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	HAL088015	A. BUILDING: _____ B. WING _____	R 11/03/2023

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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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D 000	Initial Comments The Adult Care Licensure Section and the Transylvania County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 10/31/23-11/03/23. The complaint investigation was initiated by the Transylvania County Department of Social Services on 10/27/23.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure walls, floors, and furnishings were kept clean in a resident's bathroom. The findings are: Observation of a resident's bathroom on 10/31/23 at 10:05am revealed there was a dried, brown-colored substance smeared on the elevated commode seat arm and leg, sink, floor in front of the commode, and wall/doorway. Observation of the resident's room on 11/02/23 at 9:50am revealed there was a strong odor of urine in the room.	D 074		

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D 074	Continued From page 1 Interview with the resident's family member on 11/02/23 at 9:50am revealed: -The resident's bathroom was usually dirty when she visited. -She noticed a strong odor of urine in the room when she arrived this morning. -She visited the resident on 10/29/23 and the bathroom had stool smeared all over the sink, the wall/doorway, floor, and elevated commode seat which was still present today. -She never saw a housekeeper cleaning the residents' rooms. Interview with a PCA on 11/02/23 at 11:46am revealed the facility did not currently have a housekeeper. Interview with a medication aide (MA) on 11/02/23 at 2:56pm revealed the facility did not have a housekeeper for the last 3 months. Interview with a PCA on 11/03/23 at 9:05am revealed she did not know if the resident's bathroom that was observed dirty today (11/03/23) had been cleaned since she cleaned it about a week ago. Interview with the Administrator on 11/03/23 at 11:53am revealed: -The facility did not have a housekeeper currently. -The PCAs were responsible for taking the garbage out of the residents' rooms while rounding, cleaning up spills, but not for deep cleaning in the residents' rooms/bathrooms. -She, the Business Office Manager, or Special Care Coordinator (SCC) rotated working on the weekends and would clean the residents' rooms/bathrooms. -She did not know there was dried, brown stool	D 074		

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D 074	Continued From page 2 smeared on a resident's sink, elevated commode seat, floor, and doorway/wall since 10/29/23 that had not been cleaned.	D 074		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interviews, the facility failed to ensure at least one staff person was always on the premises, on 3rd shift, who successfully completed a course in cardio-pulmonary resuscitation (CPR) within the last 24 months for 11 of 14 shifts from 10/20/23 through 11/02/23. The findings are: Review of staff assignment sheets and the time	D 167		

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punch detail reports for third shift dated 10/20/23 revealed there were no CPR certified staff that worked from 12:00am - 8:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 10/21/23 revealed there were no CPR certified staff that worked from 12:00am - 7:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 10/22/23 revealed there were no CPR certified staff that worked from 12:00am - 7:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 10/23/23 revealed there were no CPR certified staff that worked from 12:30am - 8:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 10/24/23 revealed there were no CPR certified staff that worked from 12:00am - 7:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 10/26/23 revealed there were no CPR certified staff that worked from 12:00am - 8:00am.
Review of staff assignment sheets and the time punch detail reports for third shift dated 10/28/23 revealed there were no CPR certified staff that worked from 12:00am - 8:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 10/30/23 revealed there were no CPR certified staff that worked from 12:15am - 8:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 10/31/23

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revealed there were no CPR certified staff that worked from 12:00am - 8:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 11/01/23 revealed there were no CPR certified staff that worked from 12:15am - 8:00am.

Review of staff assignment sheets and the time punch detail reports for third shift dated 11/02/23 revealed there were no CPR certified staff that worked from 12:15am - 7:30am.

Interview with the Administrator on 11/03/23 at 2:30pm revealed:
-She had discussed with corporate staff several months ago regarding staff who had expired and not taken the CPR training.
-She had not yet received clarification from corporate whether staff were responsible to update their CPR training or if corporate would provide a trainer for the staff to renew their CPR certification.
-She was not aware until 11/03/23 that she did not have staff on 3rd shift who were CPR certified or their CPR certification had expired.
-Any staff working who had CPR certification, even if it had expired, could perform CPR in an emergency.

_____

The facility failed to ensure at least one staff was always on the premises who had completed a course in CPR within the last 24 months on 3rd shift for 11 of 14 shifts from 10/20/23 through 11/02/23. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/03/23 for

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D 167	Continued From page 5 this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 18, 2023.	D 167		
D 206	10A NCAC 13F .0604 (2--b) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staff The following describes the nature of the aide's duties, including allowances and limitations: (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure any assigned housekeeping tasks (cleaning resident rooms and the facility linen and laundering residents' clothing) by personal care aides and medication aides were limited to occasional, non-routine tasks between 7:00am through 9:00pm. The findings are: Review of the facility census on 10/31/23 revealed there were 40 residents currently residing in the facility.	D 206		

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D 206	Continued From page 6 Observation of the hallway on 11/02/23 at 11:38am revealed there was a personal care aide (PCA) cleaning a resident's room with the housekeeping cart parked outside the doorway of the room. Interview with a first shift PCA on 11/02/23 at 11:46am revealed: -The facility did not have a housekeeper or laundry person and she was assigned to change the bed linens, sweep, and mop the residents' rooms and launder the residents' clothing while providing care to the residents. -She was given verbal instructions by the Administrator of the housekeeping tasks to complete during her shift at the beginning of each shift during the stand-up meeting. Interview with a medication aide (MA) on 11/02/23 at 2:56pm revealed: -The facility did not have a housekeeper or laundry person for the last 3 months. -There were usually 3 staff working on first shift for approximately the last 4 months. -Staffing was short the last 9 months. -She was responsible for administering the resident's medications, helping the PCAs provide care to the residents, assisting with the resident's laundry, and whichever area she was assigned to complete housekeeping duties at the beginning of her shift including changing bed linens, sweeping, mopping, and wiping down the surfaces in the residents' bathrooms. Interview with a second, first-shift PCA on 11/02/23 at 3:45pm revealed: -She was doing a lot of other duties other than her PCA work since they were so short staffed on most of her shifts. -She and other PCAs and MAs were doing	D 206		

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laundry and housekeeping duties in addition to their PCA work.
-It was difficult to get everything done for the residents.
-Dental care was a particular area that was not always given to the residents because of understaffing.

Interview with a MA on 11/03/23 at 9:45am revealed:
-The extra job duties on her shift included laundry, cleaning handrails, sweeping, mopping and laundry.
-The staff tried to get everything done for the residents, but it was not always possible.
-Rounds every two hours did not always happen.

Interview with a first and second shift PCA on 11/03/23 at 10:08am revealed:
-Staffing for at least the last couple of months was not adequate.
-Some days she worked first and second shift.
-She was required to provide personal care and assistance to the residents as well as doing laundry every day and completing housekeeping duties such as cleaning the resident's rooms, sweeping, mopping, and taking out the trash each shift she worked.
-She tried to round on the residents while performing the housekeeping duties.
-She could not supervise the residents to prevent falls from occurring while she was in the laundry room doing the laundry.

Interview with a first shift PCA on 11/03/23 at 9:05am revealed the facility did not have a housekeeper or laundry person and she was verbally assigned at the beginning of her shift by the Administrator to clean the residents' rooms and do the laundry while providing care to the

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residents on first shift.

Observation of the laundry room on 11/03/23 at 9:06am revealed:
-There was one tall laundry hamper filled with dirty clothes and labeled with a resident's name.
-There were 5 large garbage cans labeled as "dirty" overflowing with dirty clothes and linens and 1 large garbage can filled ¾ full of dirty clothes and linens.
-There was one washing machine and 2 dryers all full of laundry.
-The left side of the room had a 2-tiered clothing rack full of clean clothing on hangers.
-There was a large rectangular table with piles of clothes with hangers lying in stacks on the table identified as clean clothing by a PCA.
-There were at least 3 tall laundry hampers and one short laundry hamper full of clean clothing.
-The Maintenance Director was lying on the floor with the bottom portion of one of the dryers removed and was working on the dryer.

