STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081042	A. BUILDING: _____ B. WING _____	R 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE RETIREMENT HOME	1600 U.S. HIGHWAY 221 S. FOREST CITY, NC 28043

(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 Rutherford County Department of Social Services conducted an annual and follow-up survey on 04/12/22 through 04/14/22.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 5 exit doors accessible to a resident who was known to be constantly disoriented, had a history of wandering, and who eloped from the facility twice without staff knowledge were equipped with a sounding device when the door was opened. The findings are: Review of the undated facility policy and	D 067		

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procedure for a missing resident revealed:
-There was no documentation provided on prevention of elopements or use of door alarms.
-After an incident of elopement, a plan would be developed to ensure elopement would not reoccur.

Interview with the Resident Care Coordinator (RCC) on 04/12/22 at 8:00am revealed there were 33 residents who resided at the facility.

Observation during the facility tour on 04/12/22 at 8:00am revealed:
-The sunroom entrance door was not locked.
-The sunroom entrance door alarm was not engaged.
-There was no sounding device activated upon entering the front entrance.

Observation of the upstairs exit door on 04/12/22 at 3:30pm revealed:
-There was a flight of stairs that led down to another door and directly accessed the outside of the facility.
-There was a white alarm box attached to the door frame set to the off position.
-There was no sound from the alarm box when the door was held in an open position.

Observation of the exit door off the short hallway leading to the smoking area on 04/12/22 at 3:36pm revealed:
-There were 2 white alarm boxes attached to the door frame with 2 white plastic pieces attached to the door.
-There was no sound from either alarm box when the door was opened and held in an open position.

Review of Resident #4's current FL2 dated

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04/13/22 revealed:
-Diagnoses included dementia, intellectual disability, and paranoid schizophrenia.
-He was ambulatory.
-He was constantly disoriented and had a history of wandering.
-Recommended level of care was documented as Special Care Unit.

Review of Resident #4's Care Plan dated 03/08/22 revealed:
-Resident #4 had a significant loss of memory and must be directed.
-Resident #4 was always disoriented.
-Resident #4 was "more confused" and eloped from the facility on 03/07/22.
-Staff would increase monitoring checks.

Interview with the RCC on 04/12/22 at 10:33am revealed Resident #4 eloped on 03/07/22 and 04/10/22.

Interview with a personal care aide (PCA) on 04/12/22 at 3:00pm revealed:
-The alarm on the back door was turned off until 7:30pm every evening.
-The door alarm on the back door leading to the smoking area was turned on with the sound engaged around 7:30pm every night.
-Resident #4's room was upstairs on the second floor.
-She did not know if the upstairs exit door that led down a flight of stairs to directly access the outside of the building had an alarm.
-She did not think Resident #4 was aware of the exit door on the second floor.
-Resident #4 would only try to go out the living room door which had an alarm engaged at all times.
-She did not know which door Resident #4 had

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D 067	Continued From page 3	D 067		

exited when he eloped from the facility on 03/07/22 or 04/10/22.

Second interview with the RCC on 04/12/22 at 4:20pm revealed:
-Resident #4 was confused and had eloped from the facility twice with 2 additional attempts of elopement on 04/10/22.
-Not all exit doors at the facility had alarms with the sound engaged to alarm when the door was opened.

Interview with the Administrator on 04/13/22 at 1:25pm revealed:
-The door alarm on the second-floor exit door was turned off.
-Resident #4 eloped on 04/10/22 by exiting the facility from the second-floor exit door.
-The door alarm on the second floor was not set to alarm because staff would not hear the alarm and because "we don't have to".

Interview with a MA on 04/13/22 at 1:49pm revealed:
-Resident #4 had eloped once before the 04/10/22 incident.
-The facility staff "just tried" to keep a "closer eye on him".
-Some doors at the facility had alarms that worked, and some door alarms did not work.
-One of the MAs that worked on weekends informed the Administrator some of the door alarms needed to be replaced.

Telephone interview with Resident #4's guardian on 04/13/22 at 3:57pm revealed:
-She did not remember an alarm sounding when she opened the door at the facility when visiting Resident #4 on 03/31/22.
-The RCC ensured her Resident #4 knew his

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D 067	Continued From page 4 "boundaries" and was not supposed to leave the facility's property. -She was concerned Resident #4 was able to elope from the facility a second time and staff were unaware. [Refer to tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision] _____ The failure of the facility to ensure exit doors accessible to Resident #4 who was known to have a diagnosis of dementia, a history of wandering, and intellectual disability were equipped with sounding device that activated when the doors were opened, which resulted in Resident #4 eloping from the facility twice without staff knowledge. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 29, 2022.	D 067		
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.	D 270		

