STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034058	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERNER RIDGE ASSISTED LIVING	250 HOPKINS ROAD KERNERSVILLE, NC 27284

(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 survey on October 25-27, 2022.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide supervision according to the resident's needs for 1 of 5 sampled residents (#2) who had a history of falls. The findings are: Review of the facility's Falls Management Policy dated 07/15/20 revealed: -A fall assessment was to be completed at admission, every 6 months, change in condition or for safety precautions, and when a resident had two or more falls, unrelated to a health condition in a 1 month period. -Each fall was to be investigated and analyzed to determine the possible contributing factors and the effective of implemented safety measures to minimize falls. -Interventions were to be documented on the resident's Individualized Service Plan as well as communicated to appropriate caregivers. -The Fall Intervention Check List/Plan was to be used to assist in the revision of the individualized	D 270		

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plan for residents with falls when there were changes to interventions and during the bi-monthly comprehensive resident review meeting.
-There was no information regarding increasing supervision for residents after a fall.

Review of Resident #2's current FL2 dated 04/29/22 revealed:
-Diagnoses included essential hypertension, atrial fibrillation, dysphagia, other sequelae of cerebral infarction, and urinary frequency.
-Resident #2 was intermittently disoriented and semi-ambulatory.

Review of Resident #2's care plan dated 09/30/22 revealed:
-There had not been a significant change.
-Resident #2 was ambulatory with the aid of a wheelchair and was able to wheel himself about in his wheelchair.
-He needed assistance with activities of daily living.
-He did not like asking for help and had a history of falls.
-Resident #2 had a new transfer bar on his bed, a perimeter mattress, and a hospital bed.
-Resident #2 had physical therapy (PT) for strengthening, and he was currently receiving hospice services.
-Resident #2 was not able to get to the toilet unassisted and may not be aware of need; the facility was to provide extensive assistance which included, cuing, ambulating to the toilet, assist with clothing, wiping, and cleansing.
-Resident #2 required extensive assistance with ambulation and staff was to assist him with all ambulation inside and outside the facility.
-Resident #2 required extensive assistance with transferring and staff was to assist him with all

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transfers.

Review of Resident #2's licensed health professional support (LHPS) evaluation dated 08/07/22 revealed Resident #2 used a wheelchair requiring staff assistance at times to propel and he required assistance with transfers daily.

Review of Resident #2's Fall Risk Assessment dated 10/05/22 revealed:
-A total score of 10 or higher represented a high risk for falls requiring added interventions to prevent falls on the resident's care plan.
-Resident #2's total score was 11.
-Additional interventions for prevention of falls had been added to Resident #2's care plan due to the assessment findings.

Review of Resident #2's safety check monitoring log for September and October 2022 revealed:
-Safety checks were scheduled for every 2 hours.
-There was documentation of safety checks beyond the 2-hour time period.
-There was no documentation of any increased safety checks after falls in September and October 2022.

a. Review of Resident #2's progress note dated 09/02/22 revealed:
-Resident #2 was observed on the floor of his bedroom laying on his right side.
-Staff observed a skin tear on his left thumb and a golf ball sized bruise on his right shoulder.
-When asked what happened, Resident #2 stated, "I was trying to put on my pants."

Review of Resident #2's Incident/Accident Report dated 09/02/22 revealed:
-Resident #2 was observed on his bedroom floor laying on his right side at 5:35pm.

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-His wheelchair was beside the bed.
-The cause of Resident #2's fall was determined to be poor safety awareness and not using the call bell for assistance.
-Resident #2 had injuries including a golf ball sized bruise on his right should and a skin tear on the thumb of his left hand.
-Resident #2's old call bell was removed from his room due to him using the old call bell instead of the new call bell.
-Resident #2 was placed in the "hot box." (When a resident was placed in the hot box, the resident's vitals were checked, and the resident was assessed for pain, bruising, and changes on each shift, twice a day, for 72 hours.)
-Resident #2 was education to pull the call bell for assistance.

Interview with the Special Care Unit Coordinator (SCUC) who documented the Incident/Accident Report (09/02/22) on 10/27/22 at 12:57pm revealed:
-She was working in the SCU on 09/02/22 and was walking over to the assisted living side of the facility.
-As she walked by Resident #2's room, she noticed he was on the floor by the wall and his television.
-He could not tell her what happened.
-Resident #2 had a skin tear on his right thumb and a bruise on his right shoulder.
-Resident #2 did not have his pants on and his wheelchair was close by.
-Resident #2 was not sent out to the hospital.
-She did not know what interventions were put in place for Resident #2, but she knew he was placed in the hot box for documentation of vitals on both shifts for 3 days.
-She did not see in the documentation system where there were increased safety checks put in

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place for Resident #2 after his fall on 09/02/22.
-Staff did not necessarily increase safety checks for residents after a fall.
-They looked at implementing interventions more so than increasing safety checks.

Review of Resident #2's 24-Hour Post Fall Checklist dated 09/02/22 revealed:
-There was documentation completed on 09/03/22 at 1:35am, 9:35am and at 5:35pm.
-The documentation at all three times indicated there were no complaints of pain or discomfort, there was no change in Resident #2's walking ability, there was no outward rotation of his legs or arms, Resident #2 did not have increased drowsiness, and he did not have any trouble nor was he reluctant to get out of bed.

Review of Resident #2's Post Fall Investigation Report dated 09/02/22 revealed:
-Resident #2 fell in his room on 09/02/22 at 5:35pm during second shift.
-Resident #2 was changing his clothes, trying to put on his pants, prior to the fall.
-Resident had last been seen at 5:00pm prior to the fall.
-Resident #2 had an injury of a skin tear on his left thumb and bruise on his right shoulder.
-Resident #2 was not sent out to the hospital.
-Resident #2 needed a 1 person assist with transfers.
-There were safety interventions for fall prevention in place prior to the fall on 09/02/22 and the interventions were documented in Resident #2's care plan.
-Interventions were reviewed and updated as necessary in Resident #2's care plan and medical record.
-Staff was informed of necessary changes going forward.

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-There were no specific interventions documented on the Post Fall Investigation Report.

Review of Resident #2's electronic Medication Administration Records (eMARs) for September 2022 revealed:
-There was an entry for Hot Box Documentation and a full set of vitals scheduled twice a day between 7:00am and 6:59pm and between 7:00pm and 6:59am.
-There was documentation of vitals twice a day from 09/02/22 through 09/04/22.

Based on record reviews and interviews, there was no documentation increased supervision was implemented for Resident #2 after his fall on 09/02/22.

Attempted telephone interview with the facility's PCP on 10/27/22 at 10:01am was unsuccessful.

Refer to the interview with Resident #2's responsible party on 10/26/22 at 3:38pm.

Refer to the interview with a personal care PCA on 10/27/22 at 9:12am.

Refer to the interview with the Administrator on 10/27/22 at 9:43am.

Refer to the interview with the RCD on 10/27/22 at 12:03pm.