Interview with the Administrator on 11/03/23 at 11:53pm revealed:
-The facility did not currently have housekeeping or laundry personnel.
-The MAs and PCAs job responsibilities included removing garbage bags from the resident's rooms and 3rd shift staff completed 2-3 loads of laundry at night.
-The first and second shift PCAs and MAs were not required to perform housekeeping duties or do laundry except if there were not enough clean linens.
-She did not know why staff said she assigned the housekeeping and laundry duties to complete during their shifts.
-She, the Business Office Manager, or the SCC rotated working on the weekends and would do

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D 206	Continued From page 9 deep cleaning in the resident's rooms.	D 206		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 residents (Resident #1 and #3) related to a resident who had a diagnosis of dementia and a history of wandering and eloped from the facility without staff knowledge (#3) and for a resident who experienced 2 falls in one month requiring first aid and admission to hospice (#1). The findings are: 1. Review of the facility's policy and procedure for missing residents on 10/27/23 at 10:00am revealed: -A resident will be considered missing when he/she is not in the Community and we cannot determine his/her whereabouts; and in addition, there is a reason to be concerned for the resident's safety. -If the community discovers a resident is missing, we will: Notify the supervisor and all other staff immediately, Perform a hasty search of the	D 270		

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building and the immediate areas outside the building.
-If the resident is not found, we immediately notify local law enforcement-call 911, the residents family member/responsible party, the county department of social services, management on call, divisional vice president and divisional director of clinical services.
-Post notifications, staff will initiate a Level II search (thorough search of the building, grounds, outside structures, dumpsters, storage buildings and vehicles). Staff will ensure that required agencies are notified and an accident/incident report is sent to DS within 48 hours.
-DSS is called immediately in the event of a missing resident.
-We will cooperate fully with law enforcement and/or authority in charge of search and rescue.

Review of Resident #3's current FL2 dated 01/26/23 revealed:
-Diagnoses included dementia, atrial fibrillation and gastic reflux disease.
-Recommended level of care was documented as Special Care Unit.
-The resident was ambulatory with wandering behaviors.

Review of Resident #3's Care Plan dated 7/22/23 revealed:
-There was documentation the resident had a history of wandering.
-Under "Social Mental Health history" a diagnosis of dementia was documented.
-There was no documentation of interventions to address wandering behaviors or adequate supervision.

Review of Resident #3's Incident Report dated 10/25/23 at 6:30pm revealed:

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-The incident report was not completed until 10/27/23 at 7:49pm.
-The location of the incident was documented as "outside of building unaccompanied."
-The elopement occured on 10/25/23 at 6:30pm "outside 100 halls door."
-Kitchen staff reported to a personal care aide (PCA) Resident #3 was outside of the building and there were no staff with her.
-The PCA went outside and assisted Resident #3 back into the building.
-There was documentation the facility Director was notified of incident immediately when staff found Resident #3 outside the facility door.
-Resident #3's Power of Attorney (POA) was notified on 10/25/23 at 7:00pm.
-Resident #3 should be monitored at least every hour and progress notes written throughout the shift for 72 hours with an intervention date of 10/27/23 - 10/30/23.

Review of Resident #3's record revealed:
-There was no documentation of the elopement that occurred on 10/25/23 at 6:30pm.
-There was documentation on 10/25/23 at 10:47pm Resident #3 was hitting staff with hands and other objects and as needed anti-anxiety medication was administered.

Interview with a PCA on 10/27/23 at 10:30am revealed:
-She did not recall any training for a missing resident.
-She was the staff member that went outside and brought Resident #3 back inside without incident.
-She did not know how Resident #3 got outside.
-She reported the elopement to the medication aide (MA).

Interview with a MA on 11/01/23 at 9:26am

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revealed:
-She could not recall any elopement training or missing person training.
-She would look for the resident and call the Administrator if a resident eloped from the facility.
-Rounds were to be completed every two hours when the facility was fully staffed.
-She was not working the evening Resident #3 eloped.

Interview with Dietary Manager on 11/01/23 at 9:01am revealed:
-She received training on what to do if a resident eloped.
-The back door to the kitchen was always closed.
-The door between the dining room and the kitchen was to be closed and when no one was in the kitchen the door was to be locked.

Interview with the Administrator on 10/27/23 at 10:12am revealed:
-She received a call on 10/25/23 at 6:45pm from the MA.
-She did not know how Resident #3 eloped.
-She did not know how long Resident #3 was outside.
-She notified the maintenance staff on 10/26/23 to check the magnetic locks.
-Elopement drills were completed monthly on all three shifts.

Interview with the Special Care Coordinator (SCC) on 10/27/23 at 10:00am revealed:
-She received a call from the MA on 10/25/23 at 6:45pm
-She did not know how Resident #3 eloped.
-She instructed the MA to inform the responsible party and complete an incident report.
-She was uncertain when the last elopement drill was held.

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-She instructed the MA to perform 1-hour checks on Resident #3 after she eloped from facility on 10/25/23.

Telephone Interview with a second shift MA on 10/27/23 at 3:30pm revealed:
-She was the MA on 10/25/23 when Resident #3 eloped.
-She did not know which door Resident #3 eloped from.
-The PCA reported to her Resident #3 was outside of the building.
-She notified the SCC of Resident #3's elopement.
-The staff was instructed by SCC to perform 1-hour checks on Resident #3 after she eloped from facility on 10/25/23.

Telephone Interview with Resident #3's family member on 11/01/23 at 1:45pm revealed:
-The facility called to notify her that Resident #3 had eloped from the facility on 10/25/23 around 7:00pm.
-She was concerned about staff being outside in the evening instead of in the building.
-She did not know how her family member eloped from the facility.

Telephone Interview with Nurse Practitioner on 11/01/23 at revealed:
-He was informed of the elopement that occurred on 10/25/23 at 6:30pm.
-He stated the family member was hestitant for Resident #3 to take anxiety medication for fear of overmedicating her.
-He preferred that staff attempt redirection of Resident #3.

Based on observations, interviews, and record reviews it was determined Resident #3 was not

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D 270	Continued From page 14 interviewable. 2. Review of the facility's Safety Measures for Fall Reduction Policy dated September 2021 revealed: -The facility will evaluate fall risk on admission and readmission and document interventions according to the resident's care needs and physician's orders. -The resident was evaluated with each fall and appropriate reports were completed with documentation of each new intervention implemented. -When a fall occurred, an Incident and Accident Report was completed, and a 72 hour fall management follow-up was completed. -The MAs completed vital signs and observed the resident who experienced a fall for 72 hours and documented the results in the resident's chart notes. -A fall risk banner was added to the computer system and a fall risk emblem was added to the resident's door name plate. -The Special Care Coordinator (SCC) added interventions to the resident's orders in the computer system and a new intervention must be added for each additional fall. Review of Resident #1's current FL2 dated 06/15/23 revealed: -Diagnoses included vascular dementia and vertigo. -She was semi-ambulatory and used a walker or cane and wheelchair as an assistive device. Review of Resident #1's Resident Register revealed an admission date of 08/23/21. Review of Resident #1's Care Plan dated 05/24/23 revealed:	D 270		

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D 270	Continued From page 15 -She was independent with transfers. -She was independent with ambulation with the use of a cane or walker. -There was no documentation of interventions to put in place to ensure supervision. Review of Resident #1's unsigned Care Plan dated 07/24/23 revealed: -She was independent with transfers. -She was independent with ambulation with the use of a cane or walker. -There was no documentation of interventions to put in place to ensure supervision. Observation of Resident #1 on 10/31/23 at 10:05am revealed: -She was sitting in a recliner chair in her room wearing a shirt, adult brief, and slip resistant socks on her feet with a light blanket draped partially over her legs. -She had extensive yellow, green, blue, and purple bruising covering her entire face except the tip of the nose, upper lip, and chin just below the bottom lip. -There was bright purple and red bruising to the right side of her neck. -There was purple and red bruising on her left inner arm. -There was purple and red bruising covering her right hip and right-side area extending down towards her right knee. -Resident #1 leaned forward to rub her leg and bright purple and red bruising was seen on her lower back and upper buttocks extending down below the adult brief. -There was a dressing taped to the center of her forehead with documentation handwritten on the bandage reading the dressing was changed on 10/30/23 with due to be changed again on 11/02/23.	D 270		

