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
	HAL041010	A. BUILDING: _____ B. WING _____	R-C 12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up, COVID-19 focused infection control and complaint investigation survey with an onsite visit on 12/10/20 and 12/11/20 and desk review survey on 12/14/20 to 12/15/20 and an exit via telephone on 12/15/20.	{D 000}		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to ensure at least one staff was always on the premises who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months for 24 of 42 shifts sampled for 14 days from 11/26/20 through 12/09/20 for 3 of 6	D 167	CPR trainings were conducted on 12/15/2020 and 01/04/2021. Additional trainings will be Conducted in February and March. The MCC and RCD Will ensure that there is a Person on each shift who is CPR Certified and we are compliant with state regulations. CPR will be monitored bi- weekly for compliance to begin 01/29/2021.	01/29/21

Reviewed and Accepted on 02/02/21 by KHH

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D 167	Continued From page 1 sampled staff (Staff C, E and F). The findings are: 1. Review of Staff C, medication aide's (MA), personnel record revealed: -Staff C was hired on 09/22/20. -There was no documentation Staff C had completed training on CPR within the last 24 months. Telephone interview with Staff C on 12/15/20 at 12:20pm revealed: -She had CPR training prior to working at the facility. -Her CPR certification had expired in June 2020. -She had not completed CPR training since she started working at the facility in September 2020. Review of the facility's work schedule from 11/26/20 through 12/09/20 revealed: -Staff C worked 8 hours on third shift (11:00pm to 7:00am) on 11/28/20, 11/29/20, 12/01/20, and 12/06/20. -There were no staff who worked with Staff C on third shift on the above dates who had current CPR certification. -Staff C worked 4 hours on third shift on 12/04/20 from 4:45am to 8:10am and there were no staff who worked with Staff C on third shift on 12/04/20 who had current CPR certification. Refer to telephone interview with the Memory Care Unit Coordinator (MCUC) on 12/15/20 at 11:01am. Refer to telephone interview with the Resident Care Director (RCD) on 12/15/20 at 10:36am. Refer to telephone interview with the	D 167		

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D 167	Continued From page 2 Administrator on 12/14/20 at 3:16pm. 2. Review of Staff E, personal care aide's (PCA), personnel record revealed: -Staff E was hired on 10/28/20. -There was no documentation Staff E had completed training on CPR within the last 24 months. Telephone interview with Staff E on 12/15/20 at 11:34am revealed: -She had worked at the facility for 2 months as a PCA. -She never had CPR training and was not told she needed to have CPR. -She had not been aware of the availability of any CPR classes until last week when she was told by management that a CPR class was going to be provided for staff. Review of the facility's work schedule from 11/26/20 through 12/09/20 revealed there were no staff present on the third shift who had current CPR certification when staff E worked on the following dates 11/26/20, 11/28/20, 11/29/20, 11/30/20, 12/02/20, 12/03/20, 12/04/20 and 12/07/20. Refer to telephone interview with the Memory Care Unit Coordinator (MCUC) on 12/15/20 at 11:01am. Refer to telephone interview with the Resident Care Director (RCD) on 12/15/20 at 10:36am. Refer to telephone interview with the Administrator on 12/14/20 at 3:16pm. 3. Review of Staff F, personal care aide's (PCA), personnel record revealed:	D 167		

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D 167	Continued From page 3 -Staff F was hired on 11/02/20. -There was no documentation Staff F had completed training on CPR within the last 24 months. Review of the facility's work schedule 11/26/20 through 12/09/20 revealed: -Staff F worked 8 hours on third shift (11:00pm to 3:00pm) on the following dates 11/26/20, 11/28/20, 11/29/20, 11/30/20, 12/02/20, 12/03/20, 12/04/20, and 12/07/20. -When Staff F worked on the above dates there were no staff who worked with Staff F on the third shift who had current CPR certification. Attempted telephone interview with Staff F on 12/15/20 at 12:01pm was unsuccessful. Refer to telephone interview with the Memory Care Unit Coordinator (MCUC) on 12/15/20 at 11:01am. Refer to telephone interview with the Resident Care Director (RCD) on 12/15/20 at 10:36am. Refer to telephone interview with the Administrator on 12/14/20 at 3:16pm. Telephone interview with the MCUC on 12/15/20 at 11:01am revealed: -She started working at the facility three months ago and her responsible was to prepare the work schedules for the medication aides and personal care aides who were assigned to the memory care unit and the assisted living unit. -She was aware there needed to be at least one person on every shift who was CPR certified. -She was not aware that all staff at the facility had current CPR certification. -The first of November 2020, she found out most	D 167		

