pharmacy staff as needed.
-Humulin R 5 units three times daily,1 vial was sent on 05/27/20.
-At 5 units daily,1 vial of Humulin would last for 30 days.

Telephone interview with Resident #1's NP on 07/08/20 at 4:44pm revealed:
-He was not aware Resident #1 was not receiving his morning medications on the days he had dialysis treatment.
-Resident #1's insulin had to be administered consistently before meals to maintain a stable blood sugar.
-He expected to be notified if a resident was not receiving his scheduled medication for any reason.
-He discontinued Resident #1's Humulin before meals on 06/13/20 due to low FSBS readings.

Telephone interview with a medication aide (MA) on 07/08/20 at 2:03pm revealed:
-She checked Resident #1's FSBS and administered 5 units of Humulin insulin on the mornings she worked.
-Resident #1 did not refuse his medications in the

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morning or in the evening when she worked.
-He refused his insulin if he thought his FSBS was too low.
-There was no directive on the eMAR to do anything different on the days Resident #1 went out to dialysis.
-She did not know if Resident #1 received his morning medications when he returned from dialysis.

Telephone interview with a second MA on 07/08/20 at 2:33pm revealed:
-She checked Resident #1's FSBS and administered 5 units of Humulin insulin on the mornings she worked.
-Resident #1 was compliant with his medications.
-If Resident #1 thought his FSBS was too low in the morning, he would refuse his scheduled insulin.
-She did not work when Resident #1 returned from dialysis and did not know what medications were administered to him.

Telephone interview with a third MA on 07/08/20 at 3:47pm revealed:
-She administered medications to Resident #1 on her shift.
-On the days he went to dialysis, Tuesday, Thursday and Saturday, she would check his FSBS when he returned.
-When Resident #1 returned from dialysis, she "picked up on his scheduled medications".
-If Resident #1 returned at 2:00pm, she administered medications after 2:00pm as they were scheduled.
-She did not notify the NP Resident #1 had missed several medications while at dialysis, because she had documented he was out of the facility at his treatment.
-If it was a day Resident #1 was not at dialysis

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D 358	Continued From page 29 and he missed his medications, she would send a fax to the NP. Telephone interview with a fourth MA on 07/10/20 at 10:10am revealed: -She checked Resident #1's blood sugar and administered his insulin in the morning. -Resident #1 left for dialysis treatment around 9:00am or 10:00am. -The morning medications that Resident #1 missed were due to his dialysis treatments on Tuesday, Thursday and Saturday. -She documented Resident #1 was "OOF" (out of the facility) as the reason he missed his medications. -"Everyone knows he was at dialysis." (The staff, NP and management) -If a resident was not in the building when his medications were due she was not required to administer them. -There was no facility policy for missed medications. -She would fill out a Health Care Concern form and fax it to the NP if blood pressure or insulin parameters were out of range, a resident had falls or other health issues. -She did not send a fax to the NP for missed medications on days the resident went to dialysis because everyone knew the resident was at dialysis. -The physician, the Director of Resident Care, the Administrator and the MAs knew Resident #1 was at dialysis on Tuesday, Thursday and Saturday. -"I can't administer meds (medications) if he is out of the building." Refer to telephone interview with the first MA on 07/08/20 at 2:03pm. Refer to telephone interview with a second MA on	D 358		

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D 358	Continued From page 30 07/08/20 at 2:33pm. Refer to telephone interview with a third MA on 07/08/20 at 3:47pm. Refer to telephone interview with the Administrator on 07/09/20 at 3:49pm. Telephone interview with a MA on 07/08/20 at 2:03pm revealed: -She was the part time MA from 7:00pm-7:00am. -She was never instructed on administering medications to residents who were out of the facility when they returned. -It was the responsibility of the MA to send a fax to the primary care physician if a resident missed medications, refused medications, had a new symptom or an accident/incident. -She did not fax the physician when a resident missed their medications the morning of their dialysis treatment. -She documented the resident was out of the facility and that was sufficient. -Everyone knew when residents were at their dialysis treatment. (The staff, the physician and management). -If a medication was administered to a resident when they returned from dialysis, she would not know how to document that. Telephone interview with a second MA on 07/08/20 at 2:33pm revealed: -She was the MA from 7:00pm-7:00am. -She administered 6:00am-7:00am medications. -Some residents who had dialysis treatments chose not to take their medications before their treatment. "It was their choice." -She did not know how that would be documented if a resident was administered their medications after it was documented as "out of	D 358		

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the facility".
-She would send a fax to the physician if a resident missed a medication, had a new health condition, had a fall or other medical concern.
-"If it was a serious medication, like insulin, she would send a fax after one missed dose.
-Other medications she may wait for 2 missed doses before notifying the physician.
-She would not send a fax to the physician if the resident missed medications on a day they went to dialysis.
-"Everyone (the staff, the physician and management) knew on dialysis days the resident was not here" (at the facility) for medications to be administered.
-She would document OOF (out of facility) on the eMAR on those days.

Telephone interview with a third MA on 07/08/20 at 3:47pm revealed:
-She was an MA from 7:00am-7:00pm.
-She had an hour before and an hour after the scheduled time for the administration of medications.
-If a resident was out of the building during that time frame, she documented "OOF" as the reason the medication was not administered.
-She did not notify the physician if a resident has missed several medications while at dialysis, because she had documented he was out of the facility at his treatment.
-The physician checks the eMARS regularly and was able to see the resident had missed medications on dialysis days.
-She had not been instructed on what to do with medications when residents were at dialysis.
-Dialysis was a scheduled and re-occurring event and that was the reason the staff did not notify the physician when medications were missed on dialysis days.