Refer to the interview with the RCC on 10/27/22 at 1:35pm.

Refer to the telephone interview with the Interim Director at Resident #2's hospice provider's office on 10/27/22 at 1:50pm.

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D 270	Continued From page 6 b. Review of Resident #2's progress note dated 09/11/22 revealed: -Resident #2 was observed sitting on the floor at 8:45pm. -Resident #2 stated that he was trying to get into the bed and the mattress covering slipped from under him. -Resident #2 stated he was not in any pain and he did not hit his head. -Resident #2's hospice provider was contacted and advised staff that a hospice nurse visit was scheduled for 09/12/22 and Resident #2's equipment (type not indicated) would be assessed during the visit. Review of Resident #2's Incident/Accident Report dated 09/12/22 revealed: -Resident #2 was observed sitting on the floor on 09/11/22 at 8:45pm on his bedroom floor laying on his right side at 5:35pm. -Resident #2 stated he was trying to get into the bed when the mattress covering slipped from under him. -Resident #2 stated he was not in any pain and did not hit his head. -Resident #2's power of attorney (POA) was contact and the POA voiced concerns regarding the mattress covering and wheelchair provided from hospice -Resident #2's hospice provider was scheduled to visit him on 09/12/22 and would also assess Resident #2's equipment. -The cause of Resident #2's fall was determined to be due to Resident #2 trying to get into the bed and the mattress covering slipped from under him. -There were no injuries. -Resident #2 was placed in the hot box and a non-slip material was placed on the mattress for	D 270		

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D 270	Continued From page 7 grip. Interview with the medication aide (MA) who documented the Incident/Accident Report (09/12/22) on 10/27/22 at 12:34pm revealed: -Resident #2 fell on 09/12/22 while trying to get into bed and he did not have any injuries. -She was not told to do increased supervision for Resident #2 after his fall on 09/11/22, but she took it upon herself to check on Resident #2 every 30 to 45 minutes during her shift; she peeked in when she passed his room. Review of Resident #2's 24-Hour Post Fall Checklist dated 09/11/22 revealed: -There was documentation completed on 09/12/22 at 6:45am, 2:45pm and at 10:45pm. -The documentation at all three times indicated there were no complaints of pain or discomfort, there was no change in Resident #2's walking ability, there was no outward rotation of his legs or arms, Resident #2 did not have increased drowsiness, and he did not have any trouble nor was he reluctant to get out of bed. Review of Resident #2's Post Fall Investigation Report dated 09/11/22 revealed: -Resident #2 fell in his room on 09/12/22 (date should have been 09/11/22) at 8:45pm during second shift. -Resident #2's mattress slipped off his bed when he was getting into the bed. -Resident #2 had last been seen at 8:35pm prior to the fall and last toileted at 8:00pm. -Resident #2 did not have any injuries. -Resident #2 needed a 1 person assist with transfers; Resident #2 was independent with assistive devices -Improper bedding was a possible contributing factor to Resident #2's fall on 09/11/22.	D 270		

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-Safety devices in place at the time the fall occurred included low bed, bed in low position, nightlight working in bedroom and bathroom.
-There were safety interventions for fall prevention in place prior to the fall on 09/11/22 and the interventions were documented in Resident #2's care plan.
-Interventions were reviewed and updated as necessary in Resident #2's care plan and medical record.
-Staff was informed of necessary changes going forward.

Review of Resident #2's electronic Medication Administration Records (eMARs) for September 2022 revealed:
-There was an entry for Hot Box Documentation and a full set of vitals scheduled twice a day between 7:00am and 6:59pm and between 7:00pm and 6:59am.
-There was documentation of vitals twice a day from 09/22/22 through 09/14/22.

Review of Resident #2's hospice provider's progress note dated 09/12/22 revealed:
-Resident #2 had a fall over the weekend prior to the visit on 09/12/22.
-There were no visible signs of injuries.
-The hospice nurse was going to order a new wheelchair for Resident #2 due to him having trouble locking his brakes.

Review of the facility's primary care provider's (PCP) progress note dated 09/13/22 revealed:
-Resident #2 was evaluated on 09/13/22 due to a recent fall.
-Staff indicated Resident #2 was trying to get into the bed and the mattress covering slipped from underneath him.
-Resident #2 denied having pain and denied

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hitting his head.

Based on record reviews and interviews, there was no documentation increased supervision was implemented for Resident #2 after his fall on 09/11/22.

Attempted telephone interview with the facility's PCP on 10/27/22 at 10:01am was unsuccessful.

Refer to the interview with Resident #2's responsible party on 10/26/22 at 3:38pm.

Refer to the interview with a personal care PCA on 10/27/22 at 9:12am.

Refer to the interview with the Administrator on 10/27/22 at 9:43am.

Refer to the interview with the RCD on 10/27/22 at 12:03pm.

Refer to the interview with the RCC on 10/27/22 at 1:35pm.

Refer to the telephone interview with the Interim Director at Resident #2's hospice provider's office on 10/27/22 at 1:50pm.

c. Review of Resident #2's progress note dated 10/08/22 revealed:
-Resident #2 stated he slipped when he was getting into the bed.
-Resident #2 stated he was trying to get into the bed and the mattress caused him to slip.
-He stated he was not in any pain nor had any issues.

Review of Resident #2's Incident/Accident Report

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dated 10/09/22 revealed:
-Resident #2 fell in his bedroom on 10/08/22 at 8:45pm.
-Resident #2 stated his bed mattress slipped when he was getting into the bed.
-He did not have any pain or any issues.
-The cause of Resident #2's fall was determined to be his mattress caused him to slip when he was getting in the bed.
-Resident #2 was placed in the hot box.
-There were no injuries.
-Resident #2 received a new mattress and a non-slip material was placed under his mattress from the previous fall on 09/12/22.
-Resident #2's hospice provider was to replace the non-slip material under mattress to ensure effectiveness.
-Resident #2 frequently refused staff assistance with transfers.

Interview with the medication aide (MA) who documented the Incident/Accident Report (10/09/22) on 10/27/22 at 12:34pm revealed:
-Resident #2's mattress and sheets were slick when he fell on 10/08/22.
-Resident #2 stated his whole mattress slipped when he was trying to get on the bed.
-Resident #2's mattress was changed from a mattress with curved, lifted sides to a flat mattress.
-She did not feel like his hospital bed was stable enough.
-She observed the bar on Resident #2's bed moved as he grabbed it to get onto the bed.
-Resident #2's falls always seemed to happen when he was trying to get into the bed.
-Staff started assisting Resident #2 with getting in the bed after his fall, but she was not told to check on Resident #2 more often.
-She took it upon herself to check on Resident #2

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every 30 to 45 minutes during her shift; she peeked in when she passed his room.

Review of Resident #2's 24-Hour Post Fall Checklist dated 10/08/22 revealed:
-There was documentation completed on 10/09/22 at 4:45am, 12:45pm and at 8:45pm.
-The documentation at all three times indicated there were no complaints of pain or discomfort, there was no change in Resident #2's walking ability, there was no outward rotation of his legs or arms, Resident #2 did not have increased drowsiness, and he did not have any trouble nor was he reluctant to get out of bed.

