STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: _____ B. WING _____	R 02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 01/27/22 and 01/28/22, and 01/31/22 and 02/01/22.	D 000		
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: Based on record review and interviews, the facility failed to ensure follow up for a referral for 1 of 5 sampled residents (Resident #1) related to an order for computed tomography (CT) scan of the cervical spine to rule out a fracture. The findings are: Review of Resident #1's current FL2 dated 03/21/21 revealed: -Diagnoses included Lewy body dementia, Parkinson's disease, and psychosis with hallucinations. -Semi-ambulatory with a walker. Review of Resident #1's chart notes revealed: -On 09/09/21 at 10:00pm the Resident Care Coordinator (RCC) performed a head to toe assessment due to complaints of neck and shoulder pain and an x-ray was ordered. -On 09/10/21 at 8:13am Resident #1 reported he had pain in his neck mostly and the facility's contracted mobile x-ray company was contacted to obtain an x-ray. -On 09/10/21 at 9:48am, a mobile x-ray order was obtained from palliative care. -On 09/13/21 at 9:55am, Resident #1's right	D 273	D273 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. The community Resident Care Director or designee will ensure appropriate referrals and follow-up of routine and acute health care needs of residents. • Medication aides and nurses will be retrained on resident care policy regarding notifying physician or healthcare provider of changes in condition using the Notification of Condition Changes communication form. The RCD or MCD will review correspondence with providers to ensure a response is received in a timely manner and new orders and referrals are completed. Documentation of communication of referrals to the resident's responsible party will be made in the chart notes. • RCD and MCD will monitor the 24-hour communication logs and Physician Notification forms routinely.	3/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Rees Jaffe Bailey — TITLE: Executive Director — (X6) DATE: 3/4/2022

Julie Grooms Reviewed and Acknowledged with Revisions via telephone 03/07/22

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D 273	Continued From page 1	D 273		

middle finger was bruised and swollen and the primary care provider (PCP) would be visiting the facility to assess.
-On 09/13/21 at 7:35pm, the PCP ordered an x-ray of the right hand.
-On 09/16/21 at 7:16pm, "late entry for 09/09/21" the supervisor reported she called the PCP to get an order for an x-ray of the spine and right shoulder.
-On 09/17/21 at 5:44am, Resident #1 complained of neck and shoulder pain.
-On 09/18/21 at 5:45am, Resident #1 complained of neck and shoulder pain.
-On 09/23/21 at 6:00am, Resident #1 asked for his cream for neck and shoulder pain then proceeded to ask for a pain medication because the cream "didn't help a bit".
-On 09/23/21 at 9:47pm, resident complained of being sore and had small red marks on his back from a fall that morning.

Review of Resident #1's chart notes revealed there was no documentation regarding a fall prior to a fall documented on 09/23/21.

Review of Resident #1's record revealed there was no Incident and Accident Report for a fall sustaining injuries requiring medical evaluation available for review in September 2021 prior to 09/23/21.

Review of Resident #1's radiology interpretation from the facility's contracted mobile x-ray company dated 09/10/21 revealed:
-The lateral view of the cervical spine was obscured by overlying soft tissues and a fracture could not be excluded.
-A clinical evaluation or CT scan was recommended for trauma and high suspicion of fracture.

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D 273	Continued From page 2 Review of Resident #1's physician's progress note dated 09/13/21 revealed: -An x-ray was completed of the right hand for diagnoses of bruising, swelling, and local pain following a fall. -No acute fracture or dislocation of the right hand was demonstrated. Review of Resident #1's physician order dated 09/16/21 revealed there was an order for a CT of cervical spine. Review of Resident #1's record revealed there was no CT of the cervical spine report available for review. Interview with the RCC on 01/31/22 at 12:58pm revealed: -Resident #1 did not have an Incident and Accident Report filled out prior to the fall on 09/23/21. -She started working for the facility in October 2021 and did not know why an Incident and Accident Report was not filled out for Resident #1's fall sustaining injury to the neck and right shoulder requiring medical evaluation in September 2021. -The medication aides (MA's) were responsible for filling out Incident and Accident Reports and gave them to the RCC or Special Care Unit (SCU) Coordinator to fax to the local county Department of Social Services (DSS). -There was an order for a CT cervical spine for Resident #1 on 09/16/21 that was never completed. Telephone interview with the facility's contracted Hospice nurse on 02/01/22 at 10:03am revealed: -Resident #1 was admitted to Hospice on	D 273		