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Telephone interview with the Administrator on 07/09/20 at 3:49pm revealed:
-The Regional LHPS Registered nurse (RN) and she reviewed the eMARS monthly.
-The process was to look for medications not signed for by the MAs, medications not administered and the reason, blood pressure and FSBS parameters, insulin administration and exceptions.
-She did not know dialysis residents were not receiving their morning medications on the days they received dialysis treatment.
-She did not know this was overlooked during the eMARS review.
-She did not know why the medications were not administered when they returned from treatment.
-Her expectation was that when medications were not administered, it would be brought to her attention.
-The MAs should notify the prescribing physician's with a fax if medications are missed.
-She expected the MAs to inform her when the medications on the eMAR needed to be adjusted.
-She could not explain why the MAs thought not administering medications 3 times a week when a resident was at dialysis was a correct procedure.

The facility failed to administer medications as ordered for Resident #1 related to medications for a contagious blood borne pathogen which needed to be administered as scheduled for effectively slowing down the progression of the virus, a hypertensive medication with blood pressure parameters to prevent a possible stroke, a blood thinner for the prevention of clotting with a central venous catheter, and a fast acting insulin before meals to prevent hyperglycemia (an increase in blood sugar); Resident #2 related to a blood thinner resulting in the risk for increased blood

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D 358	Continued From page 33 clotting in the new arteriovenous fistula, a hypertensive medication resulting in the risk of increased blood pressure, rebound hypertension, and a heart attack or stroke, and a medication used to lower phosphorous levels in patients on dialysis resulting in the risk of a heart attack. This failure resulted in serious neglect which constitutes a Type A2 Violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 07/14/20 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 14, 2020.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a	D 367	10 A NCAC 13F .1004(J) Medication Administration 10A NCAC 13F .1004 Medication Administration(j) The residents administration record (MAR) shall be accurate and include the following: (1)residents name (2) name of medication or treatment order (3) strength and dosage or quantity of medication administered, (4) instructions for administering medication or treatment (5) reason or justification for the administration of medications or treatments as needed(PRN) and documenting the resulting effect on the resident (6) date and time of administration (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals: and, (8) name and initials of the person administering the medication or treatment. If initials are used,a signature equivalent to those is to be documented and maintained with the medication administration rescord (MAR). Facility will ensure the residents medication administration rescord(MAR) is accurate. Facility ED,RCC,DRC and/or designee will review/audit eMARs for accuracy no less than monthly for one month	

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D 367	Continued From page 34 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the accuracy of the electronic Medication Administration Records (eMARs) for 1 of 5 residents (Resident #5) related to documentation of oxygen. The findings are: Review of Resident #5's current hospital FL2 dated 06/22/20 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, and depression. -An order for oxygen as needed. Review of Resident #5's subsequent physician's order dated 06/22/20 revealed a clarification for oxygen 2 liters via nasal cannula as needed for shortness of breath (SOB). Review of Resident #5's June 2020 and July 2020 electronic Medication Administration Record (eMAR) revealed: -A computer-generated entry for oxygen 2 litters via nasal cannula as needed for shortness of breath. -There was no documentation Resident #5's	D 367	Continued from page 34 Then randomly there after. Facility MA have been trained on medication administration documentation including terminology on 7/17/2020 Facility will be in compliance by 8/14/2020	

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D 367	Continued From page 35 oxygen was administered as needed 06/23/20 through 07/01/20 Telephone interview with Resident #5's home health nurse on 07/07/20 at 10:10am revealed: -She had seen Resident #5 on 06/23/20 for a follow-up due to returning from the hospital with an order for oxygen. -Resident #5 had oxygen in his room and was wearing the oxygen via nasal cannula. Telephone interview with Resident #5 on 07/09/2020 at 1:35pm revealed: -He was recently in the hospital for COPD and pneumonia. -The hospital ordered oxygen because he was SOB. -The oxygen was delivered to his room about 2 weeks ago in June 2020. -He applied the oxygen several times daily after he ambulated in the facility or after he went outside the building and became SOB. -He wore the oxygen at night to assist him with sleeping. Telephone interview with Resident #5's Primary Care Provider (PCP) on 07/10/20 at 9:30am revealed: -Resident #5 was admitted to the hospital in May 2020 and June 2020 for respiratory failure, pneumonia and a pulmonary embolus. -Resident #5 was ordered oxygen for his SOB in June 2020 after the last hospital admission. -The facility staff were responsible for documenting all medications Resident #5 was administered on the eMAR. -He wanted to know all the medications Resident #5 received when he reviewed the eMAR prior to a visit. -It was important for staff to document Resident	D 367		

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#5's oxygen because Resident #5's respiratory history and his COPD.

Telephone interview with a medication aide (MA) on 07/10/20 at 9:30am revealed:
-She was aware Resident #5 had an order for oxygen 2L NC as needed.
-She was aware Resident #5 had oxygen in his room and it was used for SOB.
-She never documented the administration of the oxygen as needed on Resident #5's eMAR.

Telephone interview with a second MA on 07/10/20 at 10:10am revealed:
-She knew Resident #5 came back from the hospital with an order for oxygen.
-She knew Resident #5 had oxygen in his room and it was used for SOB after he ambulated outside to smoke.
-She never documented the administration of the oxygen as needed on Resident #5's eMAR.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/20 at 2:28pm revealed:
-The facility staff were responsible for placing the entry for oxygen on the eMAR.
-The pharmacy did not enter the order on the eMAR for oxygen and they do not consider the oxygen as a medication order.
-The MAs should be documenting all as needed medications and treatments on the eMAR.

Review of Resident #5's Licensed Health Professional Support (LHPS) dated 06/30/20 revealed there was documentation Resident #5 had a task for oxygen use as needed and the facility's staff were competency validated.

