STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026062	A. BUILDING: _____ B. WING _____	C 06/29/2021

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CUMBERLAND VILLAGE ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Cumberland County Department of Social Services conducted an annual survey and complaint investigations on June 23, 24 and 25, 2021 and June 28 and 29, 2021. Complaint investigations were initiated by the Cumberland County Department of Social Services on 06/09/21 and 06/17/21.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure walls, ceilings and floors were clean and in good repair as evidence by bubbled and peeling paint on walls in resident rooms #18, #38, #40, #43, #44 and #46; yellow and brown staining, peeling paint and holes in the ceilings of resident rooms #18, #19, #43 and #44, a shared shower room on the E hall and the common area on the E hall; wall mounted air conditioning units without casing exposing foam insulation and a black substance around the wall in resident rooms #18, #38, #43, #44 and #46; leaking water on the floor in room #24, and	D 074		

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damaged and missing floor tiles with heavy accumulation of dirt and grime the floors in resident rooms #18, #38 and #40.

The findings are:

Observations of an Environmental Health Inspection certificate dated 06/28/21 for the facility which was posted on the wall at the entrance of the facility revealed a sanitation score of 70.0.

Observations of resident room #18 on 06/24/21 at 8:45am revealed:
-There was a brown stained area of swollen paint on the ceiling next to the light fixture.
-There was an area approximately the size of an orange on the swollen area next to the light fixture which was gray and black and had a fuzzy texture.
-There were areas of yellow/brown staining with loose and peeling paint on the ceiling above the head of the resident's bed.
-There was a large area of yellow and brown stains on the ceiling above the air conditioning unit.
-There was an open crack in the paint approximately eight inches long next to the outlet where the air conditioning unit was plugged in on the ceiling.
-The wall under the air conditioning unit in had multiple areas of bubbled and chipped paint from the unit down to a pipe running lengthwise approximately 12 inches from the floor.
-There was no casing around the air conditioning unit leaving a gap of approximately two inches between the unit and edges of the wall.
-There were two cracked and loose floor tiles near the window.
-There was an accumulation of dirt and grime on

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the floor with increased accumulation along the edges and at the corners of the floor.

Interview with the resident of room #18 on 06/24/21 at 8:44am revealed:
-The ceiling in his room had damp spots and areas of peeling paint.
-The area next to the light fixture appeared as if water might start leaking.
-He did not want to be in his room when that happened because he was afraid of being electrocuted.
-Water leaked from the ceiling in his room when there was a heavy rain.
-There was "black mold" on the ceiling in his room.
-The ceiling had the damp spots with peeling paint and the black substance for about six months.
-He had told the housekeeping supervisor/maintenance staff and the Administrator every week.

Observations of resident room #19 on 06/24/21 at 11:27am revealed:
-There was an area approximately three inches wide and six inches long with brown staining above the entrance door.
-There was a second area of approximately six by 13 inches with brown staining on the ceiling behind the entrance door.

Observation of resident room #24 on 06/28/21 at 10:00pm revealed:
-There were three disposable incontinence pads saturated with a clear substance on the floor next to the wall and at the entrance to the room.
-There was water noted dripping from a pipe attached to the sink in the bathroom behind the wall. The faucet to the sink was turned off.

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D 074	Continued From page 3 Interview with the Executive Director (ED) on 06/28/21 at 12:05pm revealed: -She was not aware there was a leaking valve in room # 24. -She would have maintenance look at the bathroom sink. -There had not been a plumber in the facility. Observations of resident room #38 on 06/23/21 at 9:56am revealed: -The floors had an accumulation of dirt and grime and there were floor tiles missing at the entrance to the bathroom. -The wall under the air conditioning unit in had brown drip marks and multiple areas of bubbled and chipped paint from the unit down to a pipe running lengthwise approximately 12 inches from the floor. -There was no casing around the air conditioning unit exposing a black substance on the concrete wall, foam insulation and wooden support pieces. Observations of resident room #40 on 06/23/21 at 10:04am revealed: -There were two loose and chipped floor tiles in front of the chest of drawers. -There was an accumulation of dirt and grime on the floor with increased accumulation along the edges and at the corners of the floor. -There was a hole in the wall behind the door approximately three inches in diameter. -The wall under the air conditioning unit in had brown drip marks and multiple areas of bubbled and chipped paint from the unit down to a pipe running lengthwise approximately 12 inches from the floor. Observations of resident room #43 on 06/23/21 at 10:26am revealed:	D 074		

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D 074	Continued From page 4 -There was an accumulation of a black substance on the casing under the air conditioning unit on the wall. -The wall under the air conditioning unit in had brown drip marks and multiple areas of bubbled and chipped paint from the unit down to a pipe running lengthwise approximately 12 inches from the floor. -There was an area approximately 24 by 24 inches at the corner of the ceiling near the windows that had brown marks and loose, peeling and chipped paint. Observations of resident room #44 on 06/23/21 at 10:35am revealed: -There was a square area of approximately 18 inches by 18 inches on the ceiling with exposed dry wall, peeling paint and brown stains. -The wall under the air conditioning unit in had brown drip marks and multiple areas of bubbled and chipped paint from the unit down to the electric baseboard heater approximately 12 inches from the floor. -There was an accumulation of a black substance on the casing under the air conditioning unit on the wall. Observations of resident room #46 on 06/23/21 at 10:35am revealed: -The wall under the air conditioning unit in had multiple areas of bubbled paint from the unit down to the bed. -There was no casing around the air conditioning unit exposing a black substance on the concrete wall and foam insulation. Observations of the common area on the E Hall on 06/23/21 at 10:29am revealed: -There was an area approximately 6 by 24 inches in length along the center of the ceiling that had	D 074		

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brown marks and loose, peeling and missing paint.
-There was an area approximately 18 inches in diameter neat the corner of the ceiling near the windows that had brown marks and loose, peeling and missing paint.
-There was a second area of approximately 6 inches in diameter on the ceiling near the corner by the window with missing paint and a brown stain.

Observations of the shared shower room on the E Hall across from the library on 06/23/21 at 10:59am revealed:
-There was a four inch by eight inch area of peeling paint on the ceiling next to the light fixture.
-At the center of the peeling was hole approximately three inches wide where yellow insulation material was visible.

Interview with a resident on 06/23/21 at 10:30am revealed:
-The ceilings in resident rooms and the common area have been stained and peeling for years.
-The ceiling in the common area on the E Hall leaked a couple days ago.
-Staff had seen the ceiling leaking, but nothing has been done by the facility to fix it.

Interview with a second resident on 06/23/21 at 10:35am revealed staff never cleaned the air conditioning unit.

Interview with a housekeeper on 06/23/21 at 10:41am revealed:
-The housekeeping supervisor/maintenance staff cleaned and repaired the air conditioning units in resident rooms.
-She had never seen the stained areas on

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ceilings in resident rooms or the common areas leak.
-The ceilings looked wet sometimes, but the water had not come through yet.
-The floors in resident rooms had the appearance of dirt and grime build up even after they were cleaned.

Interview with a Housekeeper on 06/28/21 at 1:00pm revealed:
-She cleaned resident room.
-She cleaned the activity room whenever she saw it looking dirty.
-She had never seen a deep cleaning schedule for the facility.
-She thought the facility still used a deep cleaning schedule.
-She swept and mopped the tv room and emptied the trash.

Interview with a personal care aide (PCA) on 06/23/21 at 10:57am revealed:
-She had seen the peeling paint and stained areas on ceilings in resident rooms and the common areas on the E Hall.
-Over the years those areas had leaked, but it had been a long time since they had leaked.

Interview with the housekeeping supervisor/maintenance staff on 06/24/21 at 10:50am revealed:
-The resident of room #18 had not reported wet marks on the ceiling in his room.
-He had noticed wet marks on the ceiling throughout the building.
-He had seen loose, cracked and missing tiles in resident rooms.
-He was responsible for cleaning and maintaining the air conditioner units.
-He had not gotten to cleaning and repairing them

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due to other duties in the facility.
-He was responsible for housekeeping and maintenance duties.
-He had reported the ceilings and floors to the ED approximately two weeks ago so a repair request could be sent to the corporate Maintenance Director.

Second interview with the housekeeping supervisor/maintenance staff on 06/25/21 at 2:47pm revealed:
-He was responsible for cleaning floors, dusting furniture, cleaning bathrooms and he wrote down anything that was broken.
-If aides saw anything in need of repair, they wrote the needed repairs in the maintenance book which was kept by the time clock.
-He checked the maintenance book daily on arrival to work.
-Housekeeping and maintenance duties were done together daily.
-There were two to three housekeepers on duties each day.
-"Every so often" he would check the areas of the other housekeepers to make sure those areas were cleaned.
-He randomly checked four to five rooms each day.
-His maintenance duties included replacing light bulbs and fixtures, replacing broken blinds, tightening loose toilet seats and replacing sink faucets.

Interview with the Resident Care Coordinator (RCC) on 06/28/21 at 3:58pm revealed:
-Any concerns related to the environment and needed repairs went directly to the ED.
-The Housekeeping Supervisor/Maintenance Director made rounds daily to check the environment.

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D 074	Continued From page 8 Interview with the ED on 06/24/21 at 11:25am revealed: -She had noticed the stains and peeling paint on the ceilings in resident rooms and common areas. -She had seen the ceiling in resident room #18 three weeks ago, but had not noticed the fuzzy gray and black substance or the swelling of the paint. -Today (06/24/21) the ceiling looked like there was water coming in somewhere and the roof needed to be checked. -If water came in near the light fixture there was a risk of an electrical fire. -She had seen the cracked, loose and missing tiles on the floors and air conditioning units without the casings three weeks ago. -Over the past six months residents had reported seeing pieces of ceiling paint falling from the ceiling. -She tried to lay eyes on each resident room once a month; the last time she made rounds was approximately three weeks ago. -Prior to 06/24/21, there had not been any leaks or problems with the roof since November 2020. -She put a work order request in with the corporate office for the ceilings, walls and floors; she could not say exactly when. Second interview with the ED on 06/28/21 at 4:30pm revealed: -Staff were expected to report any environmental concerns and need repairs directly to her so she knew to follow up. -Sometimes staff reported directly to the housekeeping supervisor/maintenance staff. -The housekeeping supervisor/maintenance staff would let her know when he made repairs or if he was not able to.	D 074		

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D 074	Continued From page 9 -If the housekeeping supervisor/maintenance staff was not able to make a needed repair she put a request in to the corporate Maintenance Director. _____ The facility failed to keep walls, ceilings and floors in good repair in 6 resident rooms (#18, #19, #38, #40, #43, #44 and #46), a common area and shared shower room resulting in exposure of ceiling insulation near a light fixture in the shared shower room and evidence of water damage in the ceiling near a light fixture in resident room #18 resulting in potential exposure to building insulation materials and electrical fires. This failure was detrimental to the health, safety and well-being of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/24/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 13, 2021.	D 074		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more;	D 077		

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D 077	Continued From page 10 This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85 or above at all times. The findings are: 1. Review of the facility's current license effective 01/01/21 through 12/01/21 revealed the facility had a 163 bed capacity. Review of the facility's current North Carolina (NC) Division of Environmental Health inspection report dated 06/28/21 revealed the facility's score was 70 with 30 total demerits. Review of the facility's NC Division of Environmental Health inspection dated 02/10/20 revealed the facility's score was 72.5 with 27.5 total demerits. Review of the facility's NC Division of Environmental Health inspection dated 06/10/19 revealed the facility's score was 81.5 with 18.5 total demerits. Interview with a local Environmental Health Program Specialist (EHPS) on 06/24/21 at 5:34pm revealed: -She had been able to complete inspections for three of the six halls on 06/24/21. -Findings of concern included peeling paint on ceilings throughout, insulation visible and the	D 077		

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ceiling hanging down on the C Hall, a live spider on the pillow in resident room #24, windows cracked throughout, bed linens were soiled and thin, knobs for pull out drawers missing, exposed electrical wiring in resident room #24, cracked toilets in resident rooms #18 and #24 and air conditioning units not properly secured and leaking in almost every room.
-There was not much improvement from the last inspection (02/10/20).
-The facility had 30 days from inspection to contact the local health department for reinspection.

Interview with the Executive Director (ED) on 06/24/21 at 11:25am revealed:
-She saw the sanitation score posted near the entrance to the facility but did not see the report until the county Department of Social Services worker reviewed the report with her approximately one month ago.
-She replaced light fixtures and bulbs, ordered new sink faucets and was waiting for the pipes/fittings to place on the new faucets on sinks and the carpets in common areas had been shampooed.

Telephone interview with the Corporate Maintenance Director on 06/29/21 at 3:09pm revealed:
-Corporate maintenance staff did not visit the facility on a scheduled basis.
-If the ED called or emailed him with a repair need, he went or sent one of the corporate maintenance staff to the facility.
-There were a few corporate maintenance staff at the facility a few weeks ago; he did not remember the specifics of the visit.
-He responded to repair requests as soon as possible, usually within a week for repair jobs he

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and/or his staff were able to complete.
-He contacted contractors when needed.
-He received a copy of the facility's sanitation report and was responsible for anything maintenance related.
-There were roofing contractors scheduled to go out to the facility before the COVID-19 pandemic came, but contractors were not permitted to enter the building under the pandemic guidelines.
-There was work that was completed by corporate maintenance during the pandemic, he would have to check his list for the details.
-It was not until April 2021 that the facility started having outside contractors inside the building.

Second interview with the ED on 06/28/21 at 4:30pm revealed:
-She was expected to scan a copy of the sanitation report to her supervisor at the corporate office.
-She was responsible for assuring completion of repairs by facility maintenance staff.
-The corporate maintenance completed repairs facility staff were not able to complete.
-She did not have to submit a request for repairs related to the sanitation report because the corporate office had a copy of the report.

Refer to findings in Tag 0074 regarding 10A NCAC 13F .0306 (a)(1) Housekeeping and Furnishings.

2. Review of the facility's current North Carolina (NC) Division of Environmental Health inspection report dated 06/24/21 revealed the facility's kitchen score was 76 with 24 total demerits.

Review of the facility's previous NC Division of Environmental Health Inspection dated 11/28/18 revealed the facility's kitchen score was 91.5 with

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D 077	Continued From page 13 8.5 total demerits. Refer to findings in Tag 0282 regarding 10A NCAC 13F .0904 (a)(1) Nutrition and Food Service. _____ The facility failed to make repairs to walls, ceilings, air conditioning units and the kitchen oven, resulting in water leaking into the facility and around light fixtures and a lower North Carolina Division of Environmental Health sanitation score of of 70 on 06/28/21 from the previous sanitation score of 72.5 on 02/10/20, and a kitchen inspection score of 76 on 06/28/21 from the previous sanitation inspection score of 91.5 on 11/28/18. This failure demonstrates serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/24/21 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 29, 2021.	D 077		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.	D 079		

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D 079	Continued From page 14 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of hazards as evidenced by the storage of three portable oxygen tanks freestanding on the floor in a resident's room, and two portable oxygen tanks not secured in oxygen storage racks in a room designated for oxygen storage that contained numerous portable oxygen tanks. The findings are: Observations of a resident's bedroom on 06/23/21 at 10:04am revealed: -There was an oxygen concentrator positioned against the wall to the left of the entrance to the room. The oxygen concentrator machine was turned off. -There were three upright unsecured small oxygen cylinders standing on the floor beside a chair. -There was a white plastic seal around the center of the top section of the oxygen cylinder. Review of a physician electronically signed hospital discharge summary for the resident who resided in the room where the three unsecure portable oxygen cylinders were observed revealed: -The resident was admitted to the hospital with a diagnosis of hypoxia, pneumonia of both lower lobes due to infectious organism, and hypervolemia unspecified type and discharged on 05/28/21. -The resident's discharge diagnosis was documented as acute hypoxemic respiratory failure secondary to acute on chronic heart (exacerbation of long standing heart failure) failure with reduced ejection fracture exacerbation.	D 079		

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-Diagnoses listed included dementia, atrial fibrillation, and chronic obstructive pulmonary disease.
-The resident was discharged with oxygen therapy.

Review of a hospital discharge note for the resident revealed:
-Oxygen was delivered to the hospital from a local durable medical equipment company for transport with the resident to the facility upon discharge.
-The facility would be picking up the resident from the hospital to transport back to the facility.