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D 273	Continued From page 3 01/26/22 due to diagnoses of Parkinson's disease, dementia, and chronic pain with a decline in health status and decreased mobility. -She was not aware if Resident #1 had experienced any falls. Telephone interview with the PCP on 02/01/22 at 11:22am revealed: -Resident #1 had a different PCP when he fell in September 2021. -There was a note by the former PCP on 09/13/21 the former SCU coordinator called and reported bruising and swelling to right middle finger when Resident #1 fell, and staff heard a "cracking" sound. -The former PCP ordered an x-ray on 09/10/21 for neck and shoulder pain. -The SCU coordinator called on 09/16/21 and requested an order for a CT scan of the cervical spine for Resident #1 because the x-ray could not rule out a fracture. -There were no notes by the former PCP that a CT of cervical spine was completed for Resident #1 or of any notification by the facility that the CT was not completed. Interview with the Administrator on 02/01/22 at 3:30pm revealed: -The RCC and SCU coordinator were responsible for making sure orders for health care follow-ups and referrals were completed for residents. -She did not know why Resident #1 did not have a CT of the cervical spine completed after it was ordered on 09/16/21.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health	D 280		

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D 280	Continued From page 4 Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly licensed health professional support (LHPS) assessments were completed for 2 of 2 sampled residents (#1 and #2) with LHPS tasks for ambulation with assistive devices (#1) and finger stick blood sugars (FSBS) three times weekly (#2). The findings are: 1. Review of Resident #1's current FL2 dated 03/21/21 revealed:	D 280	D280 10A NCAC 13F .0903(c) Licensed Health Professional Support (LHPS) The community Resident Care Director, RN or Designee with RN licensure will ensure compliance with the requirements for the Licensed Health Professional Support for each resident requiring tasks as outlined in the rule. • The community will amend the policy on health assessment and service plan to address the specific tasks requiring the Licensed Health Professional Support. This will include using the state recommended forms for documentation of assessment findings and quarterly updates. • The Resident Care Director or designee will be responsible for completing the initial assessment within 30 days of admission or within 30 days of the date the resident develops the need for the task and at least quarterly thereafter. Documentation of assessments and care plans, updates, and revisions will be noted and signed, and dated by the RN or other licensed health professional as appropriate. • A system will be established to track due dates for quarterly LHPS assessments and monthly random chart audits will be	~~3/30/2022~~ 03/04/22

			conducted by the Executive Director to ensure continued compliance with the regulation. • Completion date: 3/4/2022	

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D 280	Continued From page 5 -Diagnoses included Lewy body dementia, Parkinson's disease, and osteoarthritis. -Semi-ambulatory with a walker. Review of Resident #1's LHPS quarterly review dated 12/22/21 revealed: -Personal care task was marked ambulation using assistive devices that requires physical assistance. -Physical assessment as related to diagnoses was documented as "stable" and no assessment was provided. -The signature/title line was not signed but had the name of the Resident Care Coordinator stamped on the document with title documented as registered nurse (RN). Review of the weekly rehabilitation summary dated 01/19/22 from the facility's contracted rehabilitation company revealed Resident #1 was a 2 person assist with transfers and limited gait with 2 people. Telephone interview with Resident #1's responsible person on 01/31/22 at 1:37pm revealed: -Resident #1's health status declined, and he required additional assistance from staff with transfers. -Resident #1 had experienced several falls within the past year. -Resident #1 used to be ambulatory with a walker about 6 months ago but now used a wheelchair for mobility. Interview with the RCC/LHPS nurse on 01/31/22 at 5:10pm revealed: -She was hired by the facility in October 2021 as the RCC and assumed the role of LHPS nurse. -The facility's contracted pharmacy completed the	D 280		

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D 280	Continued From page 6 previous LHPS task for Resident #1. -She completed the LHPS quarterly evaluation for Resident #1 on 12/22/21. -She did not know she had to document an assessment related to why Resident #1 needed LHPS task and could not write "stable" for the assessment. -She did not know she had to sign the LHPS document with her signature and title. Refer to the interview with the Administrator on 02/01/22 at 3:30pm. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. 2. Review of Resident #2's current FL2 dated 09/16/21 revealed: -Diagnoses included dementia, Alzheimer's disease, and type 2 diabetes. -There was an order for FSBS 3 times per week. Review of Resident #2's LHPS quarterly review dated 12/22/21 revealed: -Personal care task was marked collecting and testing of fingerstick blood samples. -Physical assessment as related to diagnoses was documented as "stable" and no assessment was provided. -The signature/title line was not signed but had the name of the Resident Care Coordinator stamped on the document with title documented as registered nurse (RN). Interview with the RCC/LHPS nurse on 01/31/22 at 5:10pm revealed: -She was hired by the facility in October 2021 as the RCC and assumed the role of LHPS nurse. -The facility's contracted pharmacy completed the	D 280		