Telephone interview with the Administrator on

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D 367	Continued From page 37 07/10/20 at 10:30am revealed: -She knew Resident #5 wore his oxygen in his room for SOB but was not showing signs of SOB since he returned from the hospital in June 2020. -She was unaware the MAs were not documenting Resident #5's oxygen on the eMAR. -She expected the MAs to document all as needed medications on the eMAR's.	D 367		
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 interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and medication administration. The findings are: 1. Based on record reviews and interviews, the facility failed to respond immediately and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #1) who had bleeding from a central venous catheter that became dislodged which required an immediate emergency response. [Refer to Tag 0271, 10A NCAC 13F .0901 (c) Personal Care (Type A1 Violation)].	D912	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. Staff were trained on policy and procedure of how to respond to an emergency situation. on 6/23/2020 and 6/30/2020 ED, RN reviewed residents rights with all staff completed on 7/17/2020 In-service with all staff on residents right conducted by Ombudsman completed via zoom on 7/31/2020 DRC,ED conducted an in-service on correct Medication Administration, documentaion for MA including terminology completed on 7/17/2020 Facility will be in compliance by 8/14/2020	

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D912	Continued From page 38 2. Based on record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents, related to medications for a contagious blood borne pathogen, hypertension, a blood thinner, elevated levels of potassium, fast acting insulin to lower blood sugar before meals and daily blood pressure checks with parameters (Resident #1); and related to blood pressure medications and blood pressure checks with parameters, medications used to prevent blood clots, medications used to lower blood sugars and medications used to lower high phosphorus levels in patients on dialysis (Resident #2). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to ensure residents were free of neglect for 2 of 5 sampled residents related to one resident (#1) who had a physician's order for a "Full Code" status and did not receive cardio pulmonary resuscitation (CPR) when in cardiac arrest due to blood loss from a central venous catheter that was dislodged; and a resident (#2) who had received a new surgical Arteriovenous Fistula (AVF dialysis port) on 06/30/20 with	D914	D914 G.S.131D-21(4)Delcaration of Residents Rights G.S.131D-21 Declaration of Residents Rights. Every resident shall have the following rights: 4. To be free of mental, and physical abuse,neglect and exploitation. ED,RN Immediately reviewed residents rights with all staff on 7/17/2020. In-service with all staff on residents rights conducted by Ombudsman via zoom completed on 7/31/2020 ED, DRC reviewed with all staff CPR and how to respond in an emergency situation on 6/23/2020 and 6/30/2020 In-service with all staff on Dialysis patients, the difference of an established and un establisted access port, and what to look for. conducted by Collins Fomunung NP.on 7/22/2020 Facility will be in compliance by 8/14/2020	

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D914	Continued From page 39 discharge instructions and his CPAP machine and tubing due to unclean conditions and not providing a full face mask (Resident #2). 1. Review of Resident #1's current FL2 dated 06/03/20 revealed: - Diagnoses included diabetes mellitus II (DM II), a contagious blood borne pathogen, end stage renal disease (ESRD) and hyperkalemia. -There was documentation Resident #1 had a "port in the right upper chest". Review of Resident #1's Resident Register revealed an admission date of 05/27/20. Review of the American Heart Association's definition of a Full Code revealed: -A full code means a person will allow all interventions needed to get their heart started. -This may include chest compressions and defibrillation to shock the heart out of a life-threatening heart rhythm. a. Review of Resident #1's Physician's Order Report dated 06/03/20 revealed Resident #1 was a "Full Code". Review of Resident #1's Resident Register dated 05/27/20 revealed Resident #1 was listed as a Full Code. Review of Resident #1's electronic medication administration record (eMAR) from 06/01/20 through 06/23/20 revealed documentation of "Full Code" in bold letters next to Resident #1's name. Review of the facility's Accident /Falls/Emergency and Fire Safety Policy revealed: -When an accident or emergency occurs, staff should:	D914		

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D914	Continued From page 40 -Call for help. -Evaluate the resident. -Call 911 -Determine if the resident is breathing, conscious and check for a pulse. -Administer cardiopulmonary resuscitation (CPR) if appropriate-check for Do Not Resuscitate (DNR status). -Administer first aide as appropriate. -Continue emergency intervention until EMS arrives. Review of the Emergency Medical Services (EMS) report for Resident #1 dated 06/23/20 revealed: -The facility called EMS at 6:11am. -The unit was dispatched to the facility and arrived at 6:16am. -EMS was dispatched to the facility for an individual experiencing cardiac/respiratory arrest. -"There were several liters of blood puddled throughout the room." -"The patient's bed was soaked with blood, the patient was covered in blood, his wheelchair was soaked in blood, and there were several puddles in the room of congealed blood." -"It appeared the patient's port in his right upper chest was removed which caused severe bleeding." -"The patient was moved to the floor and CPR was administered." -"While performing CPR, blood spewed out of the chest area where the port was removed." -EMS tried to control the blood flow but it was difficult. -"Due to the severity of blood loss, EMS consulted the hospital physician to determine if resuscitative efforts should be continued, or if the patient should be pronounced deceased. -Due to the cardiac arrest, severe blood loss, and	D914		

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D914	Continued From page 41 the inability to control the massive bleeding during CPR, the physician felt it was appropriate to pronounce the patient deceased. -"The patient was pronounced deceased at 0629." Telephone interview with a first responder on 07/01/20 at 9:00am revealed: -He responded to the facility for a reported patient who was "stiff, cold and bloody". -When he arrived on the scene, the Paramedics were going into the facility. -Resident #1 was sitting in his wheel chair approximately 3 feet away from the bed, facing the door to his room. -There was blood on Resident #1, on his wheelchair as well as under the wheel chair, and on his bed. -The blood under the wheelchair was "jelly like". -He assisted the Paramedics with getting Resident #1 out of the wheel chair to perform CPR. -Once Resident #1 was on the floor a second first responder performed CPR. -With every compression there was blood "shooting" out of a hole in Resident #1's chest. -The Paramedics applied pressure to the site where the blood was coming out but that did not help. -The Paramedics contacted their commander and were directed to stop compressions after one round. Telephone interview with the Fire Chief on 07/01/20 at 9:10am revealed: -He responded to the facility on 06/23/20 for a reported cardiac arrest. -When he arrived on the scene the Paramedics had just entered the facility. - Resident #1 was sitting in his wheel chair away	D914		

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D914	Continued From page 42	D914		

from the bed, facing the door to his room.
-There was blood on the bed.
-The blood under the wheel chair was "congealed".
-There was not much blood toward the door, "tracks" from someone.
-One of the first responders assisted the Paramedics in getting Resident #2 out of the wheel chair onto the floor.
-Another first responder assisted with CPR.
-With every compression blood would shoot from Resident #2's chest and pressure on the site was not stopping it.
-CPR was stopped after direction from medical command.
-There was an "excessive amount of blood" at the scene.

