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C 000	Initial Comments The Adult Care Licensure Section and Warren County Department of Social Services conducted a complaint investigation and a COVID-19 focused Infection Control Survey with onsite visit's on October 26, 2020 and October 29, 2020 and a desk review on October 27-28, 2020, October 30, 2020, and November 2-4, 2020, and a telephone exit on November 4, 2020. The complaint investigation was initiated by the Warren County Department of Social Services on October 6, 2020.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the flooring in the dining room, a leak in the ceiling in a resident bedroom, a hole in a wall, the window coverings, ceiling fans and wall air returns were kept clean and in good repair. The findings are: Observation of the flooring in the resident dining room on 10/26/20 at 8:19am revealed: -There was a large tear in the linoleum under one of the chairs at the dining room table . -The tear had created a large opening in that was	C 074		

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approximately 12 by 8 inches wide and was curled up around the edges.

Interview with the medication aide (MA) 10/26/20 at 9:22am revealed:
-The flooring under the dining room table had been put down within the last year.
-The foot of the chair tore the flooring soon after it was installed.

Observation of the ceiling in a resident bedroom on 10/26/20 at 9:10am revealed:
-There was water damage on the ceiling above one of the resident's bed.
-There were two discolored areas with dark brown rings around them; each area was approximately 12 to 14 inches in diameter.
-The corner where the ceiling met the wall was peeling from the ceiling and was various shades of brown; the peeling section of the ceiling was about 12 to 14 inches long.

Interview with a resident who resided in the room on 10/26/20 at 9:10am revealed:
-The ceiling had been leaking all summer.
-Water had ran down the wall when it rained hard.

Interview with a second resident who resided in the room on 10/26/20 at 9:11am revealed during a recent storm the ceiling leaked and the resident's bed had gotten wet.

Interview with a MA on 10/26/20 at 9:22am revealed:
-The leak in the ceiling had been there for a few months.
-She had told the Administrator about the leak; the Administrator had seen the leak.
-Nothing had gotten wet when it leaked but water had ran down the wall with the last storm.

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C 074	Continued From page 2 Observation of a second resident room on 10/26/20 at 2:20pm revealed: -There was a hole the size of a softball behind the resident's door, where the door knob hit the wall every time the door was opened. -There was a heating unit mounted to the baseboard area of the wall; the heating unit cover was broken, and the wires were exposed. Interview with a resident who resident in the room on 10/26/20 at 2:20pm revealed: -She had been at the facility for "about 10 months." -The hole behind the door had been "that way" since she moved in. -She did not think the wall unit still worked, but heat came from "somewhere" in the winter. Observation of a third resident room on 10/26/20 at 7:43am revealed: -There were two windows facing the road; one of the windows did not have a mini-blind or curtain to provide privacy. -The paint on the wall beside the bed had been scrapped off the entire length of the bed. Interview with a resident who resided in the room on 10/26/20 at 7:36am revealed: -He did not know what happened to the mini blind on the window; he would like for the window to be covered at night. -The wall had "been like that" he did not know what happened to the paint. Based on observation and interviews, it was determined the other resident in the room was not interviewable. Observation of a third resident room on 10/20/20	C 074		

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at 1:20pm revealed an area on the wall approximately 6 feet in length that was scuffed, and dirty.

Observation of the air return vent cover on the wall in the den area on 10/26/20 at 9:35am revealed a thick coating of dust on each of the metal louvers.

Observation of a second air return vent cover on the wall in the hall area on 10/29/20 at 9:52am revealed a thick coating of dust on each of the metal louvers.

Observation of the ceiling fan light fixture above the resident's dining room table on 10/29/20 at 12:10pm revealed a thick coat of dust on each of the four fan blades.

Telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:56pm revealed:
-The facility was "deteriorating" and the repairs were an ongoing concern.
-She looked at the facility as the residents' home and the needed repairs "bothered" her.
-She had brought her concerns about the repairs to the attention of the Administrator because she felt the residents deserved better.

Telephone interview with the Administrator on 10/29/20 5:46pm revealed:
-The tear in the linoleum under the dining room table just happed over the last month.
-The linoleum was replaced about 4 months ago.
-She had the facility professionally cleaned at least quarterly until the coronavirus (COVID-19) pandemic but canceled the cleaning service to reduce the risk of COVID-19 exposure.
-She was usually on "top of things", but she did not check everything every time she was at the

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C 074	Continued From page 4 facility. Telephone interview with the Administrator on 11/04/20 at 2:15pm revealed: -She had a daily check off list for cleaning at the facility and the staff followed it. -The cleaning list was posted in the office. -She ensured the staff were following the cleaning list showing up at the facility unannounced. -The staff generally did a good job of cleaning. -She expected the staff to inform her of repairs. -She walked around the facility when she visited but she may not have had time to notice everything that was broken or needed repairs. -She was not aware the resident's room did not have blinds or a curtain for a window covering. -She knew about a discolored area about 12 inches in size on the ceiling in a residents' room because it happened during a storm in September 2020. -The ceiling never leaked water and no one's belongings got wet. -She called the landlord and reported it. -She had not looked at it again, but she knew it did not leak, was only one spot and was not sagging.	C 074		
C 076	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by:	C 076		

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C 076	Continued From page 5 Based on observations and interviews, the facility failed to ensure a resident's bed and dresser were kept clean and in good repair. Observation of a residents room on 10/20/20 at 1:20pm revealed: -There was a box spring and mattress sitting on the floor. -There was no sheet on the mattress. -The mattress was stained and the fabric on the side of the box spring was torn. Second observation of the resident's room on 10/26/20 at 8:32am revealed the resident's bed was on a bed frame. Interview with a medication aide (MA) on 10/26/20 at 7:36am revealed: -She was aware the resident's bed was on the floor. -The resident's bed had been on the floor since she had started working at the facility "somewhere around the first week of September 2020". Interview with the resident who resided in the room on 10/26/20 at 8:32am revealed: -His bed had been on the floor because the bed frame broke "about a week ago." -The resident was glad to have his bed on a bed frame. Observation of a second resident's room on 10/26/20 at 7:43am revealed the dresser was missing a drawer and the resident's clothes were laying inside the open area where the drawer should be. Interview with a resident who resided in the room on 10/26/20 at 7:36am revealed the missing	C 076		

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C 076	Continued From page 6 drawer was his roommates and he did not know what happened to the drawer. Based on observation and interviews, it was determined the other resident in the room was not interviewable. Telephone interview with the Administrator on 11/03/20 at 2:16pm revealed: -She was not aware a resident's drawer was missing. -The medication aides (MA) were in the resident's room every day and should have told her if a drawer was missing. -The resident had taken his bed frame apart and as soon as she found out about it, she had the bed frame replaced. -She expected the MA to tell her when things were broken and need to be repaired. Telephone interview with the Administrator on 11/04/20 at 2:33pm revealed: -She did a walk around the facility when she was at the facility, but she did not have a check list or an inspection list when she walked around. -She "may not have had time to notice" things that needed to be repaired when she visited the facility.	C 076		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition	C 102		

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C 102	Continued From page 7 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all electrical equipment was maintained in a safe operating condition related to the light fixture in the kitchen and a resident bedroom not working; the drain in the kitchen sink, and the exhaust fan on the stove not working. The findings are: Observation of the kitchen on 10/26/20 at 8:10am revealed: -The overhead ceiling light did not have a light bulb and the socket was exposed. -The exhaust fan for the stove did not work. -There was a sign on the cabinet door under the sink that read "do not let the red bucket under the sink overflow, dump it when the water gets too high" -There was a bucket under the sink that was two-thirds full of water. Observations of the men's bathroom on 10/26/20 at 8:38am and 9:03am revealed the toilet was clogged but was not overflowing. Interview with a medication aide (MA) on 10/26/20 at 8:11am revealed: -There was a bucket under the sink in the kitchen because the drain leaked. -She emptied the bucket about once a week at the edge of the yard. -The toilet in the men's bathroom would get stopped up and was slow to go down and sometimes would overflow. -The light in the kitchen had not worked since she	C 102		

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had been working at the facility since she started working at the facility the month before.
-The exhaust fan on the stove had not worked for at least a month.

Interviews with another MA on 10/26/20 at 8:08am and 8:37am revealed:
-The overhead light in the kitchen had not worked since she started working in September 2020.
-The exhaust fan over the stove did not work.

Observation of a resident in her bedroom on 10/26/20 at 9:03am revealed the resident reached up and turned on the light bulb on the ceiling fan with her hand.

Interview with two residents who resided in the room on 10/26/20 at 9:10am revealed:
-The light on the ceiling fan in their room worked at the light switch on the wall but there was not a pull string to turn it on and off.
-When they wanted to leave the ceiling fan on but turn off the light, they would turn or twist the bulb on and off.
-One roommate was taller and could reach the bulb to turn it on and off when needed.
-The light bulb would be hot to the touch sometimes, but she had not been burned "yet".
-The light bulb had been like that for a "long time".

Interview with a MA on 10/26/ at 9:22am revealed the light worked the pull chain for the light was just missing; the chain was missing for about a month.

Telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:56pm revealed:
-She knew the kitchen sink was leaking and needed repaired.

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-She knew they overhead light in the kitchen was not working.
-She had reported her concerns about the needed repairs to the Administrator but she felt they fell on "death ears".

Telephone interview with the Administrator on 10/29/20 at 5:46pm revealed:
-The exhaust vent on the stove had not worked since the last fire inspection about a year ago.
-The sink in the kitchen had been repaired but was still leaking; she attempted to repair it on 10/20/20.
-She was usually on top of things, but she did not check everything every time she was at the facility.
-She did the best she could with the distance she had to travel to get to the facility.

Telephone interview with the Administrator on 11/04/20 at 2:15pm revealed:
-She did not know the residents in one of the rooms had to twist the light bulb with their hand to turn the light on and off but leave the ceiling fan running.
-There should have been a pull chain on the light to turn it on and off and still leave the fan running.
-She expected the staff to inform her of things that needed repairs.
-She walked around the facility when she visited but she may not have had time to notice everything that was broken or needed repairs.
-The lights to the residents' rooms were either on or off when she got there.
-She thought the overhead light in the kitchen worked; it just needed a new light bulb.
-She was not aware the overhead kitchen light did not work at the light switch on the wall; staff had not told her the light switch did not work.
-She was concerned there was not a working light

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C 102	Continued From page 10 in the kitchen because the staff would not be able to see to work.	C 102		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 4 of 4 sampled staff (A, B, C, D,) completed a two-step tuberculosis (TB) skin test according to control measures adopted by the Commission for Health Services. The findings are: 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 09/23/20. -There was documentation Staff A had a TB skin	C 140		

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test administered on 09/14/20 and read as negative on 09/17/20.
-There was documentation Staff A had a second TB skin test administered on 10/02/20 and read as negative on 10/05/20.

Interview with a Staff A on 10/26/20 at 10:30am and 2:00pm revealed:
-She was not sure exactly when she started working at the facility, but that it was March 2020.
-She had been provided blank forms by the Administrator and instructed to sign the forms in September 2020.
-She had not had a TB skin test since she started working at the facility.

Review of Staff A's time sheets revealed:
-There were no time sheets provided for Staff A prior to June 2020.
-Staff A worked 5:00pm-7:00pm on 06/24/20.
-Staff A worked 8:00am-5:00pm on 06/25/20.
-Staff A worked 8:00am-5:00pm on 06/30/20.

Telephone interview with the Administrator on 10/21/2020 at 12:06pm revealed a contracted nurse administered the TB skin test for Staff A.

Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed:
-Staff TB skin tests were completed at the health department or completed by a nurse who went to the facility.
-Staff A came from another facility, and she had not requested information on a TB skin test from that facility.

Telephone interview with the contracted nurse on 10/27/20 at 8:41am revealed:
-She had done TB skins tests for the facility "a while back" but did not recall the date.

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C 140	Continued From page 12 -She had to stop doing the TB skin test because she could no longer obtain the serum. Second telephone interview with the contracted nurse on 10/27/20 at 10:38am revealed: -She had not administered any TB skin tests in 2020. -She did not know how the facility had obtained a form with her signature on it. -She did not administer a TB skin test to Staff A. Telephone interview with the Administrator on 10/27/20 at 3:03pm revealed: -She was not requiring her staff to go out to do TB skin test because of coronavirus (COVID-19) pandemic, so she had a named contracted nurse go to the facility to administer staff TB skin tests. -She knew her staff would not drive to the nurse's office, so the nurse went to the facility. -The contracted nurse would send her a copy of the completed employee TB skin tests. 2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff B was hired on 09/21/20. -There was documentation Staff B had a TB skin test administered on 09/13/20 and read as negative on 09/16/20. -There was documentation Staff B had a second TB skin test administered on 10/05/20 and read as negative on 10/08/20. Interview with Staff B on 10/26/20 at 8:08am revealed she had not had a TB skin test administered in September 2020 or October 2020. Telephone interview with the Administrator on 10/21/2020 at 12:06pm revealed a contracted nurse administered a TB skin test for Staff B.	C 140		

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C 140	Continued From page 13 Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -The staff TB skin tests were completed at the health department or completed by a nurse who went to the facility. -She did not recall where Staff B had obtained her TB skins test but Staff B was a "rehire" and she had used Staff B's previous information. -Staff B had been out on leave and had been back at the facility for "about one month." Telephone interview with the contracted nurse on 10/27/20 at 8:41am revealed: -She had done TB skins tests for the facility "a while back" but did not recall the date. -She had to stop doing the TB skin test because she could no longer obtain the serum. Second telephone interview with the contracted nurse on 10/27/20 at 10:38am revealed: -She had not administered any TB skin tests in 2020. -She did not know how the facility had obtained a form with her signature on it. -She did not administer a TB skin test to Staff B. Telephone interview with the Administrator on 10/27/20 at 3:03pm revealed: -She was not requiring her staff to go out to do TB skin test because of coronavirus (COVID-19) pandemic, so she had a named contracted nurse go to the facility to administer staff TB skin tests. -She knew her staff would not drive to the nurse's office, so the nurse went to the facility. -The contracted nurse would send her a copy of the completed employee TB skin tests. 3. Review of Staff C's, Supervisor-in-Charge (SIC), personnel record revealed:	C 140		

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C 140	Continued From page 14 -Staff C was hired on 08/30/20. -There was documentation Staff C had a TB skin test administered on 09/01/20 and read as negative on 09/04/20. -There was documentation Staff C had a second TB skin test administered on 09/21/20 and read as negative on 09/23/20. Telephone interview with the Administrator on 10/21/2020 at 12:06pm revealed a contracted nurse administered a TB skin test for Staff C. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -The staff TB skin tests were completed at the health department or completed by a nurse who went to the facility. -She did not know where Staff C had completed his TB test; "I do not know much about him because he came from another county." Interview with Staff C on 10/27/20 at 8:12am revealed: -He had not had a TB skin test completed at the facility because he was allergic to the TB skin test serum; he had a chest x-ray completed. -He did not recall the date of the chest x-ray but he would provide a copy of the results of the chest x-ray Review of chest x-ray provided by Staff C dated 05/17/20 revealed there was documentation Staff C had no evidence of active TB. Telephone interview with the contracted nurse on 10/27/20 at 8:41am revealed: -She had done TB skins tests for the facility "a while back" but did not recall the date. -She had to stop doing the TB skin test because she could no longer obtain the serum.	C 140		

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C 140	Continued From page 15 Second telephone interview with the contracted nurse on 10/27/20 at 10:38am revealed: -She had not administered any TB skin tests in 2020. -She did not know how the facility had obtained a form with her signature on it. -She did not administer a TB skin test to Staff C. Telephone interview with the Administrator on 10/27/20 at 3:03pm revealed: -She was not requiring her staff to go out to do TB skin test because of coronavirus (COVID-19) pandemic, so she had a named contracted nurse go to the facility to administer staff TB skin tests. -She knew her staff would not drive to the nurse's office, so the nurse went to the facility. -The contracted nurse would send her a copy of the completed employee TB skin tests. 4. Review of the facility's personnel records revealed Staff D did not have a personnel record. Interview with Staff D on 10/26/20 at 7:34am revealed: -She worked at the facility every other weekend from Friday at 5:00pm until Monday at 8:00am. -She was a medication aide. -She started working at the facility the first weekend in September 2020. Telephone interview with Staff D on 11/04/20 at 12:04pm revealed: -She had not had a TB skin test completed since she began working at the facility. -No one had asked her to provide a copy of any previous TB skin test she had completed. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed:	C 140		

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C 140	Continued From page 16 -Staff D did not have a personnel record because Staff D was "just filling it." -Staff D was a "fill-in" who worked at a "peer's facility." -Staff D had been a long-term employee at the peer's facility and had a personnel record at the peer's facility. -She was sure the peer's facility had completed all state required paperwork on Staff D. _____ The facility failed to ensure all staff had TB skin testing completed upon hire, which placed the residents at increased risk for exposure to tuberculosis disease. The facility's failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/28/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 19, 2020.	C 140		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure 2 of 4 sampled staff (Staff	C 145		

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C 145	Continued From page 17 A, Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 09/23/20. -There was documentation of a Health Care Personnel Registry (HCPR) check dated 09/14/20. -There was no documentation of a HCPR check being completed when Staff A began working in June 2020. Interview with a Staff A on 10/26/20 at 10:30am and 2:00pm revealed: -She was not sure exactly when she started working at the facility, but that it was March 2020. -She had been provided blank forms by the Administrator and instructed to sign the forms in September 2020. -She did not know if or when a HCPR check was completed. Review of Staff A's time sheets revealed: -There were no time sheets provided for Staff A prior to June 2020. -Staff A worked 5:00pm-7:00pm on 06/24/20. -Staff A worked 8:00am-5:00pm on 06/25/20. -Staff A worked 8:00am-5:00pm on 06/30/20. Review of the monthly staffing schedule for September 2020 and October 2020 revealed: -Staff A worked 8:00am-5:00pm on Tuesdays and Thursdays. -Staff A worked every other Sunday from 8:00pm-8:00am.	C 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 145	Continued From page 18 Review of Staff A's time sheet for August 2020 revealed Staff A worked 10 days for six to twelve hours per day. Review of Staff A's time sheet for September 2020 revealed Staff A worked 16 days for seven to thirteen hours per day. Review of Staff A's time sheet for October 2020 revealed Staff A worked 13 days for seven to twelve hours per day. Telephone interview with the Administrator on 11/04/20 revealed: -Staff A was only working one day a week when she "first started working for the facility." -She was not sure if she did a HCPR on Staff A at that time, because she was not sure Staff A would be working out. -An employee quit in September 2020 and she had to bring Staff A on full time and that was when she completed a HCPR check on Staff A. 2. Review of the facility's personnel records revealed Staff D did not have a personnel record. Telephone interview with Staff D on 11/04/20 at 12:04pm revealed she did not know what paperwork had been completed on her since she began working at the facility. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -Staff D did not have a personnel record because Staff D was "just filling it." -Staff D was a "fill-in" who worked at a "peer's facility." -Staff D had been a long-term employee at the peer's facility and had a personnel record at the peer's facility.	C 145		

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C 145	Continued From page 19 -She was sure the peer's facility had completed all state required paperwork on Staff D.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 4 sampled staff, (Staff A, Staff D), had a criminal background check completed upon hire. The findings are: 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 09/23/20. -There was documentation of a criminal background check dated 09/14/20. -There was no documentation of a criminal background check being completed when Staff A began working in June 2020. Interview with a Staff A on 10/26/20 at 10:30am and 2:00pm revealed: -She was not sure exactly when she started working at the facility, but that it was March 2020. -She had been provided blank forms by the Administrator and instructed to sign the forms in September 2020. -She did not know if a criminal background check had been completed when she first started	C 147		

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C 147	Continued From page 20 working at the facility. Review of Staff A's time sheets revealed: -There were no time sheets provided for Staff A prior to June 2020. -Staff A worked 5:00pm-7:00pm on 06/24/20. -Staff A worked 8:00am-5:00pm on 06/25/20. -Staff A worked 8:00am-5:00pm on 06/30/20. Telephone interview with the Administrator on 11/04/20 revealed: -Staff A was only working one day a week when she "first started working for the facility." -She was not sure if she did a background check on Staff A at that time, because she was not sure Staff A would be working out. -An employee quit in September 2020 and she had to bring Staff A on full time and that was when she completed a criminal background check on Staff A. 2. Review of the facility's personnel records revealed Staff D did not have a personnel record. Telephone interview with Staff D on 11/04/20 at 12:04pm revealed she did not know what had been completed on her since she began working at the facility. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -Staff D did not have a personnel record because Staff D was "just filling it." -Staff D was a "fill-in" who worked at a "peer's facility." -Staff D had been a long-term employee at the peer's facility and had a personnel record at the peer's facility. -She was sure the peer's facility had completed all state required paperwork on Staff D.	C 147		