Interview with a Personal Care Aide (PCA) in Resident #4's room on 06/23/21 at 10:13am revealed:
-Resident #4 required oxygen use if the resident's oxygen saturation dropped.
-Oxygen cylinders were "normally" kept in the medication room.
-She did not know how long the three unsecured oxygen cylinders had been in Resident #4's room.

Interview with the Executive Director (ED) on 06/23/21 at 10:15am revealed:
-The three unsecured small oxygen cylinders should have been in the oxygen room beside the care staff station.
-The three small unsecured oxygen cylinders were full because the seal had not been broken.
-Oxygen cylinders should not be in the resident's room.
-Oxygen cylinders should be stored in a crate to prevent them from falling.
-If the oxygen cylinders were knocked over and struck with a certain force, the cylinders could explode.
-She did not know why the oxygen cylinders were

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D 079	Continued From page 16 in the resident's bedroom. -She was not sure when the portable oxygen cylinders were delivered to the resident's room. -The resident did not use the portable oxygen cylinders. -When the resident needed oxygen, the resident used the oxygen concentrator. Observations of the oxygen room on 06/23/2021 at 10:17am revealed: -The three unsecured portable oxygen cylinders from the resident's room were in the oxygen room. -There were two portable oxygen cylinders placed in a plastic tub that was sitting on the floor. -There was a cushion on the inside of the plastic tub. -The two portable oxygen cylinders were not secured properly. Observations of the resident on 06/24/21 at 8:41am, who resided in the room where the frestanding oxygen cylinders were located, revealed: -The resident was awake in bed with oxygen on at 2 liters per minute via nasal cannula per the oxygen concentrator. -There was a wheelchair and walker next to the bedside. Interview with the resident on 06/24/21 at 8:41am revealed: -He did not use or know anything about the portable oxygen cylinders. -The portable oxygen cylinder had been in his room "since the beginning" (no date provided).	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements	D 105		

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D 105	Continued From page 17 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mechanical equipment was maintained in an operating condition related to the oven. The findings are: Observations of the kitchen on 06/23/21 at 9:49am revealed the hinges of the oven doors were broken and did not close completely. Interview with the Dietary Manager (DM) on 06/23/21 at 9:57am revealed: -She started as the DM in January 2021. -The oven doors to the stove had been broken since she started as the DM. -She was not able to use the oven on the right side of the stove. -She was only able to use the oven on the left side of the stove. -She put in a work order for the oven through the Executive Director (ED) a couple of weeks ago. -The oven door was not repaired. Interview with the cook on 06/24/25 at 4:31pm revealed: -She did not remember how long the oven was broken. -She was not able to use the oven on the right side of the stove because it did not work. -She only used the oven on the left side of the stove.	D 105		

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-The oven on the left side of the stove cooked the food unevenly.
-The food is cooked completely but one side of the food item may be burned when she used the oven on the left.

Interview with the Maintenance Director on 06/29/21 at 3:09pm revealed:
-He was the Maintenance Director for all the corporation's facility's.
-He did not have a set schedule of when he visited the facility.
-He received work orders from the Executive Director (ED) through electronic mail or phone call.
-When he received a work order, he would immediately contact a contractor to send to the facility, depending on what the work order was for.
-He was not notified that the oven doors were broken until May 2021.
-He sent a worker to the facility in May 2021 but the worker was unable to repair the oven doors.
-The worker looked for the parts to repair the oven but he was unable to locate the parts.
-He visited the facility on 06/25/21 to view the oven doors.
-He ordered a new oven to replace the old oven.
-He should have been notified immediately that the oven doors were broken so he could have immediately contacted a contractor to repair the oven doors.

Interview with the Executive Director (ED) on 06/28/21 at 8:58am revealed:
-The oven doors had been broken since she became the ED in November 2020.
-She submitted a work order to the Maintenance Director in November 2020; she did not remember the exact date.

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D 105	Continued From page 19 -She called the Maintenance Director a couple of weeks ago to find out the status of the work order, but she did not hear back from him. -She was notified on 06/28/21 that the Maintenance Director ordered a new oven.	D 105		
D 169	10A NCAC 13F .0509 Food Service Orientation 10A NCAC 13F .0509 Food Service Orientation The adult care home staff person in charge of the preparation and serving of food shall complete a food service orientation program established by the Department or an equivalent within 30 days of hire for those staff hired on or after July 1, 2004. Registered dietitians are exempt from this orientation. The orientation program is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the staff person in charge of food preparation and serving of food completed a food service orientation program established by the Department, or an equivalent within 30 days of hire (Staff D). The findings are: Review of the Food Establishment Inspection Report dated 06/24/21 by the local Health Department Inspectors revealed: -A sanitation score of 76. -There was no certified food protection manager certificate provided.	D 169		

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D 169	Continued From page 20 Interview with a resident on 06/23/21 at 10:25am during the initial facility tour revealed the food was "no good" and the resident was tired of potatoes and mixed vegetables every day. Interview with a second resident on 06/23/21 at 10:57am during the initial facility tour revealed the food was not good sometimes and the food "messes up" the resident's stomach. Review of the personnel record for the Staff D revealed documentation for a certificate of achievement dated 06/28/21 for a food service orientation post-test. Interview with Staff D on 06/29/21 at 1:16pm revealed: -She was the kitchen manager. -She has been the kitchen manager since the end of December 2020 or January 2021. -She was trained by the previous kitchen manager by watching him. -He showed her "the basic, how to cook in large quantities, follow directions, cleaning the flat stove/deep fryer and the steamer". -He worked with her "a little bit on ordering of food". -She has not completed any other food service training courses yet. -She completed the food service test last night when she was sent an email from a corporate office staff which instructed her that she needed to complete the online food service training. -She did not know she had to complete the food service online orientation. -She had not been instructed by the Executive Director to complete the online food service training. -She did not receive any training with a dietician.	D 169		

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D 169	Continued From page 21 -The information provided in the online food service orientation course "opened my eyes to a lot of stuff" like diets, different diet textures, cleaning and sanitizing. -This was her first job cooking for a facility, but she had worked in positions where she prepped and served food but did not cook food. -She did not know anything about the online food service orientation. Interview with the Executive Director (ED) on 06/29/21 at revealed: -All staff training records were maintained at the corporate office. -Staff trainings were completed through the corporation online training system. -She was responsible for ensuring staff met qualifications to perform their job duties. -She did not know Staff D had not completed the required online food service orientation and post-test. -Staff D was hired as the dietary manager prior to her (ED) employment at the facility. -She had not reviewed staff personnel records since her employment as the ED.	D 169		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

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D 269	Continued From page 22 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the personal care needs for 3 of 5 sampled residents (#1, #2, and #5) were provided related to foot care (#1 and #2) and resident (#5) that required assistance with activities of daily. The findings are: 1. Review of Resident #5's current FL-2 dated 12/10/20 revealed: -Diagnoses included cerebrovascular accident, head injury, hypertension, and stroke. -He was intermittently disoriented. -He was semi-ambulatory. -He was non-verbal. -He needed assistance with bathing and dressing. Review of Resident #5's care plan dated 06/28/21 revealed: -He had limited strength in his right upper extremities. -He was ambulatory with the assistance of a wheelchair. -His speech was weak. -He required extensive assistance with toileting, bathing, dressing, and grooming. -He required limited assistance with eating, ambulation, and transferring. -He had a Power of Attorney (POA). Interview with Resident #5 on 06/28/21 at 9:30am revealed: -He was able to nod "yes" and shake his head "no" to questions. -He did not receive assistance with toileting,	D 269		

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bathing, dressing, grooming, or transferring.
-He bathe, dressed, and groomed himself.
-He transferred himself from his bed to his wheelchair and from his wheelchair back to his bed.
-He transferred himself from his wheelchair to the toilet and from the toilet to his wheelchair.
-He would like to receive help with toileting, bathing, dressing, grooming, and transferring because he could not complete those task on his own.

Observations of Resident #5' in his room on 06/29/21 from 11:09am until 11:55am revealed:
-At 11:09am, Resident #5 rang his hand bell four to five times consecutively, but staff did not respond.
-At 11:14am, 11:18am and 11:32am, Resident #5 rang his hand bell, but staff did not respond.
-Resident #5 made several attempts to sit up from lying down on his bed before successfully sitting at the edge of the bed.
-Resident #5 made several attempts and was able to stand partially erect holding into the wheelchair.
-Resident #5 was unsteady and swayed while standing, turning and hopping on his left foot to transfer into the wheelchair.
-Resident #5 sat into the chair; he was not able to guide himself down into the wheelchair.
-Between 11:46am and 11:55am Resident #5 rang the hand bell again.
-From 11:09am until 11:55am staff did not responded to Resident #5's hand bell.

Interview with a personal care aide (PCA) on 06/28/21 at 9:58am revealed:
-He was able to bathe, toilet, groom, and transfer himself.
-She did not assist Resident #5 with any activities

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of daily living (ADL).
-He would ask for help if he needed it.
-She could not remember the last time Resident #5 needed help with his ADLs.
-She knew that Resident #5 was independent because she worked with him for over a year.

Interview with a medication aide (MA) on 06/28/21 at 10:16am revealed:
-He was independent and did not require assistance with ADL's.
-He was able to bathe, groom, and transfer himself to and from his wheelchair without assistance.

Interview with Resident #5's power of attorney (POA) on 06/29/21 at 12:39pm revealed:
-He would ring his bell or call her to get staff to help him.
-He had not been eating well, had increased weakness and had an overall decline in his physical ability.
-Five months ago, Resident #5 was able to walk.
-He was paralyzed on his right side from a stroke.
-He needed help transferring to and from his wheelchair.
-He needed help with bathing, grooming, and toileting.
-He would call her when he needed assistance and the facility did not respond to his call bell.
-She would call the facility after he called her and ask the facility staff to help Resident #5.

Interview with the Resident Care Coordinator 06/29/21 at 11:05am revealed:
-He was paralyzed on his right side.
-He was able to bathe, toilet, groom, and feed himself.
-Resident #5 did need some assistance with showering; the resident had needed more hands

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D 269	Continued From page 25 on assistance with showering since March 2021 when a family member died. Interview with the Executive Director (ED) on 06/29/21 at 12:50pm revealed: -Resident #5 needed staff to help him with transfers, bathing and toileting because he was unsteady and had weakness on one side from a stroke. -She observed staff assist Resident #5 with toileting within the last month. -The resident was stiff and had a hard time moving his lower extremities. -If a resident had a change in the level of assistance needed, she verbally communicated that to staff. -She had not seen a change in Resident #5's condition or abilities since November 2020. -She did not know Resident #5's care plan was last updated in October 2019. -The RCC was responsible for completing assessments and care plans. -Resident #5 needed assistance with transferring to and from his wheelchair because his gait was unsteady. -Resident #5 had a stroke so he needed help with bathing, dressing, and toileting. -She expected the PCA's to provide Resident #5 assistance with his ADLs. -If Resident #5 had a change in status she would communicate that verbally to the PCA's and MAs. -Resident #5 did not have a change in status since he lived at the facility. -She was not aware that PCA's and MAs did not assist Resident #5 with his ADLs. -She was not aware that Resident #5 had performed his ADLs without assistance. -She was concerned that Resident #5 was not receiving the care he required. -She expected her staff to follow Resident #5's	D 269		

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care plan.
-She did not know Resident #5 was not wearing his back and right leg brace which was concerning because not wearing them could cause a fall.

2. Review of Resident #2's current FL-2 dated 11/05/20 revealed:
-Diagnoses included diabetes, atrial fibrillation, hypertension, bladder incontinence, and double knee replacement.
-Resident #2 was semi-ambulatory.

Review of Resident #2's care plan dated 04/19/21 revealed:
-She was semi-ambulatory and used a cane to ambulate.
-Her skin was normal.
-She required limited assistance with bathing and needed assistance with washing her feet.
-She required extensive assistance with grooming, personal hygiene, and nail care.

Observation of Resident #2 on 06/23/21 at 10:45am revealed:
-Her feet were swollen, dry, scaly, and appeared to have dirt on both feet.
-Her toenails were long, jagged, and had a collection of dirt underneath them.

Interview with Resident #2 on 06/23/21 at 10:36am revealed:
-She lived at the facility for a couple of months and her feet were swollen.
-She did not receive assistance with her showers.
-She did not receive foot care from the personal care aides (PCA).
-She tried her "best" to wash her when she took a bath.
-The medication aides (MA) and the PCA's did

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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 269	Continued From page 27 not look at her feet. Interview with a PCA on 06/24/21 at 10:30am revealed: -She assisted Resident #2 with her shower on Tuesdays, Thursdays, and Saturdays. -She would wash Resident #2's feet by washing the top and bottom of the foot and in between her toes. -After Resident #2's shower, she would lotion her feet. -After she completed personal care for a resident, she would document the care provided to the resident in the residents' care log. -She completed the personal care log daily for each resident. Review of Resident #2's care log dated 06/01/21 - 06/27/21 revealed documentation Resident #2 received skincare to her face, hands, and feet on the first shift. Interview with a MA on 06/24/21 at 8:54am revealed: -The PCA's were required to check residents' feet daily for sores or skin discoloration. -The PCA's were required to wash and moisturize residents' feet on shower days. -If the PCA's had any concerns about a resident's feet they were supposed to report the concerns to the MA. -She had not looked at Resident #2's feet recently. -She did not remember the last time she looked at Resident #2's feet. Interview with the Resident Care Coordinator (RCC) on 06/28/21 at 9:23am revealed: -PCA's were required to check resident's feet on their shower days.	D 269		

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D 269	Continued From page 28 -If the PCA's had a concern with the condition of a resident's feet they were required to report the concern to the MA and complete a skin assessment sheet. -After the PCA completed the skin assessment sheet they were required to turn the sheet into the MA. -The MA signed the skin assessment sheet and turn the sheet into the RCC. -The RCC turned the skin assessment sheet into the Executive Director (ED). -PCA's were expected to wash and moisturize resident's feet on their shower day. -She looked at Resident #2's feet on 06/28/21. -Resident #2 did not receive proper foot care and her feet were swollen. -She did not know why Resident #2 did not receive proper foot care. Interview with the ED on 06/28/21 at 4:45pm revealed: -She did random personal care checks on residents by watching the PCA perform personal care. -She last did a personal care check-in in May 2021. -She did not check Resident #2's feet in May 2021. -She viewed Resident #2's feet on 06/28/21. -She was concerned that Resident #2's feet were "swollen, dry, and dirty". -She did not know why Resident #2's feet were "dry and dirty". -She was concerned that without proper foot care Resident #2 could lose her feet. 3. Review of Resident #1's current FL-2 dated 03/23/21 revealed: -Diagnoses included hypertension, type II diabetes mellitus and schizophrenia.	D 269		

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D 269	Continued From page 29 -Resident #5 needed assistance with bathing and dressing. Review of Resident #1's current care plan dated 04/19/21 revealed Resident #1 required limited assistance with bathing, dressing and personal hygiene. Review of Resident #1's primary care provider's (PCP's) initial visit note dated 03/19/21 revealed: -Resident #1 was admitted to the facility from the local hospital. -Resident #1 was hospitalized with diabetic ketoacidosis and osteomyelitis of his right foot. -Resident #1 completed antibiotics on 03/13/21, received home health services for wound care and had a follow up appointment with podiatry on 03/30/21. Interview with Resident #1 on 06/28/21 at 9:39am revealed: -He thought the infection was gone from his feet. -No one had seen him to wrap his feet with bandages for two weeks. -The nail from his right great toe fell off yesterday (06/27/21); he did not tell the staff. Observations of Resident #1's feet on 06/28/21 at 9:48am revealed: -Both feet had dry skin with patches of dark colored scaly, peeling skin around the toes and ankles. -The nails on the right foot were long, thick and yellow/brown in color. -There was a nickel sized scabbed area on the side of the right foot below the great toe. -There was no nail on the great toe of the left foot; the nail bed was pink/red in color with a small amount of yellow drainage at the bottom outside corner and a small red, raw area at the	D 269		

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inner corner.
-The resident's second toe on his left foot was amputated and the third toe was partially amputated.
-The left fourth toe and pinky toe had thick nails that were yellow/brown in color.

Interview with the personal care aide (PCA) on 06/28/21 at 9:48am revealed:
-A home health nurse usually cleaned and wrapped Resident #1's feet with bandages.
-The PCA worked yesterday (06/27/21) and she did not know Resident #1's left great toenail had fallen off.
-She normally checked Resident #1's feet when she assisted him with a shower.
-Today was Resident #1's shower day, but he had not taken a shower yet.
-She would have checked his feet with the shower and reported anything of concern to the medication aide (MA).