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D 280	Continued From page 7 previous LHPS task for Resident #2. -She completed the LHPS quarterly evaluation for Resident #2 on 12/22/21. -She did not know she had to document an assessment related to why Resident #2 needed LHPS task for FSBS and could not write "stable" for the assessment. -She did not know she had to sign the LHPS document with her signature and title. Refer to the interview with the Administrator on 02/01/22 at 3:30pm. Attempted interview with Resident #2's responsible person on 01/31/22 at 2:10pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Interview with the Administrator on 02/01/22 at 3:30pm revealed: -The facility's contracted pharmacy provided the previous LHPS evaluations for residents who required LHPS tasks to be completed. -The RCC hired in October 2021 was a registered nurse and completed the LHPS evaluations for residents. -She did not know why the RCC/LHPS nurse documented "stable" for the assessments and did not document why the LHPS tasks were needed.	D 280		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened	D 307		

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D 307	Continued From page 8 liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure diet orders were clarified for 2 of 5 sampled residents (Resident #2 and #4) related to a resident with a regular diet ordered and served a no concentrated sweets diet (#2) and a second resident who had an order for a regular diet and was served a lactose free diet (#4). The findings are: 1. Review of Resident #2's current FL-2 dated 09/16/21 revealed: -Diagnoses included dementia, Alzheimer's disease, and type 2 diabetes. -An order for a regular diet. -Fingerstick blood sugars (FSBS) 3 times per week. Review of Resident #2's previous FL-2 dated 08/07/20 revealed an order for a no concentrated sweets (NCS) diet. Review of the facility's therapeutic diet list revealed Resident #2 was to be served an NCS diet. Observation of the kitchen on 01/27/21 at 10:10am revealed there was therapeutic diet	D 307	D307 10A NCAC 13F .0904(e)(1) Nutrition and Food Service The community will ensure that each resident has a specific diet order prescribed by their physician or healthcare provider on file. • The community will ensure that the diets offered by the community are approved by a registered dietitian and have a list of foods or description of items that will be included in special diets. The Dining Director will monitor compliance that diets are served matching specific orders. • The Resident Care Director and Memory Care Director will perform an audit of all diets ordered and ensure correct diets are on file with the Dining Director. • Residents on special diets (those on diets other than Regular) will be identified on a diet board by name and specific diet type or consistency. • The diet board will be maintained by the Dining Director or designee and updated with new admissions, discharges, and new diet orders. • In-service refresher training on all types of diets we provide and select restrictions to assist with specific needs of residents for	3/30/2022

			responsible staff will be completed by 3/30/2022. • Routine reviews of all residents modified diets will be completed by the Dining Director, Resident Care and Memory Care Director. Changes will be made as needed, weekly report verifications and updates to "resident tray cards." • Resident tray cards to be posted on the display board at the expo hot line for review by cooks, servers, and care staff. • Dining Director or designee will conduct pre-shift huddles to discuss any diet order changes and communicate to all staff for awareness. • Monitoring compliance will be done by Dining Director or designees random observations and audits at mealtimes of diets served compared to diets ordered. • Completion date: 3/30/2022 .	

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D 307	Continued From page 9 menu available for NCS diet. Interview with the Special Care Unit (SCU) coordinator on 01/27/21 at 4:50pm revealed: -Resident #2's current FL-2 was filled out incorrectly by the former SCU Coordinator and the primary care provider (PCP) accidentally signed the order for a regular diet instead of an NCS diet. -The SCU Coordinator was responsible for clarifying questionable orders with the PCP. -She was employed by the facility approximately three months and did not have a chance to review records for accuracy of diet orders. Refer to the interview with the Administrator on 02/01/22 at 3:30pm. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. 2. Review of Resident #4's current FL-2 dated 05/10/21 revealed: -Diagnoses included dementia, reflux, esophagitis, and eosinophilic colitis. -Regular diet. Review of Resident #4's previous FL-2 revealed an order for a regular diet. Review of the facility's therapeutic diet list revealed Resident #4 was to be served a lactose free diet. Observation of the kitchen on 01/27/21 at 10:10am revealed there was no therapeutic diet menu available for a lactose free diet.	D 307		