Telephone interview with a medication aide (MA) on 07/07/20 at 3:48pm revealed:
-She went into Resident #1's room around 6:00am to take his fingerstick blood sugar (FSBS) and administer his scheduled insulin.
- She observed Resident #1 sitting in his wheelchair with his head extended back.
-There was blood all over him, the bed, the wheelchair and the floor.
-She did not perform CPR because she could not locate any personal protective equipment (PPE).

Telephone interview with a second MA on 07/07/20 at 4:10pm revealed:
-She was the MA on the second shift, 7:00pm -7:00am.
-She contacted 911, and the operator asked if there was a defibrillator in the building and she did not know.
-Due to Resident #1's diagnosis of a contagious blood borne infection, the MAs did not want to perform CPR without PPE.

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Telephone interview with the Administrator on 07/09/20 at 3:49pm revealed:
-On the morning of 06/23/20, she instructed the MAs to perform CPR on Resident #1 until the first responders arrived.
-When she arrived at the building at approximately 8:20am, she was told the MAs had not performed CPR while waiting for the medics to arrive.
-The MAs were CPR certified and present in Resident #1's room at the time of the incident and did not follow the emergency protocol.
-She expected the CPR certified staff to perform CPR according to the facility's Accident /Falls/Emergency and Fire Safety Policy.

Telephone interview with the Regional Licensed Health Professional Support (LHPS) Registered nurse (RN) on 07/10/20 at 9:20am revealed:
-She arrived at the facility on 06/23/20 at approximately 9:30am for a scheduled training.
-When she questioned the MAs as to why they did not perform CPR on Resident #1, they both said, "we did not do CPR because there was blood everywhere".

Review of the Health Care Personnel Registry Summary report dated 06/25/20 revealed:
-The staff member present on 06/23/20 during Resident #1's cardiac event refused to initiate CPR despite the resident being a full code and being instructed to initiate CPR (by the Administrator).
-Staff member stated she refused to initiate CPR due to Resident #1's diagnosis of a contagious blood borne pathogen, and she did not have anything to protect herself.
-During the investigation, the facility noted adequate PPE located throughout the facility.

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D914	Continued From page 44	D914		

b. Telephone interview with the Clinical Manager, a Registered nurse (RN), at the dialysis center on 07/10/20 at 2:15pm revealed:
-Resident #1 had a right upper chest central venous catheter which served as an access port for his dialysis treatments.
-He had been a patient of the dialysis center since May 2019, and received treatments 3 times a week on Tuesday, Thursday and Saturday.
-She did not expect the facility to report any findings regarding a resident's fistula or port to the dialysis center unless there was an emergency, bleeding or dislodgement of the device.
-The skin around the catheter was covered with a dressing.
-Dialysis staff removed the dressing and assessed the skin when the resident came in for their treatment.
-The facility staff should only verify that the catheter was intact and not dislodged.

Telephone interview with a personal care aide (PCA) on 07/13/20 at 9:30am revealed:
-Resident #1 was in quarantine in his room due to hospital visits during the month.
-She provided care for Resident #1 on some days.
-He had a dialysis device in his chest.
-The dialysis device was a medical device and "we were not allowed to touch it".
-She was directed not to touch the dialysis device by the MA.

Refer to telephone interview with a PCA on 07/13/20 at 9:30am.

Refer to telephone interview with an MA on 07/13/20 at 9:36am.

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D914	Continued From page 45 Refer to telephone interview with the Administrator on 07/09/20 at 3:49pm and on 07/13/20 at 1:27pm. Refer to telephone interview with the Regional LHPS RN on 07/10/20 at 9:20am. 2. Review of Resident #2's current FL2 dated 04/01/20 revealed diagnoses included diabetes, diabetic chronic kidney disease, end stage renal failure, pulmonary embolism, bilateral below the knee amputation with prosthesis, hypertension, blind in the left eye, obstructive sleep apnea and hypertension. Review of Resident #2's Resident Register revealed an admission date of 03/31/20. Review of Resident #2's current Care Plan dated 04/04/20 revealed: -Resident #2 required extensive assistance with bathing. -Resident #2 required limited assistance with dressing, grooming, eating and transferring. a. Review of Resident #2's hospital discharge instructions dated 06/29/20 at 6:03pm revealed: -The physician was to be notified after he left the hospital for any of the following reasons due to the new dialysis port placement; swelling, being very tired or weak, redness, chest pain, short of breath, more pain or pain was worse, unusual bleeding, drainage, odor from incision or wound, and if temperature was above 101 or higher at any time. -Remove the dressing in 48 hours and then shower at that time, may leave open to air at that time.	D914		

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Review of Resident #2's April, May, and June 2020 skin assessment sheets revealed there was no documentation related to his dialysis access port.

Review of Resident #2's April, May and June 2020 electronic Medication Administration Record (eMAR) revealed there was no documentation related to his dialysis access port.

Review of a Resident #2's progress noted revealed there was no documentation of Resident #2 having a new dialysis port placed or observations documented related to his dialysis port.