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D 270	Continued From page 5 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#1 and #4) which resulted in a resident who set fires inside the facility twice requiring evacuation of the facility (#1) and another resident who eloped from the facility twice (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 03/08/22 revealed: -Diagnoses included schizoaffective disorder. -Recommended level of care was documented as domiciliary with rest home typed in the box. -Resident #1 was intermittently disoriented. -There was no documentation for inappropriate behaviors. Review of Resident's #1 Care Plan dated 03/21/22 revealed: -The mental health section had documentation Resident #1 was physically and verbally abusive, behaviors were more aggressive, and Resident #1 was injurious to self, others, and property. -Resident #1 was given a 30-day discharge notice due to violent behaviors towards staff. -Placement had not been found with the correct level of care to the meet the Resident #1's needs. Review of the local Department of Social Services (DSS) Complaint Intake form dated 03/20/22 revealed: -The complainant call was taken at 6:06pm. -It was reported that Resident #1 started 2 fires inside the facility and the residents were evacuated.	D 270		

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D 270	Continued From page 6 -Resident #1 was "hateful" and had caused "trouble" at the facility. Review of the local Department of Social Services (DSS) Complaint Intake form dated 03/26/22 revealed: -The complaint call was taken at 12:59pm and was made by the same complainant who called on 03/20/22. -The complainant wanted to follow-up on the complaint made on 03/20/22. -Resident #1 was "dangerous" and "mean". -The other residents residing at the facility were "afraid" of Resident #1. Attempted review of the Incident and Accident Reports on 04/12/22 at 12:00pm for the fires started inside the facility revealed there were no Incident and Accident Reports provided. Attempted review of the facility's Monitoring Logs for increased supervision checks for Resident #1 on 04/12/22 at 12:00pm revealed there were no monitoring logs. Observation of Resident #1 04/12/22 at 8:21am revealed: -He was sitting in a chair at the designated smoking area while smoking with a lighter in his hand. -No staff were present for supervision of Resident #1. Observation of Resident #1 on 04/12/22 at 8:51am revealed: -He was outside smoking and had a lighter in his hand. -No staff were present for supervision of Resident #1.	D 270		

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D 270	Continued From page 7 Observation of Resident #1 on 04/12/22 at 10:37am revealed: -He walked out to the smoking area with another resident and asked the other resident to borrow their lighter. -No staff were present for supervision of Resident #1. Observation of Resident #1 on 04/12/22 at 4:02pm revealed: -He walked out to the smoking area and asked another resident to borrow their lighter. -No staff were present for supervision of Resident #1. Observation of Resident #1 on 04/13/22 at 9:30am revealed: -He walked out to the smoking area and asked another resident to borrow their lighter. -No staff were present for supervision of Resident #1. Observation of Resident #1 on 04/13/22 at 12:15pm revealed: -He was outside smoking and had a lighter in his hand. -No staff were present for supervision of Resident #1. Observation of Resident #1 on 04/13/22 at 2:28pm revealed: -He was outside smoking and had a lighter in his hand. -No staff were present for supervision of Resident #1. Observation of Resident #1 on 04/14/22 at 8:29am revealed: -He was outside smoking and had a lighter in his hand.	D 270		

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D 270	Continued From page 8 -No staff were present for supervision of Resident #1. Interview with the Resident Care Coordinator (RCC) on 04/12/22 at 3:00pm revealed: -She had not informed staff to increase supervision for Resident #1 since Resident #1 had experienced increased aggressive behaviors and possibly set the 2 fires at the facility. -She had not found placement for Resident #1 since a discharge notice was given to Resident #1. -Facility staff were not able to keep lighters or cigarettes away from Resident #1. -She had not reached out to other Mental Health resources in the county for placement for Resident #1. Second interview with the RCC on 04/12/22 at 4:20pm revealed there were no facility Monitoring Logs for increased supervision checks for Resident #1 but the facility staff "just knew" to watch Resident #1 closely and check on Resident #1 every 30 minutes. Interview with the Administrator on 04/13/22 at 1:25pm revealed he suspected Resident #1 of setting both fires at the facility. Telephone interview with Resident #1's primary care provider (PCP) on 4/13/22 at 4:05pm revealed Resident #1 had mental health issues and behaviors that were being treated by a Psychologist. Telephone interview with Resident #1's Psychologist on 4/13/22 at 4:19pm revealed: -Resident #1 was a new patient and she saw Resident #1 once on 04/04/22. -The facility staff reported to her Resident #1	D 270		

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started the 2 fires set at the facility on 03/20/22.

Interview with another resident on 04/14/22 at 9:24am revealed:
-He wanted Resident #1 to leave the facility.
-He was fearful of Resident #1.
-Resident #1 started 2 fires inside the facility and put the other residents in danger.