Interview with a MA on 06/28/21 at 9:54am revealed the home health nurse had been taking care of Resident #1's feet and she was not sure which home health agency saw the resident or the last time they had seen him.

Second interview with the PCA on 06/29/21 at 8:29am revealed:
-She saw Resident #1's feet on 06/27/21 and the nail was on the resident's left great toe.
-There was no discoloration or loosening of the nail when she saw it.
-This morning (06/29/21) she noticed yellow drainage on Resident #1's left sock where his great toe was and reported it to the MA.

Interview with the Resident Care Coordinator (RCC) on 06/28/21 at 3:58pm revealed:

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-PCAs were expected to check the resident's feet on the resident's shower days.
-If a concern was found, the PCA was expected to complete a skin assessment form.
-MAs reviewed and signed the skin assessment form and then gave the form to her.
-When she received skin assessment forms or was told about a concern, she checked the resident.
-She was told about Resident #1's toenail the morning of 06/28/21 and the resident saw the primary care provider (PCP).
-PCAs should have known to help Resident #1 with cleaning and caring for his feet because he had diabetes and PCAs were already assisting the resident with showering.
-Foot care meant cleaning the feet, cleaning between toes, drying the feet and putting lotion on the feet.
-Resident #1's feet did not look like they had received the foot care she expected staff to provide.
-PCAs should have reported the appearance of Resident #1's feet to her and she would have his feet.

Interview with Resident #1's PCP on 06/28/21 at 11:33am revealed:
-Resident #1 was followed by home health for what looked like diabetic foot ulcers.
-The wounds on Resident #1's feet were healed, and he was no longer followed by home health.
-She saw Resident #1 the morning of 06/28/21 and had examined the left great toe.
-She was in the process of writing orders for wound care to the toe.
-Facility staff were supposed to assist residents as needed with foot cleaning and care.

Interview with the Executive Director (ED) on

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D 269	Continued From page 32 06/28/21 at 4:30pm revealed: -She was concerned Resident #1 was not receiving the foot care he needed. -Foot care was important for people with diabetes because they could lose their feet if they were cared for. -A COVID-19 outbreak at the facility had disrupted many of the oversight practices (monitoring staff performing duties, needs of residents and environment in the facility) including checking the feet of residents with diabetes to ensure foot care was done and there were no concerns. Attempted telephone interview with Resident #1's home health agency on 06/28/21 at 11:12am was unsuccessful. _____ The facility failed to ensure 3 of 5 sampled residents personal care needs were met by not providing foot care to a resident (#1) who was diagnosed with diabetes who was at risk for developing a foot wound, a resident (#1) who had a diagnoses of diabetes and had a history of an infection in his foot, and a resident (#5) who had a stroke and was paralyzed on the right side who did not receive assistance with ADLs The facility's failure was detrimental to the health, safety and well-being of the residents which constitutes a Type B Violation _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/25/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 13, 2021.	D 269		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#5) who experienced an increase in falls over a 6 week period from May 2021 to June 2021 resulting in 6 documented falls and emergency room visits for pain and head injury. The findings are: Review of Resident #5's current FL-2 dated 12/10/20 revealed: -Diagnoses included cerebrovascular accident, head injury, hypertension, and stroke. -He was intermittently disoriented. -He was semi-ambulatory. -He was non-verbal. -He needed assistance with bathing and dressing. -Medication orders included oxycodone. acetaminophen 5-325mg take one tablet every 6 hours as needed for pain, pain reliever cream 10% apply to affected two times a day as needed for pain in knees, back brace when the resident is out of bed at all times, leg brace to the right lower leg during waking hours, and wrist brace to the	D 270		

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right wrist during waking hours.

Review of Resident #5's care plan dated 06/28/21 revealed:
-He had limited strength in his right upper extremities.
-He was ambulatory with the assistance of a wheelchair.
-He required extensive assistance with toileting, bathing, dressing, and grooming.
-He required limited assistance with eating, ambulation, and transferring.
-He required monitoring for fall prevention in the shower and around the facility.
-He had a Power of Attorney (POA).

Observations during interview with Resident #5 on 06/28/21 at 12:04pm revealed he was nonverbal and communicated through gestures and mouthing simple words.

Interview with Resident #5's POA on 06/28/21 revealed:
-She could not remember the last time she notified that Resident #5 fell.
-She came to the facility on 06/22/21 to look for Resident #5 and was told by facility staff that he was sent out to the emergency room (ER) for a fall.

Review of Resident #5's care note dated 06/06/21 at 11:55am revealed:
-Resident #5 was found on the floor in his room.
-Resident #5 stated he "hit his head on the nightstand."
-Resident #5 was sent out to the ER.
-Resident #5's family was notified.

Review of Resident #5's I/A report dated 06/06/21 at 11:55am revealed:

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-The resident was found on the floor in his room.
-The resident had a head injury.
-The resident's vitals were taken.
-The resident's POA, PCP, and DSS were notified.
-The PCP recommended the resident be sent out to the ER for evaluation and treatment.
-The resident was sent to the ER.
-The resident returned to the facility with no new orders.
-When the resident returned to the facility, he was encouraged to use his call bell to receive assistance before trying to get up by himself.
-The resident was placed on every 2-hour safety checks.

Review of an ER visit encounter for Resident #5 dated 06/06/21 revealed the resident was seen for a fall out of bed and developed a headache.

Review of ER discharge instructions for Resident #5 dated 06/09/21 revealed the resident was seen in the hospital for a fall.

Review of Resident #5's incident and accident report dated 06/14/21 at 3:53pm revealed:
-The resident was found on the floor in his room.
-The resident had a head injury.
-The resident's vitals were taken.
-The resident's POA was notified and advised she would meet the resident at the hospital.
-The resident was sent to the ER.
-Local County Department of Social Services (DSS) was notified.
-The resident's PCP was called and a message was left.
-When the resident returned to the facility, he was encouraged to use his call bell to receive assistance before trying to get up by himself.
-The resident was placed on every 2-hour safety

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checks.

Review of an ER visit note for Resident #5 dated 06/14/21 revealed:
-Resident #5 was seen for a fall after trying to stand from his wheelchair and hit his head.
-Discharge instructions included a physical therapy and occupational therapy evaluation for increased falls over the last month.

Review of Resident #5's incident and accident (I/A) report dated 06/22/21 at 11:05am revealed:
-The resident was found on the floor in his room.
-The resident had a head injury.
-The resident's vitals were taken.
-The resident's POA was called and a voicemail was left.
-The resident's Primary Care Physician (PCP) was called and a message was left.
-The resident was sent to the emergency room (ER).
-When the resident returned to the facility, he was encouraged to use his call bell to receive assistance before trying to get up by himself.
-The resident was placed on every 2-hour safety checks.

Review of an ER visit note for Resident #5 dated 06/22/21 revealed the resident was seen for a fall from his wheelchair.

Interview with a medication aide on 06/28/21 at 10:16am revealed:
-The resident had a fall on 06/22/21.
-She was at the facility when Resident #5 fell on 06/22/21.
-Resident #5 called his POA while he was on the floor and requested the POA to call the facility so he could receive help.
-The POA called the facility and spoke with the

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Business Office Manager (BOM).
-The BOM sent a personal care aide (PCA) to check on Resident #5.
-The PCA found Resident #5 on the floor in his room.
-Resident #5 told the PCA he hit his head.
-Resident #5 was sent out to the ER.
-When Resident #5 returned to the facility he was not under increased supervision.
-Residents are always sent to the ER if they complain of a head injury after a fall.
-She had never seen a supervision/fall policy at the facility.

Interview with a medication aide (MA) on 06/29/21 at 12:39pm revealed:
-On 06/06/21 she found Resident #5 on the floor.
-She thought he might have hit his head.
-She went to check on Resident #5 because his POA had called the facility and asked staff to check on him.

Interview with a second MA on 06/29/21 at 12:41pm revealed:
-She had completed the accident/incident report for Resident #5 on 06/06/21.
-Staff did whatever the resident's PCP ordered after a resident fell.
-Residents were checked every two hours unless ordered differently by the PCP.

Review of a care note for Resident #5 dated 06/01/21 (no time) revealed:
-Resident #5 came to staff and reported right side pain at 6:00pm and was given an as needed medication.
-At 7:55pm, Resident #5 returned reporting continued pain and wanted to go to the ER.
-When the emergency medical services (EMS) arrived Resident #5 told EMS he fell; the resident

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had not reported the fall to staff.

Review of an ER visit encounter for Resident #5 dated 06/01/21 revealed the resident was seen for right knee, hip and shoulder pain after a fall two days prior (05/30/21).

Interview with a third MA on 06/29/21 at 5:10pm revealed:
-She wrote the care note dated 06/01/21.
-Resident #5 was in his bed; she called EMS because the resident complained of pain.
-Resident #5 did not report falling until EMS arrived.
-She did not know how he got back in his bed.

Review of Resident #5's care note dated 05/11/21 at 9:25pm revealed:
-Resident #5 had an unwitnessed fall in his bathroom.
-Resident #5 complained of right leg, right arm, and back pain.
-Resident #5's vital signs were taken.
-Resident #5 requested to be sent to the ER.
-Resident #5's POA was notified.

Interview with a third MA on 06/29/21 at 5:10pm revealed:
-She wrote the care note dated 05/11/21 although she did not remember everything about Resident #5's fall.
-She did not find Resident #5 after the fall, she was told about the fall from staff who helped the resident up off the floor.
-Resident #5 did not complain of pain at the time he fell, he reported the pain about one hour after the fall.
-Staff did not increase supervision/safety checks for Resident #5 after his falls.
-PCAs monitored more frequently when he

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returned from the ER.
-Monitoring more frequently meant she would tell the PCAs to check Resident #5 when they were on the hall and she would check Resident #5 when she was on the hall.

Review of a care note for Resident #5 dated 01/07/21 (no time) revealed Resident #5 slid from his bed to the floor at 3:37pm, denied injury and/or pain and was helped back into his bed.

Review of a care note for Resident #5 dated 03/15/21 at 3:40am revealed:
-Resident #5 was found on the floor at 3:20am with no injuries.
-The resident's PCP and POA were notified.

Observations of Resident #5 in his room on 06/29/21 from 11:09am until 11:55am revealed:
-At 11:09am, Resident #5 rang his hand bell four to five times consecutively, but staff did not respond.
-At 11:14am, 11:18am and 11:32am, Resident #5 rang his hand bell, but staff did not respond.
-Resident #5 made several attempts to sit up from lying down on his bed before successfully sitting at the edge of the bed.
-Resident #5 made several attempts and was able to stand partially erect holding into the wheelchair.
-Resident #5 was unsteady and swayed while standing, turning and hopping on his left foot to transfer into the wheelchair.
-Resident #5 sat by falling into the chair; he was not able to guide himself down into the wheelchair.
-Between 11:46am and 11:55am Resident #5 rang the hand bell again.
-From 11:09am until 11:55am no staff responded to Resident #5's hand bell.

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CUMBERLAND VILLAGE ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

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D 270	Continued From page 40 Interview with Resident #5's POA on 06/29/21 at 11:09am revealed: -Resident #5 would ring his bell or call her to get staff to help him. -He called her on 06/22/21 after he fell; she called the facility to get staff to go and help him. -He had not been eating well, had increased weakness and had an overall decline in his physical ability. Interview with a PCA on 06/29/21 at 11:57am revealed: -She did not hear Resident #5's hand bell because she was on the A Hall. -She was not able to hear the hand bell unless she was on the D Hall. -She went to help Resident #5 after he fell on 06/22/21. -Resident #5 had called Business Office Manager (BOM) on 06/22/21 and said he needed help. -When she got to Resident #5's room he was lying on the floor next to his bed with a pillow under his head. Interview with a second PCA on 06/28/21 at 9:58am revealed: -Resident #5 was able to bathe, toilet, groom, and transfer himself. -She did not assist Resident #5 with any activities of daily living (ADL). -Resident #5 would ask for help if he needed it. -She could not remember the last time Resident #5 asked for help. -She knew that Resident #5 was independent because she worked with him for so long. -She could not remember the last time that Resident #5 fell. Interview with a third PCA on 06/29/21 at	D 270		

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D 270	Continued From page 41 12:33pm revealed: -PCAs normally checked all residents every two hours. -There were no residents being checked every 15 or 30 minutes. Telephone interview with Resident #5's primary care provider (PCP) on 06/29/21 at 10:19am revealed: -She did not know Resident #5 experienced six falls between 05/11/21 and 06/22/21. -She was notified of one fall for Resident #5 but could not remember the date. -She expected staff to notify her when Resident #5 fell and/or was sent to the ER. -She was concerned Resident #5 could experience injury with continued falls. -If she had known about Resident #5's multiple falls, she would have recommended physical therapy and occupational therapy evaluations. Interview with the Resident Care Coordinator (RCC) on 06/29/21 at 4:27pm revealed: -Resident #5's falls were not really falls, he pretended to fall. -After the fall in early June 2021, Resident #5 went to the ER for stomach issues and told the hospital staff he fell. -Resident #5's narcotic pain reliever was discontinued in May 2021 and the resident complained of pain ever since. -Resident #5 frequently complained of pain and asked to go to the hospital. -She knew he was not having pain because Resident #5 would say the paralyzed side of his body was moving when it was not. -All the falls occurred during business hours and there was one fall where Resident #5 was lying on the floor with a pillow under his head. -None of Resident #5's falls were witnessed and	D 270		

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she could not say how Resident #5 ended up on the floor.
-She did not know if it was possible for Resident #5 to reach for a pillow while he lie on the floor waiting for staff.
-Not all six ER visit between 05/11/21 and 06/22/21 were because of falls.
-"A lot" of Resident #5's ER visits were for nausea and vomiting.
-If Resident #5 was not sent to the ER for a fall then he would not be placed on every 15 minute checks.
-Resident #5 was on every 15 minute checks once after the last fall 06/22/21.
-Resident #5's POA called the facility and requested staff check on him.
-Resident #5 was able to transfer himself to and from his bed and wheelchair.
-She or the MA on duty contacted the resident's PCP after a fall and followed orders given by the PCP.
-She had attempted to contact his PCP after Resident #5's last ER visit (06/22/21) but he was seen by the facility's contracted PCP on 06/25/21.

Interview with the Executive Director (ED) on 06/29/21 at 12:50pm revealed:
-Resident #5 needed staff to help him with transfers, bathing and toileting because he was unsteady and had weakness on one side from a stroke.
-She saw staff help Resident #5 with toileting within the last month.
-The resident was stiff and had a hard time moving his lower extremities.
-If a resident had a change in level the of assistance needed, she verbally communicated that to staff.
-She did not see a change in Resident #5's condition or abilities since November 2020.