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D 167	Continued From page 4 of the staff did not have CPR certification. -Since November 2020, she had not considered scheduling the staff with CPR certification on the first, second and third shifts to ensure each shift had one staff with current CPR certification. -Nothing had happened with residents needing CPR, but if something happened, she expected staff to call 911. Telephone interview with the RCD on 12/15/20 at 10:36am revealed: -At the beginning of November 2020, she reviewed staff records for qualifications and she discovered that a large number of staff did not have CPR certification. -The pharmacy could not schedule CPR training, so the facility switched pharmacies. -She had not tried other agencies or providers to schedule CPR training. Telephone interview with the Administrator on 12/14/20 at 3:16pm revealed: -Since November 2020 she had tried to obtain CPR training but ended up switching pharmacies because the contracted pharmacy did not offer CPR training. -She tried several avenues to schedule CPR training, but due to the COVID-19 pandemic she has had difficulties scheduling training. _____ The facility failed to ensure there were staff on duty who had training on CPR and choking management in the last 24 months for 24 of 42 shifts sampled for 14 days from 11/26/20 through 12/09/20, resulting in no staff available to perform lifesaving measures in the event of an emergency. The failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____	D 167		

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D 167	Continued From page 5 The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 12/11/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2021.	D 167		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 3 of 5 sampled residents (Residents #3, #4, and #5) related to one resident who had a pacemaker and had not followed up with a cardiologist (#5), a resident who had orders for physical therapy (#4), and a resident who had physician orders for a continuous positive airway pressure (CPAP) machine on her Care Plan and Licensed Professional Health Support but was not using it, and was refusing fingerstick blood sugar checks (#3). The findings are: 1. Review of Resident #5's current FL2 dated 06/15/20 revealed diagnoses included acute respiratory disease, sepsis, pneumonia due to other specified bacteria, diabetes mellitus without	D 273	The RCD and transportation Coordinator have implemented a Transportation binder as of 12/15/2020. RCD and TC meet weekly to discuss upcoming appointments. Once appointments are completed the RCD and TC review any additional follow up needed for the resident. Going forward RCD will ensure all appointments and acute care is followed up on. The RCD and TC will meet weekly to review and monitor appointments to begin 01/29/2021.	01/29/2021

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D 273	Continued From page 6 complications, and acute respiratory failure with hypoxia. Review of Resident #5's progress note dated 10/21/20 at 12:00am revealed: -Resident #5 had an x-ray around 3:00am on 10/22/20 due to a choking episode and the x-ray results identified Resident #5 had a pacemaker. -There was no documentation in Resident #5's record of Resident #5's diagnoses of pacemaker. Review of Resident #5's physician's order form dated 10/22/20 revealed: -The Resident Care Director (RCD) documented the request for an order to Resident #5's previous primary care provider (PCP). -The RCD documented she recently found out Resident #5 had a pacemaker. -There were no notes regarding the pacemaker in Resident #5's chart, and the RCD documented a request for information regarding who provided the pacemaker so a pacemaker check could be scheduled. -Resident #5's PCP responded on 10/28/20 with an order to follow up with cardiologist for a pacemaker check. Review of Resident #5's previous PCP's Progress Note dated 10/28/20 revealed: -Resident #5 was seen on 10/28/20 to follow up on pacemaker checks. -The RCD documented there was no record of Resident #5 having his pacemaker checked. -The previous PCP followed up with her medical director and was told Resident #5 had pacemaker checks in the past, but she could not identify when. -There was an order for a cardiology consult for a pacemaker check.	D 273		