Interview with a medication aide (MA) on 07/01/20 at 12:30pm revealed:
-Resident #2 had a dialysis port in his chest, either it had been there awhile or was brand new, she was not sure.
-He was one of her residents she administered medications to but not daily.
-She was not trained by the facility on what the dialysis access ports were, or what to look for related to signs and symptoms of infection or abnormality.
-If there was bleeding, she would apply pressure and call for help.
-All the residents at the facility were seen in dialysis and dialysis was responsible for checking the dialysis access ports.
-The facility staff was not allowed to touch the dialysis access ports and she did not check the access ports at all.

Interview with Resident #2 on 07/01/20 at 3:34pm revealed:
-He had both of his legs amputated below the

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knee due to broken ankles that did not heal and infection set in.
-He had arteriovenous fistulas (AVF, is an abnormal connection between the artery and a vein, used as a dialysis access port) in both arms which clotted and resulted in a perma-cath (a catheter placed in a vein closest to the atrium of the heart and used in an emergency for dialysis) in his left upper chest in September 2019.
-The perma-cath was considered only temporary.
-He was told by the surgeon he had one more option left for permanent dialysis port site and that was to place an AVF in his right upper chest and on 06/29/20 he received the AVF in his right upper chest.
-He was given discharge instructions for the care of the new AVF in his right upper chest.
-The discharge instructions included care of the surgical site and signs and symptoms to watch out for.
-The staff did not check his dialysis access ports; the dialysis nurse checked them on Monday, Wednesday and Fridays.
-The staff did not ask to see his dialysis access ports or the new AVF after the procedure on 06/30/20.
-He gave the discharge instructions to the medication aide (MA) when he came back to the facility after the AVF was placed on 06/29/20.
-On 06/29/30, the Director of Resident Care (DRC) asked if he had a dialysis port placed in his left chest wall as the instructions stated and he told her it was placed in his right chest. The DRC left and did not come back.
-The first time the AVF port was checked was at the dialysis clinic on 07/01/20.
-He could not see the new incision site and the staff would have to check it for redness, swelling and drainage but he could notify the staff if he had chest pain, short of breath or increased pain.

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D914	Continued From page 48 Telephone interview with Resident #2's Dialysis Nurse on 07/10/20 at 10:15am revealed: -Resident #2 received dialysis through his perma-cath (a catheter placed in a vein closest to your atrium of the heart and used in an emergency for dialysis) located in his left chest. -Resident #2 had 2 other AVFs that clotted off and could not be used so the perma-cath was placed in September 2019. -On 06/29/20, Resident #2 had an AVF placed in his right upper chest which was not a normal site for AVFs. -The placement of the AVF in his right upper chest was considered a "last resort" because of all the other typically places for an AVF were "used up", meaning clotted off and could not be used. -She expected the facility staff to check and observe the dialysis ports daily for swelling, redness, drainage or bleeding and ask Resident #2 if he had tenderness at the sites or any complaints related to the dialysis access ports. -She did not want the facility staff to "touch" the ports but to call if there was a concern. -She expected the facility staff to look at Resident #2's new AVF located in his right upper chest at least two times a day for signs of infection which included; redness, selling, odor from the wound, drainage from the wound, or the a fever of 100 or greater. -After placement of a new access port the facility staff should watch for signs of complication that would require 911 such as, shortness of breath, chest pain, and increased pain. Telephone interview with Resident #2's Cardiovascular Surgeon on 07/10/20 at 11:32am and 07/14/20 at 1:04pm revealed: -Resident #2 received a right upper chest AVF on	D914		

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D914	Continued From page 49 06/30/20 as a "last resort" for his dialysis access port. -Resident #2 had a left chest wall perma-cath (is a catheter placed through a vein into or near the right atrium and used for dialysis in an emergency or permanent until a device is ready to use) after multiple failed accesses were placed. The perma-cath was placed September 2019. -The discharge instructions were considered orders and given to Resident #2 to take back to the facility. -The discharge instructions for the surgical wound included signs and symptoms for the staff and resident to watch for which included no shower for 48 hours until the dressing was removed. -The signs to observe for included; redness, swelling, fever or drainage which would indicate infection. -If Resident #2 complained of or staff observed shortness of breath, chest pain, increased pain at the sight or bleeding, 911 should be called because that was considered more serious symptoms after a surgical procedure especially with Resident #2's history of pulmonary embolism and previous site failure due to clotting. -All the above symptoms could happen at any time within the first 48 hours after an AVF was placed. -Resident #2 was dialyzed on Monday, Wednesday and Fridays and would need for his dialysis access ports to be looked at or "laid eyes on" in between dialysis days. -Resident #2's perma-cath had a dressing on it provided by the dialysis center and should be kept clean and dry. -The perma-cath also had a clear, waterproof dressing which was placed by the dialysis center which helped to prevent infection. -This clear waterproof dressing should be	D914		

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D914	Continued From page 50 observed for a "flat seal" to prevent water or moisture from entering the wound and causing an infection. Any signs of infection or "lifting" of the clear dressing should be reported to the physician. Telephone interview with the previous Director of Resident Care (DRC) on 07/13/20 at 12:50pm revealed: -She was an Licensed Practical Nurse (LPN) started work at the facility as the DRC on June 1, 2020. -She did not receive direction about her DRC duties from the Administrator. -She was responsible for "getting the staff together" related to medication administration and "putting out little fires" related to resident and staff complaints. -She did not know Resident #2 had a dialysis access port on the left upper chest. -On 06/30/20, the Regional LHPS Nurse informed her of Resident #2's new surgical left upper chest dialysis access port and to confirm the correct site as well as giving her the instructions on the care after the procedure to "read" to Resident #2. -She took the copy of the instructions to Resident #2 and gave them to him to check his own sight. -Resident #2 informed her that the new access port was completed on the right upper chest and he had an older perma-cath on the left upper chest. -She informed the Administrator and the Regional LHPS nurse the correct site was on the right upper chest for the new surgical site. -When she informed the Administrator and the Regional LHPS nurse, she was told "they would handle it" -She did not check his site again. -There was no training for the facility staff related to what the dialysis access ports were, where	D914		

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D914	Continued From page 51	D914		

they were located or care instructions, not even for a fresh dialysis access port instruction.
-The instruction to the staff, per the Administrator and the Regional LHPS nurse was to "not touch", because the "dialysis" center handled those.
-She felt it was her role to monitor the dialysis access ports, the Administrator and the Regional LHPS nurse said that it was not.