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D 270	Continued From page 43 -She did not know Resident #5 was not receiving assistance with transfers and toileting which was concerning because the resident could fall while transferring by himself. -After a resident fell, the MA on duty was responsible for contacting the PCP and following any orders given by the PCP. -If the resident was sent to the ER, staff continue to check on the resident when they return from the ER. -Frequency of checks depend on the severity of the fall and if there were injuries such as hitting the head, a busted lip or a blue eye; those injuries would prompt every 15 minute checks for 72 hours. -Staff checked the resident for any changes and documented the 15 minute checks on a form. -There were no other interventions in place to prevent falls and injuries for Resident #5. -Resident #5 was not on 15 minute checks after any of his falls because his falls were not really falls. -She could not remember the date of the fall in June 2021, but she saw Resident #5 after he fell. -Resident #5 had a pillow under his head with his arm raised and under the back of his head. -If a resident fell, they would not lie on the floor with a pillow under their head. -She did not know how the pillow got under Resident #5's head while he was lying on the floor. Upon request on 06/25/21 and 06/28/21 a fall and/or supervision policy was not available for review. Upon request on 06/28/21 and 06/29/21 documentation of supervision checks for Resident #5 was not available for review.	D 270		

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D 270	Continued From page 44 The facility failed to provide supervision to a resident (#5) who experienced an increase in falls over a 6 week period from May 2021 to June 2021 resulting in 6 documented falls and emergency room visits for pain and a head injury. This failure was detrimental to the health, safety and well-being to the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/29/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 13, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 3 of 5 sampled (#1, #2, #4) who were referred to a Cardiologist by their Primary Care Physician, a resident (#2) who had orders for home health to treat a leg wound that, and a resident (#1) who was referred to a Podiatrist and Cardiologist. The findings are: 1. Review of Resident #2's current FL-2 dated	D 273		

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D 273	Continued From page 45 11/05/20 revealed: -Diagnoses included diabetes, atrial fibrillation, hypertension, bladder incontinence, and double knee replacement. -She was semi-ambulatory. a. Review of Resident #2's Physician order sheet dated 05/28/21 revealed Resident #2's Primary Care Physician (PCP) wrote an order to refer Resident #2 to a Cardiologist for a history of atrial fibrillation (A disease of the heart characterized by irregular and often faster heartbeat). Review of Resident #2's hospital record dated 06/14/21 revealed: -She was admitted to the hospital on 06/12/21 for chest pain. -She was discharged on 06/14/21. -She presented to the Emergency Department (ED) complaining of left side chest pain for the past 3 days -She saw a cardiologist during her hospitalization and she had an echocardiogram and a stress test completed on 06/13/21. -Her echocardiogram revealed an ejection fraction greater than 55 percent. -Her stress test showed normal Lexiscan (a pharmacologic stress agent indicated for myocardial perfusion imaging) without significant evidence of heart attack or ischemia with an ejection fraction of 71 percent. -She was discharged with a scheduled appointment on 07/15/21 to follow up with a Cardiologist after discharge. Interview with the Transportation Coordinator on 06/25/21 at 10:56am revealed: -She did not receive an order to schedule a cardiology appointment for Resident #2 from the RCC.	D 273		

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D 273	Continued From page 46 -She did not schedule a cardiology appointment for Resident #2. Interview with Resident #2's PCP on 06/25/21 at 9:15am revealed: -She referred Resident #2 to a cardiologist because of her history of atrial fibrillation. -She was not aware that the facility did not schedule Resident #2's cardiology appointment that she ordered on 05/28/21. -She was not concerned that the referral was not made because Resident #2 saw a cardiologist in the hospital when she was admitted to the hospital on 06/12/21. -When she ordered a referral she expected the referral to be made by the next business day. Interview with the RCC on 06/25/21 at 11:11am revealed: -Resident #2 had a scheduled appointment to follow up with a cardiologist on 07/15/21. -The hospital scheduled the 07/15/21 cardiology appointment. -She was not aware that Resident #2's PCP wrote an order for a cardiology appointment on 05/28/21. -She did not know how she missed the order for Resident #2 to see a cardiologist. Interview with the ED on 06/28/21 at 9:18am revealed: -She was not aware that Resident #2 had an order to follow up with a Cardiologist on 05/28/21. -She expected appointments to be scheduled by the next business day once the RCC received the referral from the PCP. -She did not know why the RCC and the Transportation Coordinator did not schedule Resident #'2 cardiology appointment.	D 273		

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b. Interview with the Resident Care Coordinator (RCC) on 06/23/21 at 10:33am revealed:
-Resident #2 had wounds to her legs.
-Resident #2 was on antibiotics and had orders for wound care for the wounds to her legs.
-Resident #2 was ordered home health for wound care but the RC was unable to find a home health provider that would accept Resident #2's insurance.

Review of Resident #2's Physician order sheet dated 05/28/21 revealed Resident #2's Primary Care Physician (PCP) wrote an order to refer Resident #2 to home health nursing for wound care due to a vascular ulcer of the right leg.

Observation of Resident #2 on 06/23/21 at 10:45am revealed:
-A dark red area on her right lower extremity (RLE) about the size of a quarter, appeared to have a dry and flaky center.
-Directly to the left of the dark red aware was a pea-sized scratch that appeared to have dried dark red blood that surrounded it.
-The RLE was dry and appeared scaly.

Interview with Resident #2 on 06/23/21 at 10:36am revealed:
-She did not remember how long she had the wounds to her right leg.
-She did not remember how she got the wounds to her right leg.
-The wounds to her right leg did not hurt.
-She did take medicine for the wounds and the medication aide (MA) had put cream on her wounds.
-She did not seen a nurse from home health to care for the wound on her leg.

Interview with a personal care aide (PCA) on

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D 273	Continued From page 48 06/25/21 at 10;40am revealed: -She was aware that Resident #2 had wounds to her right leg. -She did not know how Resident #2 got the wounds on her legs. -Resident #2 liked to "pick and scratch her legs". -Resident #2's legs were often swollen and leaked fluid. -When Resident #2's legs would leak she would notify the MA. -Resident #2's legs had not leaked in a while. -Home health nursing did not provide wound care. Interview with a MA on 06/25/21 at 8:54am revealed: -She was aware that Resident #2 had wounds to her RLE. -She did not know how long Resident #2 had wounds on her legs or where the wounds came from. -The RCC tried to get home health set up for Resident #2. -She did not think Resident #2's home health was set up. Interview with the RCC on 06/24/21 at 10:05am revealed: -She was responsible for notifying home health for residents once ordered by their PCPs. -She sent Resident #2's home health referral to 5 different home health providers, that denied the referral due to Resident #2's health insurance. -She did not notify Resident #2's PCP that there was a delay in finding a home health agency. -She sent the home health referral to a home health provider on 06/24/21 that accepted Resident #'s health insurance. Interview with Resident #2's PCP on 06/25/21 at	D 273		

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9:15am revealed:
-She ordered home health nursing for wound care for Resident #2 on 05/28/21.
-She was not aware that the home health was never set up by the RCC.
-She expected home health to be started 3 days after the RCC received the order.
-She should have been notified immediately if the RCC was unable to set up home health.

Interview with the ED on 06/28/21 at 4:45pm revealed:
-The RCC was responsible for home health referrals for residents and assuring the referral was sent to home health agencies.
-She was not aware that Resident #2 had an order for home health that was not followed up.
-She expected home health referrals to be made by the next business day after the order was written.
-The RCC should have notified the PCP immediately if she
-She was concerned that Resident #2 had diabetes and could lose her leg if her wounds were not properly treated.

Refer to the interview with the Transportation Coordinator (TC) on 06/24/21 at 10:12am.

Refer to the interview with the Executive Director on 06/25/21 at 8:25am.

Refer to interview with the Resident Care Coordinator (RCC) on 06/28/21 at 3:58pm.

2. Review of Resident #1's current FL-2 dated 03/23/21 revealed diagnoses included hypertension, type II diabetes mellitus and schizophrenia.

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D 273	Continued From page 50 a. Review of a physician's order dated 03/19/21 for Resident #1 revealed a referral order to a cardiologist for a diagnosis of tachycardia (rapid heart rate more than 100 beats per minute). Interview with Resident #1 on 06/28/21 at 9:39am revealed: -He did not know of an order to see a cardiologist in March 2021. -His heart felt like it was racing sometimes, but he did not know how often that happened. -He did not have any pain in his chest. Interview with the Transportation Coordinator on 06/25/21 at 10:55am revealed she did not receive the order for a cardiology referral and had not scheduled an appointment for Resident #1. Interview with the Resident Care Coordinator (RCC) on 06/28/21 at 3:58pm revealed she remembered the cardiology referral for Resident #1 but did not know why an appointment was not scheduled. Interview with Resident #1's primary care provider (PCP) on 06/28/21 at 11:33am revealed: -She made the referral for a cardiologist when she first saw Resident #1 in March 2021. -Resident #1 was sent to the hospital several times since then. -If the cardiology referral had been an urgent need, she would have sent Resident #1 to the emergency room. b. Review of Resident #1's primary care provider's (PCP's) initial visit note dated 03/19/21 revealed: -Resident #1 was admitted to the facility from the local hospital. -Resident #1 was hospitalized with diabetic	D 273		

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ketoacidosis and osteomyelitis of his right foot.
-Resident #1 completed antibiotics on 03/13/21, received home health services for wound care and had a follow up appointment with podiatry on 03/30/21.

Review of emergency room (ER) discharge instructions dated 03/20/21 for Resident #1 revealed an order for follow up appointment with the podiatrist on 03/30/21 at 9:30am.

Review of ER discharge instructions dated 03/29/21 for Resident #5 revealed an order for follow up appointment with the podiatrist on 03/30/21 at 9:30am.

Interview with Resident #1 on 06/28/21 at 9:39am revealed:
-He did not remember having an appointment with a podiatrist in March 2021.
-He thought the infection was gone from his feet.
-No one had seen him to wrap his feet with bandages for two weeks.
-The nail from his right great toe fell off yesterday (06/27/21), but he did not tell the staff.

Telephone interview with the receptionist at the podiatrist's office on 06/25/21 at 10:38am revealed Resident #1 was a no call, no show for his appointment on 03/30/21 and the appointment was not rescheduled.

Interview with the Transportation Coordinator on 06/25/21 at 10:55am revealed:
-Resident #1's podiatry appointment was written in on her calendar, but she did not take him for that appointment because she was not at work that day.
-She normally checked the calendar for missed appointments when she returned to work, but she

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was not sure if she had checked the calendar for the missed appointments on 03/30/21.

Interview with Resident #1's PCP on 06/28/21 at 11:33am revealed:
-She did not know that Resident #1 missed his podiatry appointment on 03/30/21.
-Staff should have let her know Resident #1 missed his podiatry appointment because he had diabetes and wound healing could have been delayed.

Interview with the Resident Care Coordinator (RCC) on 06/28/21 at 3:58pm revealed:
-Normally, when a resident missed an appointment the Transportation Coordinator rescheduled the appointment.
-She did not know why Resident #1's podiatry appointment was not rescheduled; she was not aware the appointment was not rescheduled until 06/25/21.
-She or the MA on duty contacted the resident's PCP when a resident refused an appointment.
-She or the MA documented the PCP contact on a resident care note.
-Resident #1's PCP faxed a contact note to the facility whenever staff called with a concern.
-The fax was placed in a bin in the medication room and she filed the fax in the resident's record.

Upon request on 06/23/21 and 06/28/21, documentation of contact with Resident #1's PCP related to the missed podiatry appointment was not available for review.

Interview with the Transportation Coordinator on 06/25/21 at 10:55am revealed:
-She normally got a copy of the referral order from the RCC.

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CUMBERLAND VILLAGE ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 53 -She was responsible for scheduling appointments. -She had not transported Resident #1 to any appointments since he was admitted to the facility on 03/23/21. -The RCC, Business Office Manager (BOM) or the Executive Director (ED) took residents to urgent appointments only when she was not at work. -If Resident #1 was taken to his appointment there would have been a consultation form in his chart. -She usually rescheduled any missed appointments when she returned to work. Interview with the ED on 06/28/21 at 4:30pm revealed: -There may have been a few occasions when she took a resident to an urgent appointment, but she did not normally transport resident to appointments. -She did not schedule or manage referral appointments. -All orders went to the RCC, the RCC gave orders for referrals to the Transportation Coordinator who scheduled the appointment. -Staff were expected to let the RCC or her know the same day if an appointment was not scheduled or refused. -Staff were expected to document a care note if an appointment was missed or not scheduled and what was done about it. Refer to the interview with the Transportation Coordinator (TC) on 06/24/21 at 10:12am. Refer to the interview with the Executive Director on 06/25/21 at 8:25am. Refer to interview with the Resident Care	D 273		

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D 273	Continued From page 54 Coordinator (RCC) on 06/28/21 at 3:58pm. 3. Review of Resident #4's current FL-2 dated 03/31/21 revealed diagnoses included coronary artery disease, atrial fibrillation, congestive heart failure, aortic valve stenosis, hypertension, generalized weakness, depression, hyperlipidemia, diabetes mellitus, and benign prostatic hypertrophy. Review of a hospital discharge summary for Resident #4 dated 05/28/21 revealed: -The resident was admitted to the hospital on 05/18/21 for hypoxia (oxygen deficiency). -The resident had a diagnosis of acute on chronic heart failure with reduced ejection fraction (the measurement of the percentage of blood leaving the heart each time it contracts). -The resident had a history of four coronary artery bypass grafts. -The resident had COVID-19 pneumonia in February. -There was an order for Resident #4 to follow up with the Cardiologist (named) within two weeks of discharge. -There was contact information for the Cardiologist was documented on the discharge summary. Review of a Physician's Consultation Report dated 06/08/21 for Resident #4 revealed: -The resident was seen for post hospital follow up with his Primary Care Provider (PCP). -The PCP ordered pulse oximetry checks (measurement of oxygen saturation) twice a day, if less than 90%, start oxygen at two liters via nasal cannula. -The PCP documented Resident #4 was to "keep cardiology follow up".	D 273		

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Review of Resident #4's record revealed no documentation of a cardiologist visit following the 05/28/21 hospital discharge date.

Interview with the Transportation Coordinator (TC) on 06/24/21 at 10:12am revealed:
-She knew about the cardiologist appointment for Resident #4 because information was on the hospital release paperwork.
-Resident #4's cardiology appointment would on 07/15/21 at 1:45pm.
-She scheduled the appointment.
-Resident #4's family member notified her about the needed cardiology follow up about 2 ½ weeks ago when the family was visiting the resident.
- She scheduled the appointment while the family was present.
-She did not remember the date she scheduled the appointment.
-She "got busy" making other appointments and forgot to follow up on the hospital discharge paperwork for Resident #4.

Interview with the ED on 06/25/21 at 8:25am revealed:
-She was not aware Resident #4's post hospital two-week cardiology appointment was not scheduled as ordered.
-She did not know how the cardiology follow up appointment was missed.

Second interview with the ED on 06/25/21 at 10:33am revealed the reason why Resident #4's two-week post hospital follow-up cardiology appointment was not scheduled by the facility Transportation Coordinator was because the hospital scheduled the cardiology appointment.

Telephone interview with the receptionist at the Cardiologist' office on 06/25/21 at 10:45am

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D 273	Continued From page 56 revealed: -Resident #4 had a scheduled appointment for on 07/15/21. -The appointment was modified/scheduled on 06/16/21. -She did not document who called to schedule the appointment. -If the caller requested an appointment for two weeks when the call was made, the scheduler would schedule the appointment based on the discharge note. -She was not sure why Resident #4 was given an appointment for 07/15/21. -Some appointments were scheduled according to the physician's schedule. -Resident #4 was new to the Cardiologist's office which could be a reason for the 07/15/21 appointment. Second interview with the Transportation Coordinator on 06/25/21 at 10:55am revealed: -She did not keep records of when she called a physician's office to schedule an appointment for a resident. -She reported to the RCC when she could not schedule an appointment for a resident. -She usually did not make referral appointments to new doctors, but she made the appointment for Resident #4 to the cardiologist for 07/15/21, which was a new appointment. Refer to the interview with the Transportation Coordinator (TC) on 06/24/21 at 10:12am. Refer to the interview with the Executive Director on 06/25/21 at 8:25am. Refer to the interview with the Resident Care Coordinator (RCC) on 06/28/21 at 3:58pm.	D 273		

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D 273	Continued From page 57 Interview with the Transportation Coordinator (TC) on 06/24/21 at 10:12am revealed: -Her job duties included transporting residents to appointments and scheduling appointments. -She kept up with appointments by documenting scheduled appointments in a weekly calendar notebook. -She scheduled appointments by calling the physician offices. -She received request to schedule appointments from the facility PCP, from specialty physicians, and "outside" PCP's. -The Resident Care Coordinator (RCC) was responsible for providing her (Transportation Coordinator) a copy of the request to schedule an appointment for a resident. -She always made appointments within a four-day period. -If there was an appointment that needed to be scheduled immediately, she scheduled those appointments the same day the order was written by the PCP. -By the end of the month, a copy of the appointment calendar for the upcoming month was posted in the medication room, personal care staff office, and in her office. -The Executive Director (ED) was given a copy of the appointment sometimes, and she (TC) told the ED which residents had appointments that were coming up. Interview with the Executive Director on 06/25/21 at 8:25am revealed: -She expected the Transportation Coordinator (TC) to reach out to specified physicians regarding follow up appointments for residents. -The RCC received discharge hospital paperwork for residents as soon as the resident returned from a hospital visit. -The RCC was supposed to review the hospital	D 273		

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discharge paperwork and let the TC know about any follow up appointments needed.
-She expected the TC to call the physicians office when she received the information from the RCC about needed appointments.
-If the TC was not able to speak to anybody at the physician's office, the TC was expected to leave a message and before the day was over the TC was to call the physician's office again.
-The ED expected the TC to make her aware of the appointments.
-She expected follow up appointments to be scheduled within two days.

