Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023048	A. BUILDING: _____ B. WING _____	R 12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SHELBY	1550 CHARLES ROAD SHELBY, NC 28152

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a COVID-19 Infection Control survey with an onsite visit on 12/03/04 and desk review and telephone exit on 12/04/20.	{D 000}	**PLAN** The RSD and the RCC will ensure all orders are verified within 48 hours. As orders are verified, orders will be reviewed and parameters requested if indicated. The RSD and the RCC will review vital signs and values measured such as weights and ensure abnormal or significantly changed results are communicated to the prescribing entity. **MONITORING SYSTEM** The RSD will keep a listing of the residents with special care needs such as thromboembolic stocking therapy, chair/bed alarm, etc. and make bi-weekly rounds to ensure these orders are being carried out appropriately. In addition, random checks will be made by the ED and RSD to ensure continued compliance.	12/21/20
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A1 VIOLATION Based on interviews, observations, and record review the facility failed to ensure physician notification for 2 of 5 sampled residents (Residents #2 and #1) related to not obtaining parameters and not notifying the physician of the low oxygen saturation levels (#2) and not obtaining parameters for daily blood pressures and weight parameters in a resident who both gained weight and had high blood pressure readings (#1). 1. Review of Resident #2's current FL2 dated 05/15/20 revealed diagnoses included Alzheimer's dementia, hypertension, and asthma. Review of a physician's order for Resident #2 dated 11/03/20 revealed: -There was an order to check oxygen (O2) saturation, (normal oxygen saturation was between 95%-100%), every shift for 2 weeks. -There were no parameters indicated to specify when to notify the physician.	{D 273}		

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

Executive Director 1/8/21

Karen M. Polce Reviewed and acknowledged 01/11/21

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{D 273}	Continued From page 1 Review of Resident #2's November 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check O2 saturation every shift for two weeks from 7:00am-3:00pm, 3:00pm-11:00pm, and 11:00pm-7:00am. -There were no parameters listed on the eMAR. -The O2 saturation checks were completed daily during each shift from 11/03/20-11/18/20. -The O2 saturation ranged from 76-100%. -On 12/04/20 from 7:00am-3:00pm shift, the O2 saturation was 81%. -On 12/09/20 from 3:00pm-11:00pm shift, the O2 saturation was 87%. -On 12/10/20 from 7:00am-3:00pm shift, the O2 saturation was 76%. -On 12/15/20 from 7:00am-3:00pm shift, the O2 saturation was 90%. Review of Resident #2's progress notes revealed there was no documentation the physician was contacted to request parameters and was not notified of low O2 saturations. Interview with the Medication Aide (MA)/supervisor on 12/03/20 at 4:15pm revealed: -The facility's physician provided her verbal standing orders to address oxygen levels. -The orders were given during the COVID-19 pandemic. -The physician wanted to be notified if any residents' oxygen level dropped below 94%. -If a residents oxygen saturation dropped below 93% he wanted the resident to be sent to the hospital. -Resident #2 did not have parameters so she followed the standing orders from the provider. -No one notified her that Resident #2's oxygen levels were lower than 94%.	{D 273}		

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{D 273}	Continued From page 2 -She had not contacted the primary care physician (PCP) about specific parameters for Resident #2's O2 saturations. -She had not faxed the O2 saturation checks to the physician after the order ended. Interview with a MA on 12/03/20 at 4:25pm revealed: -He obtained Resident #2's O2 saturation levels during second shift. -He recorded Resident #2's O2 saturations as 87% on 12/09/20. -He did not know when to contact the physician about Resident #2's O2 saturations. -The eMAR did not list the parameters for O2 saturations. -He would notify the Resident Care Coordinator (RCC) and the Resident Services Director (RSD) if Resident #2's O2 saturation was below 90%, because that would be considered low. -He did not remember notifying the RCC or RSD when Resident #2's O2 saturation was 87%. -He had been a MA for 3 months and had "limited understanding" of who he was supposed to notify. -He was never instructed to notify the physician of Resident #2's O2 saturations. -He never sent any of the resident's recorded O2 saturations to the physician because no one instructed him to send them. Interview with the RCC on 12/3/20 at 2:46pm revealed: -He knew Resident #2's order to have O2 saturations check for 2 weeks. -The physician wanted to know if Resident #2 would need supplemental oxygen long term. -He did not know if the physician wanted to be notified about the O2 saturations. -He thought the physician followed up with Resident #2, "I am not sure".	{D 273}		