Review of Resident #2's Post Fall Investigation Report dated 10/08/22 revealed:
-Resident #2 fell in his room on 10/08/22 at 8:45pm during second shift.
-Resident #2 slipped off his bed while trying to get into the bed.
-Resident #2 had last been seen at 8:10pm prior to the fall and last toileted at 7:45pm.
-Resident #2 did not have any injuries.
-Resident #2 was independent with assistive devices
-Safety devices in place at the time the fall occurred included low bed, bed in low position, nightlight working in the bedroom.
-There were safety interventions for fall prevention in place prior to the fall on 10/08/22 and the interventions were documented in Resident #2's care plan.
-Interventions were reviewed and updated as necessary in Resident #2's care plan and medical record.
-Staff was informed of necessary changes going forward.

Review of Resident #2's electronic Medication

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Administration Records (eMARs) for October 2022 revealed:
-There was an entry for Hot Box Documentation and a full set of vitals scheduled twice a day between 7:00am and 6:59pm and between 7:00pm and 6:59am.
-There was documentation of vitals twice a day from 10/09/22 through 10/11/22.

Review of Resident #2's hospice provider's progress note dated 10/10/22 revealed:
-Resident #2 had a large bruise on his right wrist from a fall on Saturday 10/08/22.
-Resident #2 also had a bruise and skin tear on his right ring finger.
-Resident #2 did not remember falling on 10/08/22.

Based on record reviews and interviews, there was no documentation increased supervision was implemented for Resident #2 after his fall on 10/08/22.

Attempted telephone interview with the facility's PCP on 10/27/22 at 10:01am was unsuccessful.

Refer to the interview with Resident #2's responsible party on 10/26/22 at 3:38pm.

Refer to the interview with a personal care PCA on 10/27/22 at 9:12am.

Refer to the interview with the Administrator on 10/27/22 at 9:43am.

Refer to the interview with the RCD on 10/27/22 at 12:03pm.

Refer to the interview with the RCC on 10/27/22 at 1:35pm.

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KERNER RIDGE ASSISTED LIVING	250 HOPKINS ROAD KERNERSVILLE, NC 27284

(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 270	Continued From page 13 Refer to the telephone interview with the Interim Director at Resident #2's hospice provider's office on 10/27/22 at 1:50pm. d. Review of Resident #2's progress note dated 10/12/22 revealed: -Resident #2 was observed on the floor by a personal care aide (PCA). -Resident #2 stated he was trying to get in the bed. -Resident #2 was not hurt and there were no visible marks. Review of Resident #2's progress note dated 10/13/22 revealed: -A new bandage was applied to Resident #2's skin tear on the morning of 10/13/22. (There was no documentation of where the skin tear was.) -Resident #2 had been in his room most of the day. -A fall prevention monitor was applied to Resident #2's wheelchair and to his bed. -Resident #2 did not have any complaints of pain or discomfort. Review of Resident #2's Incident/Accident Report dated 10/13/22 revealed: -Resident #2 was observed sitting on the floor of his room on 10/12/22 at 8:45pm. -Resident #2 stated he was trying to get in the bed. -The cause of Resident #2's fall was determined to be due to him attempting to get into bed. -There were no injuries. -Resident #2 was placed in the hot box. -Staff was to obtain an order for bed and chair alarms for Resident #2. Interview with the medication aide (MA) who	D 270		

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documented the Incident/Accident Report (10/13/22) on 10/27/22 at 8:35am revealed:
-If a personal care aide (PCA) found a resident on the floor, the PCA was to go get a MA to assist with obtaining vitals and getting the resident off the floor.
-The MA was to contact the residents responsible party, primary care provider (PCP) and the Resident Care Director (RCD).
-MAs had to complete a 24-hour report where they had to answer questions regarding the resident every 8 hours for 24 hours.
-All residents were checked on every 2 hours unless the electronic Medication Administration Record indicated for the resident to be checked on every hour.
-The Resident Care Coordinator (RCC) or the RCC was responsible for placing a resident on hourly checks.
-Residents were placed in the "hot box" where their vitals were checked and the resident was assessed for pain, bruising, and any changes once on each shift (twice a day) for 3 days.
-On 10/12/22, Resident #2 was found on the floor in front of his bed of his room and she helped to get Resident #2 up off the floor.
-She thought Resident #2 was in his wheelchair and had tried to get into bed by himself when he fell.
-Resident #2 had a chair and bed alarm put in placed on 10/13/22.
-She was not sure if supervision increased for Resident #2 after his fall on 10/12/22.

Interview with a PCA on 10/27/22 at 3:03pm revealed:
-She found Resident #2 on the floor in his room with his back against the bed.
-Resident #2's wheelchair was in front of him.
-Resident #2 did not complain of pain or injury.

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-She was not told to increase supervision for Resident #2 after his fall on 10/12/22, but she checked on him every 1 to 2 hours.
-All residents were checked on every 2 hours.
-It depended on the needs of the resident as to whether there was increased supervision.

Review of Resident #2's 24-Hour Post Fall Checklist dated 10/12/22 revealed:
-Documentation should have been completed on 10/13/22 at 4:45am, 12:45pm and at 8:45pm.
-The documentation at 12:45pm and 8:45pm which indicated there were no complaints of pain or discomfort, there was no change in Resident #2's walking ability, there was no outward rotation of his legs or arms, Resident #2 did not have increased drowsiness, and he did not have any trouble nor was he reluctant to get out of bed.
-There was no documentation at 4:45pm.

Review of Resident #2's Post Fall Investigation Report dated 10/12/22 revealed:
-Resident #2 fell in his room on 10/12/22 at 8:45pm during second shift.
-He fell while trying to get into the bed and did not have any injuries..
-He had last been seen and toileted at 8:00pm prior to the fall.
-Resident #2 needed a 1 person assist with transfers
-The carpet was a possible contributing factor to Resident #2's fall on 10/12/22.
-There were safety interventions for fall prevention in place prior to the fall on 10/12/22 and the interventions were documented in Resident #2's care plan.
-Interventions were reviewed and updated as necessary in Resident #2's care plan and medical record.
-Staff was informed of necessary changes going

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forward.

Review of Resident #2's electronic Medication Administration Records (eMARs) for October 2022 revealed:
-There was an entry for Hot Box Documentation and a full set of vitals scheduled twice a day between 7:00am and 6:59pm and between 7:00pm and 6:59am.
-There was documentation of vitals once on 10/12/22 and twice a day from 10/13/22 through 10/14/22.

Review of the facility's primary care provider's (PCP) progress note dated 10/11/22 revealed Resident #2 was seen on 10/11/22 due to having several skin tears and discoloration to his right hand.

Review of Resident #2's physician's orders dated 10/13/22 revealed a physician's order for a wheelchair alarm and a bed alarm at all times.