Interview with a personal care aide (PCA) on 04/14/22 at 10:27am revealed she was not told by management to increase supervision checks to every 30 minutes for Resident #1 due to the fires set inside the facility.

Telephone interview with the local Fire Marshall on 04/14/22 at 10:57am revealed:
-The local fire department responded to 2 fires intentionally set inside the facility on 03/20/22.
-The first fire was in the morning and set in the upstairs bathroom with a cigarette shoved inside a toilet paper roll.
-The same brand of cigarette used to start the fire was also found in Resident #1's room.
-The second fire was in the evening and started in a trashcan in the downstairs common bathroom which caught the shower curtain on fire.

Interview with Housekeeping staff on 4/14/22 at 11:30am revealed she was not informed by management to increase supervision checks or monitoring for Resident #1.

Based on observations, interviews and record reviews it was determined that Resident #1 was not interviewable.

2. Review of the undated, facility's policy and procedure for a missing resident revealed:

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-Enlist staff to begin a search of the entire building and grounds.
-Notify the resident's responsible person and police.
-Continue to search by foot or automobile.
-Report the missing resident to the Supervisor MA and fill out an Incident/Accident Report.
-"Work on a plan to ensure that this never can occur again".

Review of Resident #4's current FL2 dated 04/13/22 revealed:
-Diagnoses included dementia, intellectual disability, and paranoid schizophrenia.
-He was ambulatory.
-He was constantly disoriented and documented as a wanderer.
-Recommended level of care was documented as Special Care Unit.

Review of Resident #4's Resident Register dated 12/02/19 revealed:
-An admission date of 12/02/19.
-He had a local Department of Social Services (DSS) worker listed as his guardian.

Review of Resident #4's Care Plan dated 03/08/22 revealed:
-A significant loss of memory and must be directed.
-Orientation was documented as always disoriented.
-There was documentation Resident #4 was "more confused" and eloped from the facility on 03/07/22.
-There was documentation staff would increase monitoring checks.

Review of Resident #4's Incident and Accident Report dated 03/07/22 revealed:

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-Resident #4 eloped from the facility and was found on the side of the highway by a medication aide (MA) and was brought back to the facility.
-Resident #4 was missing from the facility approximately 10 minutes.
-A new FL2 was completed by the facility to have Resident #4 transferred to a facility with a Special Care Unit (SCU) since the facility did not have a SCU.

Review of Resident #4's Incident and Accident Report dated 04/10/22 revealed:
-Resident #4 tried to elope twice from the facility on 04/10/22 and was escorted to the smoking area and given a cigarette so staff could monitor him from the window.
-Resident #4 was observed by staff reentering the facility and went upstairs.
-Staff searched the facility and could not locate Resident #4 and was observed by 2 other residents outside the exit door at the bottom of the stairs.
-Resident #4 was found by staff approximately 3 to 4 miles from the facility.

Interview with the Resident Care Coordinator (RCC) on 04/12/22 at 10:33am revealed:
-Resident #4 eloped on 04/10/22.
-Resident #4 eloped once before on 03/07/22.

Interview with a personal care aide (PCA) on 04/12/22 at 3:00pm revealed:
-Resident #4's room was upstairs on the second floor.
-She did not think Resident #4 was aware of the exit door located on the second floor.
-Resident #4 would only try to go out the living room door.
-She did not know which door Resident #4 had exited when he eloped from the facility on

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03/07/22 or 04/10/22.
-She "tried" to lay eyes on Resident #4 every "couple" hours to make sure he was at the facility.

Second interview with the RCC on 04/12/22 at 4:20pm revealed:
-Resident #4 was confused and had eloped from the facility 3 times.
-He last eloped on 04/10/22 and was found by facility staff "a couple" miles down the road.
-The facility had increased monitoring checks on Resident #4 to every 30 minutes after he first eloped.
-She did not have a monitoring check log for Resident #4 because staff "knew" to increase monitoring and would just look for him in the facility every 30 minutes to make sure Resident #4 had not eloped.

Telephone interview with the primary care provider (PCP) on 04/13/22 at 11:00am revealed:
-Resident #4 had dementia and intellectual disability and she had seen a cognitive decline in Resident #4 over the past several months.
-She signed a new FL2 for Resident #4 with recommended level of care documented as SCU on 03/08/22 after Resident #4 eloped the first time on 03/07/22.
-There was no documentation logged into the computer on 04/10/22 that the facility notified the on-call provider Resident #4 eloped from the facility a second time.
-She expected the facility to notify her or the on-call provider the same day of any elopements of residents.
-Resident #4 could have wandered off and not been found, fallen and been hurt, hit by a vehicle, or been picked up by an unknown person.
-Resident #4 was in increased danger because he did not have good judgement.