Telephone interview with the Administrator on 07/14/20 at 1:30pm revealed:
-On 06/30/20, was the first time she was informed about Resident #2's dialysis access port.
-Resident #2 made his own appointments and arrangements to get to and from dialysis.
-Resident #2 made his own surgical appointment and transportation arrangements.
-She did not consider the discharge instructions as "orders" because the "were not signed".
-The DRC was responsible for checking Resident #2's surgical site and did so on 06/30/20 and informed her the site was documented on the wrong side on the instructions.
-She did not instruct the staff to check or monitor the dialysis access port because "dialysis" did that.
-It could be a possibility for a dialysis resident to have a complication after dialysis and on the weekends.

Refer to telephone interview with the Personal Care Assistant (PCA) on 07/13/20 at 9:14am.

Refer to telephone interview with a second PCA on 07/13/20 at 9:30am.

Refer to telephone interview with an MA on 07/13/20 at 9:36am.

Refer to telephone interview with the

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D914	Continued From page 52 Administrator on 07/09/20 at 3:49pm and on 07/13/20 at 1:27pm. Refer to telephone interview with the Regional LHPS RN on 07/10/20 at 9:20am. b. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for continuous positive airway pressure (CPAP, applies mild air pressure on a continuous basis to keep the airways continuously open in people who need help keeping their airway unobstructed) wear at night as tolerated and remove in the morning, make sure CPAP is on and in place while resident is sleeping. Review of Resident #2's Licensed Health Professional support (LHPS) dated 04/22/20 revealed Resident #2's tasks included monitoring of CPAP. Review of Resident #2's May 2020 eMAR revealed: -An entry to wear CPAP at bedtime as tolerated and remove in the morning, (make sure CPAP is on and in place while resident is asleep), documented as administered 05/01/20- 05/31/20. -There were no entries to clean or replace CPAP machine, filter and or tubing/mask. Review of Resident #2's June 2020 eMAR revealed: -An entry to wear CPAP at bedtime as tolerated and remove in the morning, (make sure CPAP is on and in place while resident is asleep), documented as administered 06/01/20- 06/30/20. -There were no entries to clean or replace CPAP machine, filter and or tubing/mask. Review of Resident #2's progress notes revealed:	D914		

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D914	Continued From page 53 -On 04/26/20 at 9:41am, "Resident #2 received mask and tubing for CPAP on 04/20/20". -On 07/01/20 at 1:53am, "Staff reported that resident refused to use his CPAP due to the nose mask hurting his nose. -Resident also stated the he prefers to use a full faced CPAP mask instead, health care concern reported to physician. Interview with Resident #2 on 07/01/20 at 3:34pm revealed: -He did not wear his CPAP machine at night for the last 2-3 weeks because was congested and the machine, filter, tubing and mask had not been cleaned or replaced. -He asked the staff to clean it for him when he was congested about 2-3 weeks ago. -About 2 months ago he asked the MA to order him a full-face mask because the nose mask hurt his nose and was uncomfortable. -He still did not have the full face mask. -He informed the staff again earlier this morning (07/01/20) about needing the full face mask and the machine was still dirty. Observation of Resident #2's CPAP machine on 07/01/20 at 3:40pm revealed: -There was a nose mask with tubing attached to the CPAP machine. -The machine was dusty and dirty. -The nose mask had dried brown and clear flaky pieces of debris. inside the mask. Telephone interview with second shift MA on 07/09/20 at 2:49pm revealed: -Most of the residents had their CPAPs on when she administered their evening meds. -"I was not asked to help them". -We were instructed to put water in one of the residents CPAP machine because he overfilled it	D914		

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D914	Continued From page 54	D914		

and it broke.
-We were not instructed on how to clean a CPAP machine.
-She did not know how to clean a CPAP machine.
-She knew how to assist in putting on because she was trained how to do so on her other job.

Telephone interview with Administrator on 07/09/20 at 3:49pm revealed:
-The LHPS RN checked off all staff on CPAP administration and care.
-The MAs know how to determine if the CPAP was working properly, there was airflow and it was applied properly to the face.
-The CPAPs should be cleaned monthly.
-The Resident Care Coordinator (RCC) ordered new supplies for the CPAP machine when needed.

Telephone interview with the Regional Licensed Health Professional Support (LHPS) Nurse on 07/10/20 at 9:20am revealed;
-She preformed the staff competencies for the CPAP which included; observation of the resident applying the mask, to report issues with the CPAP machine/mask to the physician and to document the mask was placed on the resident or taken off.
-The MAs were responsible for putting the CPAP mask on the resident or to assist the resident if there was an issue with ability to put it on or a adjustment to make it fit correctly.
-The MAs were responsible for cleaning the water chamber daily with distilled water and left out to dry, and replacing the tubing/mask as needed.
-If a resident had respiratory symptoms such as congestion, the mask should be cleaned daily to avoid the increased respiratory issues.
-If the CPAP machine/tubing/mask was not cleaned, it would compromise the delivery of the air to the resident.