Review of Resident #2's hospice provider's progress note dated 10/14/22 revealed:
-Resident #2's right hand was bruise from a reported fall on last week.
-He was able to make a hard fist and move all digits without pain.

Based on record reviews and interviews, there was no documentation increased supervision was implemented for Resident #2 after his fall on 10/11/22.

Attempted telephone interview with the facility's PCP on 10/27/22 at 10:01am was unsuccessful.

Refer to the interview with Resident #2's responsible party on 10/26/22 at 3:38pm.

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D 270	Continued From page 17 Refer to the interview with a personal care PCA on 10/27/22 at 9:12am. Refer to the interview with the Administrator on 10/27/22 at 9:43am. Refer to the interview with the RCD on 10/27/22 at 12:03pm. Refer to the interview with the RCC on 10/27/22 at 1:35pm. Refer to the telephone interview with the Interim Director at Resident #2's hospice provider's office on 10/27/22 at 1:50pm. e. Review of Resident #2's progress notes dated 10/15/22 revealed: -Resident #2 had been shaking all day and could barely hold a cup of water. -Resident #2 fell at 10:55am on 10/15/22 and had a skin tear on his left arm. -Resident #2 stated he did not hit anything. -His bed alarm kept going off and he was not in the bed. -Medication aides (MA) nor personal care aides (PCA) could hear Resident #2's chair alarm. -Resident #2 was having a hard time understanding to use his call bell. Review of Resident #2's Incident/Accident Report dated 10/15/22 revealed: -Resident #2 fell out of his wheelchair in his room on 10/15/22 at 10:55am; his chair alarm was sounding. -The cause of Resident #2's fall was determined to be due to Resident #2's stating his Parkinson's disease was getting worse. -Resident #2 had a skin tear on the back of his	D 270		

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left elbow.
-Resident #2 was placed in the hotbox and staff requested a medical evaluation by his provider.

Interview with the medication aide (MA) who documented the Incident/Accident Report (10/15/22) on 10/26/22 at 4:41pm revealed:
-Resident #2 was found in the middle of the floor in his room.
-He had fallen out of his wheelchair.
-Resident #2 was shaking badly and had a skin tear on his left elbow; he denied having any pain.
-Resident #2's wheelchair alarm was sounding, but it was not connected to the sounding device on the medication cart.
-Staff could only hear Resident #2's wheelchair alarm if they were in front of his room or walking down the hallway.
-She regularly checked on Resident #2 every 2 hours; she checked on him a lot, about 10 times during her shift, because of his history of falls.
-The Resident Care Coordinator (RCC) or the Resident Care Director (RCD) told her how often to check on a resident after a fall.
-All residents were put in the "hot box" after a fall.
-In the "hot box," residents were observed and documented on for 3 days.

Review of Resident #2's 24-Hour Post Fall Checklists revealed there was no checklist dated 10/15/22.

Review of Resident #2's Post Fall Investigation Report dated 10/15/22 revealed:
-Resident #2 fell in his room on 10/15/22 at 10:55am during first shift.
-He had last been seen and toileted at 9:30am prior to the fall.
-He had an injury of a skin tear on his left elbow.
-He needed a 1 person assist with transfers.

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-Resident #2's chair alarm was in place
-There were safety interventions for fall prevention in place prior to the fall on 10/15/22 and the interventions were documented in Resident #2's care plan.
-Interventions were reviewed and updated as necessary in Resident #2's care plan and medical record.
-Staff was informed of necessary changes going forward.

Review of Resident #2's electronic Medication Administration Records (eMARs) for October 2022 revealed:
-There was an entry for Hot Box Documentation and a full set of vitals scheduled twice a day between 7:00am and 6:59pm and between 7:00pm and 6:59am.
-There was documentation of vitals twice a day from 10/17/22 through 10/18/22.
-There was not a third day of Hot Box Documentation.

Review of the facility's primary care provider's (PCP) progress note dated 10/18/22 revealed:
-Resident #2 tried to transfer himself and had increasing weakness in his lower extremities.
-Resident #2's medications would be reviewed to see if they were a contributing factor causing him to fall.
-Resident #2 had shown progression of his Parkinsonism's which was contributing to his overall decline.

Based on record reviews and interviews, there was no documentation increased supervision was implemented for Resident #2 after his fall on 10/15/22.

Attempted telephone interview with the facility's

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D 270	Continued From page 20 PCP on 10/27/22 at 10:01am was unsuccessful. Refer to the interview with Resident #2's responsible party on 10/26/22 at 3:38pm. Refer to the interview with a personal care PCA on 10/27/22 at 9:12am. Refer to the interview with the Administrator on 10/27/22 at 9:43am. Refer to the interview with the RCD on 10/27/22 at 12:03pm. Refer to the interview with the RCC on 10/27/22 at 1:35pm. Refer to the telephone interview with the Interim Director at Resident #2's hospice provider's office on 10/27/22 at 1:50pm. _____ Interview with Resident #2's responsible party on 10/26/22 at 3:38pm revealed: -Resident #2 wanted to be as self-sufficient as possible. -Resident #2 had falls when he attempted to put himself to bed. -During his last fall, Resident #2 rolled off the bed from a seated position onto the floor. -Resident #2 had a mattress on his hospital bed that was raised on both sides; they thought it would help keep him in the bed. -Resident #2 would still get out of bed, but when he got to the raised part of the mattress, he would roll out of bed to the floor. -She suggested that the facility change mattresses and a regular hospital bed mattress had worked better. -Resident #2 had fallen about 3 times in the last 2 to 3 weeks.	D 270		

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D 270	Continued From page 21 -He sustained skin tears from his falls, but there had been no significant injuries. -She did not recall the facility saying they were doing anything differently for Resident #2. -The facility installed a bed alarm on Resident #2's bed and a chair alarm on Resident #2's wheelchair; she came in the facility one day and the alarms were in place. -She initiated the hospital bed and the halo on Resident #2's bed. -When she came into Resident #2's room today, 10/26/22, Resident #2's bed alarm was on the chair instead of the bed. -She thought Resident #2 had taken the bed alarm and placed it on the chair. -After she started playing with the bed alarm, staff came into the room to check on Resident #2. -Staff had told her that the bed alarm was sounded at the nurse's station, but the chair alarm did not, so they left Resident #2's door open so they could hear if the chair alarm went off. -She had not been told staff would increase supervision for Resident #2. -Staff peeked their heads in his room and brought him water and snacks, but she did not know how often. Interview with a PCA on 10/27/22 at 9:12am revealed: -If a resident had a fall, she called a medication aide (MA) via walkie talkie and sat with the resident until the MA got to the location of the fall. -The MA asked the resident questions and the PCA and the MA got the resident up from the floor together. -Resident #2 was a high fall risk and had a lot of falls because he tried to be independent. -He had not experienced any falls since his bed and chair alarms were put in placed.	D 270		