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D 270	Continued From page 16 -There was a call button attached to the recliner chair. Review of Resident #1's Incident and Accident (I&A) Report dated 09/29/23 revealed: -Resident #1 had an unwitnessed fall at 12:40pm in the hallway and was laying on her right side with her head "gashed" open. -There was laceration and bruising on Resident #1's forehead. -First aid was administered, and pressure was applied to the wound. -Resident #1 was transported by the local emergency medical services (EMS) to the local hospital emergency department (ED). Review of Resident #1's chart notes dated 09/29/23 revealed: -On 09/29/23 at 1:30pm, there was documentation Resident #1 was heard yelling for help from the hallway and was found lying on her right side in her doorway and blood was present from a "obvious head injury"; staff applied pressure to the head wound, and Resident #1 was transported by EMS to the local ED for an evaluation. -On 09/29/23 at 3:00pm, a registered nurse (RN) from the local ED called the Special Care Coordinator (SCC) to give an update on Resident #1, dissolvable sutures were used to close the laceration to Resident #1's forehead and Resident #1 was awaiting transport to return to the facility. -There were no interventions ordered or put into place to prevent falls documented after Resident #1's fall on 09/29/23. -There were no vital signs or observations of Resident #1 documented each shift for 72 hours per the facility's policy regarding falls after Resident #1 fell on 09/29/23 and returned from	D 270		

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the local ED.

Review of Resident #1's I&A Report dated 10/26/26 revealed:
-Resident #1 had an unwitnessed fall at 1:45am in her room sustaining a laceration on the forehead.
-First aid was administered, and pressure was applied to the wound.
-Resident #1 was transported by the local EMS to the local hospital ED.
-There was documentation of instructions to check Resident #1's vital signs every shift for 3 days, monitor Resident #1 for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall, and complete a chart note every shift for 72 hours.

Review of Resident #1's chart notes dated 10/21/23-10/28/23 revealed:
-On 10/21/23 at 6:17am, Resident #1 refused to have her vital signs checked by the facility staff.
-On 10/24/23 at 5:29am, Resident #1 refused to have her vital signs checked by the facility staff.
-On 10/25/23 at 5:43am, Resident #1 refused to have her vital signs checked by the facility staff.
-On 10/26/23 at 2:22am, Resident #1 was transported to the local ED for an evaluation for a fall and there was no other documentation provided.
-On 10/26/23 at 4:30am, Resident #1 returned to the facility from the local ED.
-On 10/26/23 at 7:16am, there was documentation Resident #1 sustained 2 forehead lacerations with a fall and received sutures requiring removal in 5 days.
-There were no interventions ordered or put into place to prevent falls documented after Resident #1's fall on 10/26/23.
-There were vital signs documented on 10/26/23

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at 5:13am, 6:19am, and 8:52am, 10/27/23 at 6:19am, 10/28/23 at 9:35am and 8:46pm, and 10/29/23 at 9:39am and 4:16pm.
-Vital signs for Resident #1 were not documented each shift for 72 hours per the facility's policy regarding falls after Resident #1 fell on 10/26/23 and returned from the local ED.
-On 10/27/23 at 6:27am, a follow-up note from a fall documented Resident #1 was administered a mild pain medication for a headache and the PCP was notified through a messaging system due to bleeding "profusely" from a previous laceration.
-On 10/27/23 at 11:24am, there was documentation Resident #1's PCP was notified of Resident #1 bleeding "aggressively" from a previous head laceration with instructions received to send Resident #1 to the local ED for an evaluation if the bleeding did not stop and notify the PCP of any further acute changes.

Interview with a MA on 11/02/23 at 9:13am revealed there were 2 MAs and 1 PCA working in the facility on first shift for a census of 40 residents.

Interview with a PCA on 11/02/23 at 11:46am revealed:
-Resident #1 was independent with ambulation and transfers before her falls occurring on 09/29/23 and 10/26/23 but now was a 3 person assist.
-She was working on 09/29/23 when Resident #1 fell and was found lying on the floor in the doorway to Resident #1's room.
-She was never instructed by management to increase supervision for Resident #1 and did not know of any other interventions implemented to prevent Resident #1 from falling again.
-She often had to wait on a MA to get done with administering medications to ask for the MAs

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assistance with transferring residents that required assistance from more than 1 person.
-She was supposed to check on each resident and provide care as needed at least every 2 hours but was unable to do so due to being short staffed and she completed rounds "periodically" instead.

Interview with a MA on 11/02/23 at 2:56pm revealed:
-She was responsible for administering the resident's medications, helping the PCAs provide care to the residents, assisting with the resident's laundry, and whichever area she was assigned at the beginning of her shift to complete.
-She and the other MAs or PCAs were not able to properly supervise the residents who were at high fall risk.
-She was never instructed by management to increase supervision for Resident #1 and did not know of any other interventions implemented to prevent Resident #1 from falling again.

Interview with a PCA on 11/03/23 at 10:08am revealed:
-She could not supervise Resident #1 or other residents to prevent falls from occurring while she was in the laundry room doing the laundry.
-She did not know why Resident #1 did not have a bed alarm or chair alarm like some of the other residents.
-She was never instructed by management to increase supervision for Resident #1 after Resident #1 fell on 09/29/23 or 10/26/23.
-She was not instructed to complete any other interventions for Resident #1 to prevent future falls.

Interview with the Special Care Coordinator (SCC) on 11/01/23 at 11:54am revealed:

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-When a resident experienced a fall, the MA was responsible for filling out an I&A Report in the computer system and it placed the information in the dashboard of the computer.
-There was nothing to alert her of any I&A Reports in the dashboard, she just had to check the dashboard as often as possible.
-She was responsible to retrieve the I&A Reports from the dashboard and order the 72-hour monitoring for the resident who fell, order to check vital signs for 72 hours after a fall, and any other interventions needed so that it prompted a task for the MAs to complete.
-There was no 72-hour monitoring implemented after Resident #1 fell on 09/29/23 per the facility's policy.
-There were no interventions entered in the computer system for Resident #1's falls occurring on 09/29/23 or 10/26/23.
-She was responsible for contacting Resident #1's PCP to get orders for interventions to try to prevent Resident #1 from falling again, but the PCP was not contacted for orders because she missed it by error.

Telephone interview with Resident #1's family member on 11/01/23 at 3:02pm revealed:
-She was scared for the health and safety of Resident #1 and was trying to find Resident #1 somewhere else to reside.
-Resident #1 fell on 09/29/23 and 10/26/23 sustaining head lacerations with both falls requiring being sent to the local hospital ED and sutures.
-Resident #1 was independent with ambulation before the falls but required a lot of assistance now since the 2 falls.
-Resident #1 had a change in demeanor since the falls and now acted scared and was not talkative.

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-Resident #1 had dementia and could not verbally express how she was feeling.
-She could not understand why the bruising of Resident #1's buttocks, right hip, and right leg were so bad if Resident #1 fell forward hitting her face on the ground as staff reported to her.
-She visited Resident #1 at least monthly but increased her visitations with Resident #1 since the fall on 09/29/23.

Interview with Resident #1's PCP on 11/02/23 at 8:28am revealed:
-Resident #1 had dementia and would not call out for assistance from staff.
-He was notified of "a lot" of falls for Resident #1 "recently".
-Resident #1 fell on 09/29/23 and 10/26/23 hitting her head both times and was sent to the local ED to have sutures placed for the head lacerations sustained in the falls.
-Resident #1 had a decline in health since the 2 falls and he ordered hospice care.
-After Resident #1 fell on 09/29/23, he asked the facility staff to move Resident #1's bed in the room to see if it would help prevent future falls.
-The facility did not contact him after Resident #1's falls for new orders for interventions to prevent falls.

