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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation 06/22/22 - 06/23/22.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide incontinence care to 1 of 4 sampled residents (Resident #5) and use a lift for transfers for 1 of 1 sampled resident (#5) who required a lift for transfers. The findings are: Review of Resident #5's current FL2 dated 02/16/22 revealed: -Diagnoses included dementia, cognitive impairment, and muscle weakness. -Resident #5 was intermittently disoriented. -Resident #5 was incontinent of bladder and bowel. Review of Resident #5's Care Plan dated 02/16/22 revealed: -Resident #5 was totally dependent for toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transfers. -Resident #5 required two-person transfers.	D 269		

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D 269	Continued From page 1 -Resident #5 was ambulatory with a wheelchair. -Resident #5 was non-weight bearing and staff were to propel the resident in the wheelchair. 1. Interview with Resident #5 on 06/22/22 at 12:34pm revealed: -Resident #5 required staff assistance with incontinence care. -Resident #5 wore adult briefs for management of incontinence. -Resident #5 pointed to the top of a chest of drawers in the room indicating the adult briefs lying on top of the chest of drawers belonged to her. Observation in Resident #5's recliner on 06/22/22 at 12:35pm revealed: -There were two open bags of adult briefs available on the top of the chest of drawers. -Multiple pairs of adult briefs remained in the two bags. Observation of Resident #5 on 06/22/22 at 12:36pm revealed: -Resident #5 was seated in a recliner fully dressed with a blanket covering her from her chest to her feet. -Two personal care aides (PCAs) entered Resident #5's room to transport the resident to the dining room for the lunch meal service. -The PCAs preceded to transfer Resident #5 from her recliner into a wheelchair. -A large white cotton pad was visible in the seat of Resident #5's recliner once the resident was transferred into the wheelchair. -One of the PCAs placed Resident #5's blanket onto the seat of the recliner covering the white cotton pad. -The PCAs propelled Resident #5 from the room in the wheelchair and into the dining room a short	D 269		

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distance from the resident's room.

Observation of Resident #5's room on 06/22/22 at 12:38pm revealed the seat of the recliner covered with a large cotton pad was saturated with urine over the entire surface of the pad.

Observation of Resident #5 on 06/22/22 at 12:40pm revealed:
-Resident #5 was seated in a wheelchair in the dining room at a table.
-The back of the wheelchair covered Resident #5's back and seat of her pants making it impossible to see the resident's clothing.
-A PCA was seated next to Resident #5.

Interview with a PCA on 06/22/22 at 2:03pm revealed:
-She did not realize Resident #5's pants were wet when she and the other PCA had transferred Resident #5 from the recliner into the wheelchair prior to taking her to lunch.
-She and another PCA had provided incontinence care to Resident #5 "immediately" after Resident #5 had finished eating lunch.

Interview with another PCA on 06/22/22 at 10:35am and 2:10pm revealed:
-Incontinent care rounds were routinely done before breakfast, when they got residents up for lunch between 9:30am to 11:00am, when they laid residents down after lunch, and again at 2:30pm right before the end of their shift.
-She checked Resident #5 at 10:30am and the resident did not need incontinence care.
-She did not realize Resident #5's pants were wet when she and the other PCA had transferred her from the recliner into the wheelchair prior to taking her to lunch.
-Resident #5 did not have any skin breakdown.

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-Incontinence care was provided to Resident #5 as soon as Resident #5 finished the lunch meal.

Interview with the Special Care Coordinator (SCC) on 06/22/22 at 3:42pm revealed:
-She was not aware of the incident which had occurred with Resident #5 before lunch.
-She expected the PCAs to provide incontinence care to any resident who was wet or soiled prior to taking them to the dining room for a meal.
-Staff should have provided incontinence care to Resident #5 prior to taking her into the dining room for lunch if they knew she was wet.
-If the cotton pad was wet beneath the resident, then Resident #5's clothing would have been wet as well and should have been noticed by the PCAs upon transfer.
-Resident #5 usually would yell out to make staff aware when she needed incontinence care.
-She and the Resident Care Coordinator (RCC) were usually in the dining room observing the residents brought into the dining room.
-If either she or the RCC had seen Resident #5 being brought into the dining room with wet pants, they would have immediately made the PCAs take Resident #5 back to her room for incontinent care and clean, dry clothing.