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D 307	Continued From page 10 Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 4:58pm revealed: -She did not know why Resident #4 was listed on the therapeutic diet menu as lactose free because she had only been ordered regular diets previously. -She was employed by the facility approximately three months and did not have a chance to review records for accuracy of diet orders. -The RCC was responsible for clarifying questionable orders with the PCP. Refer to the interview with the Administrator on 02/01/22 at 3:30pm. Interview with the Administrator on 02/01/22 at 3:30pm revealed: -She did not know why the former RCC did not clarify the regular diets ordered for residents when they were being served therapeutic diets. -The RCC had been employed for about 3 months and was still transitioning into her role in the company and had not gotten diet orders clarified. -Resident #2 and #4 were receiving the therapeutic diets instead of the regular diets ordered.	D 307		
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	D 358	D358 10A NCAC 13F .1004(a) Medication Administration The community will assure that the preparation and administration of medications will be done in accordance with prescribed orders and that medication is available in the community for each resident as prescribed. • The Resident Care Director or designee will retrain the	3/30/2022

			medication aides on the proper procedures for monitoring as needed medications that expire, matching medications on the cart to prescribed orders, notifying the prescriber if an as needed medication has not been requested or needed for more than 90 days. • The Resident Care Director or designee will institute a process for medication cart audits for availability of medications. • A report will be run each month from the EMAR to review any as needed medication not given in the last 90 days. • The Resident Care Director and Memory Care Director will review the cart audit findings and conduct random audits monthly for the next three months. • Medication cart audits are completed by the Pharmacy on the quarterly basis. • Completion date: 3/30/2022	

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D 358	Continued From page 11 and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were available for administration for 3 of 5 sampled residents (#1, #3, and #4) related to, a medication used to treat anxiety and agitation (#1), a medication used to treat dry eyes and a medication used to treat cough (#3), and a medication used to treat anxiety, a medication used to reduce secretions, and a medication used to treat cold sores (#4). The findings are: Review of the facility's Medication Policy revealed: -The preferred pharmacy should be asked to review residents electronic Medication Administration Records (eMARS) and inspect the medication carts at least quarterly. -The Resident Care Coordinator (RCC) was responsible for reviewing eMARs each day for any variances or omissions with follow-up as needed. -The RCC or pharmacy consultant will review residents charts on a regular basis to ensure that physician's orders are on file for all medications on the eMARs and that orders and eMARs documentation match. -The hot box was to be used for any new order, refill, repack, or request. -If a medication was not available from the pharmacy or they were completely out of a medication, staff were to immediately notify the RCC. -The RCC was to check the hot box daily for any missing medications. -The RCC verified that all items were moved to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: _____ B. WING _____	R 02/01/2022

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ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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D 358	Continued From page 12 the RCC box on the medication cart and on the eMAR. 1. Review of Resident #3's current FL2 dated 04/22/21 revealed diagnoses included progressive supranuclear palsy, macular degeneration, hypertension, congestive heart failure and hypercholesterolemia. a. Review of Resident #3's current FL2 dated 04/22/21 revealed there was an order for hyoscyamine (used to reduce secretions) 0.125mg every 4 hours as needed. Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for hyoscyamine 0.125mg every 4 hours as needed. -Hyoscyamine 0.125mg every 4 hours as needed was not documented as administered from 12/01/21 through 12/31/21. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for hyoscyamine 0.125mg every 4 hours as needed. -Hyoscyamine 0.125mg every 4 hours as needed was not documented as administered from 01/01/22 through 01/31/22. Observation of Resident #3's medications on hand on 01/31/22 at 2:50pm revealed Hyoscyamine 0.125mg was not available for administration. Interview with a Medication Aide (MA) on 01/31/22 at 3:15pm revealed: -Resident #3 Hyoscyamine 0.125mg had not been used, had expired and was either returned	D 358		

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D 358	Continued From page 13 to the pharmacy or destroyed. -He should have contacted the PCP to discontinue the medication as it had not been used in greater than 90 days. -The facility should keep as needed medications on hand and if cart audits had been conducted it would have been discovered the medication was not available for administration. -He did not know when a cart audit had last been conducted. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 02/01/22 at 9:04am revealed: -Hyoscyamine 0.125mg was originally ordered on 07/15/2020 and 30 tablets were dispensed on 07/16/2020. -As needed medications were only refilled upon request and they had never been contacted by the facility for a refill. -The pharmacy did not track medication returns unless it was a controlled substance, so they did not know if the Hyoscyamine 0.125mg was returned or destroyed at the facility. Telephone interview with Resident #3's Primary Care Provider (PCP) on 02/01/22 at 10:10am revealed: -Resident #3 was receiving hospice care and hyoscyamine 0.125mg was a routine order for comfort care. -Resident #3 did not need hyoscyamine at this time and the facility should have contacted her to discontinue the medication. Refer to the interview with the RCC on 01/31/22 at 5:10pm. Refer to the interview with the Administrator on 02/01/22 at 3:30pm.	D 358		