Interview with the Administrator on 11/01/23 at 10:45am revealed:
-All falls, vital signs, 72-hour monitoring, or other interventions to prevent falls were documented in the computer system by the MA.
-When a fall occurred, the SCC was responsible to order the vital signs and 72-hour monitoring in the system so that a task was prompted for the MAs to check off.
-The types of interventions the facility used to prevent falls were floor mats, bed alarms, chair

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alarms, and increased supervision or her and the SCC would look at the resident's medications and contact the PCP to see if the medications needed changing.
-She knew Resident #1 fell on 09/29/23 and 10/26/23 but she did not know Resident #1 did not have any interventions ordered for fall prevention after the falls.
-The SCC was responsible for contacting the PCP for any new orders needed.
-She expected staff to increase supervision for any residents who fell but there was no system in place to document the increased supervision.

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

_____

The facility failed to provide supervision for Resident #3, who had a diagnosis of dementia, resulting in eloping from the facility without staff's knowledge and being found by a member of the community and Resident #1, who had 2 falls and was sent to the local hospital emergency department to receive sutures in the forehead for head lacerations on both occasions, large areas of bruising covering a multitude of areas, and had a decline in health after the falls requiring an admission to hospice care and there were no interventions put in place by the facility to prevent future falls. This failure was detrimental to the health and wellness of Resident #1 and #3 and constitutes a Type B Violation.

_____

The facility provided and plan of protection on 11/01/23 in accordance with G.S. 131D-34 for this violation.

THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER

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D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to implement physician's orders for 3 of 5 sampled residents (Resident #1, #3, and #5) related to an ophthalmology consult (#5) and daily blood pressure and heart rate checks (#1 and #3). The findings are: 1. Review of Resident #1's current FL2 dated 06/15/23 revealed diagnoses included congestive heart failure, hypertension, atrial fibrillation, and dementia. Review of Resident #1's physician's order dated 08/03/23 revealed there was a medication order for metoprolol (used to treat high blood pressure and control heart rates) 25mg take ½ tablet (12.5mg) daily and hold if the blood pressure (BP) was less than 100/60 or the heart rate (HR) was less than 60 and notify the primary care provider (PCP).	D 276		

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D 276	Continued From page 24 Review of Resident #1's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol 25mg take ½ tablet (12.5mg) daily with instructions to hold if the BP was less than 100/60 or if the HR was less than 60 and notify the PCP. -There was documentation metoprolol was administered at 8:00am on 09/01/23-09/04/23, 09/06/23-09/25/23, and 09/27/23-09/30/23. -There was documentation metoprolol was not administered at 8:00am on 09/05/23 with the reason documented as resident could not have any food or drinks, and on 09/26/23 with the reason documented as Resident #3 did not make it in time for breakfast. -There was an entry for daily BP and HR. -There was documentation that the daily BP and HR was not completed from 09/01/23-09/30/23 due to Resident #1 refused. Review of Resident #1's October 2023 eMAR revealed: -There was an entry for metoprolol 25mg take ½ tablet (12.5mg) daily with instructions to hold if the BP was less than 100/60 or if the HR was less than 60 and notify the PCP. -There was documentation metoprolol was administered at 8:00am from 10/02/23-10/31/23. -There was documentation metoprolol was not administered at 8:00am on 10/01/23 with the reason documented as Resident #1 refused. -There was an entry for daily BP and HR. -There was documentation that the daily BP and HR was not completed from 10/01/23-10/25/23, 10/27/23, and 10/30/23-10/31/23 due to Resident #1 refused. Review of Resident #1's record revealed there	D 276		

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was no documentation of Resident #1's daily BP and HR for September 2023 and October 2023.

Interview with a medication aide (MA) on 11/02/23 at 9:13am revealed:
-Resident #1 refused on most days to have a BP or HR checked.
-She administered Resident #1's metoprolol on various days in September 2023 and October 2023 without checking Resident #1's BP and HR because the order just read to hold the metoprolol if the BP was less than 100/60 or the HR was less than 60.
-She did not call the PCP to see if she should administer Resident #1's metoprolol when Resident #1 refused to have a BP or HR checked.
-She thought she was only supposed to call the PCP when Resident #1 let her check Resident #1's BP and HR and the values were less than the parameters ordered.
-Resident #1's PCP was aware that Resident #1 refused most things such as medications and checking vital signs including the BP and HR.

Interview with the Special Care Coordinator (SCC) on 11/01/23 at 11:54am revealed:
-The MAs were trained to check the resident's BPs and HRs and document the values in the eMAR.
-If Resident #1 had orders to hold the metoprolol if the BP was less than 100/60 and HR was less than 60, the MAs were required to check a BP and HR as ordered and document the results on the eMAR.
-She did not know why the MAs administered Resident #1's metoprolol without checking Resident #1's BP and HR beforehand.
-There was no documentation Resident #1's PCP was contacted prior to administering metoprolol to

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Resident #1 without checking a BP or HR.
-She was responsible for eMAR audits but had not completed audit since she started working at the facility on 09/05/23.

Interview with the PCP on 11/02/23 at 8:28am revealed:
-The facility staff did not notify him that Resident #1's metoprolol was administered in September 2023 and October 2023 without checking Resident #1's BP or HR first.
-If Resident #1 refused to have a BP or HR checked he expected the facility staff to call to see if new orders were needed before administering metoprolol to Resident #1.
-He was aware of Resident #1 refusing most care due to advanced dementia.
-Resident #1 experienced 2 falls on 09/29/23 and 10/26/23 and it was possible the falls could have been related to being administered metoprolol if Resident #1's BP or HR were too low.
-Resident #1 could experience a BP or HR that was too low causing dizziness, passing out, or increased falls if she was administered metoprolol outside the parameters ordered without checking a BP or HR beforehand.
-He expected the facility staff to check BPs and HRs as ordered or notify him if they were unable to so that he could give new orders if needed.

Interview with the Administrator on 10/31/23 at 2:42pm revealed:
-She thought the MAs checked Resident #1's BP and HR as ordered before administering metoprolol to Resident #1.
-The MAs did not know they had to document the BP or HR for Resident #1 because the computer system did not prompt the MAs to document the values.
-The SCC was responsible for making sure the

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computer system prompted a section on the eMAR for the MAs to document BP and HR values, but the SCC started working for the facility on 09/05/23 and had not had time to go through all the resident's records to check for accuracy.
-When Resident #1 refused to have a BP or HR checked, she expected the MAs to contact the PCP to see if new orders were needed or if the metoprolol should be administered.

2. Review of resident #3's FL2 dated 1/26/23 revealed diagnoses included atrial fibrillation (A-Fib).

Review of Resident #3's signed physician order dated 2/2/2023 revealed:
-An order for metoprolol succinate tablet extended release 24 hr; 25mg take one tablet by mouth once daily-hold if blood pressure (BP) was less than 100/60 or if heart rate was less than 60 and notify PCP.

Review of Resident #3's progress notes revealed there was a note signed by Resident #3's primary care provider (PCP) to continue to have facility staff obtain BP and heart rate prior to metoprolol succinate administration, and hold if BP was less than 100/60 or if heart rate was less than 60 and notify PCP.

Review of Resident #3's August, September, and October 2023 medication administration record (MAR) revealed:
-There was an entry to hold if BP was less than 100/60 or if heart rate was less than 60 and notify PCP.
-There was no documentation of BP results.

Interview with a medication aide (MA) on 11/01/23

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at 3:15pm revealed:
-She checked blood pressures prior to giving medication.
-She was never been told to record blood pressures.

Interview with Special Care Coordinator (SCC) on 11/01/23 at 3:00pm revealed:
-She was not aware that they were not recording blood pressures.
-She assumed the MAs were checking blood pressures before administering medications.
-She was not sure why there was nowhere to record the blood pressures on the MAR.

Interview with a second MA on 11/01/23 at 2:45pm revealed:
-She was unaware of Resident #3's blood pressure order.
-She administered the medications that were in the multi dose pack.
-She may not always read the orders.

Interview with the PCP on 11/01/23 at 8:45am revealed:
-The facility staff did not notify him that Resident #3's BP and heart rate was not checked before being administered metoprolol.
-If Resident #3's metoprolol was administered and the blood pressure was lower than 110/60 or heart rate was less than 60, Resident #3 could have syncopal episodes, falls, become bradycardic or lightheaded.
-His expectation was that the facility staff would follow through with orders that he wrote.

Interview with the Administrator on 11/01/23 at 10:45am revealed:
-She was unaware of the staff not recording blood pressures.