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D 273	Continued From page 7 Interview with the RCD on 12/10/20 at 4:16pm revealed: -She had talked to Resident #5's previous PCP in October 2020 regarding an order for a cardiologist consult. -She knew the previous PCP wrote the order for a cardiologist consult. -The transportation staff was responsible for scheduling resident appointments. -She provided a copy of the order to the transportation staff, who scheduled the appointment, and informed her of when the appointment was. -She "thought" the transportation staff called on 11/09/20 to set up an appointment with a cardiologist, but she did not see the scheduled appointment in the appointment book. -She contacted the cardiologist office listed in the appointment book on 12/10/20 at 4:28pm and she was informed that Resident #5 was not in their system and there was no appointment scheduled for him. -She did not know an appointment had not been scheduled for Resident #5. -She had not made Resident #5's new PCP aware Resident #5 had a pacemaker and needed to be seen by a cardiologist for a pacemaker check because his information as a new patient was still being processed by the new PCP. Interview with the transportation staff on 12/11/20 at 9:38am revealed: -She was responsible for making appointments for residents once a referral was ordered by the physician. -The RCD received and reviewed the physician's orders, gave them to her, and then she contacted outside medical providers to schedule appointments for residents. -She received the order written by Resident #5's	D 273		

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previous PCP for a cardiology consult in November 2020 and contacted a local cardiologist who provided care for another resident.
-She was told by the local cardiology office and was told Resident #5 did not have a file, so she did not schedule an appointment for Resident #5.
-She told the RCD Resident #5 did not have a file at the local cardiology office and the RCD said she was going to contact the Resident #5's new PCP to get another referral for a different cardiologist.
-She did not know if another order for a cardiologist consult was obtained from Resident #5's new PCP.
-She had not reached out to Resident #5's family for information regarding Resident #5's cardiologist.

Interview with the RCD on 12/11/20 at 12:18pm reveled:
-She did not reach out to Resident #5's family to confirm the name of his cardiologist because she thought the transportation staff did.
-She had not looked through Resident #5's thinned records for any information regarding Resident #5's pacemaker and information regarding his cardiologist.

Interview with Resident #5's family member on 12/15/20 at 11:50am revealed:
-Resident #5 has had a pacemaker for about 15 years.
-She did not know who Resident #5's cardiologist was or if he had seen a cardiologist for pacemaker checks while at the facility.

Interview with Resident #5's previous PCP on 10/11/20 at 10:27am revealed:
-She wrote the order dated 10/28/20 for Resident

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D 273	Continued From page 9 #5 to see a cardiologist for a pacemaker check. -The facility did not notify her the appointment had not been made for Resident #5 to see a cardiologist. -She did not know Resident #5 had a pacemaker, but she spoke to the medical director who remembered Resident #5 had to go out to have pacemaker checks. -The medical director did not recall who Resident #5's cardiologist was or when Resident #5 last had a pacemaker check, but she thought it had been a year or two. -She looked through Resident #5's record at the facility and did not see any information regarding a pacemaker. -She told the RCC to make sure Resident #5 was scheduled as soon as possible with a cardiologist to get his pacemaker check. -She expected the facility to call her if there were issues with scheduling for Resident #5 to be seen by a cardiologist because she would have been able to assist with scheduling. -Her order for a cardiologist consult did not include a referral to a specific provider. -If the pacemaker was not checked as recommended by a cardiologist, it could cause irregular heartbeats and Resident #5's heart could stop. Interview with Resident #5's PCP on 10/11/20 at 9:52am revealed: -She was a new provider with the facility and had not made an initial visits with all the residents, including Resident #5. -The facility only included an electronic Medication Administration Record (eMAR) in the information that was sent to her office for residents. -She had not seen any information regarding Resident #5 and no one from the facility informed	D 273		

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her Resident #5 needed a cardiology consult for a pacemaker check.
-The length of time between pacemaker checks depended on the person.
-Some pacemakers required a 6 month check while others could be checked every 6 months to a year.
-If the pacemaker was not checked as recommended by a cardiologist, Resident #5's batteries could not function properly, or the batteries could die, and it could be detrimental to his health.
-It was important Resident #5 get his pacemaker checked regularly.
-If staff had notified her of Resident #5's need for a pacemaker check, she would have written an order for a cardiology consult.