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D 358	Continued From page 14 b. Review of Resident #3's current FL2 dated 04/22/21 revealed there was an order for lorazepam (used to reduce anxiety & agitation) 0.5mg every 4 hours as needed. Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lorazepam 0.5mg every 4 hours as needed. -Lorazepam 0.5mg every 4 hours as needed was not documented as administered from 12/01/21 through 12//31/21. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for lorazepam 0.5mg every 4 hours as needed. -Lorazepam 0.5mg every 4 hours as needed was not documented as administered from 01/01/22 through 01/31/22. Observation of Resident #3's medications on hand on 01/31/22 at 2:50pm revealed Lorazepam 0.5mg was not available for administration. Interview with a Medication Aide (MA) on 01/31/22 at 3:15pm revealed: -Resident #3's Lorazepam 0.5mg had not been used, had expired and was either returned to the pharmacy or destroyed. -He should have contacted the PCP to discontinue it as it had not been used in greater than 90 days. -The facility should keep as needed medications on hand and if cart audits had been conducted it would have been discovered lorazepam was not available for administration. -He did not know when a cart audit had last been	D 358		

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D 358	Continued From page 15 conducted. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 02/01/22 at 9:04am and 2:00pm revealed: -Lorazepam 0.5mg was originally ordered on 07/15/2020 and 42 tablets were dispensed on 07/16/2020. -As needed medications were only refilled upon request and they had never been contacted by the facility for a refill. -The 42 tablets of Lorazepam 0.5mg that were dispensed on 07/16/2020 were returned to the pharmacy on 12/24/21. Review of Resident #3's Controlled Substance County Sheet (CSCS) revealed: -The CSCS was for lorazepam 0.5mg. -There was a hand-written note documenting the medication was expired and returned to the pharmacy on 12/24/21. Telephone interview with Resident #3's Primary Care Provider (PCP) on 02/01/22 at 10:10am revealed: -Resident #3 was receiving hospice care and lorazepam 0.5mg was a routine order for comfort care. -Resident #3 did not need lorazepam at this time and the facility should have contacted her to discontinue the medication. Refer to the interview with the RCC on 01/31/22 at 5:10pm. Refer to the interview with the Administrator on 02/01/22 at 3:30pm. c. Review of Resident #3's record revealed there was an order dated 09/15/21 for Abreva (used to	D 358		

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D 358	Continued From page 16 treat cold sores) 10% topical cream applied to lip every hour as needed. Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Abreva 10% topical cream. -Abreva 10% topical cream was not documented as administered from 12/01/21 through 12/31/21. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for Abreva 10% topical cream. -Abreva 10% topical cream was not documented as administered from 01/01/22 through 01/31/22. Observation of Resident #3's medications on hand on 01/31/22 at 2:50pm revealed Abreva 10% topical cream was not available for administration. Interview with a Medication Aide (MA) on 01/31/22 at 3:15pm revealed: -Resident #3 Abreva 10% topical cream was not needed after the cold sore healed in September 2021 so it was not reordered. -He should have contacted the PCP to discontinue the Abreva as it was no longer needed. -The facility should keep as needed medications on hand and if cart audits had been conducted it would have been discovered the medication was not available for administration. -He did not know when a cart audit had last been conducted. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on	D 358		

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D 358	Continued From page 17 02/01/22 at 9:04am revealed: -Abreva 10% topical cream was originally ordered on 09/15/21 and 1 tube was dispensed on 09/15/21. -As needed medications were only refilled upon request and they had never been contacted by the facility for a refill. Telephone interview with Resident #3's Primary Care Provider (PCP) on 02/01/22 at 10:10am revealed: -Resident #3 was receiving hospice care and hyoscyamine 0.125mg and lorazepam 0.5mg were routine orders for comfort care. -Resident #3's cold sore healed in September 2021 and therefore no longer needed Abreva and the facility should have contacted her to discontinue it. Refer to the interview with the RCC on 01/31/22 at 5:10pm. Refer to the interview with the Administrator on 02/01/22 at 3:30pm. 2. Review of Resident #1's current FL2 dated 03/21/21 revealed: -Diagnoses included Lewy body dementia and psychosis with hallucinations. -There was a medication order for hydroxyzine (used to treat anxiety or agitation) 25mg take 1 tablet every 6 hours as needed for anxiety or agitation. Review of Resident #1's September 2021 eMAR revealed: -There was an entry for hydroxyzine 25 take 1 tablet every 6 hours as needed for anxiety or agitation. -There was no documentation hydroxyzine 25mg	D 358		

