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	HAL060156	A. BUILDING: _____ B. WING _____	C 08/30/2021

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ELMCROFT OF LITTLE AVENUE	7745 LITTLE AVENUE CHARLOTTE, NC 28226

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from 08/24/21-08/30/21.	D 000		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered within one hour before or one hour after the scheduled times as ordered for 2 of 2 sampled residents (#4 & #8). The findings are: Review of the facility's Medication Administration policy dated 01/21/18 revealed the Resident Services Director (RSD) was to ensure all residents were administered their medications within a two-hour time frame (i.e., one hour before or one hour after the medication order time or unless physician states otherwise) in accordance with the resident's service plan. 1. Observation on 08/24/21 between 9:30am and 10:10am of a medication pass revealed: -There was one Medication Aide (MA) administering medications in the Special Care	D 364		

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D 364	Continued From page 1	D 364		

Unit (SCU).
-The MA administered Resident #4's medications at 9:51am from the medication cart located in activity room of the SCU.

Review of Resident #4's current FL2 dated 04/15/21 revealed diagnoses included dementia with behavioral disturbances, hypertension, arthritis, and hyperlipidemia.

Review of Resident #4's Physician's orders dated 04/15/21 revealed:
-There was an order for aspirin(to treat heart disease) 81mg daily at 8:00am.
-There was an order for metoprolol XL (to treat blood pressure) 25mg daily at 8:00am.
-There was an order for simvastatin (to treat heart disease) 20mg daily at 8:00am.
-There was an order for clonazepam (to treat anxiety) 0.5mg twice daily at 8:00am and 8:00pm.
-There was an order for vitamin B-12 (to treat vitamin B-12 deficiency) 1000mcg once daily at 8:00am.

Review of Resident #4's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for aspirin 81mg daily at 8:00am.
-There was an entry for metoprolol XL 25mg daily at 8:00am.
-There was an entry for simvastatin 20mg daily at 8:00am.
-There was an entry for clonazepam 0.5mg twice daily at 8:00am and 8:00pm.
-There was an entry for vitamin B-12 1000mcg once daily at 8:00am.

Review of Resident #4's August 2021 Medication Administration Compliance report revealed:

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D 364	Continued From page 2	D 364		

-Resident #4's scheduled 8:00am medications; aspirin, metoprolol, simvastatin, clonazepam, vitamin B-12 were documented as administered on 08/02/21 at 9:29am, 08/09/21 at 10:12am, 08/10/21 at 9:29am, 08/13/21 at 9:45am, 08/14/21 at 9:49am, 08/16/21 at 9:14am, 08/17/21 at 9:34am, and 08/24/21 at 9:51am.
-Resident #4's scheduled 8:00am medications were administered late 8 out of 24 days.

Telephone interview with Resident #4's physician on 08/25/21 at 9:30am revealed:
-She did not know Resident #4 received his scheduled 8:00am medications late.
-She expected the facility to notify her to change Resident #4's medication administration times if Resident #4 needed them changed to a later time.

Refer to the interview with the medication aide (MA) on 08/25/21 at 9:30am.

Refer to the interview with the Special Care Coordinator (SCC) on 08/24/21 at 10:15am.

Refer to the interview with the Resident Service Director (RSD) on 08/25/21 at 12:00pm.

Refer to telephone interview with the Administrator on 08/30/21 at 12:50pm.

2. Observation on 08/24/21 between 9:30am and 10:10am of a medication pass revealed:
-There was one Medication Aide (MA) administering medications in the Special Care Unit (SCU).
-The MA administered Resident #8's medications at 10:02am from the medication cart located in activity room of the SCU.

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D 364	Continued From page 3	D 364		

Review of Resident #8's current FL2 dated 07/15/21 revealed diagnoses included depression, dementia, heart disease, hyperthyroidism, constipation, and hypertension.

Review of Resident #8's signed Physician orders dated 07/15/21 revealed:
-There was an order for buspirone (to treat depression)15mg twice daily at 8:00am and 8:00pm.
-There was an order for memantine (to manage dementia) 10mg take twice daily at 8:00am and 8:00pm.
-There was an order for aspirin (to treat heart disease) 81mg daily at 8:00am.
-There was an order for acetaminophen (to treat pain) 1000mg twice daily at 8:00am and 8:00pm.
-There was an order for bupropion SR (to treat depression) 100mg daily at 8:00am.
-There was an order for levothyroxine (to treat hypothyroidism) 75 mcg daily at 8:00am.
-There was an order for lisinopril (to treat hypertension) 20mg daily at 8:00am.
-There was an order for lactulose (to treat constipation) 10gm/15mL twice daily at 8:00am and 8:00pm.