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C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family 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 and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, within the last 24 months for 3 of 4 sampled staff (Staff A, Staff B, and Staff D). The findings are: 1.Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 09/23/20. -There was a copy of a CPR card dated 09/19/20 with an expiration date of 2 years.	C 176		

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C 176	Continued From page 22 Observation on 10/29/20 at 9:48am revealed Staff A and six residents were the only individuals at the facility. Interview with a Staff A on 10/26/20 at 10:30am and 2:00pm revealed: -She was not sure exactly when she started working at the facility, but that it was March 2020. -She had been provided blank forms by the Administrator and instructed to sign the forms in September 2020. -She shadowed a second shift medication aide (MA) on her first day (she did not recall the date) for a "couple of hours." -When she worked, she was the only staff at the facility. -Her previous employment had been in housekeeping. -She had not had a CPR class since she started working at this facility. -She had never taken a CPR class. -She had not provided a copy of a CPR card to the Administrator. Review of Staff A's time sheets revealed: -There were no time sheets provided for Staff A prior to June 2020. -Staff A worked 5:00pm-7:00pm on 06/24/20. -Staff A worked 8:00am-5:00pm on 06/25/20. -Staff A worked 8:00am-5:00pm on 06/30/20. Review of the monthly staffing schedule for September 2020 and October 2020 revealed: -Staff A worked 8:00am-5:00pm on Tuesdays and Thursdays. -Staff A worked every other Sunday from 8:00pm-8:00am. -No other staff was scheduled on the dates Staff A worked.	C 176		

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C 176	Continued From page 23 Review of Staff A's time sheet for August 2020 revealed Staff A worked 10 days for six to twelve hours per day. Review of Staff A's time sheet for September 2020 revealed Staff A worked 16 days for seven to thirteen hours per day. Review of Staff A's time sheet for October 2020 revealed Staff A worked 13 days for seven to twelve hours per day. Review of all staff time sheets for August 2020, September 2020, and October 2020, revealed one medication aide worked on scheduled shifts. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -She was responsible for personnel records. -All staff had CPR training before they began working at the facility and provided a copy of their CPR cards to her. -The CPR card in Staff A's personnel record was provided by Staff A. Telephone interview with a representative from the organization listed on Staff A's CPR card on 10/27/20 at 8:30am revealed: -The CPR card provided by the Administrator on Staff A was not registered with their organization. -All valid CPR cards would be registered when CPR was completed with an approved trainer. -CPR cards could only be obtained once an approved course had been completed. -She did not have any information Staff A had completed CPR training through their organization. Interview with the facility's contracted CPR	C 176		

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instructor on 10/29/20 at 11:22am revealed:
-She had not conducted any CPR instruction for the Administrator since 12/30/19.
-She did not have a record of providing CPR instruction for Staff A.
-The certification number on the CPR cards issued by the American Red Cross (ARC) upon completion of the coarse and could be verified through the ARC; the ARC could provide the name of the card holder through the certification number.
-If the certification number on the card was not valid the ARC would not be able to reference the name on the card.

2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed:
-Staff A was hired on 09/21/20.
-There was a copy of a CPR card dated 12/07/19 with an expiration date of 2 years.

Observation on 10/26/20 at 9:00am revealed Staff B and six residents were the only individuals at the facility.

Interview with Staff B on 10/26/20 at 8:08am revealed:
-She started to work at the end of the year in 2019 but went out on leave and "just came back."
-She had a CPR class at "her old job."
-She thought her CPR was expiring soon.
-No one had asked her for a copy of her CPR card, and she had not provided a copy of her CPR card to the Administrator.
-She had not taken a CPR class since she started working at this facility.

Observation on 10/26/20 at 9:34am revealed Staff B and six residents were the only individuals

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C 176	Continued From page 25 at the facility. Review of the monthly staffing schedule for September 2020 and October 2020 revealed: -Staff B worked 8:00am-5:00pm on Mondays, Wednesdays and Fridays. -Staff B worked every other Sunday from 8:00am-8:00pm. -No other staff was scheduled on the dates Staff B worked. Review of Staff B's time sheet for September 2020 revealed: -Staff B worked 8:00am-8:00pm on 09/20/20. -Staff B worked five days for nine hours per day. Review of Staff B's time sheet for October 2020 revealed Staff B worked 14 days for three to twelve hours per day. Review of all staff time sheets for August 2020, September 2020, and October 2020, revealed one medication aide worked on scheduled shifts. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -She was responsible for personnel records. -All staff had CPR training before they began working at the facility and provided a copy of their CPR cards to her. -The CPR card in Staff B's personnel record was provided by Staff B. Telephone interview with a representative from the organization listed on Staff B's CPR card on 10/27/20 at 8:30am revealed: -The CPR card provided by the Administrator on Staff B was not registered with their organization. -All valid CPR cards would be registered when CPR was completed with an approved trainer.	C 176		

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-CPR cards could only be obtained once an approved course had been completed.
-She did not have any information Staff B had completed CPR training through their organization.

Interview with the facility's contracted CPR instructor on 10/29/20 at 11:22am revealed:
-She had not conducted any CPR instruction for the Administrator since 12/30/19.
-She did not have a record of providing CPR instruction for Staff B.
-The certification number on the CPR cards issued by the American Red Cross (ARC) upon completion of the coarse and could be verified through the ARC; the ARC could provide the name of the card holder through the certification number.
-If the certification number on the card was not valid the ARC would not be able to reference the name on the card.

3. Review of the facility's personnel records revealed Staff D did not have a personnel record.

Observation on 10/26/20 at 7:34am revealed Staff D and six residents were the only individuals at the facility.

Interview with Staff D on 10/26/20 at 7:34am revealed:
-She worked from 5:00pm on Friday until 8:00am on Monday; she did this schedule every other weekend.
-She started working at the facility the first weekend in September 2020.

Telephone interview with Staff D on 11/04/20 at 12:04pm revealed:
-Her CPR certification expired in September

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(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
C 176	Continued From page 27 2019. -She had not renewed her CPR because she did not have the money to take a CPR class. -She had not provided a copy of her CPR card to the Administrator. Review of the monthly staffing schedule for September 2020 and October 2020 revealed: -Staff D worked every other weekend from 5:00pm on Friday until 8:00am on Monday. -No other staff was scheduled on the dates Staff D worked. Review of Staff D's time sheet for September 2020 revealed Staff A worked 09/25/20 at 5:00pm until 8:00am on 09/28/20. Review of all staff time sheets for August 2020, September 2020, and October 2020, revealed one medication aide worked on scheduled shifts. Staff D did not have an October 2020 time sheet available to review. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -She was responsible for personnel records. -Staff D did not have a personnel record because Staff D was "just filling it." -Staff D was a "fill-in" who worked at a "peer's facility." -Staff D had been a long-term employee at the peer's facility and had a personnel record at the peer's facility. _____ The facility failed to ensure at least one staff person was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management in the last 24 months. The facility's failure to have	C 176		

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C 176	Continued From page 28 staff on duty who had CPR certification and choking management placed the residents at harm and 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 10/28/20 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 19, 2020.	C 176		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record	C 185		

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reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to infection prevention and control program related to COVID-19, medication administration, health care, training on cardio-pulmonary resuscitation, test for tuberculosis, adult care home medication aide training and competency evaluation requirements, housekeeping and furnishing, building service equipment, orders for self-administration of medication, and staff qualifications.

The findings are:

Interview with a resident on 10/26/20 at 2:22pm revealed:
-The Administrator was at the facility once a month.
-She wished the Administrator was at the facility more often so the Administrator could see what was going on in the facility.
-She wanted the Administrator to see "how the residents act" because the other residents were always asking for things from "me."

Interview with a medication aide (MA) on 10/26/20 at 8:37am revealed:
-The Administrator was at the facility once a month.
-The Administrator was usually at the facility on the 6th of the month and stayed "about 3-hours."
-She had not seen the Administrator at the facility in October 2020.

Interview with another resident on 10/29/2020 at 5:48pm revealed:
-The Business Office Manager (BOM) had been to the facility a couple of times.
-The BOM was at the facility about an hour, every

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C 185	Continued From page 30	C 185		

other month.
-The Administrator was at the facility the 6th of every month and stayed about an hour.

Telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm revealed:
-She was concerned there were not supervision of the staff to ensure the day to day operations of the facility were completed.
-She acknowledged there was an Administrator and as the RN she could not overstep her boundaries.
-She had told the Administrator, the Administrator should be at the facility weekly: "I had told her that early on."
-She did not get a response like, "I am going to try or anything."
-The Administrator needed to be at the facility once a week.

Telephone interview with the Administrator on 10/27/20 at 12:30pm revealed:
-Her business partner [Business Office Manager (BOM)] was responsible for the "business" because the BOM had her own business.
-She handled billing, staffing schedule and payroll, as well as went to the facility once a month.

Telephone interview with the Administrator on 10/29/20 at 6:30pm revealed:
-She went to the facility one day a month to do business.
-She was at the facility on the evening of 10/13/20.
-It was "quite a hike" to the facility, so she and the BOM shared the responsibility.
-The BOM went to the facility once a month.
-She usually tried to go to the facility on the 6th of the month.

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C 185	Continued From page 31 -She was based an hour away and it was not the best situation. -It would be easier to manage the facility if it was closer. Noncompliance identified during the survey included: 1. Based on observations, interviews and record reviews, the facility failed to ensure follow-up for acute and routine healthcare needs for 2 of 3 residents sampled (#1, #3) including a resident who had a referral appointment for an Epileptologist for seizures, notification to the Neurologist for seizures and complaint of toothache (#3); and a resident who experienced increased weakness and slurred speech after being administered another resident's medication, and whose primary care physician (PCP) had referred the resident to a Neurologist due to increased tremors (#1). [Refer to Tag C246 10A NCAC 13G .0902(b) Health Care (Type A1 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic regarding recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff not wearing facemasks, staff not maintaining a social distance of 6 feet from residents when not wearing facemasks, and no screening of staff and visitors. [Refer to Tag C601 10A NCAC 13G .1701 Infection Prevention and Control Program	C 185		

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C 185	Continued From page 32 (Type A2 Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure 4 of 4 staff sampled (Staff A, B, C, and D) who administered medications had completed their medication clinical skills competency validation prior to administering medications and completed the 5-hour and 10-hour medication aide training courses under the direction of a registered nurse or licensed pharmacist or successfully completed the required state examination (Staff A). [Refer to Tag C935 G.S. § 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 2 of 3 sampled residents (#1 and #3) including a medication used to treat asthma, an allergy nasal spray and a supplement (#1) and an oral tooth medication (#3). [Refer to Tag C330 10A 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, within the last 24 months for 3 of 4 sampled staff (Staff A, Staff B, and Staff D). [Refer to Tag C176 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 6. Based on record reviews and interviews, the facility failed to ensure 4 of 4 sampled staff (A, B,	C 185		

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C, D,) completed a two-step tuberculosis (TB) skin test according to control measures adopted by the Commission for Health Services. [Refer to Tag C140 10A NCAC 13G .0405(a) Test for Tuberculosis (Type B Violation)].

7. Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 4 of 4 sampled staff (Staff A, B, C, and D) prior to hire. [Refer to Tag C992 G.S. 131D-45 Examination and Screening for the Presence of Controlled Substances Required for Applicants for Employment in Adult Care Homes (Type B Violation)].

8. Based on observations and interviews, the facility failed to ensure the flooring in the dining room, a leak in the ceiling in a resident bedroom, a hole in a wall, the window coverings, ceiling fans and wall air returns were kept clean and in good repair. [Refer to Tag C076 10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings (Standard Deficiency)].

9. Based on interviews, and record reviews, the facility failed to ensure 2 of 2 sampled staff (Staff A, Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag C145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications (Standard Deficiency)].

10. Based on record reviews and interviews, the facility failed to ensure 2 of 2 sampled staff, (Staff A, Staff D), had a criminal background check completed upon hire. [Refer to Tag C147 10A NCAC 13G .0406(a)(7) Other Staff Qualifications (Standard Deficiency)].

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C 185	Continued From page 34 11. Based on observations, record reviews, and interviews, the facility failed to assure the implementation of physician's orders for 1 of 1 sampled resident (Residents #1) with orders for finger stick blood sugar (FSBS) checks. [Refer to Tag C249 10A NCAC 13G .0902(c)(3-4) Health Care (Standard Deficiency)]. 12. Based on observations and interviews, the facility failed to ensure a resident's bed and dresser were kept clean and in good repair. [Refer to Tag C074 10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings (Standard Deficiency)]. 13.Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records for 3 of 3 sampled residents (Resident #1, #2 and #3). [Refer to Tag C342 10A NCAC 13G .1004(j) Medication Administration (Standard Deficiency)]. 14. Based on observations, record reviews, and interviews, the facility failed to ensure the record of controlled substances was maintained and reconciled accurately with the documented receipt and administration of controlled substances for 1 of 1 sampled resident (#1) with an order for a controlled sleeping medication and an anti-anxiety medication. [Refer to Tag C367 10A NCAC 13G .1008(a) Controlled Substances (Standard Deficiency)]. 15. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 residents sampled (#1 and #3) who self-administered medications had orders to self-administer prescription medications that were	C 185		

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C 185	Continued From page 35 kept in the residents' rooms including a nebulizer treatment and an inhaler (#1); and oral dental pain medication (#3). [Refer to Tag C350 10A NCAC 13G .1005(a) Self-Administration of Medications (Standard Deficiency)]. 16. Based on observations and interviews, the facility failed to ensure all electrical equipment was maintained in a safe operating condition related to the light fixture in the kitchen and a resident bedroom not working; the drain in the kitchen sink, and the exhaust fan on the stove not working. [Refer to Tag C102 10A NCAC 13G .0317 Building Service Equipment (Standard Deficiency)]. _____ The Administrator failed to ensure the overall management, operations, and policies of the facility were implemented by failing to ensure the medication aides, who were solely responsible for the care of the residents, were trained in medication administration which resulted in a resident (#1) being administered the wrong medication which was contraindicated for this resident, who had a history of Myasthenia Gravis; the MAs were trained to notify the residents physicians, which resulted in a resident (#3) having multiple seizures that were not reported to the resident's Primary Care Provider and Neurologist and a toothache was not reported to the resident's Dentist; FSBS were not implemented for a resident (#1) with a diagnosis of diabetes; medication administration records and control logs were not completed and accurate, and therefore unable to determine if residents' medications were administered correctly; a system was in place to screen residents and staff for COVID-19 per the Center for Disease Control guidelines and ensuring staff were wearing facemasks; and there was always	C 185		

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C 185	Continued From page 36 staff scheduled who were trained in cardio-pulmonary resuscitation. This failure of the Administrator resulted in serious neglect and serious physical harm of the residents' which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 4, 2020	C 185		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure follow-up for acute and routine healthcare needs for 2 of 3 residents sampled (#1, #3) including a resident who had a referral appointment for an Epileptologist for seizures, notification to the Neurologist for seizures and complaint of toothache (#3); and a resident who experienced increased weakness and slurred speech after being administered another resident's medication, and whose primary care physician (PCP) had referred the resident to a Neurologist due to increased tremors (#1). The findings are:	C 246		

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C 246	Continued From page 37 1. Review of Resident #3's current FL-2 dated 11/01/19 revealed diagnoses included seizures, depression and mild intellectual disability. a. Review of Resident #3's physician assessment plan dated 01/15/20 revealed: -The assessment was from a visit with Resident #3's Neurologist. -Under seizure there was documentation to follow up in three months if she had more seizures. -There was a note to follow up with an Epileptologist; the Neurologist would schedule the appointment. Review of the Neurologist encounter summary and progress notes from a telehealth visit dated 06/02/20 revealed: -The visit was a follow up visit for seizures. -Resident #3 told the Neurologist her seizures had gotten worse since her last visit. -The facility staff reported Resident #3 had a few seizures since her last visit. -Resident #3 had 17 seizures from March 2020 to 05/30/20. -Resident #3 had two seizures per week and the duration of each seizure was a few minutes. -Resident #3 did not have any warning signs prior to the onset of a seizure. -Resident #3's seizures were described as automatisms (the performance of actions without conscious thought or intention) and generalized convulsions with associated symptoms being fatigue. Telephone interview with a representative from Resident #3's Neurologist office on 10/27/20 at 1:10pm revealed: -Resident #3 had been referred to an Epileptologist by the Neurologist for her seizures.	C 246		

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C 246	Continued From page 38 -The Neurologist's office made the appointment with the Epileptologist and the Epileptologist's office informed the facility of the appointment. -Resident #3's appointment with the Epileptologist was scheduled for 06/04/20. Telephone interview with a representative from Resident #3's Neurologist office on 11/03/20 at 11:34am revealed Resident #3 was referred to the Epileptologist office to see if she was having epileptic episodes and to get specific help for her seizures because the Neurologist did not think he could continue care for Resident #3 without the diagnosis from the referral. Telephone interview with a medication aide (MA) on 10/28/20 at 12:51pm revealed: -Staff took residents to medical appointments in their personal cars. -There was a folder for each resident; the folder had paperwork that the facility Registered Nurse (RN) has placed in the folder. -The folder was then taken to the resident's medical appointment. -The physician would place any visit information and paperwork into the folder and the staff would bring the folder back to the facility. -She did not know who reviewed the information in the folder after it was returned to the facility. Telephone interview with a second MA on 10/28/20 at 1:16pm revealed: -She had taken residents to medical appointments and would take a folder with the resident's information to the appointment. -The physician would place paperwork from the visit into the folder and she would take the folder back to the facility. -The facility RN would put any paperwork into the resident's record after the medical appointment.	C 246		

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C 246	Continued From page 39 -Facility staff were responsible for documenting appointments on the office calendar. Telephone interview with a third MA on 10/29/20 at 9:52am revealed: -She had taken Resident #3 to her physicians' appointments. -She took the folder with information for Resident #3 to the physician's appointments but had never put the seizure log in the folder. -If the physician gave new instructions on anything, she would call the Administrator and let her know. -If there was a follow up appointment made for Resident #3, she would put the appointment down on the calendar. Telephone interview with the facility's RN on 10/29/20 at 2:43pm revealed: -The Neurologist wanted to send Resident #3 to the Epileptologist in another city for a follow up related to the resident's seizures. -She and the Administrator did not want to drive the resident to another city during the pandemic because they did not want to expose Resident #3 to the COVID-19 virus. -She did not know anything about a telehealth appointment with the Epileptologist for Resident #3. Telephone interview with the facility's RN on 11/03/20 at 2:57pm revealed: -The Neurologist had referred Resident #3 to a Epileptologist to identify the resident's seizures. -She did not know if the specialist [Epileptologist] would have made accommodations for a telehealth appointment for Resident #3 and she never requested a telehealth appointment for the resident.	C 246		

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C 246	Continued From page 40 Telephone interview with a representative from the Epileptologist office on 10/29/20 at 4:16pm revealed: -The appointment for Resident #3 was scheduled for 06/04/20 and was canceled by the facility staff on 06/03/20. -The appointment was not rescheduled. Telephone interview with a representative from the Epileptologist office on 11/02/20 at 11:43am revealed: -The appointment for 06/04/20 was made in March 2020. -The facility had requested to cancel the appointment and had not requested to reschedule the appointment. -The resident could have been seen via telehealth for the appointment scheduled for 06/04/20. -They were trying to do telehealth appointments for patients that could not come into the office; they wanted everyone to have access to care whether it be through telehealth or in person visits. -The office had not restricted in person visits. -If Resident #3 had been referred by the Neurologist, she should have been rescheduled for the visit. Telephone interview with the Administrator on 10/29/20 at 5:06pm revealed: -The Epileptologist's office had notified her that they were not seeing any patients that lived in Family Care Homes in the office during the pandemic. -She was also told by the Epileptologist's office the first visit with them had to be in person and could not be done via telehealth. -After the initial visit Resident #3 would be able to do a telehealth visit with the Epileptologist.	C 246		

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C 246	Continued From page 41 -The Epileptologist's office had called and canceled Resident #3's appointment and did not reschedule the appointment. b. Review of Resident #3's seizure log dated 08/04/20 to 10/09/20 revealed: -There was documentation of the date, the time of day, the observations, the length, comments and staff initials made for each time Resident #3 had a seizure. -There was documentation Resident #3 had 16 seizures between 08/04/20 to 10/09/20. -There was documentation of a seizure on 08/04/20, and 08/18/20 at 12:00am for 2 minutes. -There was documentation of a seizure on 08/11/20 at 4:20am for 2 minutes. -There was documentation of a seizure on 08/19/20 at 12:19am for 2 minutes. -There was documentation of a seizure on 08/21/20 at 5:21am for 1.5 minutes. -There was documentation of a seizure on 08/26/20 at 3:00am for 1.5 minutes. -There was documentation of a seizure on 08/31/20 at 12:21am for 3 minutes. -There was documentation of a seizure on 09/01/20 at 12:02am for 2 minutes. -There was documentation of a seizure on 09/13/20 at 5:20am for 2 minutes. -There was documentation of a seizure on 09/20/20 at 3:30am for 2 minutes. -There was documentation of a seizure on 09/21/20 at 1:26am for 1 minute. -There was documentation of a seizure on 09/26/20 at 11:30pm for 1 minute and 53 seconds. -There was documentation of a seizure on 09/27/20 at 4:09am for less than 1 minute. -There was documentation of a seizure on 10/01/20 at 3:30am for 2 minutes. -There was documentation of a seizure on	C 246		

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10/03/20 at 2:30am for 1 minute.
-There was documentation of a seizure on 10/09/20 at 2:30am for 1.5 minutes.
-There was no documentation of notification to the Neurologist or a primary care provider (PCP) for any of the seizures.