Interview with the Resident Care Coordinator (RCC) on 06/28/21 at 3:58pm revealed:
-All referrals were given to the Transportation Coordinator and she followed up with the Transportation Coordinator to make sure appointments had been scheduled.
-If the Transportation Coordinator was not at work, she would schedule the appointments and enter the appointment on the calendar.
-She normally kept track of referral appointments with sticky notes on her own calendar.

_____

The facility failed to assure 3 of 5 residents sampled (#1, #2, #5) received referral and follow-up related to orders for all 3 residents to be seen by a cardiologist for heart related diagnoses that were never scheduled which resulted in a resident (#2) being admitted to the hospital for 2 days for chest pain and a resident (#1) that had orders to be referred to a Podiatrist to treat long term foot issues as a result of diabetes. The facility's failure was detrimental to the health, safety and well-being of the residents which constitutes a Type B Violation

_____

The facility provided a plan of protection in

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D 273	Continued From page 59 accordance with G.S. 131D-34 on 06/25/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 13, 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 observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#5) who suffered from a stroke related to wear a back brace, a leg brace, and a wrist brace. The findings are: Review of Resident #5 ' s current FL-2 dated 12/10/20 revealed: -Diagnoses included cerebrovascular accident (the medical term for a stroke), head injury, hypertension, and stroke. -Medication orders included back brace when the resident is out of bed at all times, leg brace to the right lower leg during waking hours, and wrist brace to the right wrist during waking hours.	D 276		

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D 276	Continued From page 60 Observation of Resident #5 on 06/28/21 at 9:30am revealed: -Resident #5 was laying in bed. -Resident #5 did not have on his wrist brace or leg brace. -Resident #5 ' s back brace was hanging on the end of his bed frame. Interview with Resident #5 on 06/28/21 at 9:35am revealed: -He did not know where his wrist brace was located. -He did not remember the last time he wore his wrist brace. -He last wore his back brace 2 months ago. -He knew where his leg brace was, but he had not worn it in a few months. -He did not know how often he was supposed to wear his leg brace, back brace, or wrist brace. Interview with a personal care aide (PCA) on 06/28/21 at 9:58am revealed: -She worked at the facility for over a year. -She did not know if Resident #5 wore a leg, wrist, or back brace. -She had never seen Resident #5 wear any type of brace in the past. Interview with a medication aide (MA) on 06/28/21 at 10:16am revealed: -Resident #5 wore a leg brace daily. -The PCAs helped Resident #5 put on his leg brace. -She did not remember the last time she observed Resident #5 wearing his leg brace. -She did not think Resident #5 wore any other braces. Observation of Resident #5 on 06/29/21 at 7:15am revealed:	D 276		

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D 276	Continued From page 61 -Resident #5 was in his wheelchair in the hallway. -Resident #5 did not have on the wrist, leg, or back brace. Interview with Resident #5 on 06/29/21 at 7:29a revealed: -He found his wrist brace in his rollator in his room. -His wrist brace had been broken for the past 4 months. -He did not have on the leg, back, or wrist brace. Interview with Resident #5's previous Primary Care Physician (PCP) revealed: -She saw Resident #5 in her office about 3 months ago. -She did not remember if she originally ordered the leg, wrist, or back brace for Resident #5. -Resident #5 needed his braces because he was paralyzed on his right side. -She was not aware that Resident #5 was not wearing his braces as ordered. -When he came in for appointments, he always had on all his braces. -She did not receive any calls from the facility informing her Resident #5 refused to wear his braces. -She was concerned that his right wrist and right leg could become contracted if he did not wear his braces as ordered. -She was concerned that Resident #5 could potentially fall if he did not have his leg brace on for support. -The wrist brace and leg brace were to be worn continuously during waking hours. Interview with the Resident Care Coordinator (RCC) on 06/29/21 at 11:05am revealed: -Resident #5 was supposed to wear a wrist, leg, and back brace.	D 276		

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D 276	Continued From page 62 -Resident #5's July 2021 electronic medication administration record (eMAR) there was an entry apply leg brace to the right lower leg during waking hours. -The column to the right of that entry was for documenting the hours the resident wore the brace. -On Resident 5's July 2021 eMAR there was an entry apply wrist brace to the right wrist during waking hours. -In the column next to the leg brace entry under hours FYI was entered. -The FYI indicated that the leg and wrist brace could be worn as needed (PRN). -She knew that Resident #5 was supposed to wear his back when he was in his wheelchair. -She had never seen Resident #5's wrist brace. -She was not aware that Resident #5's wrist brace was broken. -She helped him put on his leg brace a while ago but she could remember when she helped him. -She could not remember the last time she saw Resident #5 wear his back brace. Interview with the Executive Director (ED) on 06/29/21 at 1:28pm revealed: -She was aware that Resident #5 was supposed to wear a wrist brace daily. -She did not remember the last time she saw Resident #5 wear his wrist brace. -She was not aware that Resident #5 had an order for a leg brace to be applied to his right leg during waking hours. -She was not aware that Resident #5 was not wearing his leg brace as ordered. -She was not aware that Resident #5 had an order to wear a back brace when he was out of bed. -She was not aware that Resident #5 did not wear his back brace as ordered.	D 276		

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D 276	Continued From page 63 -She was concerned that her staff did not follow physician orders. -She expected her staff to follow the order as written. -She did not know why the RCC said that "FYI" meant "PRN". -FYI on the eMAR mean was 'for your information".	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the kitchen and food storage areas were kept clean and free of contamination. The findings are: Observations of the kitchen on 06/23/21 at 9:49am revealed: -There were no paper towels accessible at the handwashing sink. -The paper towels were stored on a food preparation countertop. -The tiled floors in the kitchen were covered with white stains with small food debris scattered across the floor.	D 282		

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D 282	Continued From page 64 -There was a thick accumulation of yellow grease on the oven hood of the stove. -There was an accumulation of black and dark brown substances on the oven doors. -The oven doors were broken and did not close completely. -There was an accumulation of black and dark brown substances around the burner knobs of the stove. -There was an accumulation of food debris on the floor around the stove. -In the walk-in cooler there was a large box of ready-to-eat potatoes stored on a wire rack underneath several rows of eggs that were in an opened carton. Review of the facility's North Carolina (NC) Division of Environmental Health inspection report dated 06/24/21 revealed the facility's score was 76 with 24 total demerits. Review of the facility's NC Division of Environmental Health Inspection dated 11/28/18 revealed the facility's score was 91.5 with 8.5 total demerits. Interview with the Dietary Manager (DM) on 06/23/21 at 9:57am revealed: -She had become the DM in January 2021. -She was not aware that the North Carolina (NC) Division of Environmental Health inspection report had expired. -She had not seen a health inspector come to the facility and inspect the kitchen while she had been the DM. -The oven doors to the stove had been broken since she started as the DM in January 2021. -She was not able to use the oven on the right side of the stove. -She was only able to use the oven on the left	D 282		

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side of the stove.
-She put in a work order for the oven through the Executive Director (ED) a couple of weeks ago.

Interview with the local Environmental Health Program Specialist (EHPS) on 06/24/21 at 12:59pm revealed:
-She completed inspection of the facility's kitchen on 06/24/21.
-There was an NC Division of Environmental Health inspection completed in 2019 or 2020 but she was unable to locate the inspection report or facility's score.
-The facility was inspected on 06/24/21 and the kitchen received a score of 76 with 24 total dermits.
-There were 12 demerits that needed to be corrected by the facility before she left the facility for the day.
-All pots, pans, can opener attached to the prep table, cutting boards, dessert plates, dinner plates, utensils, ladles, microwave, and coffee cups were observed to be excessively soiled with hair, food debris, grease, and dust.
-She observed stacked eggs that were out of the carton observed stored in the walk-in cooler above fresh ready-to-eat potatoes.
-She observed a cleaning agent stored on a wire rack above packaged bread.
-All of the kitchen floors, walls, and ceilings needed to be thoroughly cleaned.
-Paper towels were missing from the kitchen hand sink.
-Dead cockroaches were found on dry food storage shelves and on floors next to food containers, and inside of an in-use microwave.
-Several cockroach bait traps were observed filled to the capacity of cockroaches.
-The over door and ice machine needed to be repaired or replaced.

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D 282	Continued From page 66 Observation of the kitchen on 06/24/21 at 1:59am revealed: -The DM swept the pantry and kitchen. -There were 5 cockroach bait traps that were filled with cockroaches swept in a pile. -There were 3 dead cockroaches observed in the swept pile of cockroach bait traps. -The dietary aide washed dinner plates, utensils, and coffee cups. A second interview with the DM on 06/25/21 at 8:50am revealed: -She had not cleaned the entire kitchen since she was hired as the DM in January 2021. -She was not able to clean the entire kitchen because COVID-19 made it difficult for her to focus on cleaning. -She did not have a weekly cleaning schedule for the kitchen. -She swept and mopped the entire kitchen every week on Friday. -She cleaned the top part of the stove daily. -She did not clean the inside of the oven because it was a gas oven and she was nervous about the gas. -Someone from corporate cleaned the oven hood every 6 months. -The oven hood hand not been cleaned since she was hired as the DM. -She always stored the eggs on the second to last rack in the walk-in cooler. Interview with the ED on 06/28/21 at 8:58am revealed: -The kitchen staff was expected to clean the kitchen daily. -The DM was responsible for ensuring the kitchen was clean. -The kitchen staff was expected to clean the prep	D 282		

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	HAL026062	A. BUILDING: _____ B. WING _____	C 06/29/2021

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D 282	Continued From page 67 table, dishes, dishwasher, plates, door handles, sweep, mop, and clean the inside of the walk-in cooler daily. -There was a facility contracted cleaning company that cleaned the oven hood every 6 months. -The facility contracted company last cleaned the oven hood in November but had not been back to the facility due to COVID-19. -The DM was expected to deep clean the kitchen every weekend. -She was not aware that the kitchen staff was not cleaning the kitchen daily. -She last inspected the kitchen for cleanliness last month and found cockroaches in the pantry. -She swept up the cockroaches and notified the facility contracted pest exterminator last week that she found cockroaches in the kitchen. -The facility contracted pest exterminator came to the facility monthly to complete routine treatments. -She tried to check the kitchen for cleanliness as often as she could, but the facility "was an older building and needed so much work". _____ The facility failed to clean their kitchen daily which included food storage areas, food prepartion areas, and floors and keep the kitchen free of dead pests which placed all of the residents at risk for consuming contiminated food and resulted in the facility receiving a facility score of 76 on their current North Carolina Division of Environmental Health inspection report dated 06/24/21 to the health, safety, and well-being of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/28/21 for this violation.	D 282		

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D 282	Continued From page 68 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 13, 2021.	D 282		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews and review of the facility's activity calendar, the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Observation on 06/23/21 at 9:35am during the initial tour of the facility revealed there was an activity calendar posted in the hallway of the facility. Review of the June 2021 Activity Calendar on 06/23/21 at 9:35am posted on a bulletin board in hallway revealed that there were at least fourteen hours of activities scheduled weekly on the calendar.	D 315		

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Interview with seven residents on 06/23/2021 from 9:35am to 10:35am during the initial tour revealed:
-The residents only played bingo.
-There were not different activities.
-The residents used to do a lot of activities before COVID.
-Sometimes they played music.
-Activities were fun before "the lady left".
-They had not gone on outings since COVID started.
-The activity calendar was always posted.
-The residents used to do crafts and baking activities.

Interview with the Executive Director (ED) on 6/23/21 at 1:10pm revealed:
-There had not been an Activity Director (AD) since March 2021.
-She was responsible for making and posting the activity calendar.
-Activities at facility were conducted by volunteers and religious groups for the most part.
-Sometimes other staff conducted activities.
-An Activity Director had been hired and was in the process to complete training. The AD was scheduled to start on 6/25/2021 or 06/28/2021.

Interview with ED on 06/25/2021 at 9:05am revealed:
-The "Nails Day" activity would be conducted by a Personal Care Aide (PCA) from 10:00am to 11:00am in the library.
-The PCA was aware this activity was to be conducted.

Observations on 06/25/2021 from 10:00am-11:00am revealed:
-There were no residents at the library at 10:15am, 10:30am and 10:45am.

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D 315	Continued From page 70 -Library lights were off at 10:15am, 10:30am, and 10:45am. - The "Nails Day" activity was not observed during the time scheduled. Interview with a PCA on 06/28/21 at 10:20am revealed: -They do not do many activities, but they try to do things. - "Nails Day' activity was not conducted because "they could not find any nail polish". -She was not aware a new activity director would be starting employment any time soon. - The residents wanted to do more things and staff were going to start a fitness activity involving both residents and staff. Observations on 06/28/21 at intervals from 8:30am-5:00pm revealed no activities were conducted:	D 315		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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D 344	Continued From page 71 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure contact with the primary care provider for clarification of medication orders for 1 of 5 sampled residents (#4) prior to implementing changes in medications used for breathing disorders, fluid retention, depression, high cholesterol, urinary disorder, and a vitamin supplement. The findings are: Review of Resident #4's current FL-2 dated 03/31/21 revealed diagnoses included coronary artery disease, atrial fibrillation, congestive heart failure, aortic valve stenosis, hypertension, generalized weakness, depression, hyperlipidemia, diabetes mellitus, and benign prostatic hypertrophy. a. Review of Resident #4's FL-2 dated 03/31/21 revealed a physician's order for breo ellipta inhaler (used to treat breathing disorders) 200-25mcg (micrograms) one puff every day for wheezing. Review of an unsigned medication list dated 05/28/21 from a recent local hospital stay revealed Resident #4 was to continue the breo ellipta inhaler daily at 8:00am. Review of a physician's electronically signed hospital discharge summary dated 05/28/21 revealed: -Resident #4 was to continue the breo ellipta 200-25mcg. -There were no instructions printed for the number of puffs or frequency of administration for the breo ellipta inhaler.	D 344		

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D 344	Continued From page 72 Review of a medication list for Resident #4 dated 06/17/21 from a Veteran's Administration (VA) hospital revealed: -The medication list was not signed by a physician. -There was a printed entry to stop breo ellipta. Review of Resident #4's May 2021 medication administration records (MARs) revealed: -There was an entry for breo ellipta 200-25mcg inhaler one puff every day for wheezing. -The breo ellipta inhaler was documented as administered at 8:00am daily from 05/29/21 through 05/31/21. Review of Resident #4's June 2021 MARs revealed: -There was an entry for breo ellipta 200-25mcg inhaler one puff every day for wheezing. -The breo ellipta inhaler was documented as administered at 8:00am daily from 06/01/21 through 06/14/21. -There was a diagonal line drawn across the breo ellipta printed instructions with a handwritten note of "d/c 6/17/21". Review of physician's orders for Resident #4 revealed there was no clarification with the Primary Care Provider (PCP) for the breo ellipta inhaler prior to 06/25/21 when the facility received a verbal order to approve all VA orders for the next 4 days until reviewed by the PCP on 06/28/21. b. Review of Resident #4's FL-2 dated 03/31/21 revealed there was a physician's order for cymbalta (used to treat depression) 30mg one capsule daily.	D 344		

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D 344	Continued From page 73	D 344		

Review of a physician electronically signed hospital discharge summary dated 05/28/21 revealed Resident #4 was to continue the Cymbalta 30mg capsule daily.

Review of a medication list for Resident #4 dated 06/17/21 from a veteran's administration hospital revealed:
-The medication list was not signed by a physician.
-There was a printed entry to lower the duloxetine (generic for Cymbalta) to 20mg once a day.

Review of Resident #4's June 2021 MARs revealed:
-There was a printed entry for Cymbalta 30mg capsule daily with documented administration 06/01/21 through 06/16/21.
-There was a diagonal line drawn across the Cymbalta 30mg printed instructions with a handwritten note of "order changed 6/17/21".
-There was a handwritten entry for Cymbalta 20mg one tablet once a day.
-The Cymbalta 20mg tablet was documented as administered at 8:00am daily from 06/18/21 through 06/25/21.

Review of physician's orders for Resident #4 revealed there was no clarification with the Primary Care Provider (PCP) for the Cymbalta 30mg capsule prior to 06/25/21 when the facility received a verbal order to approve all VA orders for the next 4 days until reviewed by the PCP on 06/28/21.

c. Review of Resident #4's FL-2 dated 03/31/21 revealed there was a physician's order for tamsulosin (used to treat urinary flow disorders) 0.4mg take two capsules (0.8mg) at bedtime.

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Review of an unsigned medication list dated 05/28/21 from a recent hospital stay revealed Resident #4 was to continue the tamsulosin 0.4mg take two capsules (0.8mg) at bedtime.