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{D 273}	Continued From page 3 -He had not contacted the physician regarding Resident #2's O2 saturations. -He was not sure if the MAs contacted the physician regarding Resident #2's O2 saturations. -The MAs were responsible for contacting the physician regarding low O2 saturations, "I am not sure if they did, I don't know". -He was not sure what was low and when the MAs were to contact the physician. -His responsibility was to ensure the orders the physician wrote were transcribed correctly to the electronic medication administration record (eMAR) within 48 hours. -He had not faxed Resident #2's O2 saturations to the physician after 2 weeks and did not know why he had not done it. Interview with the RSD on 12/03/20 at 3:05pm revealed: -She was the nurse for the facility. -She did not provide much clinical oversight with physician orders. -The RCC was responsible for processing physician's orders. -She did not know Resident #2's order for O2 saturation checks did not include parameters. -She did not know the O2 saturations were not faxed to the physician after the order ended. -She would expect the RCC, MA or supervisor to contact the physician to obtain parameters. -She expected the RCC to fax the O2 saturations to the physician when the 2 weeks were over. - The RCC completed a 24 and 48-hour check of the eMAR in which he should be checking to ensure parameters were listed. Interview with Resident #2's PCP on 12/04/20 at 10:00am revealed: -He ordered O2 saturations to be checked due to Resident #2's respiratory issues.	{D 273}		

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{D 273}	Continued From page 4 -He was not concerned about the O2 saturations being in the 80's, but he would want to be notified if her saturations were in the 70's. -He would have expected the staff to repeat the O2 saturation if it were in the 70's, and if it did not increase, he expected her to be sent to the hospital. -He should have put parameters, however thought staff would use "common sense" and notify him of low O2 saturations. -He did not know if the facility contacted him about O2 saturations for Resident #2, he had a new computer system that uploaded faxes from the facility, and he did not have the information in front of him. Interview with the Administrator on 12/04/20 at 9:05am revealed: -She was not aware Resident #2 had an order for O2 saturation checks on 11/03/20. -She expected the order to have parameters, so that staff could act accordingly. -The RCC was the main point of contact with the physician. -The RCC was responsible for making sure orders had parameters and contacting the physician if parameters were not indicated. -The RCC would have been responsible for making sure the physician was faxed the results of the O2 saturations after the 2 weeks were over and not notifying him of the low results. -The RSD was responsible for overseeing all clinical operations of the facility. Based on observations and record reviews, it was determined Resident #2 was not interviewable. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/04/20 at 10:33am	{D 273}		

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{D 273}	Continued From page 5 2. Review of Resident #1's current FL2 dated 12/02/2020 revealed diagnoses included chronic heart failure, chronic respiratory failure and chronic renal insufficiency. a. Review of a physician's order for Resident #1 dated 11/20/20 revealed: -There was an order to check and record daily weights. -There were no parameters indicated on the order for daily weights. Review of Resident #1's November 2020 electronic Medication Administration Record (eMAR), from 11/20/20 through 11/27/20 revealed: -There was an entry to check and record weights daily between 7:00am-3:00pm. -There were no weight parameters listed on the eMAR. -The weights recorded during this time were 296 pounds (lbs.) through 308.6 lbs. -There was no documentation the physician was notified of Resident #1's weights from 11/20/20 through 11/27/20. -The order was for one week, 11/20/20 through 11/27/20. Review of Resident #1's Progress Notes revealed: -There was no documentation the physician was contacted to request parameters nor was he notified of daily weights from 11/20/20-11/27/20. -There was documentation Resident #1 was sent to the hospital on 11/21/20 for shortness of breath and with a diagnosis of heart failure. Interview with the first shift Medication Aide (MA) on 12/03/20 at 2:25pm revealed:	{D 273}		