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-She thought staff took Resident #3's BP and heart rate before administering the medication but did not document the results.
-She was unaware that there should be a place on the MAR to document the blood pressure.
-The PCP did not tell them to document the blood pressures.

3. Review of Resident #5's current FL2 dated 01/05/23 revealed diagnoses included unspecified dementia with behavioral disturbance and glaucomatous flecks subcapsular (glaucoma flecks of opacity of the eye lens).

Review of Resident #5's Nurse Practitioner's (NP) order dated 03/02/23 revealed ophthalmology consultation of eyes and vision.

Review of Resident #5's record revealed there was no documentation of completion of ophthalmology consultation.

Telephone interview with Resident #5's Healthcare Power of Attorney (HCPOA) on 11/01/23 at 12:22pm revealed:
-She did not think Resident #5 had received the ophthalmology consultation ordered on 03/02/23.
-It had been at least two years since Resident #5 had received an eye examination.

Interview with the Administrator on 11/01/23 at 3:00pm revealed:
-She could find no documentation Resident #5 had received the ophthalmology consult ordered 03/02/23.
-She called the local ophthalmology office the facility used and they had no record of ever having seen Resident #5.
-The facility kept a transport calendar of all

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resident appointments.
-The transport calendar she referred to was taken by an employee who left employment in July 2023.
-She was unable obtain history of resident appointments prior to July 2023.

Interview with Resident #5's NP on 11/02/23 at 8:23am revealed:
-Resident #5 had not received the ophthalmology consult he ordered on 03/02/23.
-He had ordered the ophthalmology consult as a routine screening.
-As long as the resident was not having any eye pain, he was not really concerned about when the facility obtained the consult.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

_____

The facility failed to ensure physician's orders were completed to check a blood pressure and heart rate daily before administering metoprolol to Resident #1 and Resident #3 which placed the residents at an increased risk of falls, dizziness, passing out, syncopal episodes, or heart rate or blood pressures that were too low, and Resident #5 who was not taken for a routine screening at an ophthalmology consult. This failure was detrimental to the health and wellness of Resident #1, #3, and #5 and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/22/23 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER

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D 276	Continued From page 31 18, 2023.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 4 sampled residents (#4 and #3) were served physician ordered therapeutic diets related to honey thickened liquids (#4) and a double portion diet (#3). The findings are: 1. Review of Resident #4's current FL2 dated 01/05/23 revealed: -Diagnoses included advanced dementia with behavioral disturbance and gastroesophageal reflux disease. -The resident was constantly disoriented. Review of Resident #4's Care Plan dated 05/25/23 revealed the resident required extensive assistance with meals and snacks. Review of Resident #4's Nurse Practitioner's order dated 08/03/23 revealed mechanical soft diet entire meal chopped. Review of Resident #4's physician order dated	D 310		

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D 310	Continued From page 32 09/27/23 revealed initiate honey thick liquids. Review of the regular lunch meal menu for 10/31/23 revealed hamburger steak with gravy, baked potato, fresh cooked zucchini, baked roll, beverage of choice, and strawberry ice cream. Review of the mechanical soft chopped lunch meal menu for 10/31/23 revealed soft and bite sized hamburger steak with gravy, baked potato with moistened with skin removed, soft and bite sized pieces of cooked zucchini, baked roll in moistened bite sized pieces, beverage of choice at ordered thickness, and strawberry ice cream at ordered thickness. Observation of the lunch meal and beverage service on 10/31/23 at 12:36pm revealed Resident #4 received a room meal tray with chopped hamburger steak with gravy, mashed potatoes, chopped pieces of cooked broccoli, a roll, two cups of honey thickened lemon water, and an individual 4 oz. cup of strawberry ice cream. Interview with Resident #4's family member on 10/31/23 at 12:37pm revealed: -She was there to provide eating assistance to Resident #4 during the lunch meal. -The facility staff usually brought the resident ice cream or pudding. -Resident #4 usually did "okay" when eating ice cream. Interview with the Dietary Manager (DM) on 10/31/23 at 12:58pm revealed: -She prepared Resident #4's lunch meal tray. -She "messed up" and gave the resident ice cream even though he was ordered honey thickened liquids.	D 310		

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-Resident #4 should have received pudding instead of strawberry ice cream for dessert.

Interview with the personal care aide (PCA) on 11/01/23 at 11:15am revealed:
-She delivered Resident #4's lunch meal tray to his room on 10/31/23.
-The kitchen staff were responsible for ensuring items on the meal trays were appropriate for a resident's therapeutic diet order.
-She was aware Resident #4 was supposed to receive only honey thickened consistency liquids.
-The kitchen was responsible for preparing all thickened liquids for the residents with orders for thickened liquids.
-She had never received any training on the thickened liquid consistency differences or items that should not be served to a someone who was on a thickened liquid diet.
-She did not know ice cream should not be served to a resident with orders for honey thickened liquids.

Interview with a second PCA on 11/01/23 at 12:15pm revealed:
-She had not received training on therapeutic diet consistencies or thickened liquid consistencies.
-The kitchen staff were responsible for keeping track of resident diet orders and how to properly prepare each item appropriately for residents with therapeutic diet orders.
-The PCAs were responsible only to deliver the trays to the residents kitchen staff instructed.

Telephone interview with Resident #4's Nurse Practitioner (NP) on 10/31/23 at 4:10pm revealed:
-He ordered a mechanical soft chopped diet and honey thickened liquids for Resident #4 due to the resident having advanced dementia.
-Resident #4 needed honey thickened liquids.

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-Resident #4 was at an increased risk of aspiration pneumonia (occurs when food or liquids are breathed into the airways or lungs, instead of being swallowed) when given thin liquids such as melted ice cream.

Interview with the Administrator on 11/01/23 at 3:00pm revealed:
-The DM usually served Resident #4 pudding.
-The DM had received thickened liquid training and knew Resident #4 should not receive ice cream.

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

2. Review of Resident #3's current FL2 dated 01/26/23 revealed diagnoses included dementia and gastric reflux disease.

Review of Resident #3's care plan dated 07/22/23 revealed the resident required supervision with meals and snacks.

Review of Resident #3's physician order dated 09/14/23 revealed a diet order for double portions.

Observation of the lunch meal on 10/31/23 at 12:20pm revealed:
-The lunch meal consisted of hamburger steak covered with gravy, scalloped potatoes, broccoli, a roll, strawberry ice cream and various beverages.
-Resident #3 was served a regular sized meal, not a double portion of each item during the lunch meal service.

Interview with the Dietary Manager on 10/31/23 at

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12:30pm revealed:
-She delivered Resident #3's lunch plate to her.
-Resident #3 did not have a double portion on her lunch plate.
-She had attended a dietary class and was taught if you overload a plate for a resident with dementia it could be overwhelming to them.
-She would wait until Resident #3 was finished with her first plate and then ask Resident #3 if she wanted a second plate.

Interview with the Special Care Coordinator (SCC) on 10/31/23 at 12:45pm revealed:
-The facility staff try to approach mealtime differently with residents that have dementia.
-If residents with orders for double portions are given the food all at once, they get overwhelmed and may not eat at all.
-If the resident was being asked if they wanted more during a meal, the food did not have to be offered all at once.

Review of Resident #3's medical chart revealed:
-Her weight was 106 pounds (lbs.) on 06/01/23.
-Her weight was 103 lbs. on 07/01/23.
-Her weight was 97.50 lbs. on 08/01/23.
-She refused to be weighed on 09/01/23.
-On 09/14/23 there was a physician's order to initiate "double portions" at mealtimes.
-Her weight was 96.50 on 10/01/23.