Review of a physician electronically signed hospital discharge summary dated 05/28/21 revealed:
-Resident #4 was to continue the tamsulosin 0.4mg 24-hour capsule.
-There were no instructions printed for the frequency of administration for the tamsulosin.

Review of a medication list for Resident #4 dated 06/17/21 from a veteran's administration hospital revealed:
-The medication list was not signed by a physician.
-There was a printed entry of tamsulosin hcl 0.4mg capsule (status=pending) take one capsule at bedtime.

Review of Resident #4's June 2021 MARs revealed:
-There was a handwritten entry on the MARs for Flomax (brand name for tamsulosin) 0.4mg take one capsule at bedtime.
-The tamsulosin 0.4mg capsule was documented as administered at 8:00pm daily from 06/17/21 through 06/22/21.
-There was a diagonal line drawn across a printed entry with instructions of tamsulosin 0.4mg take two capsules at bedtime. There was a handwritten note of "order changed".

Review of physician's orders for Resident #4 revealed there was no clarification with the Primary Care Provider (PCP) for the tamsulosin 0.4mg capsule prior to 06/25/21 when the facility received a verbal order to approve all VA orders

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D 344	Continued From page 75 for the next 4 days until reviewed by the PCP on 06/28/21. d. Review of a physician electronically signed hospital discharge summary dated 05/28/21 revealed there was a physician's order to start furosemide (used to treat fluid retention) 20mg tablet daily. Review of a physician's orders for Resident #4 dated 06/08/21 revealed Resident #4's PCP increased the furosemide to 20mg twice daily. Review of a medication list for Resident #4 dated 06/17/21 from a VA hospital revealed: -The medication list was not signed by a physician. -There was a printed entry for furosemide 20mg tablet daily. Review of Resident #4's May 2021 MARs revealed there was a handwritten entry for furosemide 20mg tablet daily with documentation for administration beginning 05/29/21 through 05/31/21. Review of Resident #4's June 2021 MARs revealed: -There was a handwritten entry for furosemide 20mg tablet daily with documentation for administration beginning 06/01/21 through 06/07/21. -There was a handwritten entry for furosemide 20mg tablet twice daily with documentation for administration beginning 06/08/21 through 06/17/21. -There was a second handwritten entry for furosemide 20mg tablet daily with documentation for administration beginning 06/18/21 through 06/23/21.	D 344		

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D 344	Continued From page 76 Continued review of physician's orders for Resident #4 revealed there was no clarification with the PCP for decreasing the furosemide 20mg from twice daily to once daily prior to 06/25/21 when the facility received a verbal order to approve all VA orders for the next 4 days until reviewed by the PCP on 06/28/21. e. Review of a medication list for Resident #4 dated 06/17/21 from a VA hospital revealed: -The medication list was not signed by a physician. -There was a printed entry for cholecalciferol (generic for Vitamin D3, a dietary supplement) 25mcg tablet daily. Review of Resident #4's June 2021 MARs revealed there was a handwritten entry for Vitamin D3 25mcg take one tablet once daily with documentation for administration beginning 06/18/21 through 06/23/21. Review of physician's orders for Resident #4 revealed there was no signed physician's order for the Vitamin D3 25mcg tablet daily. Continued review of physician's orders for Resident #4 revealed there was no clarification with the Primary Care Provider (PCP) for the vitamin D3 25mcg tablet prior to 06/25/21 when the facility received a verbal order to approve all VA orders for the next 4 days until reviewed by the PCP on 06/28/21. f. Review of a medication list for Resident #4 dated 06/17/21 from a veteran's administration hospital revealed: -The medication list was not signed by a physician.	D 344		

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D 344	Continued From page 77 -There was a printed entry for atorvastatin calcium (generic for Lipitor used to treat high cholesterol) 20mg tablet at bedtime. Review of Resident #4's June 2021 MARs revealed there was a handwritten entry for Lipitor 20mg take one tablet at bedtime with documentation for administration beginning 06/18/21 through 06/22/21 at 8:00pm. Review of physician's orders for Resident #4 revealed there was no signed physician's order for the Lipitor 20mg tablet daily. Observations of medications on hand on 06/25/21 at 9:50am for Resident #4 revealed there was a pharmacy labelled medication blister pack for atorvastatin 20mg take one tablet bedtime. Interview with the MA on 06/25/21 at 10:07am revealed she had not seen a physician's order to administer atorvastatin to Resident #4. Interview with the Resident Care Coordinator (RCC) on 06/24/21 at 12:04pm revealed: -She sent a copy of Resident #4's FL-2 to the VA hospital physician to establish care (no date provided). -She received the unsigned list of medications for Resident #4 from a VA hospital that came with a cover sheet from a physician. -She thought the list of medications from the VA hospital was in response to the FL-2 she had faxed to the veteran's hospital. -She had not received a physician signed copy of the medications yet. -She faxed a clarification request to the VA hospital physician on 06/17/21 because there were medications on the unsigned list that were different from those listed on Resident #4's	D 344		

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signed FL-2.
-Resident #4's Power of Attorney (POA) switched the resident to the VA's physician.
-She considered Resident #4's PCP to be the physician that signed the FL-2 for the resident.
-She transcribed the medication information from the VA hospital medication list dated 06/17/21 on to Resident #4's medication administration records (MARs).
-She thought the PCP who signed the most current FL-2 dated 03/31/21 for Resident #4 was no longer the PCP because Resident #4's POA was arranging for the resident to get medications through the VA hospital.
-She did not know she could contact the PCP who signed the FL-2 dated 03/31/21, for clarification of the orders if the resident's PCP was changing.

Telephone interview with the Medical Assistant at Resident #4's PCP's office on 06/25/21 at 8:57am revealed:
-The facility was supposed to follow the physician orders from the PCP because the PCP was signing the orders for Resident #4.
-She expected the facility to send any request for medication changes to the PCP to evaluate and approve.

Interview with the RCC on 06/28/21 at 9:22am revealed:
-Her process for clarifying orders included faxing the order to the PCP.
-The PCP would fax the signed orders back to the facility.
-She changed the instructions for administration of Resident #4's medications prior to receiving clarification for the 06/17/21 medication list or a signed copy of physician orders because she thought the medication list received from the VA

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hospital were physician's orders.
-She sent a medication clarification to the VA hospital physician on 06/17/21 because she knew Resident #4 was a veteran.
-If she thought the PCP who signed the 03/31/21 FL-2 for Resident #4 was the PCP, she would have sent the medication clarification of orders to him.

Interview with the Executive Director (ED) on 06/28/21 at 9:59am revealed:
-A physician's signature was needed on a medication order before the instructions for administration to the resident were changed.
-The facility should document order changes on a medication clarification form.

Second interview with the ED on 06/28/21 at 4:54pm revealed:
-The RCC was responsible for transcribing physician orders to the MARs.
-The RCC was responsible to make sure physician orders were complete orders and were signed by the physician.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 06/29/21 at 10:49am revealed:
-The pharmacy expected the facility to get clarifications of orders.
-It took from 06/17/21 until 06/25/21 for clarifications on Resident #4's medications.

Telephone interview with Resident #4's PCP on 06/29/21 at 1:57pm revealed:
-He received a call from the facility on 06/25/21 about changes made to Resident #4's orders from a medication list sent the VA hospital.
-He gave the facility temporary orders until he reviewed the medication list from the veteran's

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D 344	Continued From page 80 hospital. -He requested the facility to send the medication list to him for review. -He was not aware Resident #4 was being seen at the VA hospital. -He had concern that he was not aware the VA hospital was managing Resident #4, and it was not good for two providers to manage the same resident.	D 344		
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: (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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 6 residents observed during the morning medication pass including errors with inhalers, anti-depressant, oral diabetic and supplemental medications (#4). The facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #4) which included to hold Humalog insulin for finger stick blood sugars (FSBS) less than 120 before meals (#1); and an inhaler and an oral diabetic medication not administered, wrong dosages of medications administered including a medication	D 358		

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used to treat urinary flow issues, an anti-depressant and a medication used to treat fluid retention, and a medication used to treat high cholesterol administered without a signed physician's order (#4).

The findings are:

1. The medication pass error rate was 14% as evidence by the observation of 4 errors out of 26 opportunities during the morning medication pass on 06/24/21

Review of Resident #4's current FL-2 dated 03/31/21 revealed diagnoses included coronary artery disease, atrial fibrillation, depression, hyperlipidemia, diabetes mellitus, hypertension, generalized weakness, aortic valve stenosis, benign prostate hypertrophy and congestive heart failure.

Observations during the morning medication pass on 06/24/21 from 8:00am until 8:14am revealed:
-At 8:00am, the medication aide (MA) prepared 9 oral medications for Resident #4's; lisinopril 2.5mg (used to treat high blood pressure), duloxetine 20mg (used to treat depression), vitamin D3 25mcg (used as a supplement), zinc 220mg (used as a supplement), Eliquis 5mg (used to treat blood clots), vitamin C 500mg (used as a supplement), oxybutynin 5mg (used to treat bladder issues), furosemide 20mg (used to treat urinary retention) and metoprolol 25mg (used to treat high blood pressure).
-At 8:05am, the MA administered 9 oral medications to Resident #4 in his room with water.
-Resident #4 was sitting on the edge of his bed receiving 2 liters of oxygen via a nasal canula.
-The MA did not check Resident #4's blood

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pressure (BP) prior to administering the medications.
-There were no inhaled medications administered to Resident #4.

Review of electronically signed hospital discharge instructions dated 05/28/21 for Resident #4 revealed:
-There was an order for lisinopril 2.5mg daily.
-There was an order to continue Breo Ellipta 200/25mcg inhaler.
-There was an order to continue duloxetine 30mg daily.
-There was an order to continue glimepiride 1mg.
-There was no order for Vitamin D3.

Review of a visit summary for Resident #4 from the local Veteran's Administration (VA) clinic dated 06/17/21 revealed:
-The visit summary did not name a provider and was not signed.
-Lisinopril 2.5mg was listed twice on the medication list with instructions to hold for systolic blood pressure (SBP) under 110 included with the first entry.
-There was an order to stop Breo Ellipta.
-There was an order to decrease duloxetine to 20mg daily.
-There was an order to stop glimepiride.
-There was an order to start Symbicort 2 inhalations every 12 hours.
-Vitamin D3 25 mcg daily was included on the medication list.

Review of Resident #4's June 2021 medication administration record (MAR) revealed:
-There was an entry for Lisinopril 2.5mg daily, hold for SBP under 110; there were no SBP results documented.
-Lisinopril was documented as administered

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D 358	Continued From page 83 06/01/21 through 06/25/21. -There was an entry for Breo Ellipta 1 puff daily with strike through and "D/C 06/17/21" handwritten over the entry. -The Breo Ellipta was not documented as administered from 06/15/21 through 06/24/21. -There was an entry for duloxetine 30mg daily with strike through and "D/C (discontinue) 06/17/21" handwritten over the entry. -Duloxetine 30mg was not documented as administered from 06/15/21 through 06/24/21. -There was a handwritten entry for duloxetine 20mg daily and documented as administered 06/18/21 through 06/24/21. -There was an entry for glimepiride 1mg daily with strike through and "D/C 06/17/21" handwritten over the entry. -Glimepiride was not documented as administered from 06/15/21 through 06/24/21. -There was a handwritten entry for Symbicort 2 puffs every 12 hours; staff initials were circled from 06/18/21 through 06/24/21. -There was an entry on the back of the MAR documenting Symbicort was not administered on 06/23/21 at 8:00am due to awaiting delivery from the pharmacy. -There was a handwritten entry for vitamin D3 25mcg daily and documented as administered 06/18/21 through 06/24/21. Interview with a medication aide (MA) on 06/28/21 at 9:54am revealed: -There was a blood pressure (BP) log sheet for Resident #4 and she had documented the resident's BP that morning (06/24/21). -Resident #4's BP log sheet could not be located. -She had checked Resident #4's BP at 6:00am the morning of 06/24/21. -She did not remember the BP result. -Primary care provider (PCP) orders did not go to	D 358		

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D 358	Continued From page 84 MAs, unless the order was written on the MAR the MAs did not know of new or changed orders. -The Resident Care Coordinator (RCC) entered new and changed orders on the MAR. Interview with a second MA on 06/24/21 at 10:36am revealed: -She could not find a BP log sheet with the MAR for Resident #4. -Resident #4 should have had a BP log sheet because there were parameters written on the MAR with the lisinopril. Interview with Resident #4 on 06/29/21 at 12:29pm revealed he did not remember not getting his inhaler medication. Interview with the RCC on 06/24/21 at 12:13pm revealed: -The orders from the VA clinic were written in a progress note. -She sent a clarification to the provider at the VA clinic on 06/17/21. -Resident #4 had a community based primary care provider (PCP) but was in the process of obtaining services from the VA clinic. -She transcribed the orders from the progress note to Resident #4's MAR on 06/17/21. Second interview with the RCC on 06/24/21 at 4:16pm revealed: -There was confusion over whether to check Resident #4's BP or not because there were two orders for lisinopril on the medication list included on the visit summary from the VA clinic; one order had BP parameters and the other did not. -She received the signed clarification orders from the VA provider that afternoon (06/24/21) for Resident #4 which were an electronically signed copy of the visit form dated 06/17/21.	D 358		

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D 358	Continued From page 85 -Resident #4 was followed by both the community PCP and the VA provider. -She had not notified Resident #4's PCP (VA and/or community) the resident had not received the Breo Ellipta inhaler and glimepiride because those medications were discontinued on 06/17/21 by the VA provider. -She had not notified Resident #4's PCP (VA and/or community) the resident had not had a BP check prior to administration of lisinopril because the order had not been clarified until 06/24/21. -She had not notified Resident #4's PCP (VA and/or community) the resident received the wrong dose of duloxetine because the order was changed on 06/17/21 by the VA provider. -She had not notified Resident #4's PCP (VA and/or community) the resident and received vitamin D3 without an order because there was an order included on the VA visit summary dated 06/17/21. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/25/21 at 11:48am revealed: -The facility faxed the VA visit summary to the pharmacy on 06/17/21. -The medication orders were entered on Resident #4's profile at the pharmacy. -The staff was waiting for clarification orders from the VA provider. Telephone interview with Resident #4's community PCP on 06/29/21 at 1:57pm revealed: -He received a call from the facility on 06/25/21 about changes made to Resident #4's orders from a medication list sent by the VA. -He gave the facility temporary orders until he reviewed the medication list from the VA. -He requested the facility to send the medication list to him for review.	D 358		

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-He was not aware Resident #4 was being seen at the VA.
-He had concern the VA was managing Resident #4, and it was not good for two providers to manage the same resident.
-The changes made in Resident #4's medications were not concerning as long as the changes were instituted and reviewed by the physician.

Third interview with the RCC on 06/28/21 at 3:58pm revealed:
-She was responsible for reviewing the new MARs for accuracy each month.
-She had reviewed the MARs just before 06/01/21.
-She was responsible for new and changed medication orders.
-She faxed orders to the pharmacy and entered the order on the MAR.
-If medications were not in the building, she expected the MAs to let her know so she could contact the pharmacy.

Interview with the Executive Director (ED) on 06/28/21 at 4:30pm revealed:
-She expected MAs to administer the right medication, the right dose and at the right time to the right resident.
-MAs were responsible for making sure medications were available for administration.
-MAs were expected to contact the pharmacy for new medications not received by the pharmacy and to request refills on existing medications.
-The RCC was responsible for transcribing all orders onto the MAR.
-The RCC was responsible for making sure orders that were transcribed on the MAR were legible, complete and signed by the PCP.