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{D 273}	Continued From page 6 -She was the primary MA on first shift. -She had sent the request to the physician to check and record Resident #1's daily weights due to lower leg edema. -She knew there were no parameters on the order, but her previous experience had been to contact the physician if there was a 3-pound (lb.) weight gain in 24 hours. -She had not been informed by the physician or management to contact the physician for a weight gain. -She had not contacted the physician to determine parameters. -Resident #1 had not had a 3 lb weight increase on her shift, so she had not contacted the physician. Interview with another first shift MA on 12/03/20 at 3:18pm revealed: -She worked first shift and checked and recorded the residents' weights that were entered on the eMAR. -If there were no parameters or directives to notify the physician, she only recorded the daily readings. -She followed what was entered on the eMAR. -She assumed the physician reviewed the information on the eMAR. Interview with the Resident Care Coordinator (RCC) on 12/3/20 at 2:46pm revealed: -He knew Resident #1 had a physician's order to record daily weights. -The order did not contain any parameters or directions to notify the physician. -The MA or the RCC would send new orders to the pharmacy. -The pharmacy would enter new orders onto the eMAR. -The RCC compared the physician's order and	{D 273}		

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{D 273}	Continued From page 7 the eMAR entry in 24 hours and again in 48 hours to verify the order was entered correctly on the eMAR. -He did not know when he should notify the physician in regard to Resident #3's weight gain. Interview with the Resident Service Director (RSD) on 12/03/20 at 3:05pm revealed: -The RCC was responsible for processing physician's orders. -She would expect the RCC, MA or supervisor to contact the physician to obtain parameters. -The RCC completed a 24 and 48-hour check of the eMAR in which he should be checking to ensure parameters are listed on orders to check weights. Interview with the second shift Medication Aide (MA) on 12/03/20 at 4:00pm revealed: -She had been working for over a year at the facility and was familiar with the resident's baseline blood pressure and weights. -She knew Resident #1 was retaining fluid because her lower legs were edematous at times. -She worked second shift and did not routinely take the residents' weights-they were obtained on first shift. -There were no parameters on the eMAR entry to check and record daily weights. -She would not contact the physician for parameters on an order. -The RCC and RSD contacted the resident's physicians for order clarifications. -If she contacted the physician for any resident, she would make an entry in the 24-hour book and record the directives given by the physician. -She had never contacted Resident #1's physician for her weight gain. Interview with Resident #1 on 12/03/20 at 4:30pm	{D 273}		

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{D 273}	Continued From page 8 revealed: -She thought the physician had told her to let the staff know she needed to be weighed daily and contact him if her weight increased. -She thought the physician was to be notified if she gained "3 pounds in one day." -She could not remember if she mentioned the 3-pound parameter to the staff. Telephone interview with Resident #1's primary care physician (PCP) on 12/04/20 at 10:00am revealed: -The staff had requested Resident #1 to have daily weights checked and recorded due to possible fluid retention. -He signed the order and should have added parameters for the weight gain, (weight gain greater than 3 lbs in one day to contact him). -He should have put parameters along with the order to weigh Resident #1 daily, however he thought the staff would use "common sense" and notify him of weight increases of 3 lbs or more in one day. -The staff did not contact him to clarify parameters for the weight gain and as to when he should be notified. -He reviewed the eMARS when visiting with the residents and would have reviewed the weights at that time. Telephone interview with the Administrator on 12/04/20 at 9:05am revealed: -She was not aware Resident #1 had an order to check and record daily weights. -She expected orders for daily weights to have parameters, so the staff could act accordingly and notify the physician when needed. -The RCC was the main point of contact with the physician and the pharmacy. -The RCC was responsible for ensuring orders	{D 273}		

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{D 273}	Continued From page 9 were entered on the eMAR correctly, and contacting the physician if parameters were indicated but not specified. -The Resident Service Director (RSD) was a Registered Nurse and was responsible for verifying that orders were complete. -The RSD was responsible for overseeing clinical staff and all clinical operations of the facility. b. Resident #1 had a signed physician's order dated 04/02/19 for blood pressure checks daily. Review of Resident #1's September 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check and record blood pressure (BP) daily at 8:00am. -There were no parameters for the BP readings listed on the eMAR. -The BP readings were documented from 09/01/20 through 09/30/20 between 140/66 - 195/97. -There was no documentation the physician was notified of Resident #1's BP readings in September 2020. Review of Resident #1's October 2020 eMAR revealed: -There was an entry to check and record BP daily at 8:00am. -There were no parameters for the BP readings listed on the eMAR. -The BP readings were documented from 10/01/20 through 10/31/20 between 120/58 - 196/88. -There was no documentation the physician was notified of Resident #1's BP readings in October 2020. Review of Resident #1's November 2020 eMAR	{D 273}		