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D 270	Continued From page 22 -She had been told to check on Resident #2 every hour, but she did not know when; if she had checked on Resident #2 every hour, it would have been documented on his electronic Medication Administration Records (eMARs) system in his record of activities of daily living (ADL). -She thought Resident #1 had been placed on hourly checks because of his incontinence and need for frequent changes; she did not remember when he was placed on hourly checks. Interview with the Administrator on 10/27/22 at 9:43am revealed: -Residents received increased safety checks after falls. -If safety checks had been increased and a resident had another fall, safety checks were to be increased again. -Increased safety checks were usually in place for a week or 2. -The Resident Care Director (RCD) or the Resident Care Coordinator (RCC) reviewed the Incident/Accident Reports and determined interventions and increased safety checks. -The PCAs documented any increased safety checks on the ADL log. Interview with the RCD on 10/27/22 at 12:03pm revealed: -If a resident had a fall, they were checked on 8 hours, 16 hours, and 24 hours post fall and MAs were to document answers to questions regarding pain and mobility. -MAs were also to complete a Post Fall Investigation Report and Incident/Accident Report. -She reviewed the reports and put interventions in place. -Residents were to be checked on every 2 hours, 1 hour, or 30 minutes according to their needs.	D 270		

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D 270	Continued From page 23 -Checking on residents did not just mean sticking your head in the door. -When checking on residents, staff should have offered toileting, food, or anything the resident might need sot the resident would not feel the impulse to get up independently. -There were interventions added for Resident #2 after each of his falls. -There were no increases in supervision put in place for Resident #2 after any of his falls. -Safety checks were good, but they were not a long-term solution. -She tried to figure out what would help prevent future falls like being proactive with toileting needs and chair and bed alarms. -Resident #2 had not had any falls since his chair and bed alarms were put in place. -Resident #2's chair alarm did not connect to the sounding device on the medication cart; the chair alarm only sounded from the resident's chair. Interview with the RCC on 10/27/22 at 1:35pm revealed: -After a fall, MAs completed a 24-hour Post Fall checklist, documented chart notes, and placed the resident in the hot box for 3 days on both shifts. -Staff requested for residents to visit with the facility primary care provider (PCP) after a fall. -She knew about Resident #2's falls in September and October 2022, but she did not recall if there was an increase in supervision after any of his falls. -She and the RCD were responsible for determining if a resident had increased supervision after a fall. -All residents were routinely checked on every 2 hours. -Residents were not necessarily placed on increased 1 hour or 30-minute safety checks after	D 270		

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D 270	Continued From page 24 a fall. Telephone interview with the Interim Director at Resident #2's hospice provider's office on 10/27/22 at 1:50pm revealed: -Resident #2 was admitted to hospice services on 05/10/22 and was currently receiving visits once a week with 3 additional visits as needed for symptom management. -The hospice provider ordered a wheelchair for resident #2 on 08/12/22 and there was a replacement order for a wheelchair on 09/12/22 and anti-lock brakes on 10/03/22. -The skilled nurse documented on the last visit, 10/24/22, that there was a bed alarm and fall alarm in place for Resident #2; he was a high risk for falls. -There was documentation Resident #2 had 2 skin tears on his right arm, but they were healed.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure referral and follow up for 1 of 5 (#4) sampled residents who had a neurology referral ordered by a licensed practitioner in May 2022. The findings are: Review of Resident #4's current FL-2 dated 07/05/22 revealed diagnoses included paroxysmal atrial fibrillation, essential	D 273		

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hypertension, anxiety disorder, chronic obstruction pulmonary disease (COPD), chronic kidney disease, dyslipidemia, back pain, benign prostatic hypertrophy (BPH), and pacemaker.

Review of Resident #4's Primary Care Provider (PCP) orders dated 05/24/22 revealed there was an order for a neurology consult to evaluate tremor.

Review of Resident #4's PCP visit dated 05/24/22 revealed:
-There was documentation that Resident #4 reported he had tremors in his right hand that were becoming worse.
-Resident #4 reported he previously was recommended to see a neurologist, but never saw one.
-There was documentation that the PCP would write a referral for neurology.

Review of Resident #4's record revealed there was no documentation of a after visit summary for a neurology appointment.

Observation of Resident #4 in his room on 10/27/22 at 9:02am revealed:
-He was eating his breakfast meal.
-His right hand had tremors when he held his fork.
-His right hand had tremors while he spoke and maneuvered his napkin.

Interview with Resident #4 on 10/27/22 at 9:02am revealed:
-His right hand had tremors but he did not know the reason for the tremors.
-He did not recall an injury or reason that caused his right hand to tremor.
-He did not have tremors anywhere else but his

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KERNER RIDGE ASSISTED LIVING	250 HOPKINS ROAD KERNERSVILLE, NC 27284

(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
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right hand.
-He wanted to know what caused his right hand to tremor and had asked his PCP about the tremors.
-He had not seen a neurologist since his admission at the facility.

Interview with a medication aide (MA) on 10/27/22 at 11:10am revealed the referrals and appointments were managed by the Resident Care Coordinator (RCC) and the transportation person.

Telephone interview with the transportation person on 10/27/22 at 12:09pm revealed:
-She was given the order sheets with orders for referrals or consults.
-If the resident had family who were involved, she called the family to ask if the resident had seen a specialist previously.
-If the resident was seen previously by the same type of specialist that the referral or consult required, she made an appointment with the same specialist's office.
-If the family told her that they would make the appointment, she would ask if the family also planned to transport the resident.
-She transported the resident if the family did not plan to do so.
-She made the appointment when the family did not make the appointment.
-She wrote appointments on a board at the work station so that the aides knew who to prepare to leave the facility for an appointment.
-She did not recall receiving the order in May 2022 for Resident #4, but she was also in another role in May 2022.
-She was the dietary manager (DM) and the transportation person in May 2022.
-There was a medication aide (MA) who helped

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with transportation while she was the DM.
-She did not know if the MA made an appointment with neurology for Resident #4.
-She could not find any documentation in her work area concerning an appointment for Resident #4 with neurology.
-She had recently taken Resident #4 to an appointment with an eye doctor at a federal government hospital.
-He received some of his medical care at the federal government hospital and his PCP at that hospital had told Resident #4 that he would order a consult for neurology.
-She thought Resident #4's PCP at the federal government hospital did not follow through and order the referral for neurology.
-Resident #4's family member also took him to some appointments, but she did not remember Resident #4 attending an appointment for neurology with his family.

Interview with the RCC on 10/27/22 at 1:46pm revealed:
-She knew about Resident #4's referral for neurology.
-When the PCP ordered a referral or consult, she gave it to the transportation person.
-The transportation person telephoned the family member to determine if the resident had seen a specialist previously.
-The transportation person also determined if the family member would make the appointment and transport the resident.
-If the family was not planning to make the appointment then the transportation person made the appointment at the selected specialists office.
-There was no process in place to check to ensure resident's appointments were made for referrals or consults.
-She did not know Resident #4's neurology

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appointment was not made.
-The transportation person was responsible for ensuring Resident #4's appointment was made in a timely manner.