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D 358	Continued From page 18 was administered from 09/01/21 through 09/30/21. Review of Resident #1's October 2021 eMAR revealed: -There was an entry for hydroxyzine 25 take 1 tablet every 6 hours as needed for anxiety or agitation. -There was documentation hydroxyzine 25mg was administered on 10/04/21 at 8:04pm. Review of Resident #1's November 2021 eMAR revealed: -There was an entry for hydroxyzine 25 take 1 tablet every 6 hours as needed for anxiety or agitation. -There was no documentation hydroxyzine 25mg was administered from 11/01/21 through 11/30/21. Review of Resident #1's December 2021 eMAR revealed: -There was an entry for hydroxyzine 25 take 1 tablet every 6 hours as needed for anxiety or agitation. -There was no documentation hydroxyzine 25mg was administered from 12/01/21 through 12/31/21. Review of Resident #1's January 2022 eMAR revealed: -There was an entry for hydroxyzine 25 take 1 tablet every 6 hours as needed for anxiety or agitation. -There was no documentation hydroxyzine 25mg was administered 01/01/22 through 01/31/22. Observation of Resident #1's medications on hand on 01/31/22 at 4:22pm revealed there was no hydroxyzine 25mg available for administration.	D 358		

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D 358	Continued From page 19 Interview with a medication aide (MA) on the Special Care Unit (SCU) on 01/31/22 at 4:25pm revealed: -Resident #1's hydroxyzine 25mg was not available for administration on the medication cart. -The MA's were responsible for ordering residents' medications when they ran out or were unavailable for administration. -Resident #1's hydroxyzine was last dispensed on 09/25/21 in the amount of 60 tablets and had only been documented as administered once on 10/04/21 since the dispense date. -Resident #1 should have 59 tablets of hydroxyzine available for administration. -He did not know why Resident #1's hydroxyzine was missing from the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 02/01/22 at 9:05am revealed: -Resident #1's hydroxyzine 25mg was last dispensed on 09/25/21 with a quantity of 60 tablets. -The previous dispense date for Resident #1's hydroxyzine 25mg was on 07/21/21 with a quantity of 60 tablets. Telephone interview with Resident #1's primary care provider (PCP) on 02/01/22 at 11:22am revealed: -He had never known Resident #1 to have episodes of anxiety and did not think he needed hydroxyzine ordered. -Resident #1's former PCP ordered hydroxyzine for Resident #1. -He did not know if Resident #1 had ever been administered the hydroxyzine for anxiety.	D 358		

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D 358	Continued From page 20 Refer to the interview with the RCC on 01/31/22 at 5:10pm. Refer to the interview with the Administrator on 02/01/22 at 3:30pm. 3. Review of Resident #3's current FL2 dated 05/10/21 revealed diagnoses included dementia and anxiety. a. Review of Resident #3's physician order dated 05/10/21 revealed there was a medication order for artificial tears (a medication used to treat dry eyes) apply 1 drop in each eye twice daily as needed. Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for artificial tears apply 1 drop in each eye twice daily as needed. -There was no documentation artificial tears were administered from 12/01/21 through 12/31/21. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for artificial tears apply 1 drop in each eye twice daily as needed. -There was no documentation artificial tears were administered from 01/01/22 through 01/31/22. Observation of Resident #3's medications on hand on 01/31/22 at 4:47pm revealed artificial tears eye drops were unavailable for administration. Interview with a medication aide (MA) 01/31/22 at 4:25pm revealed: -Resident #3's artificial tears eye drops were missing from the medication cart and not	D 358		

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D 358	Continued From page 21	D 358		

available for administration.
-She did not know why Resident #3's artificial tears were not on the medication cart.
-She was recently hired by the facility and did not know who completed medication cart audits or how often they were completed.
-Resident #3 did not need artificial tear eye drops since she had worked for the facility.

Telephone interview with a representative from the facility's contracted pharmacy on 02/01/22 at 9:05am revealed Resident #3's artificial tear eye drops were last dispensed on 02/24/21 in the quantity of 15ml.

Telephone interview with Resident #1's primary care provider (PCP) on 02/01/22 at 11:22am revealed:
-Resident #3's artificial tear eye drops were ordered by the former PCP and were for comfort.
-He expected ordered medications to be available for administration.

Refer to the interview with the RCC on 01/31/22 at 5:10pm.

Refer to the interview with the Administrator on 02/01/22 at 3:30pm.

b. Review of Resident #3's physician order dated 05/10/21 revealed there was a medication order for guaifenesin (a medication used to treat cough) take 15ml as directed as needed.

Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for guaifenesin take 15ml as directed as needed.
-There was no documentation guaifenesin 15ml

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D 358	Continued From page 22 was administered from 12/01/21 through 12/31/21. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for guaifenesin take 15ml as directed as needed. -There was no documentation guaifenesin 15ml was administered from 01/01/22 through 01/31/22. Observation of Resident #3's medications on hand on 01/31/22 at 4:47pm revealed guaifenesin was unavailable for administration. Interview with a medication aide (MA) 01/31/22 at 4:25pm revealed: -Resident #3's guaifenesin was missing from the medication cart and not available for administration. -She did not know why Resident #3's guaifenesin was not on the medication cart. -She was recently hired by the facility and did not know who completed medication cart audits or how often they were completed. -Resident #3 did not need the guaifenesin since she had worked for the facility. Telephone interview with a representative from the facility's contracted pharmacy on 02/01/22 at 9:05am revealed Resident #3's guaifenesin was last dispensed on 01/03/22. Telephone interview with Resident #1's primary care provider (PCP) on 02/01/22 at 11:22am revealed: -Resident #3's guaifenesin was ordered for a cough/congestion as needed. -He expected ordered medications to be available for administration.	D 358		

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D 358	Continued From page 23 Refer to the interview with the RCC on 01/31/22 at 5:10pm. Refer to the interview with the Administrator on 02/01/22 at 3:30pm. Interview with the Resident Care Coordinator (RCC) on 01/31/22 at 5:10pm revealed: -She and the Special Care Unit (SCU) Coordinator were responsible for medication cart audits and reordering missing or low medications from the medication cart. -She did not know how often medication cart audits were completed. -The company's policy regarding medication cart audits was to be completed quarterly. -She had not completed a medication cart audit since she was hired in October 2021. -The medication aide (MA) was responsible for ordering residents' medications when they were low or had run out. -The facility used cycle fill for medications from the facility's contracted pharmacy, but as needed medications were not included in cycle fill and had to be requested. -She did not know why the medications missing from the medication carts had not been requested to be refilled. Interview with the Administrator on 02/01/22 at 3:30pm revealed: -Scheduled medications were refilled by the facility's contracted pharmacy on a cycle fill but the RCC or SCU Coordinator had to request refills for as needed medications. -Medication cart audits were supposed to be performed on a weekly basis by the 3rd shift MA's but due to staffing issues cart audits had not been completed recently.	D 358		

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D 358	Continued From page 24 -A representative from the facility's contracted pharmacy performed medication cart audits quarterly. -Medication cart audits had not been completed since the RCC and SCU Coordinator were still transitioning in their roles at the facility. -She did not know when the last medication cart audits were completed.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) of incidents resulting in injury requiring emergency medical attention treatment for 2 of 4 sampled residents (#1 and #3) related to an injury to the right hand and middle finger caused by a staff member and a fall with a possible cervical spine fracture (#1) and a fall with head injury and side pain (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 03/21/21 revealed: -Diagnoses included dementia, Parkinson's disease, psychosis, and hallucinations.	D 451	D451 10A NCAC 13F. 1212 Reporting of Accidents and Incidents The community will ensure the incident reports are completed. The county department of social services is notified of any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medication treatment other than first aid. • The Med-Tech or manager on duty will complete a resident incident or accident report and document all the care given in the resident's chart along with the list of individuals notified. • The Executive Director or Resident Care Director will consult on proper follow-up related to state and county reporting family and physician notification and update the resident care plan. • The community will notify the county department of social services within the required	3/30/2022

			regulatory timeframe hours of the initial discovery or knowledge by the staff of an incident or accident requiring medical treatment or referral for emergency medical evaluation. • The Regional nurse will review the incident reporting policy and procedure with the Resident and Memory care Director on 3/1/2022. • Resident Care Director will Inservice the Med-Techs on incident reporting, investigation, and reporting process. New Med Techs will be educated during the new hire orientation. • The facility will monitor incident reporting procedures Monday through Friday at morning stand-by meetings. The manager on duty will monitor incident reporting procedures on Saturday and Sunday. Reportable events will be audited and reviewed weekly at the care coordination meeting. • Completion date: 3/30/2022	