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-She expected the facility staff to closely monitor Resident #4 after the first elopement until the facility could find proper placement at a facility with a SCU for Resident #4.

Interview with the Administrator on 04/13/22 at 1:25pm revealed:
-The facility's policy for elopement would include getting the resident transferred to a SCU as soon as possible.
-Resident #4 eloped on 04/10/22 by exiting the facility from the second-floor exit door.

Interview with a MA on 04/13/22 at 1:49pm revealed:
-She lived on the same property as the facility.
-One of the weekend MAs called around 12:00pm on 04/10/22 and said Resident #4 was missing from the facility.
-She drove around and found Resident #4 off the main highway.
-She assisted Resident #4 across the highway to her vehicle and returned Resident #4 back to the facility.
-Resident #4 had eloped once before the 04/10/22 incident.
-The facility staff "just tried" to keep a "closer eye on him".
-Another resident at the facility would sit with Resident #4 and "keeps an eye on him" for the facility staff.

Telephone interview with Resident #4's guardian on 04/13/22 at 3:57pm revealed:
-She had recently taken over guardianship of Resident #4 within the last couple weeks.
-There was documentation in the computer system the RCC notified the previous guardian of an elopement on 03/08/22.
-She asked the RCC on 03/31/22 when she

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visited the facility if she needed to find placement for Resident #4 at another facility with a SCU and she was told she could find placement elsewhere, but "all was fine".
-The RCC assured her Resident #4 knew his "boundaries" and was not supposed to leave the facility's property.
-The RCC reported Resident #4's roommate was a "trigger" and had been changed so Resident #4 did not need to be placed at another facility because Resident #4 had not tried to elope again.
-Resident #4 could not carry on a conversation and if he eloped and became lost he would not be able to tell anyone he was lost or where he resided.
-She was concerned Resident #4 was able to elope from the facility a second time and staff were unaware.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

_____

The facility failed to provide supervision for a resident, who had diagnoses of schizoaffective disorder with intermittent confusion who had set 2 fires inside the facility on 03/20/22 requiring evacuation of the facility (Resident #1) and another resident with diagnoses of dementia and intellectual disability, resulting in elopement from the facility on 03/07/22 and 04/10/22 (Resident #4). This failure placed all the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation.

_____

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 04/12/22 for this violation.

CORRECTION DATE FOR THE TYPE A2

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D 270	Continued From page 15 VIOLATION SHALL NOT EXCEED MAY 12, 2022.	D 270		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure that each resident had the opportunity to participate in at least one outing every other month. The findings are: Observation during the facility tour on 04/12/22 at 9:55am revealed the activity calendar was posted in the dining room. Review of the activity calendar revealed there were no outings scheduled on the calendar. Interview with one resident on 04/12/22 at 8:48am revealed the facility did not offer any outings for him to participate in. Interview with a second resident on 04/12/22 at 9:40am revealed: -He stayed at the facility too much. -He did not get to get out and go anywhere.	D 319		

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-Not getting to go out sometimes was "killing" him.
-As a result, he just laid around and did not do anything.
-It made him "crazy."
-He did not know what to do about it.
-He felt "terrible."
-The Administrator used to take the residents out to eat once a year at a restaurant.
-They would go to see fireworks on the fourth of July.
-They would go to church on Easter.
-Lately, they did not get to go anywhere.
-He did not know what he would do if he was not able to get out.

Interview with a third resident on 04/12/22 at 9:45am revealed it had been awhile since she had been on an outing.

Interview with a fourth resident on 04/12/22 at 10:12am revealed:
-It had been a long time since he had been on a outing.
-He would enjoy going on an outing.

Interview with the personal care aide (PCA) on 04/12/22 at 3:00pm revealed she oversaw the activities Monday through Thursday every week.

Interview with the PCA on 04/13/22 at 3:30pm revealed:
-The last outing offered to residents was around October 2021 and 5 residents were taken on a boat ride on a lake where the Administrator lived.
-The facility did not offer any other outings.

Interview with the Administrator on 04/13/22 at 3:34pm revealed:
-The facility used to offer outings to go shopping

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D 319	Continued From page 17 at a local store but stopped the outings because of COVID-19. -Only the residents that were semi-ambulatory or ambulatory were offered to participate in past outings. -The last outings offered to some of the residents was in July 2021 and October 2021 with a boat ride on the lake at his lake house.	D 319		
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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 12 sampled residents (#2 and #6) observed during medication pass including errors with a breathing treatment (#2) and a medication to treat gastroesophageal reflux disease (#6) and for 1 of 5 residents (#2) sampled for record review errors with an anticoagulation medication (#2). The findings are: 1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 30	D 358		

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opportunities during the 12:00pm medication pass on 04/12/22 and the 8:00am medication pass on 04/13/22.

a. Review of Resident #2's current FL2 dated 03/08/22 revealed:
-Diagnoses included congestive heart failure, atrial fibrillation, and dementia.
-There was an order for Duoneb (used to prevent and treat wheezing and shortness of breath) 0.5mg-3mg/3ml 1 vial via nebulizer four times daily.