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{D 273}	Continued From page 10 revealed: -There was an entry to check and record BP daily at 8:00am. -There were no parameters for the BP readings listed on the eMAR. -The blood pressure readings were documented from 11/01/20 through 11/20/20 between 140/73 - 184/72. -There was no documentation the physician was notified of Resident #1's BP readings in November 2020. Review of Resident #1's FL2 dated 11/20/20 did not include an order for daily BP checks. Review of Resident #1's Progress Notes revealed there was no documentation the physician was notified of the BP readings, or contacted to request parameters for the BP readings. Interview with the first shift Medication Aide (MA) on 12/03/20 at 2:25pm revealed: -She was the primary MA on first shift. -Resident #1 was diagnosed as hypertensive, and her BPs were usually above 140 (systolic). -She knew Resident #1 had a physician's order to check and record BP daily. -She knew there were no parameters on the order. -She had not been informed by the physician or management to contact the physician for an elevated BP. -She had not contacted the physician to determine parameters. -If Resident #1's BP was very high she would contact the physician or send her to the Emergency Department (ED). -For Resident #1, she thought a BP above 180 systolic would be high and warrant a telephone call to the physician.	{D 273}		

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{D 273}	Continued From page 11 -If she also had other symptoms, such as headaches or pain, she would call the nurse and send Resident #1 to the ED. Interview with another first shift MA on 12/04/20 at 3:18pm revealed: -She worked first shift and checked and recorded the residents' blood pressures that were entered on the eMARs. -If there were no parameters or directives to notify the physician, she only recorded the daily readings. -She followed what was entered on the eMAR. -She assumed the physician reviewed the information on the eMAR. Interview with the second shift MA on 12/03/20 at 4:00pm revealed: -She had been working for over a year at the facility and was familiar with the resident's baseline blood pressure and weights. -She knew Resident #1 was hypertensive and her BP readings were high at times. -If she thought Resident #1 was high beyond her baseline, she would contact the physician and call the Emergency Medical Services (EMS). -If she contacted the physician for any resident, she would make an entry in the 24-hour book and record the directives given by the physician. -She had never contacted the physician or the EMS for Resident #1's elevated BP. -She worked second shift and did not routinely check and record Resident #1's BP. -She would probably contact Resident #1's physician and send her out to the Emergency Department (ED) if her systolic blood pressure was 180 or 190. Interview with Resident #1 on 12/03/20 at 4:30pm revealed she knew she was hypertensive but did	{D 273}		

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{D 273}	Continued From page 12 not know what a "high" reading for her would be. Telephone interview with Resident #1's primary care provider (PCP) on 12/04/20 at 10:00am revealed: -Resident #1 was hypertensive and he had ordered daily blood pressure checks since January 2020. -He should have added parameters for the BP checks, but due to her several co-morbidities he has had several visits with Resident #1 since January 2020. -He reviewed the eMARS when visiting Resident #1 and would have reviewed the BP readings at that time. -He thought the staff would use "common sense" and notify him of "extremely high readings". -He knows the staff sent faxes to his office regarding the residents but was unable to confirm when he received them. -He did not have any visit notes stating he was concerned with her high blood pressure. Interview with the Resident Care Coordinator (RCC) on 12/3/20 at 2:46pm revealed: -He knew Resident #1 had a physician's order to record daily weights. -The order did not contain any parameters or directions to notify the physician. -The MA or the RCC would send new orders to the pharmacy. -The pharmacy would enter new orders onto the eMAR. -The RCC compared the physician's order and the eMAR entry in 24 hours and again in 48 hours to verify the order was entered correctly on the eMAR. -He did not know when to notify the physician in regard to high blood pressure readings. -It was his responsibility to contact the physician	{D 273}		