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D914	Continued From page 55 Telephone interview with a Durable Medical Equipment (DME) company on 07/15/20 at 10:00am revealed: -A CPAP machine should be cleaned externally daily with a warm damp cloth. -The tubing should be changed every 3 months, the filter every 2 weeks, a full mask every month, a nose mask every 2 weeks and the water chamber every 6 months. -The masks and tubing should be cleaned daily with a warm soapy water and allowed to air dry especially after being sick to prevent bacteria from entering your lungs. Telephone interview with the personal care aide (PCA) on 07/13/20 at 9:14am revealed: -She was a PCA on first shift and provided personal care to the residents on her assignment sheet. -She knew some information regarding dialysis and ports from a family member who had a port. -She knew the common problems of a port were bleeding from the site and dislodgement. -She had not had any specific training regarding the care of ports or fistulas from the facility. -She performed skin assessments on the residents on their shower days, 2 to 3 times a week. -She recorded any skin tears, bruising, redness or anything out of the ordinary on a Skin and Body Observation sheet. -She would give the Skin and Body Observation sheet to the MA for their signature. -The sheets were brought to the Director of Resident Care (DRC) for review. Telephone interview with a second PCA on 07/13/20 at 9:30am revealed: -There were 3 residents with fistulas. Most of	D914		

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D914	Continued From page 56 them have "patches" (dressings) to cover them up. -She did not know anyone who had a port because they were also covered up. -She knew that when a fistula became "clogged" the resident had to go to the hospital and "get a new site." That happened to a family member of hers. -The previous DRC trained the staff in completing body observations on shower days to look for bruises, bumps and anything out of the ordinary. -She would treat a fistula or a port with the same type of body observation training. -She knew to look for bleeding, swelling or pus around the site. -She was not trained by the facility specifically on the care of ports or fistulas. Telephone interview with an MA on 07/13/20 at 9:36am revealed: -She knew that an individual who had dialysis treatments could have a port in their chest. -She did not know what a fistula was. -She did not know of any resident in the facility who had a fistula. -She did not know what type of problems could arise with a resident who had a port or a fistula. -She had not received any training at the facility on the care of residents with ports or fistulas. Telephone interview with the Administrator on 07/09/20 at 3:49pm and on 07/13/20 at 1:27pm revealed: -Residents who went to the dialysis center were monitored by the staff at dialysis. -The facility staff were not supposed to provide any care (for fistulas or ports). -She and the previous DRC had instructed the staff on the proper observation of the resident's skin.	D914		

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D914	Continued From page 57 -The staff should observe the skin for redness, drainage and swelling. -Fistulas and perma catheters (central venous catheters) were observed in the same manner as the rest of the body. -There was no training on the education of fistulas and perma catheters she was aware of. Telephone interview with the Regional LHPS RN on 07/10/20 at 9:20am revealed: -She was the previous DRC from July 2019 to May 2020. -She trained the PCAs on the proper observation of the skin and body on their resident's shower day. -If a resident preferred to take their shower independently, the PCA was instructed to stay in the bedroom for safety and observe the body before the resident dressed. -The PCAs were trained to observe any visible bleeding, swelling, skin breakdown or any irregularity, record on the shower sheet and report to their supervisor. -As the DRC she would then review the Body and Skin Observation sheets left in her box. -MAs and PCAs have no responsibility for fistulas or perma catheters. -If the staff observed bleeding or the resident complained of pain, they would contact the dialysis center. -If the resident had bleeding from the site, the staff should put pressure on the site and call 911. -She did not include the care of fistulas or perma catheters on an LHPS assessment or the care plan of a resident since it was not a task The facility failed to ensure residents were free of neglect for 2 of 5 sampled residents (Resident #1) who had a"Full Code" and did not receive cardio pulmonary resuscitation (CPR) from the	D914		

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D914	Continued From page 58 facilty staff, when he was in cardiac arrest, per the facility emergency policy and was pronounced dead shortly after the first responders arrived, and who had a central venous catheter as a port for dialysis treatment without specific staff training on observation and reporting possible side effects. Resident #2 who had received a AVF (dialysis port) on 06/30/20 and could not use his CPAP machine for 2-3 weeks because of an upper respiratory complaint and the CPAP machine was not cleaned. This failure resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/14/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 14, 2020.	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on recommendations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies of the facility were implemented and rules were maintained for personal care and supervision,	D980	G.S 131D-25 Implementation G.S. 131D-25 Implementation Resposibility for implementing the provisions of this article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of Residents rights included in G.S. 131D-21 Staff were trained 6/23/2020 and 6/30/2020 on the policy and procedure of how to respond in an emergency situation. Inservice on correct Medication Administration including terminology for all MA on 7/17/2020 Immediate inservice will be held on Residents Rights, conducted by LHPS nurse Staff were trained on 7/22/2020 on the difference of an established/ unestablished fistulas and what to look for by Collins Fomunung NP DRC/RCC willl review FL2 at time of admission for DME equipment and process accordingly,documentaion will be added to the EMAR to remind staff to complete task All charts will be reviewed by RCC/ED to ensure compliance completed 7/20/2020 and 7/21/2020 Training at time of hire on the difference of established and unestablished fitulas and what to look for DRC/RCC will include on the 3050R under other task to ensure external entities (example:ports, shunts, catheters,CPAP) usage to ensure external devices will be managed effectively. Facility will be in compliance by 8/14/2020	

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D980	Continued From page 59 resident rights, and medication administration. The findings are: Interview with the first medication aide (MA) on 07/01/20 at 12:30pm revealed: -She was not trained by the facility on what the dialysis access ports were, or what to look for related to signs and symptoms of infection or abnormality. -The facility staff was not allowed to touch the dialysis access ports and she did not check the access ports at all. Telephone interview with a second MA on 07/13/20 at 9:36am revealed: -She did not know what a fistula was. -She did not know of any resident in the facility who had a fistula. -She had not received any training at the facility on the care of residents with ports or fistulas. Telephone interview with a first personal care aide (PCA) on 07/13/20 at 9:14am revealed: -She was a PCA on first shift and provided personal care to the residents on her assignment sheet. -She had not had any specific training regarding the care of dialysis ports or Arteriovenous Fistula (AVF, is an abnormal connection between the artery and a vein, used as a dialysis access port) from the facility. Telephone interview with a second PCA on 07/13/20 at 9:30am revealed: -She provided care for Resident #1 and he had a dialysis device in his chest. -She was not trained by the facility specifically on the care of ports or fistulas.	D980		

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D980	Continued From page 60	D980		

Telephone interview with the Regional LHPS RN on 07/10/20 at 9:20am revealed:
-MAs and PCAs have no responsibility for fistulas or perma catheters.
-She did not include the care of fistulas or prma catheters on an LHPS assessment of a resident since it was not a task.