Observation of the medication pass for Resident #2 on 04/12/22 revealed at 12:04pm, the noon medication aide (MA) administered magnesium oxide (used to as a supplement, an antacid, and a laxative) 400mg 1 tablet to Resident #2.

Review of Resident #2's April 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Duoneb 0.5mg-3mg/3ml use 1 vial in nebulizer four times daily scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The Duoneb 0.5mg-3mg/3ml 1 vial was documented as administered on 04/12/22 at 12:00pm.
-The Duoneb was documented as refused one time on 04/13/22 (no time documented).

Interview with the Resident Care Coordinator (RCC) on 04/12/22 at 2:20pm revealed:
-Resident #2 frequently refused his Duoneb nebulizer treatments.
-The staff would administer the Duoneb nebulizer treatments if he wanted to take them.

Review of Resident #2's February 2022 to March

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2022 eMAR revealed:
-There were entries on both eMARs for Duoneb 0.5mg-3mg/3ml use 1 vial in nebulizer four times daily scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The Duoneb 0.5mg-3mg/3ml 1 vial was documented as administered as ordered from 02/01/22 to 02/28/22 with one refusal documented on 02/05/22 at 8:00pm.
-The Duoneb 0.5mg-3mg/3ml 1 vial was documented as administered as ordered from 03/01/22 to 03/31/22 with three refusals on 03/14/22 at 12:00pm, 03/21/22 at 12:00pm, and on 03/31/22 at 4:00pm.

Interview with the MA on 04/12/22 at 2:21pm revealed:
-Resident #2's Duoneb nebulizer treatment was scheduled for 12:00pm.
-Resident #2 had refused to take the Duoneb treatment on 04/12/22 at 12:04pm when offered.
-She documented administering the medication even though she did not administer it to the resident.
-Another MA went back at 1:45pm and was able to get Resident #2 to take the Duoneb nebulizer treatment.

Interview with a second MA on 04/13/22 at 1:45pm revealed:
-She administered Resident #2's Duoneb on 04/12/22 between 11:30am and 11:40am.
-The other MA had attempted to get Resident #2 to take the Duoneb earlier and he had refused to take it.
-She knew the other MA was "overwhelmed" and administered the Duoneb to Resident #2 herself to help the other MA.
-She did not document the Duoneb administration on 04/12/22 at 11:30am.

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D 358	Continued From page 20 Observation of the nebulizer machine on the bedside table in Resident #2's room on 04/12/22 at 2:59pm revealed: -The nebulizer machine was labeled in permanent marker with another person's name (it was not the name of a current resident). -The nebulizer face mask was coated in dust and did not look as if it had just been used to administer a treatment. Interview with Resident #2 on 04/12/22 at 2:57pm revealed: -He had not used the nebulizer machine on his bedside table in "a couple months." -The staff had not been administering his breathing treatment. -He thought the Duoneb order had been discontinued. -He was not having trouble breathing at that time. -He did however have a hard time breathing "a couple months ago." -He did not feel he needed the nebulizer treatment four times a day now. Observation of Resident #2's medications on hand on 04/12/22 at 3:44pm revealed: -There were two boxes of Duoneb 0.5mg-3mg/3ml vials. -There were 55 3ml vials remaining of a quantity of 60 vials with a dispense date of 10/06/21 in the first box with 5 refills remaining. -There were 25 3ml vials remaining of a quantity of 60 vials with a dispense date of 11/19/19 with an expiration date of 05/2021. Telephone interview with a representative from the facility's contracted pharmacy on 04/12/22 at 3:55pm revealed: -The last breathing treatment order for Resident	D 358		

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#2 was Duoneb 0.5mg-3mg/3ml 1 vial four times a day dated 10/06/21.
-They dispensed 360ml (120 vials/2 boxes with 60 vials) a 30-day supply of the Duoneb on 10/06/21.
-They had not received another order.
-They had not dispensed any additional Duoneb for Resident #2.

Observation of Resident #2's medications on hand on 04/13/22 at 3:46pm revealed:
-There were two boxes of Duoneb 0.5mg-3mg/3ml vials.
-There were 50 vials remaining of quantity of 60 vials with a dispense date of 10/06/21 in the first box.
-There were 60 vials remaining of quantity of 60 vials with a dispense date of 10/06/21 in the second box.
-There were 60 vials remaining of quantity of 60 vials with a dispense date of 04/12/22 in the third box.
-The expired Duoneb vials observed on 04/12/22 at 3:44pm had been returned to the pharmacy.