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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 273}	Continued From page 13 to obtain parameters and to report high blood pressures. Interview with the Resident Service Director (RSD) on 12/03/20 at 3:05pm revealed: -The RCC was responsible for processing physician's orders. -She would expect the RCC or the MA to contact the physician to obtain parameters for an order if needed. -The RCC completed a 24 and 48-hour check of the eMAR in which he should be checking to ensure parameters are listed on orders to check blood pressures. -She had not been reviewing orders on the eMARS and had been relying on the RCC to ensure orders were accurate and complete. Telephone interview with the Administrator on 12/04/20 at 9:05am revealed: -She was not aware Resident #1 had an order to check and record blood pressures daily. -She expected orders for daily weights to have parameters, so the staff could act accordingly and notify the physician when needed. -The RCC was the main point of contact with the physician and the pharmacy. -The RCC was responsible for ensuring orders were entered on the eMAR correctly, and contacting the physician if parameters were indicated but not specified. -The RSD was a Registered Nurse and was responsible for verifying that orders were complete. -The RSD was responsible for overseeing clinical staff and all clinical operations of the facility.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

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D 276	Continued From page 14 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents regarding the application of thromboembolic deterrent hose and a chair/bed alarm (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 07/07/20 revealed diagnoses included dementia, anxiety, hypertension and coronary artery disease. a. Review of Resident #4's signed physician's orders dated 09/02/20 revealed an order to apply thromboembolic deterrent hose (TED hose) apply every morning and remove every evening. Review of Resident #4's current Care Plan dated 06/23/20 revealed she was totally dependent on	D 276	**PLAN** The RSD and ED will conduct Additional training to Med Aides and Care staff to ensure health care is Provided and documented in the Resident's record as prescribed by The physician and implemented per Physician orders. **MONITORING SYSTEM** The Clinical Operations Specialist Will perform random review of Resident records to include orders Specific to vital signs and weight Requests and ensure parameters Are requested and abnormal Results are reported.	12/31/20

Ann Watts 1/9/21

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D 276	Continued From page 15 staff for dressing. Observation of Resident #4 on 12/03/20 between 9:45am and 10:30am revealed: -Resident #4 did not have TED hose on her legs. -Resident #4 was seated in her wheelchair wearing gray socks and tennis shoes on both feet. -The skin on both of Resident #4's lower extremities from her knees to the top of her socks was dark gray color. Observation of Resident #4 on 12/03/20 between 2:00pm and 2:30pm revealed: -Resident #4 did not have TED hose on her legs. -Resident #4 was seated in her wheelchair wearing gray socks and tennis shoes on both feet. -The skin on both of Resident #4's lower extremities from her knees to the top of her socks were dark gray color. Review of Resident #4's September 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose every morning and remove every evening. -There was documentation TED hose had been applied every morning at 8:00am the entire month. -There was documentation TED hose had been removed every evening at 8:00pm the entire month. Review of Resident #4's October 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose every morning and remove every evening. -There was documentation TED hose had been	D 276		

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D 276	Continued From page 16 applied every morning at 8:00am the entire month. -There was documentation TED hose had been removed every evening at 8:00pm the entire month. Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose every morning and remove every evening. -There was documentation TED hose had been applied every morning at 8:00am the entire month. -There was documentation TED hose had been removed every evening at 8:00pm the entire month. Review of Resident #4's December 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose every morning and remove every evening. -There was documentation TED hose had been applied every morning from 12/01/20 to 12/03/20 at 8:00am. -There was documentation TED hose had been applied every evening from 12/01/20 to 12/03/20 at 8:00pm. Telephone interview with Resident #4's responsible party (RP) on 12/04/20 at 10:00am revealed: -She visited Resident #4 at least once a week. -Resident #4 required assistance with putting on TED hose. -Resident #4 needed to wear TED hose. -Resident #4's doctor ordered TED hose to be worn when her legs were swollen or to improve circulation, she did not recall the exact reason.	D 276		