Review of Resident #8's August 2021 Medication Administration Compliance report revealed:
-Resident #8's scheduled 8:00am medications; buspirone, memantine, aspirin, bupropion SR, levothyroxine, lisinopril, and lactulose were documented as administered on 08/06/21 at 9:48am, 08/16/21 at 9:33am, 08/17/21 at 9:48am, 08/19/21 at 9:19am, 08/20/21 at 9:44am, and 08/24/21 at 10:02am.
-Resident #8's scheduled 8:00am medications were administered late 6 out of 24 days.

Attempted telephone interview with the Resident

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	HAL060156	A. BUILDING: _____ B. WING _____	C 08/30/2021

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D 364	Continued From page 4 #8's physician on 08/24/21 at 2:00pm was unsuccessful. Refer to the interview with the medication aide (MA) on 08/25/21 at 9:30am. Refer to the interview with the Special Care Coordinator (SCC) on 08/24/21 at 10:15am. Refer to the interview with the Resident Service Director (RSD) on 08/25/21 at 12:00pm. Refer to telephone interview with the Administrator on 08/30/21 at 12:50pm. _____ Interview with the medication aide (MA) on 08/25/21 at 9:30am revealed: -Sometimes she was late administering medications because when an assigned MA called out, she was on-call and arrived at the facility late. -Sometimes she administered medications late because she was the only MA assigned to the unit and she had to deal with resident's behaviors or emergencies. -The Special Care Coordinator (SCC) was aware of issues causing residents' medication to be administered late. Interview with the Special Care Coordinator (SCC) on 08/24/21 at 10:15am revealed: -There was only one MA assigned to the unit on each shift. -When a MA called out on first shift the third shift MA was expected to begin administering the residents' medications until their relief MA arrived for their shift. -The residents' medication compliance reports were printed weekly and she met with the RSD to discuss it.	D 364		

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D 364	Continued From page 5 -She had not met with the RSD to discuss the residents' medication compliance reports with the RSD the last two months. Interview with the Resident Service Director (RSD) on 08/25/21 at 12:00pm revealed: -The MAs were expected to notify her when they ran into an issue preventing the residents' medications from being administered on time. -She did not know there were episodes of repeated days residents' medications were administered late. -She had not generated a medication compliance report since she started working at the facility in May 2021 because she did not get the time to do it. Telephone interview with the Administrator on 08/30/21 at 12:50pm revealed: -She expected the residents' medications to be administered within a two-hour time frame either one hour before the scheduled medication time or one hour after the scheduled medication times. -The RSD was responsible for printing a medication compliance report weekly to investigate late medication administration times. -If a MA had issues completing the medication pass the RSD or SCC was to talk with them and find out why the medications were administered late. -She did not know the medication compliance report had not been addressed by the RSD capturing the residents' medications that were administered late. -She had not had the time to check with the RSD and be informed the residents' medications were administered late.	D 364		

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D 482	Continued From page 6	D 482		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a	D 482		

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D 482	Continued From page 7	D 482		

device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to esnure full bedrails were used as a physical restraint only after an assessment, care and team planning, use of alternatives were tried and documented, and a writen order by a physician was obtained , for 1 of 1 sampled resident with restraints (Resident #3) that prevented the resident from getting out of his bed without assistance.

The findings are:

Review of Resident #3's current FL2 dated 02/09/21 revealed diagnoses included dementia.

Observation during the tour of the special care unit (SCU) 08/24/21 at 9:25am revealed:
-Resident #3 was lying on his back in a hospital bed in his room, arms across his chest and his eyes closed.
-He was fully dressed under a blanket and responded to verbal cues with single word answers.
-There were 2 full length hospital rails in the raised position on either side of the bed.
-There was a 15 inch yellow foam block on his right side between the hospital rail and his right elbow.

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D 482	Continued From page 8	D 482		

-There was a 12 inch red foam block on his left side side between the hospital rail and his left elbow.
-Resident #3 was not able to explain why he had hospital rails on his bed or how long they had been there.

Review of Resident #3's physician's order dated 06/23/21 revealed:
-An order for a semi-electric hospital bed.
-Associated diagnoses that included: falls, dementia without behavior disturbance, unspecified dementia and impaired functional mobility, balance, gait and endurance.
-There was not an order for bed rails.

Review of Resident #3's current Licensed Health Professional Support (LHPS) quarterly review dated 08/04/21 revealed:
-He required assistance with transferring and ambulation using an assistive device such as a walker.
-He resided in the SCU for safety and structure due to decreased cognition and decreased safety awareness.
-Staff assisted with all personal care and toileting needs.
-Resident #3 did not have any documented LHPS tasks related to physical restraints or alternatives.

Review of the delivery ticket dated 08/19/21 from the durable medical equipment (DME) company revealed:
-The delivery included a semi electric hospital bed, hospital bed mattress, foam and full bed rails.
-The equipment was signed for on 08/19/21 by a staff member.