Interview with the MA on 04/13/22 at 3:47pm revealed the second box of 60 vials of Duoneb dispensed on 10/06/21 must have been in the storage cabinet on 04/12/22, but she had not seen it as being in the inventory.

Telephone interview with Resident #2's primary care provider (PCP) on 04/13/22 at 8:04am revealed:
-Resident #2 was prescribed Duoneb nebulizer treatments to treat chronic obstructive pulmonary disease.
-She had refilled the Duoneb on 10/06/21 as a continuation order from Hospice.
-Resident #2 had been on oxygen continuously

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with Hospice.
-She discontinued the oxygen.
-The Duoneb order had not been discontinued or changed.
-Resident #2 was supposed to still receive the Duoneb as it was ordered.
-Back in October 2021, Resident #2 had needed the medication and it would have made a "big difference" in his symptoms.
-Resident #2 was at an increased risk for wheezing, shortness of breath, and tightness in his chest when he did not receive the Duoneb as ordered.
-The times she had seen Resident #2 "lately" his respiratory status had been "stable."
-She felt the Duoneb nebulizer treatments could now be changed to as needed.

Review of Resident #2's PCP order dated 04/13/22 revealed:
-Discontinue Duoneb nebulizer treatments four times a day scheduled.
-Change Duoneb nebulizer treatments to four times a day as needed for shortness of breath.
-Check oxygen saturation twice daily.
-In two weeks, report to the PCP if oxygen saturations are less than 90%.

Interview with the Administrator on 04/14/22 at 4:30pm revealed:
-It was the facility's policy to administer medications as they were prescribed to their residents.
-If Resident #2 had refused the Duoneb nebulizer treatments he would have expected an MA or the RCC to notify the PCP and obtain a discontinue order for the medication.
-Staff should not sign off they administered the medication if they did not administer it.

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b. Review of Resident #6's current FL2 dated 10/28/21 revealed:
-Diagnoses included dyspepsia (discomfort or pain in the upper abdomen after eating or drinking), dementia, and essential hypertension.
-There was an order for pantoprazole DR (used to treat conditions when there is too much acid in the stomach) 40mg 1 tablet daily 30 minutes before meals.

Review of Resident #6's physician's order dated 12/14/21 revealed pantoprazole DR 40mg 1 tablet once daily 30 minutes before breakfast on an empty stomach.

Observation of the 8:00am medication pass on 04/13/22 revealed the medication aide (MA) prepared 9 oral medications, including pantoprazole DR 40mg tablet and administered the medications at 7:50am to Resident #6.

Observation of Resident #6 on 04/13/22 at 7:52am revealed the resident was waiting in the sunroom to eat breakfast.

Interview with the facility Cook on 04/13/22 at 9:10am revealed:
-Breakfast was served that morning between 8:00am and 8:15am.
-Resident #6 was served breakfast with the other residents.

Review of Resident #6's April 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for pantoprazole DR 40mg 1 tablet daily 30 minutes before breakfast on an empty stomach scheduled at 7:30am.
-The pantoprazole DR was documented as administered as ordered from 04/01/22 to

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D 358	Continued From page 24 04/13/22. Interview with the Resident Care Coordinator (RCC) on 04/13/22 at 12:30pm revealed she knew Resident #6's pantoprazole was scheduled to be administered at 7:30am, 30 minutes before meals. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. 2. Review of Resident #2's current FL2 dated 03/08/22 revealed: -Diagnoses included dementia, atrial fibrillation, congestive heart failure, myocardial infarction, coronary artery disease, and history of gastrointestinal bleed. -There was an order for Plavix (an anticoagulant medication used to reduce blood clotting) 75mg take 1 tablet daily. Review of Resident #2's Incident and Accident Report dated 02/11/22 revealed: -There was documentation Resident #2 was in the shower, fell face first on the floor, had a gash on his head and complained of right shoulder pain. -Resident #2 was sent to the local hospital emergency room (ER) for evaluation. -There was documentation Resident #2 returned from the hospital and had sustained a right humerus fracture. Review of Resident #2's Care Plan dated 02/11/22 revealed: -There was documentation Resident #2 fell sustaining a fractured humerus fracture and wore an arm sling. -There was documentation to monitor Resident #2 for falls.	D 358		