Interview with the Administrator on 12/10/20 at 4:21pm revealed:
-She did not know Resident #5 had not been scheduled to see a cardiologist for a pacemaker check as scheduled.
-The RCD was responsible for following up with Resident #5 PCP regarding his pacemaker and for making sure the appointment with a cardiologist had been scheduled.
-She expected for an appointment to be made for Resident #5 to see a cardiologist by now.

Based on record reviews and interviews, it was determined Resident #5 was not interviewable.

2. Review of Resident #4's FL2 dated 06/15/20 revealed diagnoses included acute respiratory disease, acute respiratory failure with hypoxia, and diabetes mellitus without complications.

Review of Resident #4's Primary Care Provider's (PCP) Consultation Notes dated 11/11/20

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D 273	Continued From page 11 revealed: -Resident #4 had a diagnosis of osteoarthritis of multiple joints. -There was an order written for physical therapy (PT) due to decline in mobility. Review of Resident #4's record revealed no documentation of evaluation for PT or treatment after 11/11/20. Interview with Resident #4 on 12/11/20 at 2:59pm revealed: -He was not currently receiving PT. -He did not feel he was currently exhibiting any difficulty with ambulation or transfers. Interview with the Resident Care Coordinator (RCC) on 12/11/20 at 12:18pm revealed: -When she received orders for home health services, she was responsible for contacting the home health provider and sending the order to the provider. -She did not remember if she faxed the order for PT for Resident #4 to the home health provider. -She was responsible for following up with orders. Interview with a representative from the home health provider's office on 12/11/20 at 2:55pm revealed: -Resident #4 did not have any active orders for PT. -Resident #4 last received PT from 06/19/20 through 09/02/20. Interview with the physical therapist on 12/11/20 at 3:46pm revealed: -She provided PT to Resident #4 a few months ago. -She was not aware of any new orders to evaluate Resident #4 for PT.	D 273		

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D 273	Continued From page 12 -She was in the facility 3 to 4 times a week and no staff informed her there was an order for PT or inquired why Resident #4 was not receiving PT as ordered. -When she visited the facility, she asked if there were any new orders for PT and was told there were no orders when asked. Interview with the Resident Care Director (RCD) on 12/15/20 at 10:29am revealed: -She was responsible for reviewing new physician's orders and orders on the PCP's Consultation Notes. -She remembered seeing Resident #4's PCP's Consultation Notes dated 11/11/20 documenting an order placed for PT. -She had not followed up with the home health provider for PT or with Resident #4's PCP regarding PT and she did not know why. -There was not a system in place for following up to make sure new orders were in place for residents. Telephone interview with Resident #4's PCP on 12/14/20 at 12:22pm revealed: -She wrote an order for PT for Resident #4 due to his diagnosis of osteoarthritis and declining mobility. -Her office sent an order for PT to the home health provider on 11/13/20. -Her office sent a copy of any orders along with a copy of the consultation notes to the facility after each visit. -She did not know PT services had not been started for Resident #4. -She expected the facility to follow up on the order for PT with the home health provider, if PT services had not started for Resident #4. A second telephone interview with Resident #4's	D 273		

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D 273	Continued From page 13 PCP on 12/14/20 at 12:48pm revealed: -Her office staff thought she had sent the order for PT to the facilities home health provider, but when she researched, the order did not appear to transmit. -She expected the facility to follow up on with the home health provider. Interview with the Administrator on 12/14/20 at 3:00pm revealed: -She did not know Resident #4 had an order for PT. -The RCD was responsible for reviewing new orders. -Any orders written by Resident #4's PCP while she was in the facility were placed in a folder for the RCD to review. -Resident #4's PCP's office also faxed orders for treatment and medication to providers. -The RCD should have followed up with the order for PT for Resident #4. 3. Review of Resident #3's current FL-2 dated 10/29/20 revealed: -Diagnoses included major depression disorder, and diabetes mellitus type 2. -There was an order to check fingerstick blood sugar (FSBS) twice a day. Review of Resident #3's Resident Register revealed an admission date of 11/13/20. a. Review of Resident #3's subsequent physician's orders revealed: -There was a physician's order dated 11/18/20 to check FSBS twice a day. -There was a physician's order dated 12/03/20 to check FSBS before meals and at bedtime (4 times a day).	D 273		