Review of facility's Physical Restraint Policy dated

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D 482	Continued From page 9 01/23/20 revealed: -Per corporate policy all residents will live in a restraint free environment. -Half bed rails were allowed after a physician's order was received and the interdisciplinary team was not able to provide a successful alternative intervention. -Half bed rails were appropriate for residents that required the for mobility and transitioning purposes only but that had to be approved by a regional director. Interview with a personal care aide (PCA) on 08/26/21 on 1:07pm revealed: -She signed for the semi electric hospital bed on 08/19/21. -The technician with the DME company wheeled the bed into Resident #3's room and put it together. -She noticed that the hospital bed had bed rails attached to the bed when she helped Resident #3 get into bed that night. -The bed rails were in the lowered position and she did not raise them after Resident #3 got into bed. -It did not occur to her to take the bed rails off the bed and she did not know how to remove the bed rails. -She alerted the medication aide (MA) on second shift that Resident #3's hospital bed had bed rails attached and were in the lowered position. Interview with an agency staff PCA on 08/25/21 at 11:18am revealed: -The first day she saw Resident #3 laying in a hospital bed was 08/25/21. -He was asleep in bed with both side rails up when she started her shift on 08/25/21. -She lowered one side of the bed rails this morning to help him get out of bed.	D 482		

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D 482	Continued From page 10 -Resident #3 was not strong enough to lower the bed rail on his own. -She did not receive any information from 3rd shift on how often the bed rails should be up but Resident #3 typically liked to nap in his bed after lunch and she planned to put the bed rails up when he took a nap. -She had not received any training on bed rails or restraints from the facility. Interview with a MA on 08/25/21 at 11:50am revealed: -She thought Resident #3 had been falling less since the hospital bed was delivered. -She saw Resident #3's bed rails were in the up position the morning of 08/25/21 and thought 3rd shift put them up. -She alerted the Resident Services Director (RSD) the bed rails were up on Resident #3's hospital bed and the RSD removed the bed rails. -She knew the hospital bed was delivered with bed rails in the down position and the rails should have been removed. -She received training on restraints and knew not to raise the bed rails on Resident #3's hospital bed. -Appropriate fall interventions for Resident #3 included engaging him in activities, inviting him to sit in the common area and putting a wedge or pillow in the bed to keep him from rolling around in the bed. Telephone interview with a second MA on 08/26/21 at 10:19am revealed: -She worked 2nd and 3rd shifts and had observed Resident #3 on the floor after he fell out of his bed multiple times. -She never saw him fall out of the bed. -The first time she saw him in a hospital bed was 08/23/21.	D 482		

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D 482	Continued From page 11 -The bed rail closest to the window was in the up position on her evening rounds and she did not lower it into the down position. -She assumed he had an order for the bed rail since he had a history of frequent falls. -Resident #3 did not have the dexterity in his hands to lower the bed rail or climb over the bed rail. Interview with the SCU Manager on 08/25/21 at 11:35am revealed: -Resident #3 had experienced frequent falls mainly due to rolling out of bed and onto the floor. -A hospital bed was delivered on 08/19/21. -Staff placed foam wedges in the bed to help keep him from rolling around in the bed. -She knew bed rails were considered a restraint and they should not be raised on Resident #3's hospital bed. Interview with the RSD on 08/25/21 at 12:27pm revealed: -Resident #3 was on a high risk list due to multiple falls so the physician wrote an order for a hospital bed. -Resident #3's hospital bed was delivered on 08/19/21 with bed rails attached. -Typically the DME company asked the facility if the bed rails should be delivered but the company did not ask this time. -Bed rails were not allowed in the facility. -She was not aware Resident #3's hospital bed had bed rails attached until 08/25/21. -She removed the bed rails after staff alerted her the morning of 08/25/21. -If a physician ordered bed rails for a resident, then she would have elevated the situation to the facility's corporate office to decide the outcome. -Staff were trained during new hire orientation on the use of bed rails and restraints.	D 482		

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D 482	Continued From page 12 -Staff from agency staffing companies were required to provide a skills checklist for the facility to review and restraint training should have been included. Interview with the Administrator on 08/30/21 at 12:33pm revealed: -Restraints were not allowed in the facility. -If she saw a hospital bed delivered with bed rails attached, she would tell the DME company to remove the bed rails. -She did not see Resident #3's hospital bed when it was delivered. -She expected the first staff who saw the bed rails to report them to a supervisor or management. -The Maintenance Director or DME company were expected to remove the bed rails. Interview with the Regional Director of Quality Services on 08/25/21 at 3:45pm revealed the facility was restraint free and the bed rails should have been addressed when the hospital bed was delivered. Attempted telephone interview with Resident #3's Primary Care Physician on 08/25/21 at 3:22pm was unsuccessful. Attempted telephone interview with Resident #3's family member on 08/25/21 at 2:00pm was unsuccessful. Based on observations, interviews and record review it was determined that Resident #3 was uninterviewable.	D 482		