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D 358	Continued From page 25 Review of Resident #2's local ER Progress Note dated 02/11/22 revealed: -A head injury with a rough, jagged laceration on the forehead. -Resident #2 had right shoulder pain with decreased range of motion due to a right proximal humerus fracture. a. Review of Resident #2's physician order dated 02/03/22 revealed a medication order for Eliquis (a blood thinner medication that reduces blood clotting) 2.5mg twice a day for 10 days and hold Plavix while taking Eliquis. Review of Resident #2's February 2022 electronic Medication Administration Record (eMAR) revealed: -There was a hand-written entry for Eliquis 2.5mg take 1 tablet twice daily for 10 days. -Eliquis 2.5mg was documented as administered twice daily at 8:00am and 8:00pm from 02/04/22 through 02/13/22. Refer to the telephone interview with Resident #2's responsible person on 04/14/22 at 10:50am. Refer to the interview with a medication aide (MA) on 04/14/22 at 11:38am. Refer to the interview with a second MA on 04/14/22 at 11:42am. Refer to the interview with the RCC on 04/14/22 at 12:00pm. Refer to the telephone interview with the primary care provider (PCP) on 04/14/22 at 3:00pm. Refer to the interview with the Administrator on	D 358		

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D 358	Continued From page 26 04/14/22 at 4:20pm. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. b. Review of Resident #2's physician's orders dated 12/14/21 revealed a medication order for Plavix (a blood thinner medication used to reduce blood clotting) 75mg take 1 tablet daily. Review of Resident #2's February 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Plavix 75mg take 1 tablet once daily. -Plavix was documented as administered daily at 8:00am from 02/01/22 through 02/28/22. Refer to the telephone interview with Resident #2's responsible person on 04/14/22 at 10:50am. Refer to the interview with a medication aide (MA) on 04/14/22 at 11:38am. Refer to the interview with a second MA on 04/14/22 at 11:42am. Refer to the interview with the RCC on 04/14/22 at 12:00pm. Refer to the telephone interview with the primary care provider (PCP) on 04/14/22 at 3:00pm. Refer to the interview with the Administrator on 04/14/22 at 4:20pm. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	D 358		

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D 358	Continued From page 27 _____ Telephone interview with Resident #2's responsible person on 04/14/22 at 10:50am revealed: -Resident #2 had "trouble" with memory. -He did not know what medications Resident #2 had ordered. Interview with the MA on 04/14/22 at 11:38am revealed: -A different MA that no longer worked at the facility wrote Eliquis on the eMAR with the scheduled days to administer for Resident #2. -She administered Eliquis and Plavix on 02/07/22, 02/08/22, and 02/09/22 to Resident #2. -She did not know she was supposed to hold administering the Plavix to Resident #2 while administering the Eliquis during the 10 days it was scheduled to be administered. -The facility's process for new medication orders was for the Resident Care Coordinator (RCC) to review the order and write the new medication order on the eMAR. -If the RCC was not working when a new medication order for a resident was received, the MA working was supposed to call the RCC to verify if the MA should write the new order on the eMAR. -New medication orders were faxed to the facility's contracted pharmacy and the pharmacy would add the medication to the eMAR. -The RCC would review the eMAR to make sure medications orders were entered correctly. Interview with a second MA on 04/14/22 at 11:42am revealed: -She administered both anticoagulants to Resident #2 on 02/04/22, 02/05/22, 02/10/22, 02/11/22, and 02/12/22 because there was no indication on the eMAR to hold the Plavix while	D 358		

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administering Eliquis.
-The MA writing new medication orders on the eMAR was responsible for making sure medications were also placed on hold when ordered.
-She did not know who hand wrote the Eliquis on the eMAR and did not indicate to hold the Plavix while administering Eliquis to Resident #2.

Interview with the RCC on 04/14/22 at 12:00pm revealed:
-She was responsible for reviewing new medication orders and transcribed the order to the eMAR's.
-She did not review and write Resident #2's medication order dated 02/03/22 for Eliquis on the eMAR because she was out of work sick that week.
-A former MA had written Resident #2's order for Eliquis on the eMAR because she could tell by the handwriting.
-She did not know why the MA did not write to hold Resident #2's Plavix while administering Eliquis.
-Resident #2 fell on 02/11/22 and sustained a "gash" to his forehead and broke his right upper arm.
-She did not know if Resident #2 had any increased complications from being administered both blood thinner medications and falling sustaining injuries on 02/11/22.

Telephone interview with the primary care provider (PCP) on 04/14/22 at 3:00pm revealed:
-She ordered Eliquis 2.5mg take twice daily on 02/03/22 for Resident #2 and to hold Plavix while administering Eliquis.
-The facility did not notify her Resident #2 was administered both Plavix and Eliquis from 02/04/22 through 02/13/22.

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-She knew Resident #2 fell on 02/11/22 sustaining a laceration to the forehead and broke the right humerus.
-Resident #2 had an increased risk of bleeding since Resident #2 was administered both anticoagulants and fell which could have caused profuse bleeding that would have required blood transfusions, or serious harm.
-She expected the facility to hold Resident #2's Plavix when Eliquis was administered for the 10 days in February 2022.
-She expected the facility to notify her of any medication errors.