Interview with the Nurse Practitioner (NP) on 11/02/23 at 8:25am revealed:
-Resident #3 had a lower BMI (body mass index) and would benefit from some weight gain.
-She was placed on appetite stimulant medication and nutritional supplements.
-Her BMI continued to be low, and an order was given for double portions at mealtimes.
-Staff should be giving her the double portions

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D 310	Continued From page 36 and not asking her if she wanted more to eat. Interview with the Administrator on 11/03/23 at 2:30pm revealed: -She thought it would be overwhelming to present a double portion to a resident with dementia. -The staff always attempted to give a 2nd portion to the residents with a diet order for double portions. The failure of the facility to serve ice cream instead of honey thickened liquids as ordered to Resident #4 increased the resident's risk of aspiration pneumonia. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance wih G.S. 131D-34 on 11/01/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 18, 2023.	D 310		
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 B VIOLATION	D 358		

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D 358	Continued From page 37 Based on observations, interviews, and record reviews, the facility failed to administer medications as prescribed for 2 of 5 sampled residents related to medications used to treat infection (#2 and #7). The findings are: Review of the facility's medication administration of a new order policy dated September 2021 revealed: -Administration of any medication order for a systemic antibiotic shall be started no later than 9:00am of the following day unless the order is designated by the physician as urgent. -All efforts should be made to start antibiotics at the next scheduled dose. -In the event that starting a particular order within these timeframes is not possible du to extenuating circumstances, the physician shall be notified immediately, and documentation of such circumstances shall be made in the nurse's notes of the resident's medical record. Review of the facility's new order process policy dated September 2021 revealed: -All orders are reviewed by the Resident Care Coordinator (RCC) or designee. -Orders must be complete. -The RCC will fax (medication aide if after hours/weekends) fax the order to the pharmacy and scan the order into the electronic scan. -The Resident Care Manager or designee will wait for the order to be placed in the electronic medication system and then approve the order for administration. -Medication aides will review the Facility Activity Report at the beginning of each shift for order changes when a new order, or change order is	D 358		

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received.
-Whenever there is a medication change, the RCC/designee discusses the change with the resident and responsible party or guardian as appropriate and documents.

1. Review of Resident #2's current FL2 dated 01/05/23 revealed:
-Diagnoses included Alzheimer's dementia and cerebral vascular accident (CVA).
-The resident was non-ambulatory and incontinent of bladder and bowel.

Review of Resident #2's Care Plan dated 02/09/23 revealed required total assistance with toileting, bathing, dressing, and grooming.

Review of Resident #2's Nurse Practitioner's (NP) visit note dated 09/21/23 revealed a recent urinalysis was obtained and showed the presence of Escherichia coli bacteria (commonly found in the lower intestine of warm-blooded organisms) and Proteus mirabilis (a gram negative bacteria which is a frequent pathogen of the urinary tract).

Review of Resident #2's NP order dated 09/21/23 revealed Augmentin (used to treat infection) 875mg-125mg 1 tablet twice daily for 5 days for urinary tract infection (UTI).

Review of Resident #2's September 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Augmentin 875mg-125mg 1 tablet twice daily for 5 days scheduled at 8:00am and 8:00pm.
-The Augmentin was documented as administered starting 09/25/23 at 8:00am and ending on 09/26/23 at 8:00pm (a total of 4 doses of the Augmentin).

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D 358	Continued From page 39 Review of Resident #2's October 2023 eMAR revealed there was no entry for Augmentin. Observation of Resident #2's available medications on 11/02/23 at 10:58am revealed there was no Augmentin. Telephone interview with the facility's contracted pharmacy on 11/02/23 at 11:12am revealed: -The pharmacy received an order for Resident #2 on 09/21/23 for Augmentin 875mg-125mg 1 tablet twice daily for 5 days. -The Augmentin ordered for Resident #2 was delivered to the facility on 09/22/23 at 8:49am. Interview with Resident #2's NP on 11/02/23 at 12:05pm revealed: -He was not made aware Resident #2 received only 4 doses of the Augmentin out of the 10 doses he ordered to treat Resident #2's UTI. -He expected the facility to administer the full 5 days of the Augmentin as it was ordered. -He was not aware the Augmentin ordered on 09/21/23 was not started until 09/25/23 at 8:00am. -The delayed start and limited doses of Augment administered placed Resident #2 at risk of worsening UTI symptoms. -It also increased Resident #2's risk of sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death.) Interview with the Special Care Coordinator (SCC) on 11/02/23 at 10:30am revealed: -She could not find an order or results of a follow-up urinalysis for Resident #2 after the	D 358		

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09/21/23 Augmentin order.
-She did not know why the Augmentin was not started until 09/25/23, when it was ordered on 09/21/23.
-She did not know why the Augmentin was not administered for 5 days as ordered.

Interview with the Administrator on 11/02/23 at 12:15pm revealed:
-The Administrator and SCC were responsible for verifying new medication orders were entered onto the eMAR correctly by the pharmacy.
-The Administrator and SCC were responsible to ensure new medications were received timely and started as ordered.
-The Augmentin should have been started on the 09/22/23 in the morning when it was received by facility staff.
-She did not know why Resident #2's Augmentin was not started until 09/25/23.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

2. Review of Resident #4's current FL2 dated 01/03/23 revealed:
-Diagnoses included advanced dementia with behavioral disturbances.
-Resident #4 was semi-ambulatory and incontinent of bowel and bladder.

Review of Resident #4's care plan dated 05/15/23 revealed Resident #4 required total assistance with toileting, bathing, dressing, and grooming.

Review of Resident #4's Nurse Practitioner (NP) visit note dated 08/31/23 revealed:
-Resident #4 was observed with a broken right upper bicuspid (a permanent back tooth used for

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biting and chewing) tooth that was initially noted several months ago.
-Resident #4 was having increased sensitivity of the area around the right upper bicuspid tooth.
-The oral exam by the NP for Resident #4 revealed no symptoms of tooth abscess, no abnormal drainage, no erythema (redness occurring from inflammation) or bleeding at the tooth gum line.

Review of Resident #4's NP order dated 08/31/23 revealed an order for Bactrim DS one tablet twice daily for 5 days for tooth infection.

Review of Resident #4's August 2023 electronic medication administration record (eMAR) revealed there was no entry for Bactrim DS one tablet twice daily for 5 days for tooth infection.

Review of Resident #4's September 2023 electronic medication administration record (eMAR) revealed there was no entry for Bactrim DS one tablet twice daily for 5 days for tooth infection.

Observation of Resident #4's available medications on 11/01/23 at 11:45am revealed there was no Bactrim DS.

Interview with the Special Care Coordinator (SCC) on 11/01/23 at 11:52am and 3:10pm revealed:
-She was not the SCC at the time the order for Resident #4 was written.
-After the NP wrote an order, it was faxed to the contracted pharmacy.
-The family chose to use a different pharmacy than the contracted pharmacy the facility used for this medication.
-When orders were sent to the facility's

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contracted pharmacy, a representative from the pharmacy placed the order on the eMAR.
-This order was never placed on the eMAR since the contracted pharmacy never received the order.

Interview with a family member of Resident #4 on 11/01/23 at 12:40pm revealed:
-She picked up Resident #4's antibiotic to treat his tooth infection from the local pharmacy on 08/31/23.
-She gave the antibiotic to a medication aide (MA) for administration since it was a pill and had to be crushed for Resident #4 to safely swallow it.
-She was unable to remember which MA she gave the antibiotic to for administration to Resident #4.

Interview with the NP on 11/02/23 at 8:25am revealed:
-The family preferred a local pharmacy for this antibiotic for Resident #4.
-The SCC at the time should have contacted the contracted pharmacy so the antibiotic order could have been entered on the eMAR.
-It was unfortunate that there was no documentation of Resident #4 receiving this antibiotic.
-He saw Resident #4 within the first two weeks of September 2023 and his symptoms had resolved without the antibiotic.

Interview with the Administrator on 11/03/23 at 2:30pm revealed:
-She did not know there was an antibiotic that was brought to the facility for Resident #4 but there was no record of the antibiotic being given to Resident #4.
-She was unsure where the communication breakdown had occurred.

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D 358	Continued From page 43 -She did not know what had happened to the medication for Resident #4. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. _____ The facility's failure to administer Augmentin as ordered to Resident #2 increased the residents risk for worsening symptoms of urinary tract infection and for sepsis. This failure was detrimental to the health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance wih G.S. 131D-34 on 11/02/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 18, 2023.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 sampled resident (#7) had a physician's order to self-administer calcium carbonate (an antacid used to treat gastric reflux).