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	HAL011338	A. BUILDING: _____ B. WING _____	R 02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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D 451	Continued From page 25 -Intermittently confused. -Level of care was documented as assisted living-memory care. a. Interview with the Resident Care Coordinator (RCC) on 01/31/22 at 1:45pm revealed there was no documentation of an Incident and Accident Report for Resident #1 dated 09/09/21 for a staff member causing injury of bruising and swelling to Resident #1's right hand and middle finger requiring medical evaluation and an x-ray for a possible fracture. Review of Resident #1's chart notes revealed: -On 09/09/21 at 10:00pm, the RCC performed a head to toe assessment on the resident and had small, circular bruising noted to the "backs of his hands". -On 09/13/21 at 9:55am, the residents right middle finger was bruised and swollen. Family was notified. The primary care provider (PCP) was at the facility and would assess the resident's hand. -On 09/13/21 at 7:35pm, the PCP ordered an x-ray of Resident #1's right hand. The right middle finger was swollen and bruised on both sides. The resident reported it was painful. -On 09/15/21 at 7:34pm, it was documented the Administrator spoke with Resident #1's responsible person and the x-ray results were "negative for an acute injury" to the resident's right hand and middle finger. Interview with the RCC on 01/31/22 at 12:58pm revealed: -There was no Incident and Accident Report filled out for the incident on 09/09/21 for Resident #1. -The PCP ordered an x-ray of Resident #1's right hand and middle finger on 09/11/21. -The Medication Aide (MA) was responsible for	D 451		

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D 451	Continued From page 26 filling out Incident and Accident Reports resulting in injury or emergency medical assistance and she would fax the reports to DSS. Interview with the Administrator on 02/01/22 at 3:30pm revealed: -She was "certain" an Incident and Accident Report had been filled out for Resident #1 in September 2021 when a staff member was "too rough" while assisting the resident but could not locate the report. -The MA's were responsible for filling out Incident and Accident Reports and gave them to the SCU coordinator to fax to DSS if the resident resided on the SCU. -She expected staff to fill out Incident and Accident Reports when they occurred. -She did not know why an Incident and Accident Report was not filled out for the September 2021 incident with Resident #1. b. Review of Resident #1's radiology interpretation from the facility's contracted mobile x-ray company dated 09/10/21 revealed: -The lateral view of the cervical spine was obscured by overlying soft tissues and a fracture could not be excluded. -A clinical evaluation or CT scan of the cervical spine was recommended for trauma and high suspicion of fracture. Review of Resident #1's Incident and Accident Reports for September 2021 revealed there were no reports filled out prior to 09/23/21. Interview with the RCC on 01/31/22 at 12:58pm revealed: -Resident #1 did not have an Incident and Accident Report filled out prior to the fall on 09/23/21.	D 451		

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D 451	Continued From page 27 -She did not know why an Incident and Accident Report was not filled out for Resident #1's fall sustaining injury to the neck and right shoulder requiring medical evaluation in September 2021. -The medication aides (MA's) were responsible for filling out Incident and Accident Reports and gave them to the RCC or Special Care Unit (SCU) Coordinator to fax to the local county Department of Social Services (DSS). Interview with the Administrator on 02/01/22 at 3:30pm revealed: -She did not know why an Incident and Accident Report was not filled out for Resident #1 in September 2021 prior to the fall on 09/23/21. -She knew any falls requiring medical evaluation required an Incident and Accident Report to be filled out and faxed to the local county DSS. -The MA's were responsible to fill out the Incident and Accident Reports and give them to the SCU coordinator to fax. -She expected staff to follow the facility's policy for reporting incidents and accidents. 2. Review of Resident #3's current FL2 dated 04/22/21 revealed diagnoses included progressive supranuclear palsy, macular degeneration, hypertension, congestive heart failure and hypercholesterolemia.	D 451		

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D 451	Continued From page 28 Review of Resident #3's chart notes dated 06/04/21 revealed: -There was documentation Resident #3 was found on the floor in her room, had a knot on the back of her head and Resident #3's side was painful. -There was documentation Resident #3's family member was notified but the family member did not want Resident #3 transported to the hospital for evaluation. -There was documentation Hospice and emergency personnel were contacted and responded, vital signs were obtained, Resident #3 was helped back into bed and pain medication was administered. Review of Resident #3's record revealed no accident and incident report for the 06/04/21 incident was available for review. Interview with the RCC on 01/31/22 at 12:58pm revealed: -There was no incident and accident report filled out for the incident on 06/04/21 for Resident #3. -The Medication Aide (MA) was responsible for filling out incident and accident reports resulting in injury or emergency medical assistance and she would fax the reports to DSS. -She did not know why there was not an incident and accident report filled out for Resident #3 on 06/04/21 because she had been employed by the facility for 3 months. Interview with the Administrator on 02/01/21 at 4:00pm revealed: -She did not know why an Accident-Incident report could not be located. -She thought the corporate office may have a copy of the Accident-Incident report since they always want a copy.	D 451		

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