Interview with the Administrator on 04/14/22 at 4:20pm revealed:
-He did not know Resident #2 was administered Plavix and Eliquis at the same time in February 2022 when the Plavix was supposed to be held.
-He expected staff to administer or hold medications as ordered.
-The RCC was responsible for making sure medication orders were written on the eMAR correctly when a new medication order was added.
-Resident #2 should have never received Plavix while taking Eliquis.

_____

The facility failed to ensure medications were administered as ordered for 2 of 12 sampled residents during the medication pass including a breathing treatment to treat shortness of breath related to chronic obstructive pulmonary disease documented as administered and was not administered (#2), a medication to treat gastroesophageal reflux disease was not administered on an empty stomach as ordered (#6), and a resident who was administered two blood thinner medications when one of the medications was to be held which could have

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D 358	Continued From page 30 caused profuse bleeding after the resident sustained a fall (#2). This failure placed residents at substantial risk of serious physical harm and constitutes and Type A2 Violation. _____ The facility provided a plan of protection on 04/14/22 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure the accuracy of medication administration records for 1 of 5 sampled residents (#2) related to a medication used to prevent and treat wheezing and shortness of breath.

The findings are:

Review of Resident #2's current FL2 dated 03/08/22 revealed:
-Diagnoses included congestive heart failure, atrial fibrillation, and dementia.
-There was an order for Duoneb (used to prevent and treat wheezing and shortness of breath) 0.5mg-3mg/3ml 1 vial via nebulizer four times daily.

Observation of the noon medication pass on 04/12/22 revealed the medication aide (MA) did not administer Duoneb to Resident #2.

Review of Resident #2's February 2022 to March 2022 electronic Medication Administration Record (eMAR) revealed:
-There were entries on both eMARs for Duoneb 0.5mg-3mg/3ml use 1 vial in nebulizer four times daily scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The Duoneb 0.5mg-3mg/3ml 1 vial was documented as administered as ordered from 02/01/22 to 02/28/22 with one refusal documented on 02/05/22 at 8:00pm.
-The Duoneb 0.5mg-3mg/3ml 1 vial was documented as administered as ordered from 03/01/22 to 03/31/22 with three refusals on 03/14/22 at 12:00pm, 03/21/22 at 12:00pm, and on 03/31/22 at 4:00pm.

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Review of Resident #2's April 2022 eMAR revealed:
-There was an entry for Duoneb 0.5mg-3mg/3ml use 1 vial in nebulizer four times daily scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The Duoneb 0.5mg-3mg/3ml 1 vial was documented as administered on 04/12/22 at 12:00pm.
-The Duoneb was documented as refused one time on 04/13/22 (no time documented).

Interview with the Resident Care Coordinator on 04/12/22 at 2:20pm revealed:
-Resident #2 frequently refused his Duoneb nebulizer treatments.
-The staff would administer the Duoneb nebulizer treatments if he wanted to take them.

Interview with the MA on 04/12/22 at 2:21pm revealed:
-Resident #2's Duoneb nebulizer treatment was scheduled for 12:00pm.
-Resident #2 had refused to take the Duoneb treatment at 12:04pm when offered.
-She documented administering the medication even though she did not administer it to the resident.

Interview with a second MA on 04/13/22 at 1:45pm revealed:
-She administered Resident #2's Duoneb on 04/12/22 between 11:30am and 11:40am.
-She did not document the Duoneb administration on 04/12/22 at 11:30am.

Interview with Resident #2 on 04/12/22 at 2:57pm revealed:
-The staff had not been administering his breathing treatment.

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D 367	Continued From page 33 -He thought the Duoneb order had been discontinued. Interview with the Administrator on 04/14/22 at 4:30pm revealed staff should not sign off on the eMAR they administered a medication if they did not administer it.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision and medication administration. The findings are: 1.Based on observations, interviews, and record review, the facility failed to ensure 3 of 5 exit doors accessible for a resident who was known to be constantly disoriented, wandered, and who eloped from the facility twice without staff's knowledge (Resident #4) were equipped with a sounding device when the door was opened. 2. Based on observations, interviews, and record reviews, the facility failed to provide supervision	D912		

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D912	Continued From page 34 for 2 of 5 sampled residents (#1 and #4) which resulted in a resident who set fires inside the facility twice requiring evacuation of the facility (#1) and another resident who eloped from the facility twice (#4). 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 12 sampled residents (#2 and #6) observed during medication pass including errors with a breathing treatment (#2) and a medication to treat gastroesophageal reflux disease (#6) and for 1 of 5 residents (#2) sampled for record review errors with an anticoagulation medication (#2).	D912		