2. Review of Resident #1's current FL-2 dated

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D 358	Continued From page 87 03/23/21 revealed: -Diagnoses included hypertension, type II diabetes mellitus and schizophrenia. -There was an order to check finger stick blood sugar (FSBS) levels before meals and at bedtime. Review of a physician's order dated 04/19/21 for Resident #1 revealed an order for Humalog insulin 10 units subcutaneously (SQ) three times daily with meals; hold for FSBS level less than 120 or if resident skips a meal. (Humalog is a fast-acting insulin used to lower blood sugar levels.) Review of Resident #1's blood sugar monitoring form for May 2021 revealed: -There were 121 FSBS results ranging from 51 to 559. -There were 30 FSBS results less than 120. Review of Resident #1's May 2021 medication administration record (MAR) revealed there was an entry for Humalog insulin three times daily with meals; hold for FSBS level less than 120 or if resident skips a meal. Review of Resident #1's May 2021 MAR and blood sugar monitoring form revealed: -There was documentation Humalog insulin 10 units SQ was administered on 12 occasions when Resident #1's FSBS was less than 120. -Examples include, on 05/01/21 at 8:00am the FSBS was 80 and staff documented the administration of 10 units of Humalog; on 05/09/21 at 12:00pm the FSBS was 73 and staff documented the administration of 10 units of Humalog; and on 05/29/21 at 5:00pm the FSBS was 98 and staff documented the administration of 10 units of Humalog.	D 358		

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D 358	Continued From page 88 Review of Resident #1's blood sugar monitoring form for June 2021 revealed: -There were 89 FSBS results ranging from 64 to 571. -There were 31 FSBS results less than 120. Review of Resident #1's June 2021 MAR revealed there was an entry for Humalog insulin three times daily with meals; hold for finger stick blood sugar level less than 120 or if resident skips a meal. Review of Resident #1's June 2021 MAR and blood sugar monitoring form revealed: -There was documentation Humalog insulin was administered on 7 occasions where Resident #1's FSBS was less than 120. -Examples include, on 06/04/21 at 8:00am the FSBS was 104, staff documented the administration of 10 units of Humalog and the FSBS result at 11:00am was 62; on 06/05/21 at 8:00am the FSBS was 73 and staff documented the administration of 10 units of Humalog; and on 06/10/21 at 8:00am the FSBS was 111 and staff documented the administration of 10 units of Humalog. Interview with Resident #1 on 06/28/21 at 9:39am revealed: -He usually received insulin injection four times each day (there was documentation on the MAR of a long acting insulin administered at bedtime). -Staff did not give him insulin when his FSBS was low; his blood sugar had to be over 70. -He used to be able to feel when his FSBS was low, but it was too hard to sense now. Interview with a medication aide (MA) on 06/28/21 at 9:54am revealed:	D 358		

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-She had initialed the 8:00am dose of Humalog on 06/10/21 for Resident #1.
-The dose was held; all doses for FSBS less than 120 were held.
-She probably forgot to circle her initials.

Interview with the Resident Care Coordinator (RCC) on 06/25/21 at 2:03pm revealed:
-She had initialed the 8:00am doses of Humalog on 06/04/21 and 06/05/21 for Resident #1.
-She was aware of the order to hold the dose of Resident #1's FSBS result was less than 120.
-The documentation for the FSBS results was not her handwriting; she did not know what happened.
-She would not have administered the Humalog dose to Resident #1 if his FSBS was less than 120.
-She was probably rushing through documentation, just signed and forgot to circle her initials.
-When a medication was not administered, MAs were expected to circle their initials for that dose on the MAR.
-There was no other place she would have documented the 8:00am doses of Humalog were not administered to Resident #1.

Interview with Resident #1's primary care provider (PCP) on 06/28/21 at 11:33am revealed:
-She saw Resident #1 on 06/28/21 and discontinued the Humalog before meals due to low blood sugars and not being administered frequently.
-Staff had not reported any doses of Humalog being administered to Resident #1 when his FSBS was less than 120.
-Administering Humalog when the FSBS was less than 120 would lower the FSBS level even more.

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Second interview with the RCC on 06/28/21 at 3:58pm revealed:
-If initials were not circled on the MAR and there was no documentation on the back of the MAR, there was no way to know a dose of medication was not given.
-MAs initialed the MAR for medications that had been administered; MAs circled their initials and wrote a note on the back of the MAR for medications that were not administered.
-She did not have a response to the drop in the FSBS result at 11:00am on 06/04/21.
-MAs were expected to look at the MAR and compare medication labels with the MAR when administering medications.

Interview with the Executive Director (ED) on 06/28/21 at 4:30pm revealed:
-MAs were expected to initial the MAR for medications that were administered and circle their initials for medications that were not administered.
-MAs were expected to document on the back of the MAR the reason the medication was not administered.

2. Review of Resident #4's current FL-2 dated 03/31/21 revealed diagnoses included coronary artery disease, atrial fibrillation, congestive heart failure, aortic valve stenosis, hypertension, generalized weakness, depression, hyperlipidemia, diabetes mellitus, and benign prostatic hypertrophy.

a. Review of Resident #4's FL-2 dated 03/31/21 revealed there was a physician's order for breo ellipta inhaler (used to treat breathing disorders) 200-25mcg one puff every day for wheezing.

Review of Resident #4's electronically signed

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D 358	Continued From page 91 hospital discharge summary dated 05/28/21 revealed: -Resident #4 was admitted to the hospital on 05/18/21 with a diagnosis of hypoxia, pneumonia of both lower lobes due to an infectious organism, and hypervolemia (fluid overload) unspecified type. -Resident #4's discharge diagnoses included acute hypoxemic respiratory failure secondary to acute on chronic heart failure with reduced ejection fracture (a measure of how well the heart pumps blood) exacerbation. -Resident #4 was to continue the breo ellipta 200-25mcg. Review of Resident #4's June 2021 medication administration records revealed: -There was an entry for breo ellipta 200-25mcg inhaler one puff every day for wheezing. -The breo ellipta inhaler was documented as administered at 8:00am daily from 06/01/21 through 06/14/21. -There was no documentation of administration for the breo ellipta inhaler from 06/15/21 to 06/23/21. -There was a diagonal line drawn across the breo ellipta printed instructions with a handwritten note of "d/c 6/17/21". Observation of Resident #4's medications on hand on 06/25/21 at 9:50am revealed there was no breo ellipta inhaler available for administration. Interview with the medication aide (MA) on 06/25/21 at 10:07am revealed: -The breo ellipta inhaler was discontinued on the MARs as of 06/17/21. -She had not seen a physician's order to discontinue the breo ellipta inhaler.	D 358		

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Interview with the Resident Care Coordinator (RCC) on 06/25/21 at 2:04pm revealed:
-Resident #4 was not on the breo ellipta inhaler anymore.
-The breo inhaler was discontinued on 06/17/21 based on the medication list from the Veteran's Administration (VA) hospital dated 06/17/21.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 06/29/21 at 1:57pm revealed he had concern with Resident #4's breo ellipta inhaler being stopped.
-Stopping the breo ellipta inhaler could cause Resident #4 to start coughing and wheezing.
-Resident #4 could have an exacerbation of his chronic obstructive pulmonary disease.

Refer to the interview with the Resident Care Coordinator (RCC) dated 06/24/21 at 12:04pm.

Refer to the interview with the Medication Aide (MA) dated 06/25/21 at 10:07am.

Refer to the interview with the Resident Care Coordinator (RCC) dated 06/28/21 at 9:22am.

Refer to the interview with the RCC dated 06/28/21 at 4:00pm.

Refer to the interview with the RCC dated 06/28/21 at 4:52pm.

Refer to the interview with the Executive Director (ED) dated 06/28/21 at 4:54pm.

Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) dated 06/29/21 at 1:57pm.

b. Review of Resident #4's FL-2 dated 03/31/21

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CUMBERLAND VILLAGE ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

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revealed there was a physician's order for cymbalta (used to treat depression) 30mg (milligrams) one capsule daily.

Review of a physician electronically signed hospital discharge summary from a local hospital dated 05/28/21 revealed Resident #4 was to continue the Cymbalta 30mg capsule daily.

Review of a medication list for Resident #4 dated 06/17/21 from a VA hospital revealed:
-The medication list was not signed by a physician.
-There was a printed entry to decrease the duloxetine (generic for Cymbalta) to 20mg once a day.

Review of Resident #4's June 2021 MARs revealed:
-There was a printed entry for Cymbalta 30mg capsule daily with documented administration 06/01/21 through 06/16/21.
-There was a diagonal line drawn across the Cymbalta 30mg printed instructions with a handwritten note of "order changed 6/17/21".
-There was a handwritten entry for Cymbalta 20mg one tablet once a day.
-The Cymbalta 20mg tablet was documented as administered at 8:00am daily from 06/18/21 through 06/25/21.

Observations of medications on hand on 06/25/21 at 9:50am for Resident #4 revealed:
-There were no Cymbalta 30mg capsules available.
-There was a pharmacy labeled medication blister pack for Cymbalta 20mg take one capsule every day, quantity of 28, dispense date of 06/22/21. There were 26 Cymbalta 20mg capsules remaining.

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D 358	Continued From page 94 Telephone interview with Resident #4's PCP on 06/29/21 at 1:57pm revealed he did not have a concern with the decrease in the Cymbalta dose. Refer to the interview with the Resident Care Coordinator (RCC) dated 06/24/21 at 12:04pm. Refer to the interview with the Medication Aide (MA) dated 06/25/21 at 10:07am. Refer to the interview with the Resident Care Coordinator (RCC) dated 06/28/21 at 9:22am. Refer to the interview with the RCC dated 06/28/21 at 4:00pm. Refer to the interview with the RCC dated 06/28/21 at 4:52pm. Refer to the interview with the Executive Director (ED) dated 06/28/21 at 4:54pm. Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) dated 06/29/21 at 1:57pm. c. Review of Resident #4's FL-2 dated 03/31/21 revealed there was a physician's order for Amaryl (used to lower blood sugar) 1mg tablet daily. Review of a physician electronically signed hospital discharge summary dated 05/28/21 revealed Resident #4 was to continue the glimepiride (generic for Amaryl) 1mg tablet daily. Review of a medication list for Resident #4 dated 06/17/21 from a VA hospital revealed: -The medication list was not signed by a physician.	D 358		

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-There was a printed entry to stop the glimepiride.

Review of Resident #4's June 2021 MARs revealed:
-There was a printed entry for Amaryl 1mg tablet every day with breakfast with documented administration 06/01/21 through 06/14/21 at 8:00am.
-There was a diagonal line drawn across the Amaryl printed instructions with a handwritten note of "d/c [discontinue] 6/17/21".
-There was no documentation of administration for 06/15/21 and 06/16/21.

Observations of medications on hand on 06/25/21 at 9:50am for Resident #4 revealed there were no Amaryl 1mg tablets available.

Interview with a medication aide (MA) on 06/25/21 at 10:07am revealed:
-The Amaryl was discontinued on Resident #4's MARs as of 06/17/21.
-She had not seen a physician's order to discontinue administering the Amaryl 1mg tablet for Resident #4.

Interview with the RCC on 06/25/21 at 2:04pm revealed the Amaryl was discontinued on 06/17/21 based on the medication list from the VA hospital dated 06/17/21.

Telephone interview with Resident #4's PCP on 06/29/21 at 1:57pm revealed he did not have a concern with the changes made in Resident #4's medications.

Refer to the interview with the Resident Care Coordinator (RCC) dated 06/24/21 at 12:04pm.

Refer to the interview with the Medication Aide

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(MA) dated 06/25/21 at 10:07am.

Refer to the interview with the Resident Care Coordinator (RCC) dated 06/28/21 at 9:22am.

Refer to the interview with the RCC dated 06/28/21 at 4:00pm.

Refer to the interview with the RCC dated 06/28/21 at 4:52pm.

Refer to the interview with the Executive Director (ED) dated 06/28/21 at 4:54pm.

Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) dated 06/29/21 at 1:57pm.

d. Review of Resident #4's FL-2 dated 03/31/21 revealed a physician's order for tamsulosin (used to treat urinary flow disorders) 0.4mg take two capsules (0.8mg) at bedtime.

Review of an unsigned medication list dated 05/28/21 from a recent hospital stay revealed Resident #4 was to continue the tamsulosin 0.4mg take two capsules (0.8mg) at bedtime.

Review of a physician electronically signed hospital discharge summary dated 05/28/21 revealed Resident #4 was to continue the tamsulosin 0.4mg 24-hour capsule.

Review of Resident #4's June 2021 MARs revealed:
-There was a handwritten entry on the MARs for Flomax (brand name for tamsulosin) 0.4mg take one capsule at bedtime.
-The tamsulosin 0.4mg capsule was documented as administered at 8:00pm daily from 06/17/21

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through 06/22/21.
-There was a diagonal line drawn across the printed entry with instructions for tamsulosin 0.4mg take two capsules at bedtime. There was a handwritten note of "order changed".
-There was documentation of administration for tamsulosin 0.4mg two tablets at 8:00pm daily from 06/01/21 through 06/21/21.
-Based on documentation of administration for the tamsulosin, Resident #4 was administered tamsulosin 0.4mg three tablets from 06/17/21 through 06/21/21.

Observation of Resident #4's medications on hand on 06/25/21 at 9:50am revealed there was no tamsulosin available for administration.

Interview with a medication aide on 06/25/21 at 10:07am revealed:
-Tamsulosin was not in the medication cart.
-The Tamsulosin was not administered last night.
-There was a note stating the facility was waiting on delivery of the Tamsulosin.

Interview with the Resident Care Coordinator (RCC) on 06/25/21 at 2:04pm revealed:
-She sent the tamsulosin back to the pharmacy for repackaging because the tamsulosin was dispensed with two tablets.
-There had been a dosage change for the tamsulosin 0.4mg from two tablets to one tablet.

Telephone interview with Resident #4's PCP on 06/29/21 at 1:57pm revealed:
-The tamsulosin was supposed to help with episodes of urinary incontinence for Resident #4.
-There would not be any lasting effect from the dosage changes of the tamsulosin.

Refer to the interview with the Resident Care

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D 358	Continued From page 98 Coordinator (RCC) dated 06/24/21 at 12:04pm. Refer to the interview with the Medication Aide (MA) dated 06/25/21 at 10:07am. Refer to the interview with the Resident Care Coordinator (RCC) dated 06/28/21 at 9:22am. Refer to the interview with the RCC dated 06/28/21 at 4:00pm. Refer to the interview with the RCC dated 06/28/21 at 4:52pm. Refer to the interview with the Executive Director (ED) dated 06/28/21 at 4:54pm. Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) dated 06/29/21 at 1:57pm. e. Review of a physician electronically signed hospital discharge summary dated 05/28/21 revealed there was a physician's order to start furosemide (used to treat fluid retention) 20mg tablet daily. Review of a physician's order dated 06/08/21 for Resident #4 revealed Resident #4's PCP increased the furosemide to 20mg two times a day. Review of a medication list for Resident #4 dated 06/17/21 from a veteran's administration hospital revealed: -The medication list was not signed by a physician. -There was a printed entry for furosemide 20mg tablet daily.	D 358		

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Review of Resident #4's June 2021 MARs revealed:
-There was a handwritten entry for furosemide 20mg tablet daily with documentation for administration beginning 06/01/21 through 06/07/21.
-There was a handwritten entry for furosemide 20mg tablet twice daily with documentation for administration beginning 06/08/21 through 06/17/21.
-There was a second handwritten entry for furosemide 20mg tablet daily with documentation for administration beginning 06/18/21 through 06/23/21.

Review of physician's orders for Resident #4 revealed the most current physician's order for furosemide was dated 06/08/21 when Resident #4's PCP prescribed furosemide to 20mg twice daily.

Observations of medications on hand on 06/25/21 at 9:50am for Resident #4 revealed there was a pharmacy labeled medication blister pack for furosemide 20mg take one tablet twice daily.

Telephone interview with the contracted provider pharmacy on 06/28/21 at 8:30am revealed:
-Furosemide 20mg twice daily was the most current order on the pharmacy profile which was dated 06/08/21.
-There had not been any change in the instructions for administering the furosemide 20mg since 06/08/21.

Refer to the interview with the Resident Care Coordinator (RCC) dated 06/24/21 at 12:04pm.

Refer to the interview with the Medication Aide (MA) dated 06/25/21 at 10:07am.