Interview with the Administrator on 06/23/22 at 11:34am revealed:
-Resident #5 was capable of expressing when she needed assistance.
-She would have expected the staff to provide incontinence care to Resident #5 and change the resident's wet clothes prior to taking the resident into the dining room to eat lunch.

2. Observation of Resident #5 on 06/22/22 at 12:36pm revealed:
-Resident #5 was seated in a recliner fully

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dressed with a blanket covering her from her chest to her feet.
-Two personal care aides (PCAs) entered Resident #5's room to transport her to the dining room for the lunch meal service.
-The PCAs preceded to transfer Resident #5 from her recliner into a wheelchair.
-One PCA grasped Resident #5 under her upper left arm and the second PCA grasped Resident #5 under her upper right arm.
-The PCAs lifted Resident #5 to a standing position, pivoted the resident, and assisted the resident into a wheelchair parked in front of the recliner.
-The PCAs propelled Resident #5 from the room in the wheelchair and into the dining room a short distance from the resident's room.

Review of Resident #5's Licensed Health Professional Support Review (LHPS) dated 05/31/22 revealed personal care tasks provided to Resident #5 included two-person transfers with wheelchair and use of Hoyer lift.

Review of Resident #5's Quarterly Care Plan Reviews dated 06/01/21 to 03/02/22 revealed:
-On 06/01/21, Resident #5 was documented as no weight bearing, wheelchair propelled by staff, Hoyer lift for transfer.
-On 12/01/21, Resident #5 was documented as requiring total assistance with activities of daily living (ADLs).
-On 03/02/22, Resident #5 was documented as requiring total assistance with ADLs.

Interview with the Special Care Coordinator (SCC) on 06/22/22 at 3:42pm revealed:
-Staff were supposed to use a Hoyer lift to transfer Resident #5.
-Staff might have chosen to do a two-person

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assisted transfer if Resident #5's lift sling was dirty or a sling had not been left in place under the resident in the chair.
-It was "next to impossible" to get a sling under Resident #5, once she was seated in the recliner.
-She wanted staff to use the Hoyer to transfer Resident #5.

Observation of Resident #5 on 06/23/22 at 8:05am revealed:
-Resident #5 was asleep in the recliner in her room.
-There was no lift sling visible under the resident.

Interview with the medication aide (MA) on 06/23/22 at 8:08am revealed:
-It did not appear as if the personal care aides (PCAs) who had assisted Resident #5 out of bed that morning had used the Hoyer lift or they would have left a sling under the resident.
-She knew the PCAs sometimes used the Hoyer lift with Resident #5.
-She saw the PCAs also doing two-person assist transfers with the resident.
-The PCAs would be able to answer better about the circumstances when they used the Hoyer lift with Resident #5.

Interview with a PCA on 06/23/22 at 8:15am revealed:
-They sometimes used the Hoyer lift with Resident #5, but most of the time they did a two-person transfer.
-Resident #5's recliner was a lift chair and the resident's bed height could be adjusted.
-Resident #5 could pivot and turn from the chair to the wheelchair.
-There were some days when Resident #5 could stand and other days when she could not.
-She had recently received another training on

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how to use the Hoyer lift.

Interview with another PCA on 06/23/22 at 10:45am revealed:
-Use of the Hoyer lift with Resident #5 depended upon how the resident was feeling that day.
-She would ask Resident #5 if she felt like standing on her feet during a two-person transfer.
-If Resident #5 did not feel strong enough to stand, they would use the Hoyer lift to transfer the resident.
-The Hoyer lift was obtained for transfers when the resident was feeling weak.

Interview with the SCC on 06/23/22 at 10:35am revealed:
-There was not a physician's order to use a Hoyer lift with Resident #5.
-It was discretionary for staff to use it or not.
-When staff came and told her they were having trouble transferring Resident #5 at times, that's when she included use of the Hoyer for transfers on the resident's care plan.
-The LHPS Registered Nurse (RN) had recently provided a Hoyer lift training for the employees.

Telephone interview with the LHPS RN on 06/23/22 at 11:07am revealed:
-He had recently completed a Hoyer lift training with the employees at the facility.
-The Hoyer list personal care task had recently been added to Resident #5's LHPS tasks, because staff had asked him to add the task because the resident was becoming more dependent.
-He never saw an order for use of a Hoyer lift.
-He left it up to the staff if they needed to use the lift or not to transfer the resident.