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D 273	Continued From page 14 Review of Resident #3's November 2020 electronic Medication Administration Records (eMARs) revealed: -There was an entry for check FSBS twice a day at 6:00am and 7:00pm with FSBS documented twice daily from 11/19/20 to 11/30/20. -The FSBS checks ranged from 70 to 227. Review of Resident #3's December 2020 eMARs revealed: -There was an entry for check FSBS twice a day at 6:00am and 7:00pm daily from 12/01/20 to 12/03/20 at 6:00am with FSBS values documented twice daily. -The FSBS values ranged from 98 to 171. -There was an entry for check FSBS 4 times a day at 6:30am, 11:30am, 4:30pm and 8:00pm from 12/03/20 at 4:30pm to 12/10/20 at 11:30am. -There was documentation Resident #3 refused FSBS checks 7 out of 28 opportunities for FSBS checks as follows: At 11:30am on 12/07/20, 12/08/20, 12/09/20, and 12/10/20; and at 8:00pm on 12/05/20, 12/08/20, and 12/09/20. -The FSBS checks ranged from 79 to 196. Observation of FSBS checks scheduled for 11:30am on 12/10/20 for the assisted living (AL) unit revealed: -At 11:20am, the AL day shift medication aide (MA) walked to the door of Resident #3's room. -The MA asked Resident #3 if she was going to get her FSBS check at this time today. -Resident #3 shook her head and said "no". -The MA turned away and said "she refused". Interview with the AL day shift MA on 12/10/20 at 11:23am revealed: -Resident #3 allowed third shift staff to obtain FSBS at 6:00am.	D 273		

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D 273	Continued From page 15 -Resident #3 had been refusing FSBS checks the last 4 days since her order changed from twice a day to 4 times a day on 12/03/20. -She was responsible to check Resident #3's FSBS at 11:30am daily during her shift. -The MA had not notified the resident's primary care provider (PCP) or the Resident Care Director (RCD) for refused FSBS checks. -She was not sure who was responsible to notify the PCP for refusal the MA or the RCD. Interview with an AL second shift MA on 12/10/20 at 4:30pm revealed: -The facility policy was for the MA to notify the Supervisor or RCD, the resident's PCP, and the responsible party for more than 2 refusals. -She was responsible to check Resident #3's FSBS 2 times, at 4:30pm and 8:00pm during her shift. -Resident #3 had not refused FSBS checks for her on the shifts she had worked. Telephone interview with Resident #3's PCP on 12/10/20 at 4:10pm revealed: -The PCP was new to the facility and the resident was a recent admission. -Resident # 3 was receiving FSBS checks in order for the PCP to monitor blood glucose levels since the resident received a long acting insulin. -The facility had not contacted her for Resident #3 refusing FSBS checks prior to earlier today when she received a faxed notification for refusing FSBS checks. -The facility should notify the PCP when any resident was refusing medications or treatments for her to evaluate the need for the specific order. -She could be notified by fax to the office, by using the telephone messaging system or e-mail directly to the provider.	D 273		

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D 273	Continued From page 16 Interview with Resident #3 on 12/10/20 at 4:35pm revealed: -She did not feel she needed FSBS 4 times a day. -She refused FSBS checks occasionally. Interview with the Administrator on 12/11/20 at 10:40am revealed: -She did not know the facility's policy for the number of refusals before the PCP should be notified. -The Resident Care Director (RCD) would be responsible to ensure Resident #3's PCP was notified for refusing FSBS. Interview with the RCD on 12/11/20 at 10:50am revealed: -She did not know Resident #3 was refusing FSBS checks at 11:30am for the last 4 days. -The MAs were responsible to notify the RCD and the PCP for 2 or more refusals of medication or treatments. -The MA should document in the eMAR computer system and fax notification to the PCP. b. Review of Resident #3's Care Plan dated 11/04/20 revealed devices needed included continuous positive air pressure (CPAP) machine. Interview with the Resident Care Director (RCD) on 12/11/20 at 10:50am revealed: -She had completed Resident #3's Care Plan on 11/04/20 and noted the resident was on a CPAP. -She knew Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 07/13/20 from the resident's previous facility had the task of monitoring her CPAP checked. -She did not know Resident #3 was not using her CPAP. -She had not audited Resident #3's record for	D 273		