Telephone interview with the previous Director of Resident Care (DRC) on 07/13/20 at 12:50pm revealed:
-She did not receive direction about her DRC duties from the Administrator.
-There was no training for the facility staff related to what the dialysis access ports were, located or care instructions, not even for a fresh dialysis access port instruction.
-The instruction to the staff, per the Administrator and the Regional LHPS nurse was to "not touch", because the "dialysis" handled those.

Telephone interview a MA on 07/07/20 at 3:48pm revealed:
-She did not know where to find PPE.
-She thought the PPE might have been in the medication room, but she did not check.

Telephone interview with a second MA on 07/07/20 at 4:10pm revealed:
-She was not aware if there was a defibrillator in the building.
-She did not know if there was PPE on the medication cart or the medication room.

Telephone interview with a sixth MA on 07/08/20 at 2:33pm revealed everyone at the facility knew on dialysis days the residents were not here for medications to be administered.

Telephone interview with a seventh MA on

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D980	Continued From page 61 07/10/20 at 10:10am revealed: -If a resident was not in the building when his medications are due they were not required to administer them. -There was no facility policy for missed medications. Telephone interview with an eighth MA on 07/10/20 at 9:30am revealed: -She knew Resident #5 had an order for oxygen 2L NC as needed. -She knew Resident #5 had oxygen in his room and it was used for SOB. -She had never documented the administration of the oxygen on Resident #5's eMAR. Telephone interview with the Administrator on 07/09/20 at 3:49pm and on 07/14/20 at 1:20pm revealed: -She was the Administrator of the facility since November 2019. -The facility Marketer was admitting residents to the facility. -The Marketer did not have clinical nursing skills. -The Administrator had reviewed some of the FL2s for the new admissions, but some she had not. -The staff were capable of caring for the higher acuity residents that were admitted to the facility, but they needed more training. -The DRC had taken a new corporate role with the company and was in the facility 1 or 2 hours a day 2 or 3 times weekly. -The Regional LHPS nurse was responsible for completing staff training but the Administrator could not recall any training on dialysis residents or how to observe/monitor resident's dialysis ports. -There were 5 dialysis residents in the facility. -She did not know until Resident #2 returned from	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060149	A. BUILDING: _____ B. WING _____	07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 62	D980		

the hospital on 06/29/20 he had a procedure for a surgical wound dialysis port.
-She considered the discharge instructions from the hospital instructions and not an order.
-The staff were not to provide any care (for fistulas or ports).
-There was no formal training on the education of fistulas and perma catheters she was aware of.
-She did not know residents had not received their morning medications on the days they received dialysis treatment.
-She could not explain why the MAs did not administer medications 3 times a week when a resident was at dialysis.
-She did not know MA were not documenting on the eMARs as needed medications.
-She was in charge of day to day operations in the facility.

Telephone interview with the Marketer on 07/14/20 at 12:45pm was unsuccessful due to she was transferred to another facility.

Non-compliance was identified in the following rule areas at the violation level:

1. Based on record reviews and interviews, the facility failed to respond immediately and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #1) who had bleeding from a central venous catheter that became dislodged which required an immediate emergency response. [Refer to Tag 0271, 10A NCAC 13F .0901 (c) Personal Care (Type A1 Violation)].

2. Based on record reviews and interviews, the facility failed to ensure residents were free of neglect for 2 of 5 sampled residents related to one resident (#1) who had a physician's order for

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D980	Continued From page 63 a "Full Code" status and did not receive cardio pulmonary resuscitation (CPR) when in cardiac arrest due to blood loss from a central venous catheter that was dislodged; and a resident (#2) who had received a new surgical Arteriovenous Fistula (AVF dialysis port) on 06/30/20 with discharge instructions and his CPAP machine and tubing due to unclean conditions and not providing a full face mask (Resident #2). Refer to Tag 914, GS 131D-21 (4) Resident Rights (Type A1 Violation)]. 3. Based on record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents, related to medications for a contagious blood borne pathogen, hypertension, a blood thinner, elevated levels of potassium, fast acting insulin to lower blood sugar before meals and daily blood pressure checks with parameters (Resident #1); and related to blood pressure medications and blood pressure checks with parameters, medications used to prevent blood clots, medications used to lower blood sugars and medications used to lower high phosphorus levels in patients on dialysis (Resident #2). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. The Administrator failed to ensure responsibility for the overall management, administration, supervision and operation of the facility which resulted in staff unsure where to locate the PPE in the facility to respond to an emergency situation and not initiating CPR to Resident #1 a full code dialysis resident, who had dislodged his dialysis port with extensive bleeding and death occurred, Resident #2 who had a emergency	D980		

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D980	Continued From page 64 procedure to place a new surgical wound dialysis port with discharge instructions to monitor and observed the surgical site while staff were not trained or instructed on what to observe or monitor; medications not administered to Resident #1 and Resident #2 on dialysis days which included insulin, autoimmune medications and anti-coagulate medication for multiple days without informing the physician or the dialysis center; and oxygen not documented on the administration medication record for Resident #5 who had two recent hospitalizations for respiratory failure. This failure resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/14/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 14, 2020.	D980		