Interview with the Director of Clinical Services (DCS) on 10/27/22 at 2:40pm revealed:
-The RCC handled referrals and consults.
-When a referral/consult was ordered, the transportation person was given the order.
-The transportation person called the family member if applicable to determine if the resident had a specialist that they had seen previously; and if the family planned to make the appointment and transport the resident.
-If the family did not plan to make the appointment and transport the resident, then the transportation person made the appointment and transported the resident.
-There was no process in place to ensure residents appointments were made for referrals/consults.
-There was no process in place to follow-up with the transportation person to ensure an appointment was made for referrals/consults.
-She did not remember an order for a neurology consult for Resident #4.
-She knew Resident #4 had tremors and complained about the tremors every once in a while.
-The RCC was responsible for ensuring resident's referrals/consults were completed.

Interview with the Administrator on 10/27/22 at 3:16pm revealed:
-She expected referrals to be managed by the RCC, transportation person and DCS appointments made in a timely manner.
-She expected appointments to be made within 2-3 days of the referral by the transportation

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D 273	Continued From page 29 person. -She called the transportation person when attempting to locate documentation of a neurology appointment for Resident #4, but no documentation could be found. -The RCC, transportation person, and DCS were responsible for ensuring appointments for referrals were made in a timely manner. Attempted telephone interview with Resident #4's PCP on 10/27/22 at 10:01am was unsuccessful.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to clarify medication orders for amlodipine with the prescribing practitioner for 1 of 5 sampled residents (Resident #5) who had orders for a scheduled dose and as needed dose of amlodipine with parameters for systolic blood pressure.	D 344		

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D 344	Continued From page 30 The findings are: Review of Resident #5 current FL-2 dated 10/14/22 revealed: -Diagnosis included hypertension, congestive heart failure (CHF), type 2 diabetes mellitus, cardiomyopathy, chronic kidney disease. -A medication order for amlodipine 2.5 mg by mouth as needed, without a frequency. -There was another mediation order for amlodipine 2.5mg by mouth "routine", without a frequency. Review of Resident #5's previous Primary Care Provider (PCP) orders revealed: -There was an order dated 08/12/22 for amlodipine 2.5mg daily as needed for systolic blood pressure more than 159mmHG. -There was an order dated 09/06/22 to discontinue amlodipine 2.5mg one tablet daily as needed for systolic blood pressure more than 159 mmHG. -There was an order dated 09/06/22 amlodipine 2.5mg tablet take one tablet daily as needed for systolic blood pressure more than 150 mmHG. -There was an order dated 09/20/22 amlodipine 2.5mg tablet every morning and there was documentation in parenthesis to keep the as needed order. Review of Resident #5's pharmacy review dated 10/25/22 revealed there were comments from the pharmacist that amlodipine was administered once for October 2022 but Resident #5's systolic blood pressure was more than 150 almost every day. Review of Resident #5's September 2022 electronic medication administration record	D 344		

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D 344	Continued From page 31 (eMAR) 09/21/22 -09/30/22 revealed: -There was an entry for amlodipine 2.5mg tablet take one tablet daily, scheduled for 9:00am. -There was documentation of administration of amlodipine from 09/21/22 to 09/30/22 at 9:00am. -There was an entry for amlodipine 2.5mg tablet take one tablet daily as needed for systolic blood pressure more than 150. -There was documentation of administration of amlodipine as needed on 09/20/22 for a systolic blood pressure of 196 and 09/21/22 for a systolic blood pressure of 179. -There was an entry to record heart rate and blood pressure daily, scheduled for 9:00am to 12:00pm. -Resident #5's systolic blood pressure was more than 150 mmHG on 09/22/22, 09/23/22, 09/26/22, 09/27/22, 09/28/22, and 09/29/22. -Resident #5 had 6 of 9 opportunities when her systolic blood pressure met the parameter for administration of amlodipine 2.5mg as needed and it was not documented as administered. Review of Resident #5's October 2022 eMAR 10/01/22-10/25/22 revealed: -There was an entry for amlodipine 2.5mg tablet take one tablet daily, scheduled for 9:00am. -There was documentation of administration of amlodipine from 10/01/22 to 10/25/22 at 9:00am. -There was an entry for amlodipine 2.5mg tablet take one tablet daily as needed for systolic blood pressure more than 150. -There was documentation of administration of amlodipine as needed on 10/15/22 for a systolic blood pressure of 173. -There was no other documentation of administration of amlodipine as needed for the month of October 2022. -There was an entry to record heart rate and blood pressure daily, scheduled for 9:00am to	D 344		

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12:00pm.
-Resident #5's systolic blood pressure was more than 150 mmHG from 10/01/22 to 10/09/22, 10/11/22, 10/12/22, from 10/16/22 to 10/18/22, 10/20/22, 10/21/22, and from 10/23/22 to 10/25/22.
-There were 19 of 24 opportunities when Resident #5's blood pressure met the parameter for administration of amlodipine 2.5mg as needed and it was not documented as administered.

Observation of Resident #5's medications on the medication cart on 10/27/22 at 12:30 pm revealed:
-There were two bubble packets of amlodipine.
-One bubble packet was for the daily dose of amlodipine and contained 8 of 28 tablets.
-The bubble packet was dispensed on 10/06/22.
-There were 26 of 30 amlodipine tablets present in a bubble packet.
-The bubble packet for amlodipine tablets as needed was dispensed on 10/15/22.

Interview with Resident #5 on 10/25/22 at 10:01am revealed:
-She resided at the facility for 3 years.
-She had diagnoses of high blood pressure and diabetes.
-She saw her PCP on Tuesdays.

A second interview with Resident #5 on 10/27/22 at 8:48am revealed:
-She thought her blood pressure was a little better.
-She thought her blood pressure was hard to control, one day it was good and the next day it was high.
-There were times her blood pressure was high as 190.
-She received blood pressure medication in the

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morning and she had her blood pressure checked in the morning.
-There was a time that she did not take amlodipine and used other medications to control her high blood pressure.
-Her PCP at the facility placed her back on amlodipine.
-When her blood pressure was high, she felt jittery.
-However, she felt the same way when her blood sugar was low so she did not know which one made her feel jittery.
-When she did not feel well, she knew to notify staff.
-Staff would check her blood pressure.

Interview with a medication aide (MA) on 10/27/22 at 11:10am revealed:
-Any new orders were given to the Resident Care Coordinator (RCC) by PCP.
-The RCC faxed new orders to the pharmacy.
-The pharmacy delivered medications for the facility and MAs placed the medications on the medication cart.
-The RCC, MA or the Director of Clinical Services (DCS) checked the order placed in the computer system by pharmacy.
-When there was an entry to check a resident's blood pressure, there was no link that prompted a MA to check the list of as needed medication.
-The resident's blood pressure was checked at the time it appeared on the computer screen.
-If a resident's blood pressure was high, she told the RCC.
-The RCC would tell her about any as needed medications or she would tell her what to do for the blood pressure.
-The RCC might tell her to notify the PCP or retake the blood pressure.
-The MA had not administered the as needed

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dose of amlodipine to Resident #5 because she received the scheduled dose of amlodipine.
-She thought a note would have to be entered on Resident #5's blood pressure check entry on the eMAR to guide MAs to refer to the as needed medication.
-She thought the order needed to be clarified for when to administer the as needed dose of amlodipine and scheduled dose of amlodipine.