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D 273	Continued From page 17 ensuring all treatments being administered as ordered and PCPs notified for any treatment refused or not completed. -Staff should have let the RCD know Resident #3's CPAP was not being used since the case was in plain view on the resident's night stand. Review of Resident #3's admissions documents revealed a Licensed Health Professional Support (LHPS) review dated 07/13/20 from the resident's previous facility with monitoring CPAP checked, and physical assessment documentation including observation of the CPAP device, adjustments, and filter change. Review of Resident #3's LHPS review dated 12/10/20 revealed monitoring CPAP was checked and physical assessment documented with CPAP unit (device) in a bag on her nightstand and resident reports device is missing parts and does not work. Interview with the LHPS nurse on 12/10/20 at 10:30am revealed: -Resident #3 had a CPAP machine in her room when she did her resident assessment on 12/10/20. -Resident #3 told her she was not currently using the CPAP machine because it needed service. Observation of Resident #3's room on 12/11/20 at 9:30am revealed: -The resident had a case for a continuous positive airway pressure (CPAP) device located on top of the night stand next to the resident's bed. -The gray case was closed and bulging. According to the National Heart, Lung, and Blood Institute (NIH), sleep apnea is a common	D 273		

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D 273	Continued From page 18 condition in the United States. It can occur when the upper airway becomes blocked repeatedly during sleep, reducing or completely stopping airflow and is known as obstructive sleep apnea. Excessive daytime sleepiness and fatigue, as well as jerking and twitching during sleep can be symptoms of sleep apnea. Interview with Resident #3 on 12/11/20 at 9:30am revealed: -She had been using a CPAP for 8 years. -She was supposed to use a CPAP at night to help her sleep apnea. -She had not used the CPAP since she arrived at the facility 11/13/20 because she thought it was missing parts. -She awoke tired each morning and coughed a lot at night. -She felt tired all the time and had trouble staying awake during the day. -She spoke to the facility's primary care provider (PCP) regarding the CPAP when she first came to the facility but that PCP was not the current PCP. -She had not spoken to the new PCP regarding the CPAP machine. -She had not asked staff at the facility to help her set up her CPAP -The CPAP had been sitting on the night stand in the gray case since she came to the facility on 11/13/20. -Staff at the previous facility assisted her daily with using her CPAP (added water to the humidifier reservoir) and cleaning the mask and hose. -Facility staff had not asked her about the gray case. -She had not asked facility staff to help her with setting up her CPAP device.	D 273		

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D 273	Continued From page 19 Interview with a day shift medication aide (MA) on 12/11/20 at 9:40am revealed: -She did not know Resident #3 used a CPAP. -There was not information regarding checking or assisting with a CPAP on Resident #3's electronic Medication Administration Record (eMAR). -The MA would routinely expect to see information regarding if a resident had a CPAP device on the eMAR. -She had not noticed the gray CPAP device case on Resident #3's night stand. Telephone interview with the facility's current contracted primary care provider (PCP) on 12/11/20 at 9:50am revealed: -She was new to the facility and providing care to Resident #3. -Resident #3 had a diagnosis of sleep apnea on documentation the PCP was able to access and should be using her CPAP. -She did not sign Resident #3's admission FL2 and was not aware Resident #3 needed a current order for her CPAP. -She signed Resident #3's Care Plan dated 11/04/20 with examination for admittance. -The facility had not notified her regarding needing an order for Resident #3's CPAP or that the resident was not using her CPAP. -Not using the CPAP can cause sleep disturbances, low oxygen levels and fatigue from labored breathing. Interview with the Administrator on 12/11/20 at 10:40am revealed the RCD would be responsible to ensure Resident #3's CPAP was being used. Interview with the Resident Care Director (RCD) on 12/11/20 at 10:50am revealed: -She had not audited Resident #3's record for ensuring all treatments were on the electronic	D 273		