The findings are:

Observation of Resident #7's bedroom on 10/31/23 at 9:10am revealed:
-There was a bottle of calcium carbonate 1000mg per tablet on the shelf beside her bed.
-The bottle of calcium carbonate held 160 tablets.
-The expiration date of the bottle of calcium carbonate was September 2023.
-There were less than 40 tablets remaining in the bottle.

Interview with Resident #7 on 10/31/23 at 9:10am revealed:
-She took the calcium carbonate whenever she had a "sour stomach."
-The last time she took the calcium carbonate was last week.

Review of Resident #7's current FL2 dated 01/05/23 revealed:
-Diagnoses included vascular dementia and heart failure.
-She was intermittently disoriented.
-She required limited to extensive assistive with all activities of daily living.

Review of Resident #7's physician orders dated 01/05/23 revealed:
-Diagnoses included gastric esophageal reflux disease.

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-An order for calcium carbonate 500mg tablet daily at 5:00pm.
-An order for calcium carbonate 500mg 2 tablets (1000mg) every 6 hours as needed.
-There was not an order for Resident #7 to self-administer any medications.

Review of the electronic medication administration record (eMAR) for September 2023 revealed:
-There was an entry for calcium carbonate 500mg tablet was administered daily at 5:00pm from 09/01/23 through 09/30/23.
-No documentation calcium carbonate 500mg 2 tablets (1000mg) were administered as needed from 09/01/23 through 09/30/23.

Review of the eMAR for October 2023 revealed:
-There was an entry for calcium carbonate 500mg tablet was administered daily at 5:00pm from 10/01/23 through 10/31/23.
-No documentation calcium carbonate 500mg 2 tablets (1000mg) were administered as needed from 10/01/23 through 10/31/23.

Telephone interview with a family member on 10/31/23 at 3:35pm revealed:
-She brought Resident #7 the calcium carbonate 1000mg tablet bottle and placed it in Resident #7's room.
-The bottle had one-third to one-half remaining tablets when she brought it to the facility about 3 weeks ago.
-She was aware her Resident #7 was not allowed to have medications in her room, but she brought the medication to Resident #7 anyway.
-She was not aware there was an order for Resident #7 to have calcium carbonate 500mg daily and an additional as needed order for up to 1000mg every 6 hours.

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D 375	Continued From page 46 Interview with the medication aide (MA) on 10/31/23 at 3:00pm revealed: -There were residents who wandered throughout the building. -The MA administered medications to Resident #7 on 10/31/23. -The MA did not see the calcium carbonate on the shelf in Resident #7's room when she administered Resident #7's medications on 10/31/23. -Resident #7 had dementia and should not have any medications in her room to self-administer. Interview with the Special Care Coordinator (SCC) on 10/31/23 at 3:07pm revealed: -They did have a resident that wandered in and out of other residents' rooms. -There were no residents who could self-administer medication in the facility. Telephone interview with a Hospice representative on 11/01/23 at 10:11am revealed: -She was at the facility weekly to see Resident #7. -She had noticed the bottle of calcium carbonate on Resident #7's shelf but had not asked the facility staff why it was there. -Resident #7 did have an order for calcium carbonate 500mg daily and an as needed order. Observation of medications for administration on 11/01/23 at 11:43am revealed calcium carbonate 500mg tablets were available. Interview with the Administrator on 11/03/23 at 2:30pm revealed: -She did not think any residents had orders to self-administer medications in the facility. -Staff had spoken with a family member	D 375		

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D 375	Continued From page 47 previously requested that she not bring medications in and give them to Resident #7. -Staff should have observed the calcium carbonate on the shelf during 2-hour rounds and removed it from Resident #7's room.	D 375		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure required staffing hours were met on all three shifts in the special care unit (SCU) based on a census of 40 for 31 of 48 shifts. The findings are: Review of the facility's current license by the Division of Health Service Regulation effective 01/01/2023 revealed the facility was a licensed Special Care Unit (SCU) with a capacity of 60 residents. Review of the facility's census record from 10/14/2023 through 10/29/2023 revealed that	D 465		

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there was a census of 40 residents which required 40 staff hours on first and second shifts and 32 staff hours on third shift.

Review of the staff time records from 10/14/2023 through 10/29/2023 revealed:
Review of staff timecard punches revealed:
-On 10/14/2023, the census was 40 requiring 40 staff hours on first shift and a total of 28 staff hours were provided leaving a shortage of 12 staff hours.
-On 10/15/2023, the census was 40 requiring 40 staff hours on second shift and a total of 32.77 staff hours were provided leaving a shortage of 7.23 staff hours.
-On 10/16/2023, the census was 40 requiring 40 staff hours on second shift and a total of 25.82 staff hours provided leaving a shortage of 14.18 staff hours.
-On 10/16/2023, the census was 40 requiring 32 staff hours on third shift and a total of 24 hours staff hours provided leaving a shortage of 8 staff hours.
-On 10/17/2023, the census was 40 requiring 40 staff hours on first shift and a total of 25.23 hours staff hours provided leaving a shortage of 14.77 staff hours.
-On 10/17/2023, the census was 40 requiring 40 staff hours on second and a total of 24.07 hours staff hours provided leaving a shortage of 15.93 staff hours.
-On 10/17/2023, the census was 40 requiring 32 staff hours on third shift and a total of 16 hours staff hours provided leaving a shortage of 16 staff hours.
-On 10/18/2023, the census was 40 requiring 40 staff hours on first shift and a total of 28.74 hours provided leaving a shortage of 11.26 staff hours.
-On 10/18/2023, the census was 40 requiring 40 staff hours on second shift and a total of 29.96

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hours provided leaving a shortage of 10.04 staff hours.
-On 10/18/2023, the census was 40 requiring 32 staff hours on third shift and a total of 32 hours provided leaving a shortage of 8 staff hours.
-On 10/19/2023, the census was 40 requiring 40 staff hours on second shift and a total of 29 hours provided leaving a shortage of 11 staff hours.
-On 10/19/2023, the census was 40 requiring 32 staff hours on third shift and a total of 24 hours provided leaving a shortage of 8 staff hours.
-On 10/20/2023, the census was 40 requiring 40 hours on first shift and a total of 33.04 hours provided leaving a shortage of 6.96 staff hours.
-On 10/21/2023, the census was 40 requiring 40 hours on second shift and a total of 36.63 hours provided leaving a shortage of 3.37 staff hours.
-On 10/21/2023, the census was 40 requiring 32 hours on third shift and a total of 16 hours provided leaving a shortage of 16 staff hours.
-On 10/22/2023, the census was 40 requiring 40 staff hours on first shift and a total of 33.93 staff hours provided leaving a shortage of 6.07 staff hours.
-On 10/22/2023, the census was 40 requiring 40 staff hours on second shift and a total of 25.54 staff hours provided leaving a shortage of 14.46 staff hours.
-On 10/23/2023, the census was 40 requiring 40 staff hours on first shift and a total of 34.93 staff hours provided leaving a shortage of 5.07 staff hours.
-On 10/23/2023, the census was 40 requiring 40 staff hours on second shift and a total of 32 staff hours were provided leaving a shortage of 8 staff hours.
-On 10/23/2023, the census was 40 requiring 32 staff hours on third shift and a total of 26.70 staff hours were provided leaving a shortage of 13.30 staff hours.