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D 358	Continued From page 100 Refer to the interview with the Resident Care Coordinator (RCC) dated 06/28/21 at 9:22am. Refer to the interview with the RCC dated 06/28/21 at 4:00pm. Refer to the interview with the RCC dated 06/28/21 at 4:52pm. Refer to the interview with the Executive Director (ED) dated 06/28/21 at 4:54pm. Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) dated 06/29/21 at 1:57pm. f. Review of a medication list for Resident #4 dated 06/17/21 from a VA hospital revealed: -The medication list was not signed by a physician. -There was a printed entry for cholecalciferol (generic for Vitamin D3, a dietary supplement) 25mcg tablet daily. Review of Resident #4's June 2021 MARs revealed there was a handwritten entry for Vitamin D3 25mcg take one tablet once daily with documentation for administration beginning 06/18/21 through 06/23/21. Review of physician's orders for Resident #4 revealed there was no signed physician's order for the Vitamin D3 25mcg tablet daily. Observations of medications on hand on 06/25/21 at 9:50am for Resident #4 revealed there was a pharmacy labelled medication blister pack for vitamin D3 25mcg take one tablet daily.	D 358		

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D 358	Continued From page 101 Interview with the MA on 06/25/21 at 10:07am revealed she had not seen a physician's order to administer Vitamin D3 to Resident #4. Refer to the interview with the Resident Care Coordinator (RCC) dated 06/24/21 at 12:04pm. Refer to the interview with the Medication Aide (MA) dated 06/25/21 at 10:07am. Refer to the interview with the Resident Care Coordinator (RCC) dated 06/28/21 at 9:22am. Refer to the interview with the RCC dated 06/28/21 at 4:00pm. Refer to the interview with the RCC dated 06/28/21 at 4:52pm. Refer to the interview with the Executive Director (ED) dated 06/28/21 at 4:54pm. Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) dated 06/29/21 at 1:57pm. g. Review of a medication list for Resident #4 dated 06/17/21 from a veteran's administration hospital revealed: -The medication list was not signed by a physician. -There was a printed entry for atorvastatin calcium (generic for Lipitor used to treat high cholesterol) 20mg tablet at bedtime. Review of Resident #4's June 2021 MARs revealed there was a handwritten entry for Lipitor 20mg take one tablet at bedtime with documentation for administration beginning 06/18/21 through 06/22/21 at 8:00pm.	D 358		

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D 358	Continued From page 102 Review of physician's orders for Resident #4 revealed there was no signed physician's order for the Lipitor 20mg tablet daily. Observations of medications on hand on 06/25/21 at 9:50am for Resident #4 revealed there was a pharmacy labelled medication blister pack for atorvastatin 20mg take one tablet bedtime. Interview with the MA on 06/25/21 at 10:07am revealed she had not seen a physician's order to administer atorvastatin to Resident #4. Interview with the RCC on 06/24/21 at 4:20pm revealed: -Resident #4's POA brought her a physician signed copy today (06/24/21) of the 06/17/21 medication list for Resident #4 from the veteran's hospital. -The PCP who signed the 03/31/21 FL-2 for Resident #4 would only be following the resident for lung disorder. Telephone interview with the Medical Assistant at Resident #4's PCP's office on 06/25/21 at 8:57am revealed: -The facility was supposed to follow the physician orders from the PCP because the PCP was signing the orders for Resident #4. -She expected the facility to send any request for medication changes to the PCP to evaluate and sign off on. -There was conflicting information regarding a discharge note (no specifics were provided). Interview with Resident #4 on 06/23/21 at 9:50am revealed: -He was administered medications by the medication aides.	D 358		

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D 358	Continued From page 103 -He did not know the names of his medications. -He denied any missed medications. Refer to the interview with the Resident Care Coordinator (RCC) dated 06/24/21 at 12:04pm. Refer to the interview with the Medication Aide (MA) dated 06/25/21 at 10:07am. Refer to the interview with the Resident Care Coordinator (RCC) dated 06/28/21 at 9:22am. Refer to the interview with the RCC dated 06/28/21 at 4:00pm. Refer to the interview with the RCC dated 06/28/21 at 4:52pm. Refer to the interview with the Executive Director (ED) dated 06/28/21 at 4:54pm. Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) dated 06/29/21 at 1:57pm. _____ Interview with the Resident Care Coordinator (RCC) on 06/24/21 at 12:04pm revealed: -She sent a copy of Resident #4's FL-2 to the VA hospital physician to establish care (no date provided). -She got the unsigned list of medications for Resident #4 from a VA hospital that came with a cover sheet with a VA physician name written on the cover sheet. -She thought the list of medications from the VA hospital was in response to the FL-2 she had faxed to the veteran's hospital. -She had not received a physician signed copy of the medications yet. -She transcribed the medication information from	D 358		

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the VA hospital medication list dated 06/17/21 on to Resident #4's medication administration records (MARs).

Interview with a Medication Aide on 06/25/21 at 10:07am revealed:
-The Resident Care Coordinator (RCC) transcribed orders to the MARs.
-She administered medications according to the instructions transcribed on the MARs.
-If a new order came to the facility during the weekend, the MA may transcribe the order to the residents MARs.
-There was a supervisor in the facility during the weekend who was a MA and could transcribe orders to the residents MARs in the absence of the RCC.
-She never saw the physician orders for residents.
-She did not know why she never saw resident physician orders.

Interview with the RCC on 06/28/21 at 9:22am revealed:-She received new orders.
-She transcribed the changes in orders to the resident MARs by documenting "change or d/c" on the MAR.
-She faxed the new orders to the pharmacy.
-She notified the MAs verbally about medication changes.
-She filed the orders in the resident's record.

Interview with the RCC on 06/28/21 at 4:00pm revealed:
-She expected the MAs to look at the MARs and compare the medication on hand with the instructions on the MARs.
-She performed medication cart audits.
-She tried to perform a medication cart audits monthly to make sure "everything" was in the

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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 105 medication cart. Continued interview with the RCC on 06/28/21 at 4:52pm revealed: -She expected the MAs to always read the resident's MARs. -If a resident's medication was not in the facility, she expected the MAs to let her know so she could get the medication in the facility or get it from back-up. -She expected the MAs to ask her if they had questions. Interview with the ED on 06/28/21 at 4:54pm revealed: -The RCC was responsible for transcribing physician orders to the MARs. -The RCC was responsible to make sure physician orders were complete orders and were signed by the physician. Telephone interview with Resident #4's PCP on 06/29/21 at 1:57pm revealed: -He received a call from the facility on 06/25/21 about changes made to Resident #4's orders from a medication list sent the veteran's hospital. -He gave the facility temporary orders until he reviewed the medication list from the veteran's hospital. -He requested the facility to send the medication list to him for review. -He was not aware Resident #4 was being seen at the veteran's hospital. -He had concern that he was not aware the veteran's hospital was managing Resident #4, and it was not good for two providers to manage the same resident. -The changes made in Resident #4's medications were not concerning as long as the changes were instituted and reviewed by the physician.	D 358		

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D 358	Continued From page 106 The facility failed to administer medications as ordered by the primary care provider (PCP) for 1 of 6 residents observed during the morning medication administration pass (#4) resulting in an error rate of 14% involving an inhaler, an oral diabetic medication, an antidepressant and a supplemental vitamin; and for 2 of 5 sampled residents (#1 and #4) resulting in 19 of 63 opportunities to hold insulin for blood sugar less than 120 being missed (#1) and medications not administered (Breo Ellipta inhaler, Amaryl), or wrong dosages of medications administered (Tamsulosin, Cymbalta, Lasix) according to signed physician's orders, and a medication administered without a signed physician's order (Lipitor) (#4). The facility's failure to administer medications as ordered by the prescribing practitioner was detrimental to the health, safety and well-being of Resident #1 and Resident #4 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/25/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 13, 2021.	D 358		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked	D 421		

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D 421	Continued From page 107	D 421		

by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to document a resident's receipt of the personal needs allowance after payment of the cost of care with a statement being signed by the resident, marked by the resident or responsible person with two witnesses' signatures for 5 of 5 sampled residents.

The findings are:

1. Review of Resident #3's current FL-2 dated 03/06/21 revealed diagnoses included mild mental retardation, anxiety, depression, paranoid schizophrenia and self-mutilation.

Review of Resident #3's Resident Register dated 02/27/01 revealed:
-The resident was admitted to the facility on 02/27/01.
-The resident did not have a responsible person by the time of his admission.

Review of Resident #3's Resident's Personal Funds Agreement revealed there was an "admission and service agreement" signed by resident on
06/12/13.

Review of Resident #3 record revealed a notarized power of attorney signed on 06/02/05.

Review of Resident #3's personal funds ledger

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D 421	Continued From page 108 from April 2021 to June 2021 revealed: -There was a balance forwarded documented in April 2021 for $534.73, in May 2021for $1,780.09 and in June for $1,717.41. -The Special Assistance received was $68 monthly. -There was documentation of a deposit of $1,400 for a third stimulus check on 04/08/21. -There was documentation of cash transactions ranging from $4 up to $50. -There was documentation of a check written on resident's power of attorney name for $1,544.37 on 06/08/21 and signed by resident -The Business Office Manager (BOM) who managed the funds had signed each entry as a witness. -There were no signatures or initials where Resident #3 had documented deposit transactions. -There was no second witness signature. Interview with Resident #3 on 06/28/21 at 9:41am revealed: -He signed every time he received his funds. -He had no concerns about the facility and his money. Refer to the interview with the Business Office Manager dated 06/25/21 at 2:20pm. Refer to the interview with the Executive Director dated 06/28/21 at 10:31am. 2. Review of Resident #1's personal funds ledger from April 2021 to June 2021 revealed: -There was no balance forwarded documented in April 2021. -There was documentation of a balance forwarded in May 2021 for $79 and in June for $0.50.	D 421		

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- The amount of Special Assistance received was documented as $66 monthly.
-The Office Manager (BOM) had signed each entry as a witness.
-There were signatures or initials where Resident #3 had documented each transaction except for deposit transactions.
-There were no second witness signatures.

Interview with Resident #1 on 06/28/21 at 4:44pm revealed:
-He signs every time he gets cash.
-He had no concerns about the facility and his money.

Refer to the interview with the Business Office Manager dated 06/25/21 at 2:20pm.

Refer to the interview with the Executive Director dated 06/28/21 at 10:31am.

3. Review of Resident #2's personal funds ledger from April 2021 to June 2021 revealed:
-There was a balance forwarded documented in April 2021 for $114.40, in May 2021 for $1,437.77 and in June for $1,401.65.
- The amount of Special Assistance received was documented as $66 monthly.
-There was a deposit of $1,400 for a third stimulus check on 04/08/2021.
-The Business Office Manager (BOM) had signed each entry as a witness.
-There were no signatures or initials where Resident #2 had documented deposit transactions.
-There was no second witness signature.

Interview with Resident #2 on 06/28/21 at 4:28pm revealed:
-She signs every time she gets cash.

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D 421	Continued From page 110 -She is always informed about the money she has available. Refer to the interview with the Business Office Manager dated 06/25/21 at 2:20pm. Refer to the interview with the Executive Director dated 06/28/21 at 10:31am. 4. Review of Resident #4's personal funds ledger from April 2021 to June 2021 revealed: - There was documentation of a balance forwarded in April 2021 for $344.85, in May 2021 for $1,438.60 and in June for $1,109.78. -The Business Office Manager (BOM) had signed each entry as a witness. -There were no signatures or initials where Resident #4 had documented deposit transactions. -There were no second witness signatures. Interview with Resident #4 on 06/28/21 at 4:47pm revealed: -He signed every time he received cash. -He has no concerns about facility and his money. Refer to the interview with the Business Office Manager dated 06/25/21 at 2:20pm. Refer to the interview with the Executive Director dated 06/28/21 at 10:31am. 5. Review of Resident #5's personal funds ledger from April 2021 to June 2021 revealed: - There was documentation of a balance forwarded in April 2021 for $268.00, in May 2021 for $78.00 and in June for $48.00. -The Business Office Manager (BOM) had signed each entry as a witness.	D 421		

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D 421	Continued From page 111 -There were no signatures or initials where Resident #5 had documented deposit transactions. -There were no second witness signatures. Refer to the interview with the Business Office Manager dated 06/25/21 at 2:20pm. Refer to the interview with the Executive Director dated 06/28/21 at 10:31am. _____ Interview with BOM on 06/25/21 at 2:20pm revealed: -She was responsible for the documentation on the residents accounts. -She was not aware a second witness was required for each resident's fund transactions. -She was aware that none of the resident's had a second witness signature for transactions documented in resident's funds ledger. Interview with Executive Director on 06/28/21 at 10:31am revealed she was not aware a second witness was required for resident's personal fund transactions.	D 421		
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	D912		

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federal and state laws and rules and regulations related to personal care and supervision, health care, housekeeping and furnishings, nutrition and food service, and medication administration.

The findings are:

1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#5) who experienced an acute increase in falls over a 6 week period from May 2021 to June 2021 resulting in 6 documented falls and emergency room visits for pain and head injury. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].

2. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 3 of 5 sampled (#1, #2, #4) who were referred to a Cardiologist by their Primary Care Physician, a resident (#2) who had orders for home health to treat a leg wound that, and a resident (#1) who was referred to a Podiatrist and Cardiologist. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

3. Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85 or above at all times. Refer to Tag D077, 10A NCAC 13F .0306(a)(4) Housekeeping and Furnishings (Type A2 Violation)].

4. Based on observations, interviews and record reviews, the facility failed to ensure walls, ceilings and floors were clean and in good repair as

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D912	Continued From page 113 evidence by bubbled and peeling paint on walls in resident rooms #18, #38, #40, #43, #44 and #46; yellow and brown staining, peeling paint and holes in the ceilings of resident rooms #18, #19, #43 and #44 , a shared shower room on the E hall and the common area on the E hall; wall mounted air conditioning units without casing exposing foam insulation and a black substance around the wall in resident rooms #18, #38, #43, #44 and #46; leaking water on the floor in room #24, and damaged and missing floor tiles with heavy accumulation of dirt and grime the floors in resident rooms #18, #38 and #40. Refer to Tag D074, 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings (Type B Violation)]. 5. Based on observations and interviews, the facility failed to ensure the kitchen and food storage areas were kept clean and free of contamination. [Refer to Tag D282, 10A NCAC 13F .0904(a)(1) Nutrition and Food Service (Type B Violation)]. 6. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 6 residents observed during the morning medication pass including errors with inhalers, anti-depressant, oral diabetic and supplemental medications (#4). The facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #4) which included to hold Humalog insulin for finger stick blood sugars (FSBS) less than 120 before meals (#1); and an inhaler and an oral diabetic medication not administered, wrong dosages of medications administered including a medication used to treat urinary flow issues, an anti-depressant and a medication used to treat fluid retention, and a medication used to treat high cholesterol administered without a signed	D912		

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D912	Continued From page 114 physician's order (#4). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 7. Based on observations, interviews, and record reviews, the facility failed to ensure the personal care needs for 3 of 5 sampled residents (#1, #2, and #5) were provided related to foot care (#1 and #2) and resident (#5) that required assistance with activities of daily. Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A	D935		

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D935	Continued From page 115 NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff B) performing medication aide duties had completed the 5 and 10, or 15 hour state approved medication aide training program or had verification of previous employment as a medication aide prior to administering medications. The findings are: Review of Staff B's personnel record revealed: -Staff B's hire date was 09/15/20. -Staff B was hired as the Resident Care Coordinator (RCC). -There was documentation Staff B successfully passed the state approved medication aide test on 02/19/16. -There was documentation a medication clinical skills competency validation was completed on 10/30/20.	D935		

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D935	Continued From page 116 -There was no documentation for medication aide employment verification. -There was no documentation the 5,10, or 15-hour medication aide training was completed. Review of resident May 2021 and June 2021 Medication Administration Records (MARs) revealed Staff B documented administration of medications. Interview with Staff B on 06/29/21 at 12:45pm revealed: -She completed medication aide training at the facility that included taking a test. -The nurse with the contracted pharmacy provider signed her off for the 5-hour medication administration training. -She had not completed any other medication aide training at the facility. -She completed some training online and thought that was all the training she needed upon hire. -She remembered completing the 15-hour medication aide training at a previous employer. -She did not provide a copy of the 15-hour state approved medication aide training. -She did not provide medication aide employment verification to the facility upon hire. -She was not hired to work as a medication aide. -She supervised the medication aides. Interview with the Executive Director (ED) on 06/29/21 at 11:50am revealed: -She was responsible for ensuring medication aide training was completed before staff could administer medications. -Upon hire of a medication aide (MA), the 5-hr and 10-hour or 15-hour state approved medication aide training was completed by the contracted pharmacy provider nurse. -She would give the MA a deadline to complete	D935		

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D935	Continued From page 117 the 5/10 hour or 15-hour state approved medication aide training. -She did not have documentation for Staff B completing the 5/10-hour or 15-hour state approved medication aide training. -She did not think Staff B completed the 5/10-hour or 15-hour state approved medication aide training. -She did not know Staff B had not completed the medication aide training. -She usually checked the online portal for the contracted pharmacy provider to ensure the 5/10 hour or 15-hour state approved medication aide training for MAs had been completed. -She usually checked the pharmacy online portal the day before the deadline for the trainings to be completed.	D935		