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D 273	Continued From page 20 Medication Administration Record (eMAR) and being administered as ordered and then PCP notified for any treatment refused or not completed. -She did not know Resident #3 was not using her CPAP. -Staff should have let the her know Resident #3's CPAP was not being used since the case was in plain view on the resident's night stand. Interview with a dash MA on 12/11/20 at 11:50am revealed: -She had not noticed a gray case in Resident #3's room. -She did not know Resident #3 had a CPAP because it did not appear on the eMAR. -She had noticed Resident #3 jerking and twitching in her sleep (also a symptom of sleep apnea). -Resident #3 had never asked her about assisting with sitting up her CPAP or mentioned the CPAP to her. -She did not recall seeing the CPAP case in Resident #3's room. _____ The facility failed to ensure PCP notification for Resident #5 who had a pacemaker and had not followed up with a cardiologist, placing the resident in danger of the device not functioning properly or at all which could result in failure to control heart rate and heart attack; and Resident #3 who had a continuous positive airway pressure (CPAP) machine but was not using it which could result in sleep disturbances, fatigue, breathing obstructions, and refusing FSBS checks that could interfere with proper control of the resident's diabetes. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	D 273		

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D 273	Continued From page 21 The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (Resident #1) related to fingerstick blood sugars (FSBS). The findings are: Review of Resident #1's current FL2 dated 11/30/20 revealed:	D 276	As of 12/152020 the RCD has implemented a new system to review paperwork, have the PCP review orders and a pharmacy consultant has been added to the team to review resident records to ensure no resident orders are missed or not documented in the resident file. RCD will ensure documentation of treatments, orders and procedures in the resident chart. A random sample of five charts will be pulled monthly for three months to ensure compliance to begin 1/29/21.	01/29/2021

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D 276	Continued From page 22 -Diagnoses included type 2 diabetes mellitus with stage 3 chronic kidney disease, dementia, schizoaffective disorder, bipolar disorder, thyroid disease, heart murmur, hyperlipidemia and hypertension. -There was an order for insulin lispro (a fast acting insulin) subcutaneous 15 minutes before meals. Review of Resident #1's hospital discharge summary report dated 11/30/20 revealed an order for FSBS 30 minutes before meals and at bedtime. Review of the Licensed Health Professional Support (LHPS) evaluation dated 09/24/20 revealed: -Collecting and testing fingerstick blood was a marked task. -There was documentation Resident #1 received FSBS twice daily. -There were no documented blood sugar ranges. Review of Resident #1's October 2020 Electronic Medication Administration Records (eMARs) revealed there was no entry for FSBS scheduled and no documented FSBS results on the October 2020 eMAR. Review of Resident #1's November 2020 eMARs revealed there was no entry for FSBS scheduled and no documented FSBS results on the November 2020 eMAR. Review of Resident #1's December 2020 eMARs revealed there was no entry for FSBS scheduled and no documented FSBS results on the December 2020 eMAR. Review of the facility's FSBS notebook revealed:	D 276		

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D 276	Continued From page 23 -The medication aide (MA) documented on 12/06/20 at 8:00pm that Resident #1 requested staff to check her FSBS. -Resident #1's FSBS result was 190. -There was no other documented FSBS for Resident #1. Observation of Resident #1's glucometer on 12/11/20 at 12:40pm revealed: -The glucometer was set with the correct date, but the time was inconsistent to the current time. -There was only one FSBS result in the glucometer for 12/06/20 9:17am. Interview with Resident #1 on 12/10/20 at 3:34pm revealed: -She was a diabetic and was supposed to have her blood sugar checked, but was unable to recall how often. -The facility staff did not check her FSBS daily. -When she remembered, she reminded staff to check her FSBS. -She did not know about orders and how often her FSBS was ordered to be checked, but she knew that it should be checked at least once daily. -She was unable to recall the last time her FSBS was checked, but thought it was one week ago. Interview with the Memory Care Unit Coordinator (MCUC) on 12/10/20 at 4:45pm revealed: -When Resident #1 was discharged from the hospital on 11/30/20, she reviewed the discharge summary report. -She realized the hospital discharge summary report had orders for FSBS four times daily, but she "overlooked" the insulin. -She obtained a glucometer for Resident #1 but did not put the order on the eMAR for the MAs to obtain the resident's FSBS.	D 276		