Telephone interview with a MA on 10/28/20 at 1:21pm revealed:
-Resident #3 usually made a loud noise and kicked her legs; her seizures usually lasted 2 to 3 minutes.
-Resident #3 usually went right back to sleep after a seizure.
-She was trained to document the seizure, what day and time and the length on a seizure log sheet.
-Resident #3's seizures were at night or early in the morning and were loud enough to be heard anywhere in the facility.
-She was never told to inform or call anyone about a seizure.
-Resident #3 had a seizure at 5:00am on 10/28/20 that lasted about 1 minute; Resident #3 went back to sleep.

Telephone interview with a second MA on 10/29/20 at 9:52am revealed:
-Resident #3 had seizures at night while she slept.
-Resident #3 made a loud noise like a moan and Resident #3 would sound like she was trying to catch her breath.
-The noise would alert her to the seizure.
-She would go into Resident #3's room and sit until the seizure was over.
-Resident #3's seizures would last 1 to 2 minutes and then she would fall back to sleep.
-Resident #3's body would "wobble" and her legs from the waist down move.

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C 246	Continued From page 43 -She thought Resident #3 was awake during the seizures; the MA would ask the resident if she was "okay", but the resident would not answer her. -After every seizure she documented the date, time and length of the seizure on the seizure log and nothing else. -Another MA told her how to fill out the log when she started working at the facility. -She was not told to notify anyone after Resident #3 had a seizure. Telephone interview with a representative from Resident #3's Neurologist office on 10/28/20 at 4:23pm revealed: -The Neurologist was not notified after each seizure. -The last seizure the facility staff notified the Neurologist for was on 01/28/20 when the resident went to the hospital for a seizure. -Resident #3's seizures were "pretty bad" and the Neurologist would like to be notified when they happened. -If the facility staff had notified the office of seizures the Neurologist would have been made aware and he could advise if needed. -She did not see a note of a seizure log anywhere in Resident #3's record. Telephone interview with a representative from Resident #3's Neurologist office on 11/02/20 at 1:47pm revealed: -Resident #3 had tonic-clonic seizures (a type of seizure that involves a loss of consciousness and violent muscle contractions; also known as a grand mal seizure). -The Neurologist had not been notified of any seizures, but he expected to be notified for each seizure. -The Neurologist told the facility staff that	C 246		

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accompanied Resident #3 to the 06/02/20 appointment to notify the him when Resident #3 had a seizure.
-The office was not being notified of any seizures, so they did not know if the number of seizures had increased or decreased or if they were lasting longer or shorter.

Interview with Resident #3 on 10/29/2020 at 9:53am revealed:
-She knew she recently had a seizure but could not remember when, but it happened at night.
-When Resident #3 had a seizure, she would shake, and the staff would stand at her bed during the seizure.
-She had about two seizures a week during the night and they lasted about a minute each.
-After her seizures, she normally went back to bed.
-After a seizure the staff would ask if she needed them to call 911; she would tell them "no" and then she would go back to bed.
-She felt better when she laid down after a seizure.
-She had seizures during the day, but most of her seizures happened at night.
-She thought her seizures were triggered by eating sweets at night.

Telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 2:43pm revealed:
-She took Resident #3 to her Neurologist appointments.
-The Neurologist never told her to instruct the facility staff to call him when Resident #3 had a seizure.
-Resident #3's seizures were milder since the Neurologist had adjusted the resident's medication about a year ago; the seizures were less frequent and the duration was shorter now.

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C 246	Continued From page 45 -Resident #3's seizures used to be two minutes but were now less than two minutes and the frequency decreased from every night to 2-3 times a week. -The seizure log sheet was used at an appointment to tell the Neurologist about Resident #3's seizures while at a scheduled appointment. -The Neurologist only wanted to be notified if there was anything different about Resident #3's seizures. -She told staff to go straight to Resident #3 when she had a seizure and to stay with her until the seizure was over. -Staff were to document the seizures on the log sheet. Telephone interview with the facility's RN on 11/03/20 at 2:57pm revealed: -The only information the Neurologist wanted from the facility was the seizure log. -The log was taken to all of Resident #3's appointments with the Neurologist. -The seizures were reported to the Neurologist during the appointments that were done via telehealth. -The Neurologist did not want to be called for each seizure. Telephone interview with the Administrator on 10/29/20 at 5:16pm revealed: -The staff did not call the Neurologist when Resident #3 had a seizure; they were to document the seizure on the log sheet. -They would be calling the Neurologist too much if they called each time Resident #3 had a seizure. -Resident #3's seizures were very mild and only lasted about 1 to 1.5 minutes at night with very little movement.	C 246		

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C 246	Continued From page 46 -Resident #3 did not have "full" seizures and were minor with shaking. c. Review of communication logs between the facility staff from 10/01/20 to 10/28/20 revealed: -On 10/16/20 Resident #3 complained of tooth pain to staff and had been in the bed most of the day. -On 10/18/20 Resident #3 complained of tooth pain and had been given warm salt water to rinse her mouth with; she then went back to bed. -On 10/20/20 a dentist appointment had been made for Resident #3 on 11/03/20. -On 10/21/20 that Resident #3 complained of a toothache all night and finally went to sleep in the morning. -On 10/23/20 that Resident #3 did not want to get out of her bed all day. -On 10/26/20 that Resident #3 had a toothache all weekend. The medication aide (MA) instructed her to brush her teeth. Observation of Resident #3 on 10/29/20 at 10:49am revealed: -Resident #3 went to the MA and requested acetaminophen (a medication used to treat minor aches and pains) because of tooth pain. -The MA told Resident #3 she could not have acetaminophen because there was not any ordered for her. -The MA offered Resident #3 warm salt water to rinse her mouth with. -Resident #3 declined the salt water rinse stating, "It did not help the last time". -The right side of Resident #3's face was slightly swollen. Interview with Resident #3 on 10/26/20 at 7:43am revealed: -She was congested because she had a	C 246		

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toothache.
-It had been hurting "for a while" but she did not know how long.
-She thought she had an appointment with the dentist today, 10/26/20.

Interviews with Resident #3 on 10/29/20 at 9:53am and 10:55am revealed:
-She was in bed because she was hurting due to a toothache.
-She had not gotten anything for the pain "yet", but she had a dentist appointment on 11/03/20.
-She declined the warm salt water rinse because it did not help the last time she did it.
-She wanted to take something for the pain but was told she did not have an order for anything for pain.
-She had tooth pain for about the last two weeks, and she was tired of just rinsing with warm salt water.
-She had not been given anything for pain during the last two weeks.
-She had told "everyone" her mouth was hurting.

Interview with a MA on 10/29/20 at 10:51am and 10:58am revealed:
-She was aware Resident #3 had bad teeth.
-Resident #3 had complained about tooth pain for about two weeks.
-Staff logged Resident #3's complaint of tooth pain in the communication book.
-The Administrator would review the communication book when she came to the facility about twice a month.
-She told the Administrator when Resident #3 started complaining about tooth pain; the Administrator made a dentist appointment for Resident #3.
-She could not give Resident #3 anything for the tooth pain because she did not have an order for

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any pain medication.
-She did not know what a standing order was.
-She did not call the facility's Registered Nurse (RN) when Resident #3 complained of tooth pain because the facility RN had been sick.
-She usually called the Administrator when there was a complaint of any kind of pain.
-She did not call the physician or the dentist when Resident #3 complained of tooth pain; she never called anyone to ask for medication for pain for any of the residents.
-The Administrator was the only one that called the physician.

Telephone interview with a second MA on 11/02/20 at 12:59pm revealed:
-Resident #3 had been complaining off and on of tooth pain for about two weeks prior to bed time.
-She was not allowed to give Resident #3 anything for the pain because there was not an order.
-She was told by the facility's RN when Resident #3 complained of pain to have her rinse her mouth with warm salt water.
-Sometimes Resident #3 needed more for the pain so she gave the resident a warm towel to hold on her face.
-She had not noticed any swelling on Resident #3's face.
-She also told Resident #3 to brush her teeth to help with the pain; "the bleeding from brushing her teeth relieved the pressure and the pain".
-She would call the facility's RN and let her know when a resident was in pain and the facility's RN would call the PCP.
-She never called the PCP unless she was told to call the PCP; she was not told to call the PCP for Resident #3's tooth pain.
-Resident #3 had complained of tooth pain for three days the last weekend she had worked;

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C 246	Continued From page 49 "sometimes she did things for attention". Telephone interview with a third MA on 11/02/20 at 2:16pm revealed: -On 10/20/20 she had called the facility's RN to let her know Resident #3 was complaining of tooth pain; the facilty's RN told her to call the dentist and make an appointment for Resident #3. -She did not tell the receptionist at the dentist office about Resident #3's tooth pain, just that she needed an appointment. -The facility's RN told her to put a warm towel on Resident #3's jaw when she told her the resident was still in pain. -Resident #3 had a bit of swelling but she did not tell the facility's RN because the resident was already scheduled to go to the dentist soon. -She had never called a physician for a request for a medication order without calling the facility's RN first; the facility's RN would instruct her to call the physician or the RN would call the physician. Interview with the facility's RN on 10/29/20 at 2:09pm revealed: -The facility did not have standing orders for the residents. -When a resident would complain of a headache or diarrhea they were told "we do not have anything". -She was made aware of Resident #3's tooth pain around the middle of October 2020. -She knew Resident #3 had a dentist appointment scheduled; one of the MAs made the appointment. -She took Resident #3 to the store on a Saturday around the middle of October 2020 to purchase oral drops to put on her tooth for pain. -Resident #3 kept the drops in her room and used them when she needed them.	C 246		

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C 246	Continued From page 50 -The facility staff had not contacted her since she took Resident #3 to get the oral drops; she was not aware Resident #3 had continued to complain of tooth pain. -MAs could call a physician and request an order for medication or acetaminophen for a resident; they did not have enough confidence to call. -MAs could also call the Administrator who could call the physician, or the Administrator would instruct the MA to call the physician. -The MAs could have called her, and she would have called the physician. Telephone interview with the Administrator on 10/29/20 at 5:06pm revealed: -The MAs could call her, and she would call the physician for an order for medication for a pain. -The MAs were not allowed to give medication without an order. -Resident #3 had a "bad mouth" and had been going to the dentist for about a year. -She told Resident #3 she could not have anything for pain because she did not have an order from the physician for pain medication. -The first time she heard Resident #3 was having tooth pain was on 10/22/20 or 10/23/20 when she went to the facility. -Resident #3 told her the next day that her tooth had gotten better, and she did not complain of pain. -Staff called the dentist and made the appointment. -She had told the staff to have Resident #3 rinse with warm salt water to help with the pain. -She had called the dentist when she heard Resident #3 was complaining of tooth pain, but the dentist said they could not order pain medication. -She did not think about calling Resident #3's primary care physician (PCP) to ask for pain	C 246		

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medication.
-The MAs could call the PCP or the dentist themselves to get an order for medication for Resident #3 or any resident; she considered that resident "care".

Telephone interview with Resident #3's dentist on 11/02/20 at 10:33am revealed:
-Resident #3 had a scheduled appointment at her office for 11/03/20; the appointment was made on 10/19/20.
-There was no reporting of Resident #3's complaint of pain when the facility staff called to make the appointment.
-If the dentist had known Resident #3 was in pain, she would have tried to see the resident that same day and would have called in medication for pain and an antibiotic.
-The facility staff had called the dentist office and requested pain medication on 10/30/20 due to swelling and complaint of pain at that time.
-She started to see Resident #3 a year ago.
-She did not instruct the facility staff to have Resident #3 rinse with warm salt water or to brush her teeth to help with tooth pain.
-She questioned why the facility failed to reach out to the PCP to request pain medication.
-She was concerned Resident #3 was in pain and she wondered how long the resident had been in pain.
-One of Resident #3's teeth could have been infected and a cause for the pain; if the facility had requested medication sooner, she would have ordered it for Resident #3.

2. Review of Resident #1's current FL-2 dated 12/30/19 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis (a weakness and rapid fatigue of muscles

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under voluntary control. Symptoms include weakness in the arm and leg muscles, double vision, and difficulties with speech and chewing), hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion.

Review of the facility's policy titled Medication Administration Errors revealed:
-If a medication error was made including wrong person, wrong medication, wrong dosage, or wrong route the following action should be taken.
-Contact physician or pharmacist immediately concerning any action to be taken, possible effects and significant symptoms that may occur, and recommendations for adjusting the next scheduled medication dosage.
-Contact emergency medical assistance immediately if error posed a dangerous situation, difficulty breathing or unconsciousness.
-Notify the Administrator.
-Complete an incident report as soon as possible.

a. Review of the medication aide's (MA) communication log dated 09/22/20 revealed:
-Resident #1 was observed having slurred speech and complained of feeling dizzy.
-Resident #1 reported she had been administered the wrong medication last night, 09/21/20.
-Resident #1 was having a hard time walking so a bedside commode was placed by Resident #1's bedside.
-It was documented "no more sitting medications on the table," and "when giving medications, call each resident one by one to the office."
-Resident #1's medications were off again because Resident #1 did not get her medication last night, 09/21/20.
-There was no documentation Resident #1's primary care provider (PCP), Neurologist or mental health (MH) provider had been notified of

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(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
C 246	Continued From page 53 the medication administration error. Interview with Resident #1 on 10/29/20 at 10:47am revealed: -The evening MA placed medication cups on the table at the dinner place setting. -Each resident's name was on a medication cup. -She always took her bedtime medications at the dinner meal. -She did not take evening medication, "just bedtime medication." -The MA told everyone to take their medication; she picked up a cup and took the medication in the cup. -Someone said, "somebody had not taken their medicine." (She did not know who said this) -She realized the cup of medication remaining on the table was her medications so that meant she had taken another resident's medication. -A named resident said he did not get his medication and that was the resident who was sitting beside her. -The MA said, "I am sorry." -She took a named resident's medication. -The MA did not mention the incident again to her. -She felt really "out of it" the next morning. -She felt "bad all over." -She told the facility's nurse (RN) the next morning and was told "nothing he takes will hurt you." -After that incident, medication was no longer administered at the table. Observation of the named resident's medications on hand on 10/26/20 at 2:44pm revealed: -There was a bubble pack labeled evening that contained 2 tablets of Magnesium 400mg. -There was a bubble pack labeled bedtime that contained 7 tablets.	C 246		

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C 246	Continued From page 54 -The 7 tablets were identified as Divalproex Sodium (used to treat seizures) ER 500mg, Levetiracetam (used to treat seizures) 1000mg, Risperidone (antipsychotic medication) 4mg, Quetiapine Fumarate (antipsychotic medication) 300mg, Melatonin (sleep aide) 3mg. Review of Resident #1's hospital discharge summary dated 03/26/20 revealed: -Resident #1 was allergic to Magnesium with a reason as myasthenia gravis. -Resident #1 had a history of myasthenia gravis with vocal cord paralysis and should avoid medications that could precipitate myasthenia gravis, such as magnesium. Interview with a MA on 10/29/20 at 11:03am revealed: -She put the residents' medications in cups labeled with the residents' names and placed them at the dining room table. -She did not know she should not administer medication "that way" until an incident where a resident took another residents medication occurred and they were told to only administer medication one-by-one in the medication room. Telephone interview with the facility's contracted RN on 10/29/20 at 1:16pm revealed: -Resident #1 had made a complaint to her about taking another resident's medication. -She could not find proof that it had happened. -The medication count was not "off." -She would have expected the MA to have notified the Administrator the night the incident occurred. -She was told the MAs had been administering medications at the dining room table and she told all the MAs to only administer medication in the medication room.	C 246		

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C 246	Continued From page 55 -She also talked to all the residents after the incident to let them know medications should only be administered from the medication room. Telephone interview with Resident #1 on 11/02/20 at 11:05am revealed: -She always took her bedtime medications with her dinner meal. -Both evening MA's put bedtime medications at the dinner meal setting. -She could not say for sure how many pills were in the cup the night she took another resident's medications "but there was a lot, more than 5 or 6." Telephone interview with another MA on 11/02/20 at 11:10am revealed: -She had heard about Resident #1 taking another resident's medication. -She thought it was the bedtime medications Resident #1 had taken in error. Telephone interview with an evening MA on 11/02/20 at 4:52pm revealed: -Evening medications were administered at 7:00pm and evening medications were administered at 5:00pm. -The 5:00pm medications were put in medication cups at the dinner table. -He had never put bedtime medications in cups at the table. -Resident #1 never took another resident's medications. -Resident #1 picked up another resident's medications off the desk one evening in the office but did not actually take the medication (he did not recall the date when this incident happened). Telephone interview with a second evening MA on 11/03/20 at 1:08pm revealed:	C 246		

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C 246	Continued From page 56 -Evening medications were administered at 5:00pm and bedtime medications were administered at 7:00pm. -She had "heard" about Resident #1 being administered another resident's medication in error. -She thought the medication administered would have been the bedtime medications because Resident #1 did not take evening medications. Telephone interview with Resident #1's Neurologist on 11/02/20 at 11:32am revealed: -Magnesium was a medication that should not be administered to patients with a diagnosis of myasthenia gravis and could have caused problems. -Resident #1's myasthenia gravis had been stable the last time she had seen Resident #1, so she did not think it would have caused Resident #1 to have experienced slurred speech, dizziness, and weakness, but she could not say for sure because she had not seen Resident #1 in 18-months due to a no-show on her last appointment scheduled in March 2020. -The other medications that possibly could have been administered were more concerning, not because of the diagnosis of myasthenia gravis, but because there were a lot of sedating medications listed. -One of Resident #1's providers should have been notified of the administered medication in error. Telephone interview with Resident #1's primary care provider (PCP) on 11/02/20 at 12:31pm revealed: -He was not notified of Resident #1 taking another resident's medication in error. -He would have expected to have been notified of the medication administration error.	C 246		

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C 246	Continued From page 57 -Had he been notified he would have a better idea of the symptoms Resident #1 was experiencing and if the symptoms were the possible effects of the medication. Telephone interview with Resident #1's MH provider on 11/03/20 at 4:31pm revealed: -She was not aware Resident #1 had been administered another resident's medication. -She would have expected to have been notified of the medication error. -Had she known of the medication error she would have instructed staff of possible side effects and how to address the side effects. -She was familiar with the resident whose medication Resident #1 took in error. -It was very concerning Resident #1 may have been administered the resident's medications because the named resident took a lot of anti-psychotic medications that were highly sedating. -Resident #1 was very fragile and to take those doses of medications was alarming because could have experienced seizures, cognitive impairments, tardive dyskinesia and increased risk of falls. -Resident #1 would have been sedated from taking the wrong medication. -Resident #1 would need to follow-up with her PCP because even though the overnight side effects had cleared up, there could be long-term side effects that would need to be addressed. Telephone interview with the Administrator on 11/04/20 at 2:16pm revealed: -She was not aware medication was being administered at the table at meals. -She was concerned because there was no control of the medication, anyone could pick the medication up and it was unsanitary.	C 246		

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C 246	Continued From page 58 -She did not allow prepouring of medication for the residents; prepouring of medication "would never fly with me" and the MAs knew that. -She felt the residents would have noticed if they were given the wrong medications because they knew what medication they took. b. Review of Resident #1's physician's visit summary dated 09/10/20 revealed: -Resident #1 was concerned about tremors. -Resident #1 had missed her neurology appointment due to lack of transportation. -Resident #1 was advised to reschedule the missed appointment with the Neurologist. -It was very important Resident #1 advise the Neurologist about the tremors. Interview with Resident #1 on 10/29/20 at 3:38pm revealed: -She had always seen a Neurologist once a year. -She had not seen her Neurologist this year (2020) because her appointment was canceled when she did not have transportation to the appointment. -Her tremors had gotten worse in September 2020, so the facility's RN took her to see her PCP (she did not recall the date). -The PCP "could not do anything for her" and wanted her to see her neurologist. -Someone (she did not recall who) wanted her to see a local Neurologist, but she wanted to see her Neurologist. -If she could not see her Neurologist, she would have agreed to see someone locally, but no one had made her an appointment. -Her tremors "come and go" and were "ok" right now, but she would still like to see her Neurologist. Telephone interview with the facility's contracted	C 246		

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C 246	Continued From page 59 RN on 10/29/20 at 1:16pm revealed: -The medication aide (MA) was responsible for reading through discharge papers and scheduling follow-up appointments ordered. -She took Resident #1 to see the resident's PCP because Resident #1 was having an increase in her tremors and she did not want her to become "catatonic like Resident #1 had been before." (Catatonic is defined as lack of movement and communication). -She was trying to "get ahead" of the problem. -Resident #1's PCP wanted Resident #1 to follow-up with Resident #1's Neurologist for the tremors. -There was an order from Resident #1's PCP to follow-up with Resident #1's neurologist on the discharge papers. -Resident #1 wanted to see her Neurologist at a named hospital clinic. -She called the office of Resident #1's Neurologist and left a voice mail about scheduling an appointment. -She told the MAs when Resident #1's neurology office staff called back, to accept whatever appointment was offered. -She had not followed up on Resident #1's neurology appointment. Telephone interview with the Administrator on 10/29/20 at 4:39pm revealed: -She knew Resident #1's PCP had recommended Resident #1 have a follow-up appointment with her Neurologist. -Resident #1 wanted to see her Neurologist at the named hospital. -Resident #1's family member did not want Resident #1 transported to the named Neurologist because of the coronavirus (Covid-19) pandemic. -She was the one who had spoken to Resident	C 246		

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C 246	Continued From page 60	C 246		

#1's family member, so she should have been the one to follow-up.