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D 465	Continued From page 50 -On 10/24/2023, the census was 40 requiring 40 staff hours on first shift and a total od33.69 staff hours provided leaving a shortage of 6.31staff hours. -On 10/24/2023, the census was 40 requiring 40 staff hours on second shift and a total of 32.14 staff hours provided leaving a shortage of 7.86 staff hours. -On 10/24/2023, the census was 40 requiring 32 staff hours on third shift and a total of 24 staff hours provided leaving a shortage of 8 staff hours. -On 10/25/2023, the census was 40 requiring 40 staff hours on second shift and a total of 35.16 staff hours provided leaving a shortage of 4.84 staff hours. -On 10/25/2023, the census was 40 requiring 32 staff hours on third shift and a total of 16 staff hours provided leaving a shortage of 16 staff hours. -On 10/26/2023, the census was 40 requiring 40 staff hours on second shift and a total of 32.33 staff hours provided leaving a shortage of 7.67 staff hours. -On 10/27/2023, the census was 40 requiring 40 staff hours on second shift and a total of 32.33 staff hours provided leaving a shortage of 7.67 staff hours. -On 10/28/2023, the census was 40 requiring 40 staff hours on second shift and a total of 18.20 staff hours provided leaving a shortage of 21.80 staff hours. -On 10/29/2023, the census was 40 requiring 40 staff hours on first shift and a total of 17.35 staff hours provided leaving a shortage of 22.65 staff hours. -On 10/29/92023, the census was 40 requiring 40 staff hours on second shift and a total of 17.41 staff hours provided leaving a shortage of 22.59 staff hours.	D 465		

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-On 10/29/2023, the census was 40 requiring 32 staff hours on third shift and a total of 16 staff hours provided leaving a shortage of 16 staff hours.

Telephone Interview with a third shift MA on 11/02/2023 at 3:00pm revealed:
-She worked 3rd shift from 6pm till 6am.
-Almost every night the facility was short staffed on 3rd shift.
-The Administration did not come in to help on the floor.
-If the Administrator was in the building, she worked in her office.
-She had worked 110 hours in two weeks.
-She was the MA and when an incident occurred, Administration will never answer their phones which leads to MA having to question what to do.
-She had to leave the building on 3rd shift to pick up a resident from the hospital before which would sometimes leave the building with only two staff members.
-She was concerned that residents were not getting the proper care or being checked every two hours due to being short staffed.

Interview with a second shift PCA on 11/02/2023 at 4:00pm revealed:
-She worked 1st and 2nd shifts with the new shift schedule 7am till 7pm.
-She was instructed by the Administration to clean her assigned rooms and do the laundry.
-She was instructed by the Administration to clean hallways.
-She was instructed to clean up any messes that occur in the facility.
-Administration did not help do personal care for residents.
-Administration would sometimes come out and help them assist the residents at mealtimes.

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D 465	Continued From page 52 Interview with the Administrator on 11/02/2023 at 11:00am revealed: -She assigned her management team to work as PCAs. -The facility had only been short staffed within the last two weeks. -She tried to hire staff but has not had many applications. -She sometimes performed housekeeping duties during the work week. -She assigned floor staff to do housekeeping and laundry. -The corporate office was aware of the staffing issues at the facility. Telephone interview with a resident's family member on 11/01/23 at 3:02pm revealed: -She visited on 10/29/23 and found the resident's bed soaking wet with urine from the head of the bed to the bottom of the bed and her family member was lying in the bed. -She could not find a PCA to help her get the resident's adult brief changed and assist the resident out of the bed. -She got a MA to help her get the resident out of the bed, change the adult brief, and change the bed linens. -The MA told her there was only one PCA working in the building. Interview with a MA on 11/02/23 at 9:13am revealed there were 2 MAs and 1 PCA working in the facility on first shift with the facility's census of 40 residents. Interview with a PCA on 11/02/23 at 11:46am revealed: -The typical staffing hours on first shift consisted of 2 MAs and 1 PCA on most days. -She knew for a resident census of 40 there was	D 465		

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	HAL088015	A. BUILDING: _____ B. WING _____	R 11/03/2023

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D 465	Continued From page 53	D 465		

supposed to be 5 staff working on day shift.
-The facility had been short staffed for about 9 months.
-She could not provide adequate care and supervision for the 40 residents residing at the facility when she was the only PCA working.
-She often had to wait on a MA to get done with administering medications to ask for the MA's assistance with transferring residents that required assistance from more than 1 person.
-She was supposed to check on each resident and provide care as needed at least every 2 hours but was unable to do so due to being short staffed and she completed rounds "periodically" instead.
-Residents dental hygiene and nail care sometimes did not get done.

Interview with a MA on 11/02/23 at 2:56pm revealed:
-There were usually 3 staff working on first shift for approximately the last 4 months.
-Staffing was short for the last 9 months but had been "critically" low for the last 3 months.
-She was responsible for administering the resident's medications, helping the PCAs provide care to the residents, assisting with the resident's laundry, and whichever area she was assigned to complete housekeeping duties at the beginning of her shift.
-The facility did not have a housekeeper or laundry person for the last 3 months.
-She or the PCAs were not able to complete 2-hour rounds on the residents due to being short staffed and only rounded every 2 hours on the residents identified as a higher level of care.
-She and the other MAs or PCAs had a hard time getting all the resident's personal care completed and were not able to properly supervise the residents who were a high fall risk.

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-She and the other MAs and PCAs tried to prioritize the resident's care by providing incontinence care and showers but dental hygiene did not get done.

Interview with the Activities Director on 11/03/23 at 3:37pm revealed staffing was short sometimes and she helped complete rounds on the residents, assisted some of the residents when they needed feeding assistance at mealtimes, and helped the floor staff with the resident's personal care needs during the week and on rotating weekends when she worked.

Interview with a PCA on 11/03/23 at 9:05am revealed the facility did not have a housekeeper or laundry person and she was assigned to clean the resident's rooms and do the laundry while providing care to the residents.

Interview with a PCA on 11/03/23 at 10:08am revealed:
-Staffing for the last couple of months was not good.
-She was required to provide personal care and assistance to the residents as well as doing laundry every day and completing housekeeping duties such as cleaning the resident's rooms, sweeping, mopping, and taking out the trash each shift she worked.
-Some days the resident's bed linens could not be changed when they were soiled because there were no clean linens to put on the beds, but she would try to use a flat sheet as a bottom sheet if there were any available.
-Sometimes she was not able to give the residents a shower as scheduled or provide dental hygiene and mouth care because there was not enough staff to get everything done.
-The last 2 weeks there were not any clean

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towels, washcloths, or sheets available to use so she would get them out of the dryer if there were any available.
-She tried to round on the residents while performing the housekeeping duties.
-She could not supervise residents to prevent falls from occurring while she was in the laundry room doing the laundry.

Interview with the Administrator on 11/03/23 at 11:53pm revealed:
-She was responsible for completing the staffing schedule since July 2023.
-She and the other management staff rotated working extra hours on the weekends to fill in hours short.
-Some of the facility staff worked overtime hours to fill in shifts on the schedule that were short hours.
-Staffing was an issue but she posted job openings on 2 different websites and checked daily to see if there were any applicants.
-She was supposed to interview 2 applicants on 11/02/23 and neither showed up for the interview.
-The Business Office Manager reached out to the local unemployment office recently to see if they were able to provide any assistance for open positions at the facility.
Interview with a family member of a resident on 10/31/23 at 9:33am revealed:
-The family member was in the facility daily anytime between 8:00am and 8:00pm.
-The family member had to leave the room to find staff for assistance when the resident needed incontinence care.
-The family member had to frequently wait for assistance and had waited up to an hour recently for help for the resident.
-The resident required total assistance with all activities of daily living (ADL's).

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D 465	Continued From page 56 Interview with a personal care aide (PCA) on 11/02/23 at 3:45pm revealed: -The facility had been understaffed almost every shift for several months. -There was a posting at the door of how many staff were supposed to be working and that's how she knew the facility was understaffed. -She was doing a lot of other duties other than her PCA work since they were so short staffed. -She and other PCAs and MAs were doing laundry and housekeeping duties in addition to their PCA work. -It was difficult to get everything done for the residents. -Dental care was a particular area that was not always given to the residents because of understaffing. Interview with a medication aide (MA) on 11/03/23 at 9:45am revealed: -They were short staffed frequently on 3rd shift. -The extra job duties for 3rd shift included laundry, cleaning handrails, sweeping and mopping. -The 3rd shift staff was required to complete at least 3 loads of soiled laundry each night. -The staff tried to get everything done for the residents, but it was not always possible. -Rounds every two hours did not always happen. _____ The facility failed to ensure there was adequate SCU staff for 31 of 48 shifts from 10/14/23-10/29/23 to meet the daily needs of the residents. This failure was detrimental to the health, safety, and welfare of the residents on the SCU and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/03/23 for	D 465		

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D 465	Continued From page 57 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 18, 2023.	D 465		