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D 276	Continued From page 24 -It was her responsibility to ensure the order for FSBS four times daily was put on the eMARS, but she did not do so because she forgot. -Resident #1 had new Primary Care Provider (PCP), when the resident returned from the hospital the PCP signed that she had reviewed the orders and agreed with the orders. -Resident #1 had a glucometer on the medication cart but she was not aware if the glucometer was being used. -She would usually contact the PCP or write a physician's order saying, "the resident got a medication do you want her to have it." -She was unable to recall if she had contacted Resident #1's PCP to determine if she needed to implement the order for FSBS or administer the insulin. Telephone interview with Resident #1's PCP on 12/11/20 at 9:52am revealed: -She became Resident #1's PCP last week. -She was not aware of any documentation of medical records other than eMARs. -She was not aware Resident #1 was diabetic. -Yesterday (12/10/20), late evening she got an email asking if facility should do FSBS for Resident #1. -She asked the facility staff if the resident a diabetic, and was told no, the resident was not a diabetic. -She had requested a Glycated Hemoglobin Test (A1C) on Resident #1 and was waiting on results. -Requesting an A1C was her process for all her new patients regardless if they were a diabetic. -When she received Resident #1 as new patient, she was not given the hospital discharge summary report. -The only documents that she was given were Resident #1's eMARs. -There was no FSBS or insulin documented on	D 276		

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D 276	Continued From page 25	D 276		

the eMARs that she received.
-If facility staff questioned the order, she expected them to contact her for better understanding to ensure the order was implemented correctly.
-The facility should make her aware of orders they were not sure if they should implement.

Telephone interview with Resident #1's previous PCP on 12/11/20 at 10:21am revealed:
-She was Resident #1's PCP until the first week of November 2020.
-She thought Resident #1 had orders for FSBS from a previous hospital visit.
-She remembered the hospital ordered FSBS to determine if Resident #1 was a true diabetic or the high blood sugar was a result of a medication.
-She expected the facility staff to contact her to clarify orders from the hospital if they were not sure to implement the orders.

Interview with the medication aide (MA) on 12/11/20 at 12:40pm revealed:
-Before Resident #1 went to the hospital in November 2020, her blood sugar was checked once in the morning.
-Since Resident #1 returned from the hospital her blood sugar had not been checked.
-She thought maybe the order was discontinued.
-The MCUC would ensure the MAs were aware of orders for FSBS.
-The MCUC did not have staff enter FSBS in the eMAR system but in a notebook that was kept in the medication cart.

Interview with the Resident Care Director (RCD) on 12/11/20 at 12:26pm revealed:
-The MCUC was responsible for reviewing hospital summary reports when a resident returned from the hospital.
-There was no system to check behind the

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D 276	Continued From page 26 MCUC to ensure orders on the discharge summary report were implemented. Interview with the Administrator on 12/11/20 at 4:03pm revealed: -She was not aware when orders were received. -She expected staff to contact the resident's PCP when they received orders they did not understand.	D 276		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related cardio-pulmonary resuscitation and health care. The findings are: 1. Based on interviews and record reviews the facility failed to ensure at least one staff was always on the premises who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months for 24 of 42 shifts sampled for 14 days	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	R-C 12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 27 from 11/26/20 through 12/09/20 for 3 of 6 sampled staff (Staff C, E and F). [Refer to tag 0167, 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation).]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 3 of 5 sampled residents (Residents #3, #4, and #5) related to one resident who had a pacemaker and had not followed up with a cardiologist (#5), a resident who had orders for physical therapy (#4), and a resident who had physician orders for a continuous positive airway pressure (CPAP) machine on her Care Plan and Licensed Professional Health Support but was not using it, and was refusing fingerstick blood sugar checks (#3). [Refer to tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).].	D912		