Telephone interview with Resident #1's Neurologist on 11/02/20 at 11:32am revealed:
-Resident #1 had called her on 09/11/20 and complained of being "jittery" and had been evaluated by the resident's PCP.
-She did not think Resident #1's complaints of being "jittery" were related to the diagnosis of myasthenia gravis and was possibly related to psychiatric medications.
-She reached out to Resident #1's family member but had not received a return call.
-She did not know Resident #1 was in a family care home setting.
-Resident #1 should be seen by a Neurologist to evaluate "tremors" versus "jittery" and it would need to be done in a clinic setting to evaluate the tremors.
-No one had called her about an appointment for Resident #1 except Resident #1.

Telephone interview with Resident #1's PCP on 11/02/20 at 12:31pm revealed:
-He had seen Resident #1 on 09/10/20 due to worsening of tremors.
-He wanted Resident #1 to be evaluated by neurology to see if Resident #1's tremors were related to the worsening of Resident #1's myasthenia gravis or maybe Parkinson's disease.
-He was not aware Resident #1 had not seen the Neurologist.
-He expected the order for Resident #1 to see a neurologist to have been completed.

Telephone interview with Resident #1's family member on 11/03/20 at 4:48pm revealed:
-He knew Resident #1 saw her PCP because of Resident #1's tremors getting worse (he did not

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recall the date).
-He did not know the results of the PCP's visit.
-Someone from the facility (he did not recall the name of the facility staff) called him about an appointment with Resident #1's Neurologist but did not ask him to take Resident #1 to the appointment.
-The facility staff who called talked about COVID-19, and he felt the facility staff were using COVID-19 as an excuse to "get out of taking Resident #1 to see her Neurologist because of the distance."
-The facility always called him if Resident #1 had an appointment out of the county and he felt the facility should be responsible for taking Resident #1 to her appointments no matter where they were because she was paying to live at the facility and be cared for.
-He would have taken Resident #1 to see the Neurologist had he known Resident #1's PCP had recommended following up with the Neurologist.

_____

The facility failed to ensure medical providers were notified when two residents had medical and mental health issues that resulted in a resident (#3) having complaints of a toothache for fifteen days with no treatment, who had experienced multiple seizures and the Neurologist was not notified and was referred to and had an appointment with an Epileptologist, that was canceled and never rescheduled; and a resident (#1) who was a "no show" at her annual neurology appointment and who was having an increase in tremors in September 2020, was evaluated by her primary care provider (PCP) and was ordered to see a Neurologist, and did not have an appointment scheduled with her Neurologist, and who was also administered another resident's anti-psychotic and seizure

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C 246	Continued From page 62 medication, resulting in the resident taking a mediation that was contraindicated due to myasthenia gravis and experiencing a change in condition. This failure resulted in serious neglect and physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 4, 2020	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .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: Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 1 sampled resident (Resident #1) with orders for finger stick blood sugar (FSBS) checks. The findings are: Review of Resident #1's current FL-2 dated 12/30/19 revealed:	C 249		

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C 249	Continued From page 63 -Diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion. -There was an order for finger stick blood sugar (FSBS) checks daily. Review of Resident #1's December 2019 medication administration record (MAR) revealed there was no entry for checking FSBS daily. Review of Resident #1's August 2020 and September 2020 MAR revealed there was no entry for checking FSBS daily. Review of Resident #1's October 2020 MAR revealed: -There was an entry to check fasting FSBS weekly. -There was a hand-drawn square around the dates of 10/05/20, 10/12/20, 10/19/20, and 10/26/20. -There was documentation in the hand-drawn square dated 10/19/20 Resident #1's FSBS was 214. -There were no other FSBS documented on Resident #1's MAR. Review of Resident #1' physician's visit summary dated 09/10/20 revealed: -Resident #1 reported she was out of her FSBS glucose monitoring supplies. -There was documentation accu-checks were daily. -The plan was to perform weekly blood sugar checks and keep a FSBS log. Interview with a medication aide (MA) on 10/29/20 at 5:08pm revealed: -She had checked Resident #1's FSBS before	C 249		

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C 249	Continued From page 64 but she had not checked Resident #1's FSBS "in a while." -She did not think she had checked Resident #1's FSBS since last winter when Resident #1 moved into the facility and Resident #1's FSBS were checked "about 2-3 times a week." Interview with a second MA on 11/02/20 at 2:35pm revealed: -She checked Resident #1's FSBS on 10/19/20. -The order dated 09/10/20 had been misplaced and when the order was found on 10/19/20, Resident #1's FSBS was checked. -She did not know why Resident #1's FSBS was not checked on 10/26/20. -She worked on 10/26/20, but the weekend MA administered the morning medications before she came in. Telephone interview with Resident #1's primary care provider (PCP) on 11/02/20 at 12:31pm revealed: -He first saw Resident #1 on December 30, 2019. -Resident #1 had a current order to check her FSBS weekly. -He did now know if Resident #1's FSBS order for daily FSBS had been discontinued prior to her visit on 09/10/20, but he was okay with weekly FSBS because Resident #1's A1C had improved from 6.4 in December 2019 to 5.9 in September 2020. (An A1C test is a blood test that reflects your average blood glucose levels over the past 3 months. An A1C level below 5.7 percent is considered normal). -He expected the order for Resident #1's FSBS to be checked weekly and documented so he could make sure her diabetes was being controlled. Interview with Resident #1 on 10/26/20 at 10:30am revealed:	C 249		

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C 249	Continued From page 65 -She checked her FSBS at home daily. -She had to ask for her FSBS to be done at the facility; no one had done daily FSBS checks since she moved to the facility in December 2019. -She asked, "about once a week just to keep it in check." Observation of Resident #1's glucometer on 10/26/20 at 10:51am revealed: -A FSBS of 214 was recorded; there was no date or time stamp. -A FSBS of 170 was recorded; there was no date or time stamp. -There was no other FSBS recorded in the glucometer. Telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm revealed: -She took Resident #1 to the PCP herself and was aware of the order to check FSBS weekly. -She thought FSBS were being done daily for a while because she recalled seeing a FSBS sheet on Resident #1 at the facility. -Whoever saw the order on the FL-2 for daily FSBS would have been responsible for transcribing the order to the MAR. -She was aware the order for the weekly FSBS dated 09/10/20, had not been followed through. -She saw the weekly FSBS were not being done when she saw Resident #1 on 10/12/20 and she drew blocks around the dates the FSBS should be completed as a reminder for the MAs. -She did not know why she did not write the order for weekly FSBS on the MAR because she was the one who took Resident #1 to her appointment. -She was concerned the order was not being followed because without checking Resident #1's FSBS, it was not known what Resident #1's FSBS were.	C 249		

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C 249	Continued From page 66 Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/29/20 at 3:52pm revealed the only dispensing of Resident #1's FSBS glucose supplies were on 09/10/20 when an order was received from Resident #1's PCP; 50-strips were dispensed. Telephone interview with the Administrator on 10/29/20 at 4:39pm revealed: -She was not aware Resident #1's current order to check FSBS weekly was not being done. -She was concerned Resident #1's FSBS could not be monitored if the FSBS were not checked as ordered. -She expected the order for weekly FSBS to be implemented.	C 249		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 2 of 3 sampled residents (#1 and #3) including a medication used	C 330		

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to treat asthma, an allergy nasal spray and a supplement (#1) and an oral tooth medication (#3).

The findings are:

1. Review of Resident #1's current FL-2 dated 12/30/19 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion.

a. Review of Resident #1's current FL-2 dated 12/30/19 revealed there was a medication order for Symbicort 160-4.5mcg (bronchodilator used to treat asthma) take two inhalations two times a day.

Review of Resident #1's August 2020 medication administration record (MAR) revealed:
-There was an entry for Symbicort 160-4.5mcg two puffs twice daily with a scheduled administration time of 8:00 am and 8:00 pm.
-There was documentation Symbicort 160-4.5mcg was administered at 8:00am and 8:00pm from 08/01/20-08/30/20.

Review of Resident #1's September 2020 MAR revealed:
-There was an entry for Symbicort 160-4.5mcg two puffs twice daily with a scheduled administration time of 8:00 am and 8:00 pm.
-There were 3 days Symbicort 160-4.5mcg was not documented as administered at 8:00am.
-There were 8 days Symbicort 160-4.5mcg was not documented as administered at 8:00pm.
-There were no exceptions documented for the doses left blank.

Review of Resident #1's October 2020 MAR

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C 330	Continued From page 68 revealed: -There was an entry for Symbicort 160-4.5mcg two puffs by mouth twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -There were 9 days Symbicort 160-4.5mcg was not documented as administered at 8:00am. -There were 7 days Symbicort 160-4.5mcg was not documented as administered at 8:00pm. -There were no exceptions documented for the doses left blank. Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed there was no Symbicort inhaler available for administration. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/29/20 at 3:52pm revealed: -Medications that were scheduled to be administered on a regular basis were automatically refilled. -Medication that was prn (as needed), inhalers, eye drops, and ointments, were not refilled automatically and would need to be requested for a refill. -There was an order for Symbicort 160-4.5mcg two puffs twice daily for Resident #1. -Symbicort was not automatically dispensed to the facility; it would need to be requested for refill. -Symbicort was dispensed on 12/27/19, 04/27/20, 05/19/20, and 08/03/20. -The Symbicort inhaler would last for 30-days based on the order for 2 puffs twice daily. Observation of Resident #1 on 10/26/20 at 7:53am revealed she had an audible wheeze that could be heard approximately 8 feet away. Interview with Resident #1 on 10/26/20 at 7:53am revealed:	C 330		

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-She had allergies and asthma.
-She wheezed "every day."
-She had an inhaler and nebulizer treatment that helped her with her wheezing and shortness of breath.

Interview with Resident #1 on 10/29/20 at 9:51am and 10:47am revealed:
-She used a Symbicort inhaler for her asthma; "it helped her breathing."
-She had used a Symbicort inhaler at the facility.
-She did not recall when she last used a Symbicort inhaler.
-She had not asked anyone about her Symbicort inhaler.

Telephone interview with Resident #1's primary care provider (PCP) on 11/02/20 at 12:31pm revealed:
-Resident #1 was prescribed a Symbicort inhaler for maintenance of Resident #1's asthma.
-Resident #1 should have been using the Symbicort inhaler as ordered.
-Resident #1 was prone to have an asthma "flare" and it was important to use her maintenance medication.
-If Resident #1 did not use her maintenance medication as ordered, it would explain why Resident #1 was using her "emergency inhaler" daily.

Review of Resident #1's August 2020, September 2020, and October 2020 MARs revealed:
-There was an entry for Ipratropium Bromide 0.02% solution four times daily as needed for wheezing.
-There was an entry for Pro-Air 90MCG Inhaler 2 puffs four times daily as needed for cough or shortness or breath.
-There was documentation Resident #1 was

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administered Ipratropium Bromide nebulizer treatments 32 times and her Proair inhaler 25 times in August.
-There was documentation Resident #1 was administered Ipratropium Bromide nebulizer treatments 24 times and her Proair inhaler 34 times in September.
-There was documentation Resident #1 was administered Ipratropium Bromide nebulizer treatments 28 times and her Proair inhaler 36 times in October.

Interview with a medication aide (MA) on 10/29/20 at 3:44pm revealed:
-She administered an inhaler to Resident #1 when she worked.
-She thought the inhaler she administered was Resident #1's Symbicort.
-The inhaler on hand for Resident #1 was "pro-air" and there were no other inhalers available for Resident #1

Interview with a second MA on 10/29/20 at 6:30pm revealed she thought the inhaler in the medication cabinet (pro-air) was Resident #1's Symbicort; she had just "overlooked it."

Telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:16pm revealed:
-She was not aware Resident #1 did not have Symbicort available to be administered.
-She expected Resident #1's Symbicort to be available so the Symbicort could have been administered as ordered.

Telephone interview with the Administrator on 10/29/20 at 4:39pm revealed:
-She did not know Resident #1's Symbicort was not available to be administered.
-She expected Resident #1's Symbicort to have

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C 330	Continued From page 71 been administered as ordered. b. Review of Resident #1's current FL-2 dated 12/30/19 revealed there was a medication order for Vitamin D3 1000IU (a supplement used to treat a vitamin D deficiency) take one tablet daily. Review of Resident #1's August 2020 medication administration record (MAR) revealed: -There was an entry for Vitamin D3 1000IU daily with a scheduled administration time of 8:00am. -There was documentation Vitamin D3 was administered on 08/01/20-08/30/20 at 8:00am. Review of Resident #1's September 2020 MAR revealed: -There was an entry for Vitamin D3 1000IU daily with a scheduled administration time of 8:00am. -There were 10 days Vitamin D3 1000IU was not documented as administered. -There were no exceptions documented for the doses left blank. Review of Resident #1's October 2020 MAR revealed: -There was an entry for Vitamin D3 1000IU daily with a scheduled administration time of 8:00am. -There were 6 days Vitamin D3 1000IU was not documented as administered. -There were no exceptions documented for the doses left blank. Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed: -Resident #1's medication was in a pre-packaged bubble pack. -All of Resident #1's morning medication was packaged in one bubble pack with the name of the medications listed on the bubble pack. -Vitamin D3 was not listed on Resident #1's	C 330		

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C 330	Continued From page 72 bubble pack and was not available for administration. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/29/20 at 3:52pm revealed: -Resident #1 had an active order for Vitamin D3. -Resident #1's Vitamin D3 should have been in Resident #1's bubble pack. -Resident #3's Vitamin D3 had not been dispensed since 02/18/20. -He did not know why Resident #3's Vitamin D3 did not get carried forward. -He would have expected the MAs to notify the pharmacist the medication was not in the bubble pack. Interview with Resident #1 on 10/29/20 at 9:51am and 10:47am revealed: -She knew she took Vitamin D3 but did not know if it was in her pill pack every day. -If Vitamin D3 had been stopped, she did not know why it was stopped or when it was stopped. Telephone interview with Resident #1's primary care provider (PCP) on 11/02/20 at 12:31pm revealed: -Resident #1 was prescribed Vitamin D3 secondary to a low Vitamin D level. -Resident #1 should have been taking Vitamin D3 as ordered because Resident #1's Vitamin D was "deficient." -He would have expected Resident #1's Vitamin D3 to have been administered as ordered. Interview with a medication aide (MA) on 10/26/20 at 9:53am revealed: -She punched the medication from the bubble pack into Resident #1's cup at the time she administered the medication.	C 330		

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C 330	Continued From page 73 -She did not compare the medication in the bubble pack to the MARs. -Resident medication was prepackaged in bubble packs; she "assumed the medications in the bubble matched the MARs." -No one had told her she should look at the bubble pack and compare the medication in the resident's bubble pack to the resident's MARs. Telephone interview with the same MA on 10/30/20 at 9:23am revealed: -She had assumed the Vitamin D3 tablet was in Resident #1's bubble pack and had documented Vitamin D3 as administered on the MAR. -She had not noticed Resident #1's Vitamin D3 was not in Resident #1's bubble pack prior to 10/26/20. -She had not told anyone about the missing Vitamin D3 tablet, "I forgot." Telephone interview with the facility's RN on 10/29/20 at 1:16pm revealed: -She was not aware Resident #1's Vitamin D3 was not in the prepackaged bubble pack. -"That was why the MAs should compare the bubble pack to the resident's MARs." Telephone interview with the Administrator on 10/29/20 at 4:39pm revealed: -She was not aware Resident #1 had not received her Vitamin D3 as ordered. -She did not understand why the Vitamin D3 was not packaged in Resident #1's bubble pack. -She expected Resident #1's Vitamin D3 to have been administered as ordered. c. Review of Resident #1's current FL-2 dated 12/30/19 revealed there was a medication order for Flonase 50mcg (a nasal spray used to relieve allergy symptoms) daily.	C 330		

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C 330	Continued From page 74 Review of Resident #1's August 2020 medication administration record (MAR) revealed: -There was no entry for Flonase 50mcg daily. -There was no documentation Flonase 50mcg was administered on 08/01/20-08/30/20. Review of Resident #1's September 2020 MAR revealed: -There was no entry for Flonase 50mcg daily. -There was no documentation Flonase 50mcg was administered on 09/01/20-09/30/20. Review of Resident #1's October 2020 MAR revealed: -There was no entry for Flonase 50mcg daily. -There was no documentation Flonase 50mcg was administered on 10/01/20-10/26/20. Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed there was no Flonase 50mcg available to be administered. Interview with Resident #1 on 10/29/20 at 9:51am revealed: -She was using Flonase at home daily but did not recall if she had ever used Flonase at the facility. -She thought using the Flonase nasal spray helped her breathe better but she had not asked anyone about the medication. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/29/20 at 3:52pm revealed: -Medication that was prn (as needed), inhalers, eye drops, and ointments, were not refilled automatically and would need to be requested for a refill. -Resident #1 had an active order for Flonase 50mcg.	C 330		

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-Flonase 50mcg had not been requested to be filled for Resident #1.
-Flonase 50mcg was not dispensed for Resident #1.
-Flonase 50mcg was not automatically dispensed to the facility; it would need to be requested for a refill.

Telephone interview with Resident #1's primary care provider (PCP) on 11/02/20 at 12:31pm revealed:
-Resident #1 was prescribed Flonase.
-He would have expected Resident #1's Flonase to have been administered as ordered.
-If Resident #1's issue had been resolved he would have discontinued the medication.

Interview with a medication aide on 10/26/20 at 9:53am revealed she was not aware Resident #1 had an order for nasal spray.