Telephone interview with a MA on 10/27/22 at 12:23pm revealed:
-She knew Resident #5 had an order for as needed amlodipine.
-However, the PCP changed the as needed amlodipine to scheduled.
-Resident #5 would use her call bell to call if she did not feel well.
-She checked Resident #5's blood pressure when she did not feel well.
-If Resident #5's blood pressure was high she told the RCC.
-If it was a weekend she would call the RCC on the phone.
-Resident #5's blood pressure was always high when she obtained it.
-When giving Resident #5 medications, she first checked her blood pressure then administered medications to her.
-If Resident #5 had an as needed medication for high blood pressure she would administer it.
-She knew Resident #5 had an as needed medication for high blood pressure because she had previously worked with her.
-She did not think a new MA or agency MA would know Resident #5 had an as needed order for high blood pressure.
-The eMAR system did not guide MAs to the as needed medication list and MAs had to click on a specific button to view the as needed

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medications.

Telephone interview with another MA on 10/27/22 at 12:38pm revealed:
-She did not remember Resident #5's medications.
-If a resident's blood pressure was high she would give the medication and call the PCP.
-The PCP would provide instructions for what to do for the resident's high blood pressure.
-Usually, there were notes on an entry for blood pressure, such as call the PCP if it was a certain measurement, or instructions for what to do next.
-She did not know of any link between the vital signs and as needed medications.
-A note had to be on the entry in the eMAR system referring MAs to as needed medications for vital sign parameters.

Telephone Interview with the pharmacist on 10/27/22 at 11:53am revealed:
-She completed a pharmacy review on 10/25/22 and provided some input on Resident #5's amlodipine order.
-A MA would not be referred to any as needed medication in the eMAR system as the result of obtaining a vital sign.

Telephone interview with Resident #5's PCP on 10/27/22 at 9:35am revealed:
-Resident #5 had intermittent episodes of high blood pressure.
-She did not recall Resident #5's blood pressure reading but she noted them in her visit notes.
-She expected staff to administer Resident #5's as needed amlodipine as ordered.
-She did not want staff to administer the scheduled dose with the as needed dose.
-She did not specify when to take Resident #5's blood pressure but she thought Resident #5

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would call when she felt her blood pressure was high.
-She expected staff to recheck Resident #5's blood pressure if it was high.

Interview with the RCC on 10/27/22 at 1:46pm revealed:
-If a resident had a high blood pressure, she expected the MAs to recheck the blood pressure.
-She expected the MAs to administer the as needed medication if the resident had one to administer for blood pressure readings that met the parameter.
-She was a MA and always reviewed residents list of as needed medications.
-She expected MAs to do as she did and read through the as needed medications.
-She expected the MAs to ask for guidance when a resident had a high blood pressure reading.
-She knew the facility used agency staff for MA coverage.
-To her knowledge, there was no link between obtaining an abnormal vital sign and the as needed medications.
-She thought a MA not familiar with Resident #5 would obtain her BP, administer the scheduled dose of blood pressure medications and not look for an as needed medication.
-She thought Resident #5's orders needed to be clarified or rewritten to provide clear guidance to MAs.
-She had not discussed clarifying Resident #5's amlodipine order with the PCP.

Interview with the Director of Clinical Services on 10/27/22 at 2:40pm revealed:
-She expected the MAs to obtain blood pressures and document the values on the eMAR.
-Full time staff were good about making she and the RCC aware when a low or high blood

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D 344	Continued From page 37 pressure was obtained. -The facility had agency staff and new MAs who did not always know the expectations. -Resident #5 had an order for blood pressure monitoring without guidance to administer the as needed amlodipine. -Resident #5 also had a scheduled order for amlodipine. -There was no guidance for when to use the as needed dose of amlodipine in conjunction with the scheduled dose or to use at a different time. -The pharmacist had made her aware of the lack of guidance regarding Resident #5's amlodipine orders. -She did not think agency staff or new MAs would know Resident #5's list of medications. -She had not contacted Resident #5's PCP concerning the amlodipine orders. -She and the RCC were responsible for obtaining clarification for orders. Interview with the Administrator on 10/27/22 at 3:16 pm revealed: -If an order was unclear, she expected the MA, RCC or DCS to contact the PCP. -She thought orders for blood pressures needed parameters with guidance. -She did not know if the eMAR system guided MAs to use a as needed medication in response to a vital sign. -She thought Resident #5's blood pressure entry and amlodipine as needed order needed to be connected within the eMAR system so that it would be clear for MAs. -She held the clinical staff responsible for ensuring orders were clarified.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 38 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: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 5 residents (#5) to include an as needed order for amlodipine with parameters to administer based on the systolic blood pressure (SBP). The findings are: Review of Resident #5 current FL-2 dated 10/14/22 revealed: -Diagnosis included hypertension, congestive heart failure (CHF), type 2 diabetes mellitus, cardiomyopathy, chronic kidney disease. -A medication order for amlodipine 2.5 mg by mouth as needed, without a frequency. Review of Resident #5's previous Primary Care Provider (PCP) orders revealed: -There was an order dated 08/12/22 for amlodipine 2.5mg daily as needed for a SBP of more than 159 mmHG. -There was an order dated 09/06/22 to discontinue amlodipine 2.5mg one tablet daily as needed for SBP of more than 159 mmHG. -There was an order dated 09/06/22 amlodipine 2.5mg tablet take one tablet daily as needed for SBP of more than 150 mmHG.	D 358		

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	HAL034058	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERNER RIDGE ASSISTED LIVING	250 HOPKINS ROAD KERNERSVILLE, NC 27284

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-There was an order dated 09/20/22 amlodipine 2.5mg tablet every morning and there was documentation in parenthesis to keep the as needed order.

Review of Resident #5's August 2022 electronic medication administration record (eMAR) 08/12/22-08/31/22 revealed:
-There was an entry for amlodipine 2.5mg take one tablet daily as needed for SBP more than 159 mmHG.
-Amlodipine 2.5mg was administered as needed on 08/16/22, 08/18/22, 08/19/22, 08/20/22, 08/21/22, 08/22/22, 08/23/22, 08/28/22, 08/30/22, and 08/31/22.
-On 08/22/22 and 08/23/22, amlodipine 2.5mg was administered twice to Resident #5.
-There was an entry to record heart rate and blood pressure daily, scheduled for 9:00am to 12:00pm.
-Resident #5's SBP was more than 159 mmHG on 08/12/22 (182), 08/13/22 (187), 08/14/22 (163), 8/17/22 (170), 08/24/22 (163), and 08/26/22 (161).
-There were 6 opportunities when Resident #5's SBP met the parameter for administration of amlodipine 2.5mg and it was not documented as administered.