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D 276	Continued From page 17 Interview with a first shift medication aide (MA) on 12/03/20 at 2:05pm revealed: -She was responsible for ensuring Resident #4 had her TED hose on. -She documented Resident #4 had her TED hose were applied on the eMAR without looking for them. -She assumed they were in place because other staff routinely put them on Resident #4, and she didn't look for them. -After she was notified today (12/03/20) that Resident #4's TED hose was not on her she found Resident #4's TED hose hanging in her bathroom and applied them. Interview with Memory Care Manager (MCM) on 12/03/20 at 2:15pm revealed: -The MAs were responsible for ensuring Resident #4's TED hose were applied when ordered. -She did not know Resident #4 did not have TED hose on until she looked for them this afternoon (12/03/20). -Resident's #4's TED hose was supposed to be on her in the morning when she got out of bed. -The MA was to verify the TED hose were in place prior to documenting them on the eMAR. -The RCC and RSD completed monthly audits of Resident #4's physician's orders. Interview with Resident Care Coordinator (RCC) on 12/03/20 at 2:45pm revealed: -On 11/25/20 Resident #4 had a skin tear on her right lower leg that occurred when she hit her leg after stiffening up during a transfer from her wheelchair to her bed. -Resident #4 had a band aid applied to her right lower leg after the skin tear occurred. -The MAs were responsible for ensuring Resident #4's TED hose were applied when ordered.	D 276		

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D 276	Continued From page 18 -The MAs were to document TED hose were in place on the eMAR after they applied or checked they were in place. -The MAs were responsible for ensuring Resident #4's TED hose were applied when ordered. -He audited Resident #4's physician's orders monthly to ensure they were all completed according to the documentation on the eMARs. -He did not check to ensure Resident #4 had TED hose, a chair/bed alarm available on hand. -It was not part of his audit process to check to ensure Resident #4 had TED hose. Interview with Resident Service Director (RSD) on 12/03/20 at 3:00pm revealed: -She was responsible for ensuring all MAs and the RCC carried out physicians' orders as they were written for all residents. -She was responsible for auditing Resident #4's physician's orders to ensure the MAs had Resident #4's TED hose. -She did not know if Resident #4 had TED hose as ordered by the physician. -The RCC performed monthly audits to ensure the residents had TED hose. -She was responsible for the oversight of the care provided to Resident #4 by the MAs and RCC. -She did not perform a check to locate Resident #4's TED hose. -She had not been able to find enough time to provide a lot of oversight of the MAs and RCC because she was preoccupied with her other job responsibilities. Telephone Interview with the Executive Director on 12/04/20 at 9:30am revealed: -The RSD was 100% in charge of the clinical staff in the facility. -She expected the RSD to utilize an audited process that ensured Resident #4's TED hose	D 276		

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D 276	Continued From page 19 was available and applied. -She met with the RSD and RCC weekly to discuss the "here and now" issues involving all the residents' care. -The weekly meetings to discuss residents' care needs did not include reviewing TED hose. Telephone interview with Resident #4's primary care provider (PCP) on 12/04/20 at 10;30am revealed: -Resident #4 had a physician order for TED hose due to venous insufficiency in her legs. -If Resident #4 did not wear TED hose for several days it could lead to skin breakdown on her legs. -The wound on Resident #4's leg was a skin tear. b. Review of Resident #4's signed physician's orders dated 09/02/20 revealed an order to apply bed/chair alarm 24 hours a day seven days a week as tolerated by resident. Review of Resident #4's current Care Plan dated 06/23/20 revealed she was totally dependent on staff for ambulation and transfers. Observation of Resident #4 on 12/03/20 between 9:45am and 10:30am revealed: -Resident #4 did not have a chair alarm attached to her. -There was no chair alarm on her wheelchair. -There was no bed alarm on Resident #4's bed or in her room. Observation of Resident #4 on 12/03/20 between 2:00pm and 2:30pm revealed: -Resident #4 did not have a chair alarm attached to her. -There was no chair alarm on her wheelchair. -There was no bed alarm on Resident #4's bed or in her room.	D 276		

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D 276	Continued From page 20 Review of Resident #4's September 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply bed/chair alarm 24/7 as tolerated by resident. -There was documentation the bed/chair alarm had been applied every day for 24 hours the entire month. -There was no documentation the bed/chair alarm was not applied or not tolerated by the resident. Review of Resident #4's October 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply bed/chair alarm 24/7 as tolerated by resident. -There was documentation the bed/chair alarm had been applied every day for 24 hours the entire month. -There was no documentation the bed/chair alarm was not applied or not tolerated by the resident. Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply bed/chair alarm 24/7 as tolerated by resident. -There was documentation the bed/chair alarm had been applied every day for 24 hours the entire month. -There was no documentation the bed/chair alarm was not applied or not tolerated by the resident. . Review of Resident #4's December 2020 electronic Medication Administration Record (eMAR) revealed:	D 276		