Interview with the RCC on 06/23/22 at 11:10am

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D 269	Continued From page 7 revealed Resident #5 preferred not to use the Hoyer lift and the resident was able to stand up on her feet to help the PCAs to transfer her. Interview with the Administrator on 06/23/22 at 11:34am revealed: -Resident #5 was able to communicate with staff so they could understand her. -She felt Resident #5 could communicate her ability to stand to staff when asked. -In her experience, residents often found the Hoyer lift intimidating. Telephone interview with Resident #5's physician on 06/23/22 at 11:41am revealed: -Resident #5 had not walked in 12 to 15 years. -If he had ordered use of a Hoyer lift, the request had been guided by nursing staff and the appliance they stated they needed to best care for Resident #5. -He gave the nursing staff "flexibility" to do what they thought was appropriate. -He did not feel the staff had to use the lift to transfer Resident #5. -If the staff were able to get Resident #5 to stand up to safely transfer, he was "ok" with that.	D 269		
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	D 367		

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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).

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure the accuracy of the medication administration record (MAR) for 1 of 1 sampled residents (#1) who tested positive for COVID-19, related to staff not documenting who actually administered the medication.

The findings are:

Review of the current FL-2 for Resident #1 dated 04/21/22 revealed:
-He was admitted to the facility on 07/10/19.
-Diagnoses included genetic torsion dystonia (muscle contractions that produce twisting and repetitive movements or abnormal postures) and generalized disability.
-There was an order for baclofen (used to treat dystonia) 30mg every morning.
-There was an order for baclofen (used to treat dystonia) 20mg three times daily.
-There was an order for pantoprazole (used to treat gastric reflux) 40mg every day.
-There was an order for trihexyphenidyl (used to treat stiffness, tremors, spasms, and poor muscle control) 5mg four times daily.

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-There was an order for zinc sulfate (used to treat or prevent low levels of zinc) 220mg every day.

Review of the May 2022 MAR revealed:
-Baclofen 30mg was admnistered daily at 8:00am by a medication aide (MA) from 05/19/22 through 05/29/22.
-Baclofen 20mg was administered daily at 12:00pm, 4:00pm and 8:00pm by a MA from 05/19/22 through 05/29/22.
-Pantoprazole 40mg was administered daily at 6:00am by a MA from 05/19/22 through 05/29/22.
-Trihexyphenidyl 5mg was administered daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm by a MA from 05/19/22 through 05/29/22.
-Zinc Sulfate 220mg was administered daily at 8:00am by a MA from 05/19/22 through 05/29/22.

Review of nurse's notes revealed Resident #1 tested positive for COVID-19 on 05/19/22.

Interview with a MA on 06/22/22 at 9:56am revealed:
-The Administrator did not want the MA's administering medications to Resident #1 while he was quarantined for COVID-19 from 05/19/22 to 05/29/22.
-She prepared Resident #1's oral medications and gave them to a PCA to administer to Resident #1 during her shifts for several days during Resident #1's quarantine.
-She would give the prepared medication to the PCA and observe the PCA from the doorway into Resident #1's room administer the medication.
-After ensuring the PCA had administered Resident #1's medication, she documented on the Medication Administration Record (MAR) that she had administered Resident #1's medication.
-The PCA on shift while she worked gave the medication to Resident #1 for several days during

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D 367	Continued From page 10 his 10-day quarantine for COVID-19. Interview with a PCA on 06/22/22 at 3:17pm revealed: -She was told by one of the MA's that the PCA's would be administering the medications for Resident #1 while he was in quarantine for COVID-19. -Resident #1's medication was prepared by the MA. -She administered oral medication to Resident #1 on 2 different occasions while he was quarantined for COVID-19. -The MA gave her the medication for Resident #1 and watched her from the door administer Resident #1's medications. -She was not trained as a MA. -She did not document on the MAR she administered Resident #1's medications. Interview with a second MA on 06/23/22 at 10:27am revealed: -The Medication Aide Supervisor told her the Administrator wanted the MA's to let the PCA's give Resident #1 his medication while Resident #1 was on quarantine for COVID-19. -The Administrator did not want to risk any of the MA's getting sick which would require them to be out of work for several days. -She prepared the medications for Resident #1 and gave them to a PCA to administer. -She observed a PCA administer Resident #1's medication from the doorway of Resident #1's room. -After observing the PCA administer Resident #1's medications, she documented she administered Resident #1's medications on the MAR. Interview with a second PCA on 06/23/22 at	D 367		