Revealed Resident #5's September 2022 eMAR 09/01/22-09/20/22 revealed:
-There was an entry for amlodipine 2.5mg take one tablet daily as needed for SBP more than 159 mmHG.
-Amlodipine 2.5mg was administered on 09/01/22 for SBP of 179 and on 09/03/22 for a SBP of 172.
-There was documentation of "discontinued" on 09/03/22 for this entry on the eMAR.
-Resident #5's SBP was more than 159 mmHG on 09/02/22, but there was no documentation that

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amlodipine was administered.
-There was another entry for amlodipine 2.5mg take one tablet daily as needed for a systolic blood pressure more than 150 mmHG.
-Amlodipine 2.5mg was administered as needed for SBP more than 150 from 09/04/22 to 09/07/22, from 09/09/22 to 09/11/22, from 09/13/22 to 09/14/22, and from 09/16/22 to 09/20/22.
-Resident #5's SBP was more than 150 mmHG on 09/08/22 (174), 09/12/22 (171), and 09/15/22 (160).
-There were 4 opportunities when Resident #5's SBP met the parameter for administration of amlodipine 2.5mg and it was not documented as administered.

Review of Resident #5's progress notes dated 08/24/22 revealed:
-Two MAs documented administering amlodipine as needed to Resident #5 at 2:29pm and 11:41pm.
-These two doses were not documented on Resident #5's August 2022 eMAR.

Observation of Resident #5's medications on the medication cart on 10/27/22 at 12:30 pm revealed:
-There were two bubble packets of amlodipine.
-One bubble packet was for the daily dose of amlodipine and contained 8 of 28 tablets.
-The bubble packet was dispensed on 10/06/22.
-There were 26 of 30 amlodipine tablets present in a bubble packet.
-The bubble packet for amlodipine tablets as needed was dispensed on 10/15/22.

interview with Resident #5 on 10/27/22 at 8:48am revealed:
-She thought her blood pressure was hard to

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control, one day it was good and the next day it was high.
-There were times her blood pressure was high as 190.
-Her PCP at the facility placed her on amlodipine.
-When her blood pressure was high, she felt jittery.
-However, she felt the same way when her blood sugar was low, so she did not know which one made her feel jittery.
-When she did not feel well, she knew to notify staff.
-Staff would check her blood pressure and she did not recall if they gave her medication each time her blood pressure was high.

Telephone interview with the facility's contracted pharmacist on 10/27/22 at 11:53am revealed:
-Resident #5 had an order for amlodipine 2.5mg daily as needed for a SBP more than 159 dated 08/12/22.
-On 09/03/22, the parameter for the as needed amlodipine order changed to more than 150.
-She interpreted the order as staff needed to obtain Resident #5's blood pressure and administer amlodipine if the SBP met the parameter.
-The PCP's orders should be followed to assist with controlling Resident #5's BP.
-She did not think the eMAR system guided MAs to review the as needed medications (prn) in response to a blood pressure measurement.

Telephone interview with a representative at the facility's contracted pharmacy on 10/27/22 at 11:39am revealed:
-There was a current order for amlodipine 2.5mg daily as needed for SBP more than 150 mmHG sent electronically for Resident #5 on 09/03/22.
-There was an order to continue using the as

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needed order for amlodipine 2.5mg dated 09/20/22.
-Thirty tablets of amlodipine were dispensed for the as needed order on 09/07/22 and 10/15/22.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/27/22 at 9:35am revealed:
-She ordered amlodipine 2.5mg for Resident #5 after she continued having high blood pressure measurements.
-Resident #5 took other blood pressure medications in August 2022.
-Resident #5 had scheduled lisinopril, hydralazine, and she ordered a scheduled dose of amlodipine for Resident #5 in September 2022.
-She expected staff to take Resident #5's blood pressure daily.
-If Resident #5's blood pressure met the parameter for receiving amlodipine, she expected staff to follow the instructions for administering the as needed amlodipine.
-She was not notified of any concerns regarding Resident #5's as needed dose of amlodipine in August 2022 or September 2022.
-She thought staff administered the as needed dose of amlodipine as ordered.

Interview with a day shift medication aide (MA) on 10/27/22 at 11:10am revealed:
-She knew Resident #5 had an order to obtain her blood pressure daily.
-She knew Resident #5 had an order to administer amlodipine as needed based on Resident #5's blood pressure readings.
-She did not work as a MA each day and she helped where she was needed.
-The facility also used agency staff to supplement the regular staff.
-The eMAR system would not alert a MA to look

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at a resident's list of as needed medications in relation to obtaining a blood pressure.
-A note would have to be added to the eMAR entry for the blood pressure.
-She thought some MAs did not administer the as needed dose of amlodipine when Resident #5's SBP met the parameter because they were unaware of the as needed amlodipine order.

Interview with the Resident Care Coordinator (RCC) on 10/27/22 at 1:46pm revealed:
-She expected MAs to report to her when a resident's blood pressure was high.
-When MAs reported a resident's high blood pressure to her she notified the PCP, requested that a second blood pressure was obtained, or guided them to any as needed medication she knew the resident had.
-She did not know of any linkage between a blood pressure entry and as needed medications.
-A note would have to be on the entry for blood pressures to guide MAs to a specific as needed medication.
-She knew Resident #5 had an order to check her blood pressure daily and she had an as needed order for amlodipine.
-She did not know Resident #5 did not receive amlodipine as ordered in the months of August 2022 and September 2022.
-She had spoken with Resident #5's PCP concerning her high blood pressure and a scheduled dose of amlodipine was ordered.
-She held the MAs responsible for administering as needed medications as ordered.

Interview with the Director of Clinical Services (DCS) on 10/27/22 at 2:40pm revealed:
-She did not know Resident #5 did not receive as needed amlodipine as ordered during the months of August 2022 and September 2022.

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D 358	Continued From page 44 -The pharmacist brought the issue to her attention on 10/25/22 that the blood pressure entry did not refer MAs to the as needed dose of amlodipine when Resident #5 had a high blood pressure reading. -She made every effort to review orders to ensure the MAs were able to understand the order as written. -The facility had agency staff and new MAs who might not be familiar with Resident #5's as needed medications. -Resident #5's as needed amlodipine order needed additional notes on the entry in the eMAR system. -She held herself and the RCC responsible for ensuring medications were administered as ordered. Interview with the Administrator on 10/27/22 at 3:16pm revealed: -She expected MAs to read and follow the instructions for administering medications to residents. -She was a MA as well as the Administrator. -She did not think there was a link between as needed medications and a vital sign with parameters. -She thought an additional note would have to be added to the entry for the scheduled blood pressures to guide MAs to refer to an as needed medication. -She held the clinical staff responsible for ensuring medications were administered as needed. Attempted telephone interview with a MA on 10/27/22 at 12:22pm was unsuccessful.	D 358		