Telephone interview with the facility's RN on 10/29/20 at 1:16pm revealed:
-She was not aware Resident #1 had an order for Flonase.
-If there was an order for Flonase, the order should have been filled and administered as ordered.

Telephone interview with the Administrator on 10/29/20 at 4:39pm revealed:
-She was not aware Resident #1 had not received Flonase as ordered.
-She expected Resident #1's Flonase to have been administered as ordered.

d. Review of Resident #1's current FL-2 dated 12/30/19 revealed:
-Diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis,

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hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion.
-There was no order for Melatonin 10mg (Melatonin is a hormone used to regulate sleep) to be administered at bedtime.

Observation of Resident #1's medication on hand on 10/29/20 at 10:58am revealed there was an over the counter (OTC) bottle of Melatonin 10mg available for administration.

Review of Resident #1's physician's orders revealed there was no order for Melatonin.

Review of Resident #1's August 2020, September 2020, and October 2020 medication administration record (MAR) revealed there was no entry for the administration of Melatonin 10mg at bedtime.

Interview with Resident #1 on 10/29/20 at 4:00pm revealed:
-She asked for Melatonin every night to help her sleep.
-The medication aide (MA) who was working gave her Melatonin every night.

Telephone interview with Resident #1's primary care provider (PCP) on 11/02/20 at 12:31pm revealed:
-He was not aware Resident #1 was being administered Melatonin as a sleep aid.
-He had not written an order for Resident #1 to be administered Melatonin.
-Even though Melatonin could be purchased OTC, he expected to be notified Resident #1 needed the sleep aid.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/29/20 at

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C 330	Continued From page 77 3:52pm revealed: -There was no order on file for Resident #1 to be administered Melatonin. -If Resident #1 had an order for Melatonin, it would have been entered on Resident #1's MARs. -OTC medication provided through the pharmacy would have required an order. -There had been no OTC Melatonin provided for Resident #1 through the pharmacy. Interview with a MA on 10/29/20 at 6:30pm revealed: -She administered Melatonin to Resident #1 whenever Resident #1 asked for the Melatonin. -She assumed there was an order for the Melatonin. -She administered the Melatonin based on the directions on the OTC bottle. -There should have been a place to document when Melatonin was administered. -She knew she was supposed to write on the back of the MAR when prn (as needed) medication was administered. -She did not know why she had not documented administering Melatonin to Resident #1. -Medication should not be in the medication cabinet if there was no order on file. Telephone interview with the Administrator on 10/29/20 at 4:39pm revealed: -She was not aware Resident #1 was being administered Melatonin without an order. -All medication should have an order to be administered, "even OTC medication." -The MAs knew how to contact Resident #1's PCP to obtain an order for the Melatonin. 2. Review of Resident #3's current FL-2 dated 11/01/19 revealed diagnoses included seizures,	C 330		

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depression and mild intellectual disability.

Review of Resident #3's record revealed there was no order for an oral tooth medication.

Review of Resident #3's medication administration record (MAR) for October 2020 and November 2020 revealed there was no order for an oral tooth medication.

Telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 2:09pm revealed:
-She was made aware Resident #3 had a complaint of tooth pain around the middle of October 2020.
-She knew Resident #3 had a dentist appointment scheduled; one of the medication aides (MA) made the appointment.
-She took Resident #3 to the store on a Saturday around the middle of October 2020 to purchase medicated oral tooth drops to put on her tooth for pain.
-Resident #3 did not have an order for the medicated oral tooth drops; she should have gotten an order for Resident #3 to have the medicated oral tooth drops.
-She did not think about getting an order for the medicated oral tooth drops.
-Resident #3 kept the medicated oral tooth drops in her room and used them when she needed them.

Telephone interview with a MA on 11/02/20 at 2:48pm revealed:
-The facility's RN took Resident #3 to purchase oral tooth medication.
-The oral tooth medication was not on the MAR and she never documented the administration anywhere.
-She did not know anything about an order for the

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C 330	Continued From page 79 oral tooth medication. Telephone interview with a second MA on 11/03/20 at 10:26am revealed: -Resident #3 had [brand named] medicated oral tooth drops. -Resident #3 had bought the oral tooth medication herself and kept them with her in her room. -Resident #3 got the oral tooth medication sometime in October 2020. -She helped Resident #3 use the oral tooth medication two times; the medication seemed to help with the resident's pain. -She did not document helping Resident #3 with the oral tooth drops and the medication was not on the MAR. -The facility's RN knew Resident #3 had the oral tooth drops because the facility's RN took Resident #3 to the store to buy them. Telephone interview with Resident #3's dentist on 11/02/20 at 11:16am revealed she never ordered oral tooth drops for Resident #3. Telephone interview with Resident #3 on 11/03/20 at 1:47pm revealed: -The facility's RN took her to buy oral tooth medication for her tooth pain. -She kept the oral tooth medication in her room but did not know where it was at the time. -The staff would help her put the drops on her tooth or sometimes she applied the drops herself. Telephone interview with the Administrator on 10/29/20 at 4:42pm revealed: -An order for medication was needed before administering any medication, even over the counter medication needed an order. -The staff should call the primary care provider	C 330		

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C 330	Continued From page 80 (PCP) for an order for a medication and then it should be added to the MAR. -She did not know about an oral tooth medication for Resident #3; it was the first she had heard of it. -She knew there needed to be an order medications. _____ The facility failed to administer medications as ordered including medications used to treat asthma for Resident #1 had not been refilled and it was noted Resident #1 was using her prn Ipratropium Bromide nebulizer treatments and an pro-air inhaler daily and an oral tooth medication that was self-administered by a resident (#3) for tooth pain without an order. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 19, 2020	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication	C 342		

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C 342	Continued From page 81 or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records for 3 of 3 sampled residents (Resident #1, #2 and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 12/30/19 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion. a. Review of Resident #1's current FL-2 dated 12/30/19 revealed an order for Symbicort 160-4.5mcg (a bronchodilator used to treat asthma) take two inhalations two times a day. Review of Resident #1's September 2020 medication administration record (MAR) revealed: There was an entry for Symbicort 160-4.5mcg inhale 2 puffs by mouth twice daily with a scheduled administration time of 8:00am and	C 342		

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C 342	Continued From page 82 8:00pm. -There was documentation Symbicort 160-4.5mcg was administered 27 out of 30 opportunities at 8:00am. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Symbicort 160-4.5mcg inhale 2 puffs by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Symbicort 160-4.5mcg was administered 17 out of 26 opportunities at 8:00am. documented. -There was documentation Symbicort 160-4.5mcg was administered 19 out of 26 opportunities at 8:00pm. documented. Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was no Symbicort inhaler available to be administered. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/29/20 at 3:52pm revealed: -There was an order Symbicort 160-4.5mcg two puffs by mouth twice daily for Resident #1. -Symbicort was not automatically dispensed to the facility; it would need to be requested for refill. -Symbicort was dispensed on 12/27/19, 04/27/20, 05/19/20, and 08/03/20. -The Symbicort inhaler would last for 30-days based on the order for 2 puffs twice daily. Interview with a medication aide (MA) on 10/29/20 at 3:44pm revealed: -She had documented Symbicort as administered for Resident #1. -She administered an inhaler to Resident #1 when she worked.	C 342		

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C 342	Continued From page 83 -She thought the inhaler she administered was Resident #1's Symbicort. -The inhaler on hand for Resident #1 was "pro-air" and there was no other inhaler available for Resident #1 Interview with a second MA on 10/29/20 at 6:30pm revealed: -She had documented Symbicort as administered for Resident #1. -She thought the inhaler in the medication cabinet was Resident #1's Symbicort; she had just "overlooked it." Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. b. Review of Resident #1's current FL-2 dated 12/30/19 revealed an order for Vitamin D3 1000IU (a vitamin supplement) take 1 tablet daily.	C 342		

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C 342	Continued From page 84 Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Vitamin D3 1000IU was administered 20 out of 30 opportunities. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Vitamin D3 1000IU was administered 20 out of 26 opportunities. Review of Resident #1's October 2020 MAR revealed: -There was an entry for Vitamin D3 1000IU daily with a scheduled administration time of 8:00am. -There was documentation Vitamin D3 was administered on 10/01/20-10/05/20, 10/07/20, 10/09/20-10/14/20,10/16/20-10/19/20, 10/21/20, 10/23/20-10/26/20 at 8:00am. Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed: -All of Resident #1's morning medication was packaged in one bubble pack with the name of the medications listed on the bubble pack. -Vitamin D3 was not listed on Resident #1's bubble pack and was not available for administration. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/29/20 at 3:52pm revealed: -Resident #1 had an active order for Vitamin D3. -Resident #1's Vitamin D3 should have been in Resident #1's bubble pack.	C 342		

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C 342	Continued From page 85 -Resident #3's Vitamin D3 had not been dispensed since 02/18/20. -He did not know why Resident #3's Vitamin D3 did not get carried forward. Telephone interview with a MA on 10/30/20 at 9:23am revealed: -She had assumed the Vitamin D3 tablet was in Resident #1's bubble pack and had documented Vitamin D3 as administered on the MAR. -She had not noticed Resident #1's Vitamin D3 was not in Resident #1's bubble pack prior to 10/26/20. -She did not initial administering Resident #1's Vitamin D3 on 10/28/20 because she had compared the bubble pack to the MAR and saw the Vitamin D3 tablet was not in the pack. -She had not told anyone about the missing Vitamin D3 tablet, "I forgot." Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the	C 342		

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Administrator on 10/29/20 at 5:23pm.

c. Review of Resident #1's current FL-2 dated 12/30/19 revealed an order for Ferrous Sulfate 325mg (an iron supplement) take 1 tablet daily.

Review of Resident #1's September 2020 medication administration record (MAR) revealed:
-There was an entry for Ferrous Sulfate 325mg take 1 tablet one daily with a scheduled administration time of 8:00am.
-There was documentation Ferrous Sulfate 325mg was administered 21 out of 30 opportunities.

Review of Resident #1's October 2020 MARs revealed:
-There was an entry for Ferrous Sulfate 325mg take 1 tablet one daily with a scheduled administration time of 8:00am.
-There was documentation Ferrous Sulfate 325mg was administered 20 out of 26 opportunities.

Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained Ferrous Sulfate 325mg.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.

Refer to the second interview with a MA on 10/29/20 at 3:44pm.

Refer to the telephone interview with a third MA

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C 342	Continued From page 87 on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. d. Review of Resident #1's current FL-2 dated 12/30/19 revealed an order for Omeprazole 40mg (used to treat heartburn and gastroesophageal reflux disease) take 1 tablet daily. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Omeprazole 40mg daily with a scheduled administration time of 8:00am. -There was documentation Omeprazole 40mg was administered 21 out of 30 opportunities. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Omeprazole 40mg daily with a scheduled administration time of 8:00am. -There was documentation Omeprazole 40mg was administered 20 out of 26 opportunities. Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained Omeprazole 40mg. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second	C 342		

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C 342	Continued From page 88 MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. e. Review of Resident #1's physician's orders dated 03/16/20 revealed there was an order for Lisinopril 20-12.5mg (used to treat high blood pressure) take 1 tablet daily. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Lisinopril 20-12.5mg take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Lisinopril 20-12.5mg was administered 21 out of 30 opportunities. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Lisinopril 20-12.5mg take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Lisinopril 20-12.5mg was administered 20 out of 26 opportunities. Observation of Resident #1's medications on	C 342		

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hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained Lisinopril 20-12.5mg.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.

Refer to the second interview with a MA on 10/29/20 at 3:44pm.

Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm

Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.

Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm.

Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm.

f. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for Lorazepam 1mg (an anti-anxiety medication) take 1 tablet three times daily.

Review of Resident #1's physician's orders dated 09/10/20 revealed there was an order for Lorazepam 1mg take 1 tablet twice daily.

Review of Resident #1's September 2020 medication administration record (MAR) revealed:
-There was an entry for Lorazepam 1mg tablets three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.

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C 342	Continued From page 90 -There was documentation Lorazepam 1mg was administered 8 out of 10 opportunities at 8:00am. -There was documentation Lorazepam 1mg was administered 4 out of 10 opportunities at 2:00pm. -There was documentation Lorazepam 1mg was administered 8 out of 10 opportunities at 8:00pm. -There was a hand-written entry for Lorazepam 1mg three times daily that was discontinued on 09/11/20. -There was an entry for Lorazepam 1mg tablets twice daily with a scheduled administration time of 8:00am and 8:00pm with a start date of 09/10/20 at 8:00pm. -There was documentation Lorazepam 1mg was administered 15 out of 20 opportunities at 8:00am. -There was documentation Lorazepam 1mg was administered 10 out of 21 opportunities at 8:00pm. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Lorazepam 1mg tablets twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Lorazepam 1mg was administered 15 out of 26 opportunities at 8:00am. -There was documentation Lorazepam 1mg was administered 13 out of 26 opportunities at 8:00pm. Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed: -There was a bubble pack labeled Resident #1's morning medications that contained Lorazepam 1mg. -There was a second bubble pack labeled Resident #1's bedtime medications that contained Lorazepam 1mg.	C 342		

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C 342	Continued From page 91 Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. g. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for Bupropion XL 300mg (an anti-depressant) take 1 tablet daily. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Bupropion XL 300mg take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Bupropion XL 300mg was administered 20 out of 30 opportunities. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Bupropion XL 300mg take 1 tablet daily with a scheduled administration	C 342		

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time of 8:00am.
-There was documentation Bupropion XL 300mg was administered 20 out of 26 opportunities.

Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained Bupropion XL 300mg.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.

Refer to the second interview with a MA on 10/29/20 at 3:44pm.

Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm

Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.

Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm.

Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm.

h. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for Zolpidem Tartrate 5mg (used to treat insomnia) take 1 tablet at bedtime.

Review of Resident #1's September 2020 medication administration record (MAR) revealed:
-There was an entry for Zolpidem Tartrate 5mg take 1 tablet at bedtime with a scheduled

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administration time of 8:00pm.
-There was documentation Zolpidem Tartrate 5mg was administered 25 out of 30 opportunities.

Review of Resident #1's October 2020 MARs revealed:
-There was an entry for Zolpidem Tartrate 5mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm.
-There was documentation Zolpidem Tartrate 5mg was administered 21 out of 26 opportunities.

Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's bedtime medications that contained Zolpidem Tartrate 5mg.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.

Refer to the second interview with a MA on 10/29/20 at 3:44pm.

Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm

Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.

Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm.

Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm.

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C 342	Continued From page 94 i. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for Memantine 10mg (cognition enhancing medication) take 1 tablet twice daily. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Memantine 10mg take 1 tablet by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Memantine 10mg was administered 26 out of 30 opportunities at 8:00am. -There was documentation Memantine 10mg was administered 23 out of 30 opportunities at 8:00pm. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Memantine 10mg take 1 tablet by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Memantine 10mg was administered 20 out of 26 opportunities at 8:00am. -There was documentation Memantine 10mg was administered 19 out of 26 opportunities at 8:00pm. Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed: -There was a bubble pack labeled Resident #1's morning medications that contained Memantine HCL 10mg. -There was a second bubble pack labeled Resident #1's bedtime medications that contained Memantine HCL 10mg. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.	C 342		

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C 342	Continued From page 95 Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. j. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for Vitamin B1 100mg (a vitamin supplement) take 1 tablet daily. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Vitamin B1 100mg take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Vitamin B1 100mg was administered 20 out of 30 opportunities. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Vitamin B1 100mg take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Vitamin 1000mg was administered 20 out of 26 opportunities.	C 342		

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C 342	Continued From page 96 Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained Vitamin B1. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. k. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for a Multi-Vitamin (a vitamin supplement) take 1 tablet daily. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation a Multi-Vitamin was administered 20 out of 30 opportunities.	C 342		

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C 342	Continued From page 97 Review of Resident #1's October 2020 MARs revealed: -There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation a Multi-Vitamin was administered 20 out of 26 opportunities. Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained Multi-Vitamin. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. I. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for Levothyroxine 75mcg (used to treat hypothyroidism) take 1 tablet daily.	C 342		

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C 342	Continued From page 98 Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Levothyroxine 75mcg daily with a scheduled administration time of 8:00am. -There was documentation Levothyroxine 75mcg was administered 21 out of 30 opportunities. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Levothyroxine 75mcg daily with a scheduled administration time of 8:00am. -There was documentation Levothyroxine 75mcg was administered 20 out of 26 opportunities. Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained Levothyroxine 75mcg. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm.	C 342		

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C 342	Continued From page 99 Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. m. Review of Resident #1's physician's order dated 03/26/20 revealed there was an order for Azathioprine 50mg (an immunosuppressive medication) take 3 tablets daily. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Azathioprine 50mg take 3 tablets daily with a scheduled administration time of 8:00am. -There was documentation Azathioprine 50mg was administered 22 out of 30 opportunities. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Azathioprine 50mg take 3 tablets daily with a scheduled administration time of 8:00am. -There was documentation Azathioprine 50mg was administered 20 out of 26 opportunities. Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained three Azathioprine 50mg tablets. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm.	C 342		

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C 342	Continued From page 100 Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. n. Review of Resident #1's current FL-2 dated 12/30/19 revealed an order for Sertraline 100mg take two tablets daily. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Sertraline 100mg take 2 tablets daily with a scheduled administration time of 8:00am. -There was documentation Sertraline 100mg was administered 26 out of 30 opportunities. Review of Resident #1's October 2020 MARs revealed: -There was an entry for Sertraline 100mg take 2 tablets daily with a scheduled administration time of 8:00am. -There was documentation Sertraline 100mg was administered 21 out of 26 opportunities. Observation of Resident #1's medications on hand on 10/26/20 at 9:00am revealed there was a bubble pack labeled Resident #1's morning medications that contained two Sertraline 100mg tablets. Refer to the interview with a medication aide (MA)	C 342		

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C 342	Continued From page 101 on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. 2. Review of Resident #2's current FL-2 dated 11/01/19 revealed diagnoses included unspecified mental disorder, traumatic brain injury chronic, vitamin D deficiency and epilepsy. a. Review of Resident #2's current FL-2 dated 11/01/19 revealed there was an order for a Multi-Vitamin (a vitamin supplement) take 1 tablet daily. Review of Resident #2's September 2020 MAR revealed: -There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation a Multi-Vitamin was administered 20 out of 30 opportunities. Review of Resident #2's October 2020 MARs	C 342		

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revealed:
-There was an entry for a Multi-Vitamin take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation a Multi-Vitamin was administered 17 out of 26 opportunities.

Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed there was a bubble pack labeled Resident #2's morning medications that contained a Multi-Vitamin.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.

Refer to the second interview with a MA on 10/29/20 at 3:44pm.

Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm

Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.

Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm.

Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm.

b. Review of Resident #2's current FL-2 dated 11/01/19 revealed there was an order for Vitamin D3 1000IU (a vitamin supplement) take 1 tablet daily.

Review of Resident #2's September 2020 MAR

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revealed:
-There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation Vitamin D3 1000IU was administered 20 out of 30 opportunities.

Review of Resident #2's October 2020 MARs revealed:
-There was an entry for Vitamin D3 1000IU take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation Vitamin D3 1000IU was administered 17 out of 26 opportunities.

Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed:
-There was a bubble pack labeled Resident #2's morning medications that contained a Vitamin D3 1000IU.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.

Refer to the second interview with a MA on 10/29/20 at 3:44pm.

Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm

Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.

Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm.