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D 367	Continued From page 11 10:40am revealed: -The MA told her to administer medications to Resident #1. -The MA prepared Resident #1's medication and stood at the door and watched her administer Resident #1's medication. -She administered Resident #1's medication once or twice during his quarantine for COVID-19. -She was not trained as a MA. -She did not document on the MAR she administered Resident #1's medications. Interview with the Administrator on 06/23/22 at 11:12am revealed: -She told the MA's to let the PCA's administer Resident #1 his oral medication while he was on quarantine for COVID-19. -The MA's were to prepare the medication for Resident #1 and observe the PCA administer the medication from the doorway and document they adminstered the medication on the MAR. -This was only done for a few days during Resident #1's quarantine period. -She changed her mind and told the MA's to start giving the medication to Resident #1 instead of the PCA's. -She initially thought this was a good infection control strategy but changed her mind a few days into Resident #1's quarantine for COVID-19.	D 367		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform	D935		

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D935	Continued From page 12 any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 2 of 2 personal care aides (PCA's) who administered medication had completed the medication aide training, clinical	D935		

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	HAL056001	A. BUILDING: _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW MANOR CARE CENTER	150 CRISP STREET FRANKLIN, NC 28734

(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
D935	Continued From page 13	D935		

skills check off and successfully passed the medication test prior to administering medication.

The findings are:

Review of the current FL-2 for Resident #1 dated 04/21/22 revealed diagnoses included genetic torsion dystonia (muscle contractions that produce twisting and repetitive movements or abnormal postures) and generalized disability.

Review of nurse's notes revealed Resident #1 tested positive for COVID-19 on 05/19/22.

Interview with a medication aide (MA) on 06/22/22 at 9:56am revealed:
-The Administrator did not want the MA's administering medications to Resident #1 while he was quarantined for COVID-19 from 05/19/22 to 05/29/22.
-She prepared Resident #1's oral medications and gave them to a PCA to administer to Resident #1 during her shifts for several days during Resident #1's quarantine.
-She would give the prepared medication to the PCA and observe the PCA from the doorway into Resident #1's room administer the medication.
-After assuring the PCA had administered Resident #1's medication, she documented on the Medication Administration Record (MAR) that she had administered Resident #1's medication.
-The PCA on shift while she worked gave the medication to Resident #1 for several days during his 10-day quarantine for COVID-19.
-She felt that her job could have been in jeopardy if she did not allow the PCA to administer the medication to Resident #1 and document that she had administered it.

Interview with a PCA on 06/22/22 at 3:17pm

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D935	Continued From page 14	D935		

revealed:
-She was told by one of the MA's that the PCA's would be administering the medications for Resident #1 while he was in quarantine for COVID-19.
-Resident #1's medication was prepared by the MA.
-She administered oral medication to Resident #1 on 2 different occasions while he was quarantined for COVID-19.
-The MA gave her the medication for Resident #1 and watched her from the door administer Resident #1's medications.
-She was not trained as a MA.
-She did not document on the MAR she administered Resident #1's medications.

Interview with a second MA on 06/23/22 at 10:27am revealed:
-Her Supervisor told her the Administrator wanted the MA's to let the PCA's give Resident #1 his medication while Resident #1 was on quarantine for COVID-19.
-The Administrator did not want to risk any of the MA's getting sick which would require them to be out of work for several days.
-She prepared the medications for Resident #1 and gave them to a PCA to administer.
-She observed a PCA administer Resident #1's medication from the doorway of Resident #1's room.
-After observing the PCA administer Resident #1's medications, she documented she administered Resident #1's medications on the MAR.

Interview with a second PCA on 06/23/22 at 10:40am revealed:
-The MA told her to administer medications to Resident #1.

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D935	Continued From page 15 -The MA prepared Resident #1's medication and stood at the door and watched her administer Resident #1's medication. -She administered Resident #1's medication once or twice during his quarantine for COVID-19. -She was not trained as a MA. -She did not document on the MAR she administered Resident #1's medications. Interview with the Administrator on 06/23/22 at 11:12am revealed: -She told the MA's to let the PCA's give Resident #1 his oral medication while he was on quarantine for COVID-19. -The MA's were to prepare the medication for Resident #1 and observe the PCA administer the medication from the doorway. -This was only done for a few days during Resident #1's quarantine period. -She changed her mind and told the MA's to start giving the medication to Resident #1 instead of the PCA's. -She initially thought this was a good infection control strategy but changed her mind a few days into Resident #1's quarantine for COVID-19.	D935		