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D 276	Continued From page 21 -There was an entry to apply bed/chair alarm 24/7 as tolerated by resident. -There was documentation the bed/chair alarm had been applied every day for 24 hours 12/01/20 to 12/02/20. -There was documentation the bed/chair alarm had been applied on 12/03/20 until 3:00pm. -There was no documentation the bed/chair alarm was not applied or not tolerated by the resident. Telephone interview with Resident #4's responsible party (RP) on 12/04/20 at 10:00am revealed: -Resident #4 had a history of falls in the past. -Staff informed her last week Resident #4 got a skin tear on her right lower leg when they transferred the resident from her wheelchair to bed. -Resident #4 had a chair alarm that was to clip to her clothing when she was up in her wheelchair to alert staff when she attempted to get up without assistance. -Resident #4 had a bed alarm on her bed to alert staff if she attempted to get out of bed without assistance. Interview with a first shift medication aide (MA) on 12/03/20 at 2:05pm revealed: -She was responsible for ensuring Resident #4 had her chair alarm on. -She documented Resident #4 had her chair/bed alarm were applied on the eMAR without looking for them. -She assumed they were in place because other staff routinely put it in place, and she didn't look for the chair/bed alarm. -She did not find Resident #4's bed/chair alarm today (12/03/20) so she had to apply one she found in their supply closet.	D 276		

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D 276	Continued From page 22 Interview with Memory Care Manager (MCM) on 12/03/20 at 2:15pm revealed: -She did not know Resident #4 did not have a chair/bed alarm until she looked for them this afternoon (12/03/20). -She remembered Resident #4 had a chair and bed alarm, but she did know when she last saw them. -The MA was to verify the TED hose and chair alarm were in place prior to documenting them on the eMAR. -The RCC and RSD completed monthly audits of Resident #4's physician's orders. Interview with Resident Care Coordinator (RCC) on 12/03/20 at 2:45pm revealed: -On 11/25/20 Resident #4 had a skin tear on her right lower leg that occurred when she hit her leg after stiffening up during a transfer from her wheelchair to her bed. -Resident #4 had a band aid applied to her right lower leg after the skin tear occurred. -The MAs were responsible for ensuring Resident #4's chair/bed alarm were applied when ordered. -The MAs were to document the chair/bed alarm were in place on the eMAR after they applied or checked they were in place. -The MAs were responsible for ensuring Resident #4's chair and bed alarm were applied when ordered. -He audited Resident #4's physician's orders monthly to ensure they were all completed according to the documentation on the eMARs. -He did not check to ensure Resident #4 had a chair/bed alarm available on hand. -It was not part of his audit process to check to ensure Resident #4 had a chair/bed alarm. Interview with Resident Service Director (RSD) on	D 276		

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D 276	Continued From page 23 12/03/20 at 3:00pm revealed: -She was responsible for ensuring all MAs and the RCC carried out physicians' orders as they were written for all residents. -She was responsible for auditing Resident #4's physician's orders to ensure the MAs had Resident #4's chair/bed alarm available. -She did not know if Resident #4 had a chair/bed alarm applied as ordered by the physician. -The RCC performed monthly audits to ensure the residents had chair/bed alarms available. -She was responsible for the oversight of the care provided to Resident #4 by the MAs and RCC. -She did not perform a check to locate Resident #4's chair/bed alarm. -She had not been able to find enough time to provide a lot of oversight of the MAs and RCC because she was preoccupied with her other job responsibilities. Telephone Interview with the Executive Director on 12/04/20 at 9:30am revealed: -The RSD was 100% in charge of the clinical staff in the facility. -She expected the RSD to utilize an audited process that ensured Resident #4's chair/bed alarm was available and applied. -She met with the RSD and RCC weekly to discuss the "here and now" issues involving all the residents' care. -The weekly meetings to discuss residents' care needs did not include reviewing chair/bed alarms. Telephone interview with Resident #4's primary care provider (PCP) on 12/04/20 at 10;30am revealed Resident #4 had an order for a chair/bed alarm because she was at risk of having a fall. Based on observations, interviews, and record reviews it was determined Resident #4 was not	D 276		

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D 276	Continued From page 24 interviewable.	D 276		