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C 342	Continued From page 104 Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. c. Review of Resident #2's current FL-2 dated 11/01/19 revealed there was an order for Magnesium Oxide 400mg (a supplement to maintain adequate magnesium in the body) take 2 tablets three times a day. Review of Resident #2's September 2020 MAR revealed: -There was an entry for Magnesium Oxide 400mg take 2 tablets by mouth three times daily with a scheduled administration time of 8:00am, 2:00pm and 6:00pm. -There was documentation Magnesium Oxide was administered 17 out of 30 opportunities at 8:00am. -There was documentation Magnesium Oxide was administered 24 out of 30 opportunities at 2:00pm. -There was documentation Magnesium Oxide was administered 20 out of 30 opportunities at 6:00pm. Review of Resident #2's October 2020 MAR revealed -There was an entry for Magnesium Oxide 400mg take 2 tablets by mouth three times daily with a scheduled administration time of 8:00am, 2:00pm and 6:00pm. -There was documentation Magnesium Oxide was administered 17 out of 26 opportunities at 8:00am. -There was documentation Magnesium Oxide was administered 24 out of 26 opportunities at 2:00pm. -There was documentation Magnesium Oxide was administered 13 out of 26 opportunities at 6:00pm.	C 342		

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C 342	Continued From page 105 Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed: -There was a bubble pack labeled Resident #2's morning medications that contained Magnesium Oxide 400mg (2 tablets). -There was a second bubble pack labeled Resident #2's noon medications that contained Magnesium Oxide 400mg (2 tablets). -There was a third bubble pack labeled Resident #2's evening medications that contained Magnesium Oxide 400mg (2 tablets). Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. d. Review of Resident #2's current FL-2 dated 11/01/19 revealed there was an order for Divalproex ER 500mg (used to treat manic episodes) take 1 tablet at breakfast and 2 tablets at bedtime.	C 342		

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C 342	Continued From page 106 Review of Resident #2's September 2020 MAR revealed: -There was an entry for Divalproex ER 500mg take 1 tablet by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Divalproex ER 500mg was administered 20 out of 30 opportunities at 8:00am. -There was documentation Divalproex ER 500mg was administered 18 out of 30 opportunities at 8:00pm. Review of Resident #2's October 2020 MARs revealed: -There was an entry for Divalproex ER 500mg take 1 tablet by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Divalproex ER 500mg was administered 16 out of 26 opportunities at 8:00am. -There was documentation Divalproex ER 500mg was administered 14 out of 26 opportunities at 8:00pm. Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed: -There was a bubble pack labeled Resident #2's morning medications that contained Divalproex Sodium 500mg. -There was a second bubble pack labeled Resident #2's bedtime medications that contained Divalproex Sodium ER 500mg (2 tablets). Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second	C 342		

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(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
C 342	Continued From page 107 MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. e. Review of Resident #2's current FL-2 dated 11/01/19 revealed there was an order for Levetiracetam 1000mg (used to treat seizures) take 1 tablet twice a day. Review of Resident #2's September 2020 MAR revealed: -There was an entry for Levetiracetam 1000mg take 1 tablet by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Levetiracetam 1000mg was administered 18 out of 30 opportunities at 8:00am. -There was documentation Levetiracetam 1000mg was administered 16 out of 30 opportunities at 8:00pm. Review of Resident #2's October 2020 MARs revealed: -There was an entry for Levetiracetam 1000mg take 1 tablet by mouth twice daily with a	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 108 scheduled administration time of 8:00am and 8:00pm. -There was documentation Levetiracetam 1000mg was administered 16 out of 26 opportunities at 8:00am. -There was documentation Levetiracetam 1000mg was administered 14 out of 26 opportunities at 8:00pm. Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed: -There was a bubble pack labeled Resident #2's morning medications that contained Levetiracetam 1000mg. -There was a second bubble pack labeled Resident #2's bedtime medications that contained Levetiracetam 1000mg. f. Review of Resident #2's current FL-2 dated 11/01/19 revealed there was an order for Melatonin fast dissolve 3mg (sleep aid) take 2 tablets at bedtime. Review of Resident #2's September 2020 MAR revealed: -There was an entry for Melatonin Fast Dissolve 3mg take 2 tablets daily with a scheduled administration time of 8:00pm. -There was documentation Melatonin Fast Dissolve 3mg was administered 20 out of 30 opportunities. Review of Resident #2's October 2020 MARs revealed: -There was an entry for Melatonin Fast Dissolve 3mg take 2 tablets daily with a scheduled administration time of 8:00pm. -There was documentation Melatonin Fast Dissolve 3mg was administered 15 out of 26 opportunities.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 109 Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed there was a bubble pack labeled Resident #2's bedtime medications that contained Melatonin 3mg (2 tablets). Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. g. Review of Resident #2's current FL-2 dated 11/01/19 revealed there was an order for Quetiapine ER 150mg (an antipsychotic) take 2 tablets at bedtime. Review of Resident #2's September 2020 MAR revealed: -There was an entry for Quetiapine Fumarate 300mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm. -There was documentation Quetiapine Fumarate	C 342		

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C 342	Continued From page 110 300mg was administered 18 out of 30 opportunities. Review of Resident #2's October 2020 MARs revealed: -There was an entry for Quetiapine Fumarate 300mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm. -There was documentation Quetiapine Fumarate 300mg was administered 15 out of 26 opportunities. Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed there was a bubble pack labeled Resident #2's bedtime medications that contained Quetiapine Fumarate 300mg. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm.	C 342		

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C 342	Continued From page 111 h. Review of Resident #2's current FL-2 dated 11/01/19 revealed there was an order for Risperidone 4mg (an antipsychotic) take 1 tablet at bedtime. Review of Resident #2's September 2020 MAR revealed: -There was an entry for Risperidone 4mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm. -There was documentation Risperidone 4mg was administered 18 out of 30 opportunities. Review of Resident #2's October 2020 MARs revealed: -There was an entry for Risperidone 4mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm. -There was documentation Risperidone 4mg was administered 15 out of 26 opportunities. Observation of Resident #2's medications on hand on 10/26/20 at 9:30am revealed here was a bubble pack labeled Resident #2's bedtime medications that contained Risperidone 4mg 1 tablet. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's	C 342		

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C 342	Continued From page 112 Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. 3. Review of Resident #3's current FL-2 dated 11/01/19 revealed diagnoses included seizures, depression and mild intellectual disability. a. Review of Resident #3's current FL-2 dated 11/01/19 revealed there was an order for levetiracetam (a medication used to control seizures) 750mg take four tablets at bedtime. Review of a signed physician's order for Resident #3 dated 06/02/20 revealed there was an order for levetiracetam 750mg take 3 tablets twice daily. Review of a physician's order for Resident #3 dated 07/23/20 revealed an order for levetiracetam 750mg take three tablets at noon and in the evening. Review of Resident #3's medication administration record (MAR) for September 2020 revealed: -There was an entry for levetiracetam 750mg take three tables twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation levetiracetam was administered 37 times out of 60. -There was no documentation or explanation for the 23 missed doses of levetiracetam on the MAR.	C 342		

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Review of Resident #3's MAR for October 2020 revealed:
-There was an entry for levetiracetam 750mg take three tables twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation levetiracetam was administered 45 times out of 62.
-There was no documentation or explanation for the 17 missed doses of levetiracetam on the MAR.

Observation of Resident #3's medication on hand on 10/26/20 at 2:05pm revealed:
-Resident #3's levetiracetam 750mg was packaged alone into bubble packs with three tablets per bubble.
-The bubbles were dated on the back of the bubble with the dosage and scheduled time as noon and evening.
-The next available bubble for administering was dated for 10/26/20 evening.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.

Refer to the second interview with a MA on 10/29/20 at 3:44pm.

Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm

Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.

Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm and

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C 342	Continued From page 114 10/29/20 at 5:23pm. b. Review of Resident #3's current FL-2 dated 11/01/19 revealed there was an order for cyclafem (a contraceptive) 1-35-28 take 1 tablet once daily. Review of a signed physician's order for Resident #3 dated 06/02/20 revealed there was an order for cyclafem 1/35 (28) 1mg-35mcg take one tablet once daily. Review of Resident #3's medication administration record (MAR) for September 2020 revealed: -There was an entry for cyclafem 1/35 (28) 1mg-35mcg take one tablet once daily scheduled administration time of 8:00am. -There was documentation cyclafem was administered 22 times out of 30. -There was no documentation or explanation for the 8 missed doses of cyclafem on the MAR. Review of Resident #3's MAR for October 2020 revealed: -There was an entry for cyclafem 1/35 (28) 1mg-35mcg take one tablet once daily with a scheduled administration time of 8:00am. -There was documentation cyclafem was administered 24 times out of 31. -There was no documentation or explanation for the 7 missed doses of cyclafem on the MAR. Observation of Resident #3's medication on hand on 10/26/20 at 2:05pm revealed there was one package of 28 tablets for cyclafem 1/35 (28) 1mg-35mcg; there were 26 tablets available for administration. Refer to the interview with a medication aide (MA)	C 342		

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C 342	Continued From page 115 on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm and 10/29/20 at 5:23pm. c. Review of Resident #3's current FL-2 dated 11/01/19 revealed there was an order for methylphenidate (a medication used to treat Attention-deficit/hyperactivity disorder) 10mg take 1 tablet once daily. Review of a signed physician's order for Resident #3 dated 06/02/20 revealed there was on order for methylphenidate 10mg take 1 tablet once daily. Review of a physician's order for Resident #3 dated 09/17/20 revealed there was an order to discontinue methylphenidate 10mg. Review of Resident #3's medication administration record (MAR) for September 2020 revealed: -There was on order for methylphenidate 10mg take 1 tablet once daily with a scheduled administration time of 8:00am.	C 342		

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C 342	Continued From page 116 -There was documentation methylphenidate was administered 7 times after the discontinued date of 09/17/20; there was no documentation of a discontinued date on the MAR. Review of Resident #3's MAR for October 2020 revealed: -There was on order for methylphenidate 10mg take 1 tablet once daily with a scheduled administration time of 8:00am. -There was documentation methylphenidate was administered 20 times; methylphenidate was discontinued on 09/17/20 -There was no documentation of a discontinued date for methylphenidate on the MAR. Observation of Resident #3's medication on hand on 10/26/20 at 2:05pm revealed there was no methylphenidate available. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm and 10/29/20 at 5:23pm.	C 342		

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C 342	Continued From page 117 d. Review of Resident #3's current FL-2 dated 11/01/19 revealed there was an order for zonisamide (a medication used to treat partial seizures) 100mg take 6 tablets once daily. Review of a signed physician's order for Resident #3 dated 06/02/20 revealed there was an order for zonisamide 100mg take 1 tablet once daily in the morning. Review of Resident #3's medication administration record (MAR) for September 2020 revealed: -There was an entry for zonisamide 100mg take 1 tablet once daily in the morning with a scheduled administration time of 8:00am. -There was documentation zonisamide was administered 22 times out of 30. -There was no documentation or explanation for the 8 missed doses of zonisamide on the MAR. Review of Resident #3's MAR for October 2020 revealed: -There was an entry for zonisamide 100mg take 6 tablets once daily in the morning with a scheduled administration time of 8:00am. -There was documentation zonisamide was administered 24 times out of 31. -There was no documentation or explanation for the 7 missed doses of zonisamide on the MAR. Observation of Resident #3's medication on hand on 10/26/20 at 2:05pm revealed: -Resident #3's zonisamide 100mg was packaged alone into bubble packs with six tablets per bubble. -The bubbles were dated on the back of the bubble with the dosage and scheduled time as morning. -The next available bubble for administering was	C 342		

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C 342	Continued From page 118 dated for 10/27/20 morning. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am. Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm and 10/29/20 at 5:23pm. e. Review of Resident #3's current FL-2 dated 11/01/19 revealed there was an order for trazodone (a medication used to treat depression) 100mg take 0.5 tablet to one tablet at bedtime as needed. Review of a signed physician's order for Resident #3 dated 06/02/20 revealed there was an order for trazodone 100mg tablet take 0.5 tablet to 1 tablet as needed at bedtime. Review of Resident #3's medication administration record (MAR) for September 2020 revealed: -There was an entry for trazodone 100mg tablet take 0.5 tablet to 1 tablet as needed at bedtime. -There was documentation trazodone was administered 17 times; there was no	C 342		

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documentation of the explanation or effectiveness of the trazodone on the MAR.

Review of Resident #3's MAR for October 2020 revealed:
-There was an entry for trazodone 100mg tablet take 0.5 tablet to 1 tablet as needed at bedtime.
-There was documentation trazodone was administered 17 times; there was no documentation of the explanation or effectiveness of the trazodone on the MAR.

Observation of Resident #3's medication on hand on 10/26/20 at 2:05pm revealed there was a bottle of trazodone with six tablets available for administration.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.

Refer to the second interview with a MA on 10/29/20 at 3:44pm.

Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm

Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm.

Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm and 10/29/20 at 5:23pm.

f. Review of a signed physician's order for Resident #3 dated 06/02/20 revealed there was an order for divalproex ER 500mg (a medication

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(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
C 342	Continued From page 120 used to treat seizures) take three tablets at bedtime. Review of Resident #3's medication administration record (MAR) for September 2020 revealed: -There was an entry for divalproex ER 500mg take three tablets at bedtime with a scheduled administration time of 8:00pm. -There was documentation divalproex was administered 20 times out of 30. -There was no documentation or explanation for the 10 missed doses of divalproex on the MAR. Review of Resident #3's MAR for October 2020 revealed: -There was an entry for divalproex ER 500mg take three tablets at bedtime with a scheduled administration time of 8:00pm. -There was documentation divalproex was administered 22 times out of 31. -There was no documentation or explanation for the 9 missed doses of divalproex on the MAR. Observation of Resident #3's medication on hand on 10/26/20 at 2:05pm revealed: -Resident #3's divalproex ER 500mg was packaged alone into bubble packs with three tablets per bubble. -The bubbles were dated on the back of the bubble with the dosage and scheduled time as bedtime. -The next available bubble for administering was dated for 10/26/20 bedtime. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the telephone interview with a second MA on 10/27/20 at 9:30am.	C 342		

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C 342	Continued From page 121 Refer to the second interview with a MA on 10/29/20 at 3:44pm. Refer to the telephone interview with a third MA on 11/02/20 at 4:52pm Refer to the telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm. Refer to the telephone interview with the Administrator on 10/27/20 at 12:30pm. Refer to the telephone interview with the Administrator on 10/29/20 at 5:23pm. _____ Interview with a medication aide (MA) on 10/26/20 at 9:53am revealed: -She knew there were blanks on the MARs. -The blanks were because another MA did not always initial the MARs when he administered medication. -She had told the facility's RN about the blanks on the MARs. -She had also "mentioned it" to the MA who she knew was not initialing the MARs, she thought he "just forgot." Telephone interview with a second MA on 10/27/20 at 9:30am and 10/29/20 at 3:44pm revealed she documented on the MAR every time she popped the bubble pack into a resident's cup so she would not forget. Second interview with a MA on 10/29/20 at 3:44pm revealed if her initials were not on the MAR a day she worked, it was because another MA would have administered the medications before she came into work.	C 342		

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C 342	Continued From page 122 Telephone interview with a third MA on 11/02/20 at 4:52pm revealed: -The Administrator talked to him about signing the MARs when he first started to work. -He had administered medications before, but did not have to write it down, so he forgot. -He thought he had "been signing" the MARs "lately". -He signed the MARs "sometimes, but not always." -He "forgot" to sign the MARs. Telephone interview with the facility's Registered Nurse (RN) on 10/29/20 at 1:31pm and 2:53pm revealed: -She looked over the MARs when she was at the facility. -She knew there were "holes" on the MARs where staff had not initialed administering medication. -She called the Administrator about a MA because she had told the MA to sign the MARs and three days later, he still had not signed the MARs for the days he worked. -She did not feel medications were not administered, because the residents would speak up if they did not receive their medication. -She was concerned there were holes in the MAR because "if it is not signed, it did not happen." -She saw the "holes" on the MAR and agreed this was a concern. -She told the staff to be sure to sign off on the MAR because "if it was not signed on then it was not done". -She believed the residents were getting all their medications; the MAs just failed to document the administrations.	C 342		

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C 342	Continued From page 123 Telephone interview with the Administrator on 10/27/20 at 12:30pm revealed: -The facility's RN audited the MARs; she thought the facility's RN had reviewed the MARs "about a week ago." -She had "worked" with one MA the week before because he was not signing the MAR. -She had instructed the MAs not to sign the MARs if they were not the one that administered the medication; "if you did not administer the medication, then you do not sign off". Telephone interview with the Administrator on 10/29/20 at 5:23pm revealed: -Documentation was not the MAs strong point; "I have been working on it." -When she saw holes in the MARs she would look at the bubble packs to see if the medication had been administered. -The MAs were supposed to "sign off" when they administered a medication; the signature indicated the medication was administered. -If a medication was not "signed off" with initials, the medication was not administered.	C 342		
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer 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	C 350		

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prescription medications are printed on the medication label.
(b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 residents sampled (#1 and #3) who self-administered medications had orders to self-administer prescription medications that were kept in the residents' rooms including a nebulizer treatment and an inhaler (#1); and oral dental pain medication (#3).

The findings are:

1. Review of Resident #1's current FL-2 dated 12/30/19 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion.

a. Review of a physician's order for Resident #1 dated 12/30/19 revealed:
-There was an order for Ipratropium Bromide 0.02% solution use one vial via nebulizer four times daily as needed for wheezing (Ipratropium is a bronchodilator medication used to treat asthma).

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C 350	Continued From page 125 -There was no order to self-administer the Ipratropium nebulizer treatments. Observation of Resident #1's room on 10/26/20 at 9:27am revealed Resident #1 had a nebulizer machine on her bedside table (a nebulizer is a machine that turns liquid medication into a fine mist to treat asthma often called a breathing treatment). Interview with Resident #1 on 10/26/20 at 9:27am revealed: -She did "breathing treatments" 2-3 times per day. -The medication aides (MA) gave her vials of medication to use in her nebulizer; no one observed her using her nebulizer. -She had always done her nebulizer treatments herself at home. Interview with a MA on 10/26/20 at 8:37am revealed: -Resident #1 would ask for the nebulizer solution when Resident #1 needed it. -She gave Resident #1 the nebulizer solution to use on her own. -She did not check to see if there was an order for Resident #1 to self-administer her nebulizer treatment. -She knew there was supposed to be an order for residents to self-administer medications but "did not think to look to see if there was an order" because it was being done that way when she started working at the facility. Interview with a second (MA) on 10/26/20 at 10:30am revealed: -Resident #1 did her own nebulizer treatments daily. -She did not know a physician's order was	C 350		

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needed for a resident to self-administer their own medication.

Telephone interview with a third MA on 10/30/20 at 9:23am revealed:
-She gave Resident #1 a vial of medication for her nebulizer and Resident #1 would do the nebulizer treatment herself.
-She did not know Resident #1 needed a self-administer order to be able to do her own nebulizer treatments.

Telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm revealed:
-The MAs were supposed to put the Ipratropium Bromide 0.02% solution into Resident #1's nebulizer, but Resident #1 knew how to use the nebulizer herself.
-She did not know a self-administer order was required for Resident #1 to self-administer the nebulizer treatments.

Telephone interview with the Administrator on 10/29/20 revealed:
-She was not aware the MAs were giving Resident #1 vials of Ipratropium Bromide 0.02% to administer on her own.
-She expected staff to put Resident #1's medication into Resident #1's nebulizer and check on her while she was doing her breathing treatment.

Telephone interview with Resident #1's primary care provider (PCP)'s nurse on 11/02/20 at 3:22pm revealed:
-The PCP was not aware Resident #1 was self-administering her nebulizer treatments.
-No one had requested an order for Resident #1 to administer her own nebulizer treatments.
-The PCP thought Resident #1 would be "okay" to

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C 350	Continued From page 127 administer her own nebulizer treatments. b. Review of a physician's order for Resident #1 dated 03/16/20 revealed: -There was an order for ProAir 90 mcg (used to treat wheezing and shortness of breath in asthma) per actuation 1-2 puffs every 4-6 hours as needed. -There was no order to self-administer the ProAir inhaler. Observation of Resident #1's room on 10/26/20 at 9:27am revealed Resident #1 had an Albuterol inhaler on her bedside table. Review of Resident #1's August 2020 medication administration records (MARs) revealed: -There was an entry for a ProAir inhaler inhale 2 puffs four times daily as needed for shortness of breath with a scheduled administration time of 8:00am, 12:00pm, 6:00pm and 10:00pm. -There was documentation ProAir was administered 21 times at 8:00am, 2 times at 12:00pm, 1 time at 5:00pm and 1 time at 10:00pm. -There was no documentation the medication was self-administered. Review of Resident #1's September 2020 MARs revealed: -There was an entry for a ProAir 90mcg inhale 2 puffs four times daily as needed for shortness of breath with a scheduled administration time of 8:00am, 12:00pm, 6:00pm and 10:00pm. -There was documentation ProAir was administered 24 times at 8:00am, 4 times at 12:00pm, 1 time at 5:00pm and 3 times at 10:00pm. -There was no documentation the medication was self-administered.	C 350		

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C 350	Continued From page 128 Review of Resident #1's October 2020 MARs revealed: -There was an entry for a ProAir inhaler inhale 2 puffs four times daily as needed for shortness of breath with a scheduled administration time of 8:00am, 12:00pm, 6:00pm and 10:00pm. -There was documentation ProAir was administered 17 times at 8:00am, 3 times at 12:00pm, 1 time at 5:00pm and 15 times at 10:00pm. -There was no documentation the medication was self-administered. Interview with Resident #1 on 10/29/20 at 10:47am revealed: -She kept her ProAir inhaler in her room. -She used the inhaler every day, "maybe 2-3 times per day" but sometimes "just once a day." -She had used her inhaler earlier today, 10/29/20 because she was wheezing. -No one told her she could not keep her inhaler in her room. -She did not tell anyone when she had used her inhaler, "I just did it." Interview with a medication aide (MA) on 10/26/20 at 8:37am revealed: -Resident #1 had an inhaler in her room. -She did not check to see if there was an order for Resident #1 to self-administer her inhaler. -She knew there was supposed to be an order for residents to self-administer medications but "did not think to look to see if there was an order" because it was being done that way when she started working at the facility. Telephone interview with a second MA on 10/30/20 at 9:23am revealed: -She was aware Resident #1 kept an inhaler in	C 350		

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her room.
-She did not know Resident #1 needed a self-administer order for the inhaler in Resident #1's room.
-She was not sure how often Resident #1 used the inhaler Resident #1 kept in her room.

Telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm revealed:
-She was aware Resident #1 had an inhaler she kept in her room.
-She recalled the Administrator telling her an order was required for an inhaler, but she did not get an order for Resident #1 to self-administer her inhaler.

Telephone interview with the Administrator on 10/29/20 revealed:
-Resident #1 should not have any medication in her room.
-She was not aware Resident #1 had an inhaler in her room.
-She expected staff to administer Resident #1's medication.

Telephone interview with Resident #1's PCP's nurse on 11/02/20 at 3:22pm revealed:
-He was not aware Resident #1 was self-administering her Pro-Air inhaler.
-No one had requested an order for Resident #1 to administer her own inhaler.
-He thought Resident #1 would be "okay" to administer her own inhaler.
-He would like to know how often Resident #1 was using her Pro-Air inhaler.

2. Review of Resident #3's current FL-2 dated 11/01/19 revealed diagnoses included seizures, depression and mild intellectual disability.

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C 350	Continued From page 130 Review of Resident #3's record revealed there was no order for an oral tooth medication. Review of Resident #3's medication administration record (MAR) for October 2020 and November 2020 revealed there was no order for an oral tooth medication. Telephone interview with the facility's RN on 10/29/20 at 2:09pm revealed: -She was made aware Resident #3 had a complaint of tooth pain around the middle of October 2020. -She knew Resident #3 had a dentist appointment scheduled for 11/03/20; one of the medication aides (MAs) made the appointment. -She took Resident #3 to the store on a Saturday in the middle of October 2020 to purchase medicated oral tooth drops to put on her tooth for pain. -Resident #3 did not have an order for self-administering the medicated oral tooth drops; she should have gotten an order for self-medication for Resident #3 to have the medicated oral tooth drops. -She did not think about getting an order for Resident #3 to self-administer the medicated oral tooth drops. -Resident #3 kept the medicated oral tooth drops in her room and used them when she needed them. Telephone interview with a medication aide (MA) on 11/02/20 at 2:48pm revealed: -The facility's RN took Resident #3 to purchase oral tooth medication. -Resident #3 kept the oral tooth medication in her room. -She told Resident #3 to bring the oral tooth medication to her when the resident needed to	C 350		

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C 350	Continued From page 131 use it. -She told Resident #3 to wash her hands and then she put the drops on the resident's clean finger; Resident #3 put the drop of medication on her tooth herself. -The oral tooth medication was not on the MAR and she never documented the administration anywhere. -She did not know anything about an order for Resident #3 to self-administer the oral tooth medication. Telephone interview with a second MA on 11/03/20 at 10:26am revealed: -Resident #3 had [brand named] medicated oral tooth drops. -Resident #3 had bought the oral tooth medication herself and kept them with her in her room. -Resident #3 got the oral tooth medication sometime in October 2020. -She put the drops on Resident #3's finger tip and the resident put the drops on her tooth herself. -She knew how to help Resident #3 use the oral medication because she had used oral tooth medication like the one Resident #3 had before. -She helped Resident #3 use the oral tooth medication two times; the medication seemed to help with the resident's pain. -She did not document helping Resident #3 with the oral tooth drops and the medication was not on the MAR. -The facility's RN knew Resident #3 had the oral tooth drops because the facility's RN took Resident #3 to the store to buy them. Telephone interview with Resident #3's dentist on 11/02/20 at 11:16am revealed: -The facility staff never requested pain medication for Resident #3.	C 350		

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C 350	Continued From page 132 -She would have ordered a pain medication for Resident #3 if she had known the resident needed something for pain. -She never ordered oral tooth medication or a self-administer order for Resident #3 . Telephone interview with Resident #3 on 11/03/20 at 1:47pm revealed: -The facility's RN took her to buy oral tooth medication for her tooth pain. -She kept the oral tooth medication in her room but did not know where they were at the time. -The staff would help her put the oral tooth medication on her tooth or sometimes she applied the oral tooth medication herself. Telephone interview with the Administrator on 10/29/20 at 4:42pm revealed: -An order for medication was needed before administering any medication, even over the counter medication needed an order. -The staff should call the primary care provider (PCP) for an order for a medication and then it should be added to the MAR. -She did not know about an oral tooth medication for Resident #3; it was the first she had heard of it. -She knew there needed to be an order for medication to be self-administered.	C 350		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be	C 367		

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C 367	Continued From page 133 accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the record of controlled substances was maintained and reconciled accurately with the documented receipt and administration of controlled substances for 1 of 1 sampled resident (#1) with an order for a controlled sleeping medication and an anti-anxiety medication. The findings are: Review of Resident #1's current FL-2 dated 12/30/19 revealed diagnoses included diabetes mellitus, major depressive disorder, myasthenia gravis, hypertension, hypothyroidism, diaphoresis, and dyspnea on exertion. a. Review of Resident #1's physician's order dated 03/16/20 revealed an order for Zolpidem Tartrate 5mg (a sedative used to treat insomnia) at bedtime. Review of Resident #1's September 2020 medication administration record (MAR) revealed: -There was an entry for Zolpidem Tartrate 5mg daily with a scheduled administration time of 8:00 pm. -There was documentation Zolpidem Tartrate 5mg was administered at 8:00pm on 09/01/20-09/17/20, 09/22/20, and 09/24/20-09/30/20. -There were no exceptions documented for the Zolpidem Tartrate not administered. Review of Resident #1's October 2020 MAR revealed:	C 367		

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C 367	Continued From page 134 -There was an entry for Zolpidem Tartrate 5mg daily with a scheduled administration time of 8:00 pm. -There was documentation Zolpidem Tartrate 5mg was administered at 8:00pm on 10/01/20-10/02/20, 10/04/20, 10/06/20, 10/08/20-10/13/20, 10/15/20-10/22/20, and 10/24/20-10/26/20. -There were no exceptions documented for the Zolpidem Tartrate not administered. Review of Resident #1's controlled substance logs revealed: -There was a controlled substance log provided by the pharmacy for Zolpidem Tartrate 5mg at bedtime with a dispense date of 08/01/20 for 28 tablets. -There was documentation Zolpidem Tartrate 5mg was administered daily from 08/01/20-08/20/20. -There was a second page with documentation Zolpidem Tartrate 5mg was administered daily from 08/21/20-09/17/20. -There was a second controlled substance log provided by the pharmacy for Zolpidem Tartrate 5mg at bedtime with a dispense date of 09/01/20 for 28 tablets. -There was no documentation on the second controlled substance log dated 09/01/20. -There was no controlled substance log dated for October 2020. Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed: -Resident #1's medication was in a pre-packaged bubble pack. -All of Resident #1's medication was packaged in one bubble pack that was dated and labeled morning and bedtime with the name of the medications listed on the bubble pack.	C 367		

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C 367	Continued From page 135 -Zolpidem Tartrate 5mg was listed on Resident #1's bubble pack dated 10/26/20 labeled bedtime and was available for administration. Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am. Refer to the interview with a second MA on 10/26/20 at 10:30am. Refer to the telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm. Refer to the telephone interview with the Administrator on 10/29/20 at 4:39pm. b. Review of Resident #1's physician's order dated 12/30/19 revealed an order for Lorazepam 1mg three times daily (an anti-anxiety medication). Review of Resident #1's physician's order dated 09/21/20 revealed an order for Lorazepam 1mg twice daily. Review of Resident #1's September 2020 MAR revealed: -There was an entry for Lorazepam 1mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00 pm. -There was documentation Lorazepam 1mg was administered at 8:00am from 09/01/20-09/08/20. -There was documentation Lorazepam 1mg was administered at 2:00pm from 09/01/20-09/04/20. -There was documentation Lorazepam 1mg was administered at 8:00pm from 09/01/20-09/07/20. -There was a hand-written note indicating Lorazepam 1mg three times daily had been discontinued on 09/04/20. -There was a second entry for Lorazepam 1mg	C 367		

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twice daily with a scheduled administration time of 8:00am and 2:00pm.
-There was documentation Lorazepam 1mg was administered at 8:00am from 09/11/20-09/19/20, 09/21/20, 09/23/20, and 09/25/20-09/27/20.
-There was documentation Lorazepam 1mg was administered at 2:00pm from 09/11/20-09/15/20, 09/17/20, and 09/22/20-09/23/20.
-There were no exceptions documented for Lorazepam not administered.

Review of Resident #1's October 2020 MAR revealed:
-There was an entry for Lorazepam 1mg twice daily with a scheduled administration time of 8:00am and 2:00pm.
-There was documentation Lorazepam 1mg was administered at 8:00am from 10/01/20-10/03/20, 10/06/20, 10/08/20, 10/14/20, 10/16/20-10/19/20, 10/21/20, 10/23/20, and 25/20-10/27/20.
-There was documentation Lorazepam 1mg was administered at 2:00pm on 10/01/20, 10/06/20, 10/13/20, 10/15/20-10/18/20, 10/20/20, 10/23/20, and from 10/24/20-10/26/20.
-There were no exceptions documented for Lorazepam not administered.

Review of Resident #1's controlled substance log on 10/27/20 revealed:
-There was a controlled substance log provided by the pharmacy for Lorazepam 1mg three times daily with a dispense date of 08/10/20 for 84 tablets.
-The beginning count was 84 tablets dated 09/01/20.
-There were 16 of 50 entries dated 09/01/20-09/29/20 on the controlled substance log where dates, times, and medication counts were documented but there was no signature confirming the administration of Lorazepam 1mg

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for these dates and times documented.
-The last count documented was on 09/25/20 for a count of 38.
-There were signatures on 09/26/20, 09/27/20, and 09/29/20 with no count carried over.
-There were 11 of 39 entries dated 10/01/20-10/23/20 on the controlled substance log where dates, times, and medication counts were documented but there was no signature confirming the administration of Lorazepam 1mg for the dates and times documented.

Observation of Resident #1's medication on hand on 10/26/20 at 9:00am revealed:
-Resident #1's medication was in a pre-packaged bubble pack.
-All of Resident #1's medication was packaged in dated bubble packs labeled morning and bedtime with the name of the medications listed on the bubble pack.
-Lorazepam 1mg was listed on Resident #1's 10/26/20 bubble pack labeled bedtime and 10/27/20 labeled morning and bedtime was available for administration.

Refer to the interview with a medication aide (MA) on 10/26/20 at 9:53am.

Refer to the interview with a second MA on 10/26/20 at 10:30am.

Refer to the telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm.

Refer to the telephone interview with the Administrator on 10/29/20 at 4:39pm.

_____

Interview with a medication aide (MA) on 10/26/20 at 9:53am revealed:
-Resident #1 received controlled medication daily.

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C 367	Continued From page 138 -She did not count the controlled medication before she signed the control log. -She did not know she should count the control medication before she signed the controlled log. -She followed what "everyone else was doing." -She "sometimes forgot to sign the control log." Interview with a second MA on 10/26/20 at 10:30am revealed: -She did not count the controlled medication "every time." -She followed the numbers that were written down. -The facility's contracted nurse told her to count the controlled medication to keep on track. -She did not know when she had last counted the controlled medication. -She signed the control log when she administered medication, but "sometimes forgot." Telephone interview with the facility's nurse (RN) on 10/29/20 at 1:16pm revealed: -Resident #1's controlled medications were included in Resident #1's bubble packs from the pharmacy. -The MAs were supposed to document on the MAR and the control log when a control medication was administered. -The MAs were supposed to count the control medication, but she knew they did not always count the controlled medication. -It concerned her that the control sheets were not being completed. Telephone interview with the Administrator on 10/29/20 at 4:39pm revealed: -She was not aware the control logs were not being completed to reflect medication administered. -She expected all medications to be administered	C 367		

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C 367	Continued From page 139 and documented. -She was concerned the MAs were not documenting controlled medications that were administered.	C 367		
C 601	10A NCAC 13G .1701 (a) (b) Infection Prevention and Control Program 10A NCAC 13G .1701 Infection Prevention and Control Program (a) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic regarding recommended infection	C 601		

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prevention and control practices to reduce the risk of transmission and infection as related to staff not wearing facemasks, staff not maintaining a social distance of 6 feet from residents when not wearing facemasks, and no screening of staff and visitors.

The findings are:

Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the Coronavirus (COVID-19) disease in long-term care facilities revealed personnel should always wear a facemask while in the facility.

Review of the CDC guidelines for use of facemasks revealed COVID-19 is transmitted through droplet, therefore the mouth and nose are to be completely covered when wearing a facemask to prevent contamination and transmission of COVID-19.

Review of the CDC guidelines for Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities updated on 05/29/20 revealed:
-Personnel should always wear a facemask while they are in the facility.
-Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea) before starting each shift/when they enter the building.
-Designate one or more facility employees to ensure all residents have been asked daily about fever and symptoms consistent with COVID-19

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C 601	Continued From page 141 (fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea). -Educate residents and personnel about COVID-19. Review of the facility's COVID-19 policy revealed: -The policy was not dated. -The facility policy included daily screening for temperature check, presence of symptoms and known exposure to COVID-19 of all residents and staff, particularly those returning from extended visits or time outside of the facility. -The facility referenced the current CDC guidance for following policies and procedures were established and implemented consistent with the federal CDC guidelines: proper use of PPE; procedures for screening visitors and criteria for restricting visitors who exhibit signs of illness, and procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working. Observation of the outside of the facility on 10/26/20 at 7:26am revealed: -The entrance to the facility was unlocked and there was a sign posted on the door that read "Attention: need to restrict all visitors for the safety of our residents". -The CDC notification for strategies to prevent the spread of COVID-19 in Long Term Care Facilities (LTCF) was posted on the door. -A facility staff could be seen inside the facility through the window of the kitchen; the staff was not wearing a facemask. 1. Observation of the facility upon entrance on 10/26/20 at 7:33am revealed:	C 601		

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C 601	Continued From page 142 -A medication aide (MA) was working at the facility and did not greet the survey team at the door. -The MA came to the common area and she did not screen the survey team for fever or with screening questions. Observation of the facility on 10/26/20 at 7:39am revealed: -A facility staff came into the facility to take a resident to a scheduled appointment. -The staff came into the facility and did not answer screening questions or take a temperature. -The resident left the facility with the staff and got into a car; neither the facility staff nor the resident had on a facemask. Observation of the MA office on 10/26/20 at 8:38am revealed: -There was an oral thermometer with protective sleeves and a box of alcohol prep pads. -There were no temperature log sheets for staff or residents and no screening questionnaires available. Observation of a MA returning with a resident from a physician's appointment on 10/26/20 at 9:12am revealed: -The MA entered the facility and did not take her temperature. -The resident did not have his temperature taken upon returning to the facility. Interview with a resident on 10/26/20 at 7:39am revealed: -She had not had her temperature taken by staff. -Visitors were only allowed outside and could not come into the facility.	C 601		

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C 601	Continued From page 143 Interview with a second resident on 10/26/20 at 7:43am revealed no one took her temperature. Interview with a third resident on 10/26/20 at 7:53am revealed: -The MAs did not take her temperature every day; "it depends on who is working." -She had her temperature taken "last Friday" by the facility's registered nurse. Interview with a fourth resident on 10/26/20 at 7:36am revealed no one checked his temperature. Interview with a MA on 10/26/20 at 8:00am revealed: -She never took her temperature before coming into work. -She had never taken the residents' temperatures. -She had not had COVID-19 training. Interview with a second MA on 10/26/20 at 8:11am revealed: -The staff were not prescreened prior to coming into the facility. -Staff did not take her temperature prior to beginning work and neither did she. -When a provider came to the facility, the Administrator asked the provider questions over the phone, but there was nothing documented at the facility. -The providers' temperatures were not taken. -Residents were not being screened when returning from physicians' appointments. -Residents only went to physicians' appointments and nowhere else. -Visitors could visit one at a time outside and they had to wear a facemask and be socially distant. -The symptoms she knew to watch for included	C 601		

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fever, flu like symptoms and loss of smell.
-The residents' temperatures were not being taken.
-The facility's Registered Nurse (RN) came to the facility two times a week; she did not know if the RN took temperatures when she was at the facility.
-She had not had COVID-19 training while working at this facility.

Interview with a third MA on 10/26/20 at 10:48am revealed:
-The facility staff were taking the residents' temperatures and documenting them, but they had stopped doing that in June 2020 or July 2020.
-She did not know why they stopped taking the residents' temperatures and documenting them.
-Staffs' temperatures were never taken.
-There was an oral thermometer with protective sleeves and alcohol prep pads to sanitize the thermometer after each use, but she was not taking daily temperatures of residents.
-She had not had any training and had not been shown a policy related to COVID-19.

Telephone interview with the facility's RN on 10/29/20 at 3:01pm revealed:
-She did not know if the staff were taking their own temperatures prior to entering the facility.
-She did not know if the staff were taking the residents' temperature; they had been done at one time but did not think they were still being taken.
-She did not know if she ever told the staff to self screen.
-She had told the staff to self monitor for a cough, fever or just not feeling good and not to come to work if they had any symptoms.
-She did not tell the staff what to do if they

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C 601	Continued From page 145 exhibited symptoms while at work. -She was not aware of a policy specific to the facility; she had given the staff the information concerning long term care facilities that had been sent out by the state. Telephone interview with the Administrator on 10/26/20 at 11:19am revealed: -She required staff to call her to conduct any pre-screening for anyone coming into the facility. -She did the pre-screening questionnaire over the phone when someone came into the facility. -She had the questions on a list she kept with her and when there was a reason for someone to come into the facility, she would do a screening verbally over the phone and she would make the decision when someone could come into the facility. -She did not take temperatures herself; she expected the staff to take temperatures and report the temperature to her. -She had pre-screening documentation at her house. -Her questions included "Have you been around anyone with COVID-19?", "Have you had a temperature or a cough?"; "Have you been out of the country?". -The staff had a no-touch thermometer at the facility; she had a half a dozen at her house and could bring one to the facility if the staff could not find the thermometer, she had given them. -She had a copy of the COVID-19 focused infection control policy at her home. -She was not sure there was a copy of the policy at the facility; "it may not be there". -She went over the policy with new staff and when there were updates and changes made by the government. -She did not have staff sign off on any COVID-19 training, but she did do a training in April 2020.	C 601		

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C 601	Continued From page 146 -The staff should be taking their temperatures prior to entering the facility. -She did not require a pre-screening questionnaire for staff prior to beginning of work. -She probably should require screening of the staff because they left the facility and came back to work. -She did not know where staff went when they left work so that was why she should do screening of the staff. -Staff took temperatures of residents and watched them for symptoms. -If a resident had symptoms or a fever, she would expect staff to send the resident to the hospital; she told the staff to send residents to the hospital if the resident had symptoms of COVID-19 and a fever. -She got a newsletter from an organization she belonged to and she only relied on that information for updates on the pandemic. -She did not get updated information from any other organization and she did not refer to the Centers for Disease Control (CDC) web site for guidance. -She was not familiar with 10A NCAC 13G .1701 Infection Prevention and Control dated on 10/23/20. 2. Observation of the facility upon entrance on 10/26/20 at 7:33am revealed a medication aide (MA) came to the common area and did not have on a facemask. Observation of the facility on 10/26/20 at 7:39am revealed: -A facility staff came into the facility to take a resident to a scheduled appointment. -The staff came into the facility and did not wear a facemask. -The resident left the facility with the staff and got	C 601		

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C 601	Continued From page 147 into a car without a facemask. Observation of a MA returning with a resident from a physician's appointment on 10/26/20 at 9:12am revealed: -The MA entered the facility without a facemask. -The resident returned without a facemask. Interview with a resident on 10/26/20 at 7:39am revealed: -Staff did not wear facemasks when working in the facility. -She wore a facemask when she went into the physician's office during an appointment, but not while riding in the car. -Staff did not wear a facemask in the car when she rode with them. -She was not allowed to go anywhere except to physician's appointments since the pandemic. Interview with a second resident on 10/26/20 at 10:29am revealed: -The Administrator and the Business Office Manager (BOM) did not wear facemasks when they came to the facility. -The facility's Registered Nurse (RN) wore a mask when she came into the facility, but she took it off when she talked. -The Administrator gave her two facemasks to wear but she had not been anywhere to wear them. Interview with a MA on 10/26/20 at 8:00am revealed: -She had not thought about wearing a facemask while at work. -She worked the evening shift and stayed at the facility overnight. -No one had ever told her about wearing a facemask while at work.	C 601		

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C 601	Continued From page 148 Interview with a second MA on 10/26/20 at 8:11am revealed: -Residents only went to physicians' appointments and nowhere else. -She wore a facemask while in the facility by her own choice; she had not been instructed to wear a facemask. -She saw some staff with facemasks and some staff without facemasks while at work. -The facemasks at the facility were for the residents to wear when they went to see the physician. -Staff could use the facemasks from the facility if they did not have a facemask to wear. -She had used the facemasks from the facility but was now wearing her own surgical facemask. Interview with a third MA on 10/26/20 at 10:48am revealed: -She transported residents in her personal car to physicians' appointments. -She would wear a facemask once she got to the physicians' office but not when she was in the car. -The residents did not wear a facemask in the car but would put one on before they went into the physician's office. -She had been told by the Administrator to make sure the residents wore a mask when at the physician's office. -She had not been told to have the residents wear a facemask while riding in the car with her. -She had not been told to wear a facemask when the resident was in the car with her and she did not think about wearing a facemask while in the car with a resident. -She did not wear a mask while in the facility. Telephone interview with the facility's RN on	C 601		

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C 601	Continued From page 149 10/29/20 at 3:08pm revealed: -She had told the staff to wear facemasks when in the facility. -She was concerned they were not following good practices and not doing the right thing because they could make the residents sick. -She always wore a mask when she was in the facility. Telephone interview with the Administrator on 10/26/20 at 11:19am revealed: -The staff were supposed to wear facemask the entire time they were at work. -Residents were supposed to wear a facemask when in the car going to a physician's appointment and while at the appointment. -Staff should wear a facemask when in the car with a resident. -The staff should be wearing facemasks while at work. -She expected staff to wear facemasks while in the facility; she told staff to wear a facemasks while at the facility. 3. Observation of the PPE and cleaning supplies on hand on 10/26/20 at 8:38am revealed: -There was a one gallon bottle of bleach for cleaning surfaces. -There was gel hand sanitizer in a pump and a spray bottle of hand sanitizer. -There was an empty box of facemasks on the desk in the medication office. -There were no other facemasks in the facility. -There were no face shields or gowns in the facility. -There was one box of extra-large gloves in the facility; there were no other gloves. Interview with a medication aide (MA) on 10/26/20 at 8:11am revealed:	C 601		

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C 601	Continued From page 150 -There was a box of facemasks in the medication office. -There was an oral thermometer with protective sleeves and alcohol prep pads for sanitizing when taking resident temperatures. -She brought her own facemask to wear while at work. -There had only been the one box of facemasks at the facility. -She had told the Administrator on Friday, 10/23/20 they were out of facemasks. -She knew the state had provided PPE to the facility, but she could not find it now. -She did not know what happened to the PPE that the state provided. Telephone interview with the Administrator on 10/26/20 at 11:19am revealed: -The prior staff took the gowns and face shields and she had not replenished them. -She could not give a reason for not replacing personal protective equipment (PPE). -She had purchased facemasks two or three times; the last time she purchased facemasks was around September 2020. -She purchased two boxes of facemasks at a time; each box had 50 facemasks in them. -She did an inventory of PPE at least once a month. -Fifty facemasks should have lasted about a month. -She supplied facemasks for the residents and the staff to wear. _____ The facility failed to implement and maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the local health department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission	C 601		

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C 601	Continued From page 151 during the COVID-19 pandemic in which staff did not wear facemasks within the facility and staff did not screen the residents, visitors, or themselves daily. The facility's failure to complete staff and visitor screenings and properly use facemasks placed the residents at increased risk for transmission and infection from COVID-19, resulting in substantial risk of serious physical harm and neglect, and constitutes a Type A2 Violation. _____ A plan of protection was provided by the facility in accordance with G.S. 131D-37 on 10/26/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 4, 2020.	C 601		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to training on cardio-pulmonary resuscitation, adult care home medication aides training and competency evaluation requirements, tuberculosis testing, and examination and screening for the presence of controlled	C 912		

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C 912	Continued From page 152 substances. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure 4 of 4 staff sampled (Staff A, B, C, and D) who administered medications had completed their medication clinical skills competency validation prior to administering medications and completed the 5-hour and 10-hour medication aide training courses under the direction of a registered nurse or licensed pharmacist or successfully completed the required state examination (Staff A). [Refer to Tag C935 G.S. § 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, within the last 24 months for 3 of 4 sampled staff (Staff A, Staff B, and Staff D). [Refer to Tag C176 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 4 of 4 sampled staff (Staff A, B, C, and D) prior to hire. [Refer to Tag C992 G.S. 131D-45 Examination and Screening for the Presence of Controlled Substances Required for Applicants for Employment in Adult Care Homes (Type B Violation)].	C 912		

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C 912	Continued From page 153 4. Based on record reviews and interviews, the facility failed to ensure 4 of 4 sampled staff (A, B, C, D,) completed a two-step tuberculosis (TB) skin test according to control measures adopted by the Commission for Health Services. [Refer to Tag C140 10A NCAC 13G .0405(a) Test for Tuberculosis (Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure each resident was free of neglect related to health care, management and other staff, medication administration, and infection prevention and control program. The findings are 1. Based on observations, interviews and record reviews, the facility failed to ensure follow-up for acute and routine healthcare needs for 2 of 3 residents sampled (#1, #3) including a resident who had a referral appointment for an Epileptologist for seizures, notification to the Neurologist for seizures and complaint of toothache (#3); and a resident who experienced increased weakness and slurred speech after being administered another resident's medication, and whose primary care physician (PCP) had referred the resident to a Neurologist due to increased tremors (#1). [Refer to Tag C246 10A NCAC 13G .0902(b) Health Care (Type A1 Violation)].	C 914		

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C 914	Continued From page 154 2. Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to infection prevention and control program related to COVID-19, medication administration, health care, training on cardio-pulmonary resuscitation, test for tuberculosis, adult care home medication aide training and competency evaluation requirements, housekeeping and furnishing, building service equipment, orders for self-administration of medication, and staff qualifications. [Refer to Tag C185 10A NCAC 13G .0601(a) Management and Other Staff (Type A1 Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic regarding recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff not wearing facemasks, staff not maintaining a social distance of 6 feet from residents when not wearing facemasks, and no screening of staff and visitors. [Refer to Tag C601 10A NCAC 13G .1701 Infection Prevention and Control Program (Type A2 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 2 of 3 sampled residents (#1 and #3) including a medication used to treat asthma, an allergy nasal spray and a	C 914		

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C 914	Continued From page 155 supplement (#1) and an oral tooth medication (#3). [Refer to Tag C330 10A 10A NCAC 13G .1004 Medication Administration (Type B Violation)].	C 914		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration.	C935		

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C935	Continued From page 156 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 4 of 4 staff sampled (Staff A, B, C, and D) who administered medications had completed their medication clinical skills competency validation prior to administering medications and completed the 5-hour and 10-hour medication aide training courses under the direction of a registered nurse or licensed pharmacist or successfully completed the required state examination (Staff A). The findings are: 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 09/23/20. -There was documentation Staff A completed the 15-hour medication training on 09/14/20 and 09/16/20 signed by a registered nurse (RN) on 09/16/20. -There was documentation Staff A completed the medication clinical skills competency validation on 09/16/20 signed by a RN on 09/16/20.	C935		

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C935	Continued From page 157 -There were no new hire forms on file prior to 09/23/20. -There was no documentation Staff A had passed the written medication aide (MA) exam. Interview with a Staff A on 10/26/20 at 10:30am and 2:00pm revealed: -Her previous employment had been in housekeeping. -She had not had medication aide (ma) training. -She read a handbook she had been provided by the facility's RN when she started working. -She had been working at the facility since March 2020. -She was not sure when she started working at the facility. -She worked as a MA at the facility and administered medications independently when she was working. -She shadowed another MA for a "couple of hours" and then the next day she worked, she worked independently and administered medication. -She had not taken a medication administration examination. -She did not think she was "quite" ready to take the medication administration examination because she still needed to learn some of the terminologies. -She did not know the RN who signed her staff training certificates and competency validation. -She had not demonstrated medication administration to the RN for completion of a medication clinical skills competency checklist. -She had been provided blank forms by the Administrator and instructed to sign the forms in September 2020. Review of residents controlled medications logs and medication administration records (MAR) for	C935		

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C935	Continued From page 158 June 2020, August 2020, September 2020, and October 2020 revealed: -The first time Staff A documented the administration of medication was on 06/30/20 -Staff A documented the administration of medications on 14 days in August 2020. -Staff A documented the administration of medications on 12 days prior to 09/23/20 (the date of hire). -Staff A documented the administration of medications on 6 days in October 2020. Telephone interview with a contracted trainer for the facility on 10/26/20 at 12:53pm revealed: -She was a registered nurse (RN). -The Administrator had contacted her to train new staff and re-train "old" staff in August 2020. -She did medication training that included a slide show and provided each staff with a handbook. -She did medication training in the living room of the facility; the residents stayed in their rooms during training. -She completed the clinical skills checklist on-site with Staff A. -She did not have the staff sign an attendance sheet, but the dates the trainings were completed were on the staff's training certificates. -She was in the facility "at least four-times" for training. Interview with a resident on 10/26/20 at 2:22pm revealed: -She had not seen anyone do staff training in the facility. -She went into the living room area every day, multiple times. -She had not been instructed to stay in her room while staff were being trained. Telephone interview with the Administrator on	C935		

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C935	Continued From page 159 10/26/20 at 1:14pm revealed: -The facility's registered nurse had been on leave for a couple of months and not available to do training with the MAs. -A contracted trainer who was a RN had been to the facility three times to do "one on one" training with the staff. -Most of the training was one on one with the MAs, but some of the training was done as a group. -She did not recall the dates, but all training had been completed within the last month. -She did not know the dates the training forms were signed, but the trainer had been at the facility "so many times." -The trainer was in the facility for never less than 5-hours. Telephone interview with the Administrator on 11/04/20 at 2:16pm revealed: -Staff A was only working one day a week when she "first started working for the facility." -She was not sure Staff A would be working out. -An employee quit in September 2020 and she had to bring Staff A on full time and that was when she had considered Staff A as a full-time employee. 2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff B was hired on 09/21/20. -There was documentation Staff B completed the 15-hour medication training on 09/14/20 and 09/16/20 signed by a registered nurse (RN) on 09/16/20. -There was documentation Staff B completed the medication clinical skills competency validation on 09/16/20 signed by a RN on 09/16/20; the employee signed the form on 09/21/20.	C935		

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(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
C935	Continued From page 160 Interview with Staff B on 10/26/20 at 8:08am and 1:06pm revealed: -She started to work at the end of the year in 2019 but went out on maternity leave and "just came back." -She worked as a medication aide (MA) at the facility and administered medications independently when she was working. -She had not taken a medication aide class. -She was given a study guide to review on her own by the facility's nurse. -She had taken the MA exam (January/February 2020) but did not pass the exam. -She did not know the RN who signed her staff training certificates. -She had not demonstrated medication administration to the RN for completion of a medication clinical skills competency checklist. -She had been provided blank forms by the Administrator and instructed to sign the forms; she dated the forms the date of her hire, 09/21/20. -She did not do any training or paperwork for the facility prior to 09/20/20. Review of residents controlled medication logs and medication administration records (MAR) for September 2020 and October 2020 revealed: -The first time Staff B documented the administration of medication was on 09/25/20; she also documented administering medications on 09/30/20. -Staff B documented the administration of medication on 11 days in October 2020. Telephone interview with a contracted trainer for the facility on 10/26/20 at 12:53pm revealed: -She was a registered nurse (RN). -The Administrator had contacted her to train new staff and re-train "old" staff in August 2020.	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL093012	A. BUILDING: _____ B. WING _____	11/04/2020

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C935	Continued From page 161 -She did medication training that included a slide show and provided each staff with a handbook. -She did medication training in the living room of the facility; the residents stayed in their rooms during training. -She completed the clinical skills checklist on-site with Staff A. -She did not have the staff sign an attendance sheet, but the dates the training was completed was on the staff's training certificates. -She was in the facility "at least four-times" for training. Interview with a resident on 10/26/20 at 2:22pm revealed: -She had not seen anyone do staff training in the facility. -She went into the living room area every day, multiple times. -She had not been instructed to stay in her room while staff were being trained. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -The facility's registered nurse had been on leave for a couple of months and not available to do training with the MAs. -A contracted trainer who was a RN had been to the facility three times to do "one on one" training with the staff. -Most of the training was one on one with the MAs, but some of the training was done as a group. -She did not recall the dates, but all training had been completed within the last month. -She did not know the dates the training forms were signed, but the trainer had been at the facility "so many times." -The trainer was in the facility for never less than 5-hours.	C935		

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C935	Continued From page 162 3. Review of Staff C's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff C was hired on 08/30/20. -There was documentation Staff C completed the 15-hour medication training on 09/02/20 and signed by a registered nurse (RN) on 09/02/20. -There was documentation Staff C completed the medication clinical skills competency validation on 09/02/20 signed by a RN on 09/02/20; the employee signed the form but did not date the form. Telephone interview with Staff C on 11/02/20 at 4:52pm revealed: -He did not take a 15-hour medication administration class at the facility, or at any other location since he began working at the facility. -He did not have anyone observe him administering medication or complete a medication clinical skills competency validation form. -He signed an employee packet provided to him by the Administrator (he did not recall when he was given the employee packet) but it was not before he started working at the facility. -The forms he signed were blank forms. Review of resident's controlled medications logs and medication administration records (MAR) for September 2020 and October 2020 revealed: -The first time Staff B documented the administration of medication was on 09/10/20/20; he also documented administering medications on 09/21/20 and 09/23/20.. -Staff B documented the administration of medication on 5 days in October 2020. Telephone interview with a contracted trainer for the facility on 10/26/20 at 12:53pm revealed:	C935		

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C935	Continued From page 163 -She was a registered nurse (RN). -The Administrator had contacted her to train new staff and re-train "old" staff in August 2020. -She did medication training that included a slide show and provided each staff with a handbook. -She did medication training in the living room of the facility; the residents stayed in their rooms during training. -She completed the clinical skills checklist on-site with Staff C. -She did not have the staff sign an attendance sheet, but the dates the training was completed was on the staff's training certificates. -She was in the facility "at least four-times" for training. Interview with a resident on 10/26/20 at 2:22pm revealed: -She had not seen anyone do staff training in the facility. -She went into the living room area every day, multiple times. -She had not been instructed to stay in her room while staff were being trained. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -The facility's registered nurse had on leave for a couple of months and not available to do training with the MAs. -A contracted trainer who was a RN had been to the facility three times to do "one on one" training with the staff. -Most of the training was one on one with the MAs, but some of the training was done as a group. -She did not recall the dates, but all training had been completed within the last month. -She did not know the dates the training forms were signed, but the trainer had been at the	C935		

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C935	Continued From page 164 facility "so many times." -The trainer was in the facility for never less than 5-hours. 4. Review of the facility's personnel records revealed Staff D did not have a personnel record. Telephone interview with Staff D on 11/04/20 at 12:04pm revealed: -She worked as a medication aide (MA) at the facility and administered medications independently when she was working. -She had not had MA training at the facility, but the Administrator knew she already had MA training in the past. -She had not been asked to provide documentation of her MA training. Review of resident's controlled medications logs and medication administration records (MAR) for September 2020 and October 2020 revealed: -The first time Staff D documented the administration of medication was on 09/12/20/20; she also documented administering medications on 4 additional days in September 2020. -Staff D documented the administration of medication on 6 days in October 2020. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -Staff D did not have a personnel record. -Staff D was a "fill-in" who worked at a "peer's facility." -Staff D had been a long-term employee at the peer's facility and had a personnel record at the peer's facility. [Refer to Tag C330 10A 10A NCAC 13G .1004 Medication Administration (Type B Violation).]	C935		

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C935	Continued From page 165 [Refer to Tag C342 10A NCAC 13G .1004j Medication Administration (Standard Deficiency).] [Refer to Tag C367 10A NCAC 13G .1008(a) Controlled Substances (Standard Deficiency).] [Refer to Tag C350 10A NCAC 13G .1005(a) Self-Administration of Medications (Standard Deficiency).] [Refer to Tag C316 10A NCAC 13G .1002(b) Medication Orders (Standard Deficiency).] The facility failed to ensure 4 of 4 sampled staff had completed the medication clinical skills competency validation and completed the 5-hour and 10-hour medication aide training courses and continued to perform unsupervised medication aide duties with errors in medication administration, including a resident not being administered a maintenance medication who had asthma and had been having increased shortness of breath and wheezing and using her prn medication more often to relieve the increased symptoms, and a resident being administered the wrong medication which caused the resident to have adverse reactions which included slurred speech and overall weakness, residents self-administering medications without orders, medications being administered without orders, inaccurate MARs and controlled substance logs, and a medication aide failing the MA exam. The 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 11/04/20 for this violation.	C935		

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C935	Continued From page 166 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 19, 2020	C935		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination	C992		

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C992	Continued From page 167 and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 4 of 4 sampled staff (Staff A, B, C, and D) prior to hire. The findings are: 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 09/23/20. -There was documentation on a named company on a form titled Toxicology Screen, Staff A completed the examination and screen for the presence of controlled substances on 09/17/20. Interview with a Staff A on 10/26/20 at 2:00pm revealed: -She had not completed an examination and screening for controlled substances. -She had not used a urine specimen cup provided by the Administrator to complete an examination and screening for controlled substances. Telephone interview with the medical provider at the toxicology screening company on 10/26/20 at 1:35pm revealed: -His company did not do drug screens for facilities. -He did not know why there would be documentation on his agency's form on file at the facility. -He did not know how someone had obtained a form from his agency to use.	C992		

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C992	Continued From page 168 -He did not know Staff A, and had not performed a drug screen on Staff A. Telephone interview with the Administrator on 10/20/2020 at 3:31pm and 10/21/20 at 12:06pm revealed: -She had requested assistance to give her staff drug test from a friend who was a doctor. -The doctor used an online program to verify drug screening. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -She completed drug screenings on all new hires. -Drug screens were completed in the facility's employee bathroom using a urine specimen cup. -She completed a drug screen on Staff A in the facility's employee bathroom. 2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff B was hired on 09/21/20. -There was documentation on a named company form titled Toxicology Screen, Staff B completed the examination and screen for the presence of controlled substance on 09/14/20. Interview with Staff B on 10/26/20 at 8:08am revealed: -She had not completed an examination and screening for controlled substances. -She had not used a urine specimen cup provided by the Administrator to complete an examination and screening for controlled substances. Telephone interview with a provider at the named toxicology screening company on 10/26/20 at 1:35pm revealed: -His company did not do drug screens for facilities.	C992		

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C992	Continued From page 169 -He did not know why there would be documentation on his agency's form on file at the facility. -He did not know how someone had obtained a form from his agency to use. -He did not know Staff B, and had not performed a drug screen on Staff B. Telephone interview with the Administrator on 10/20/2020 at 3:31pm and 10/21/20 at 12:06pm revealed: -She had requested assistance to give her staff drug test from a friend who was a doctor. -The doctor used an online program to verify drug screening. Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed: -She completed drug screenings on all new hires. -Drug screens were completed in the facility's employee bathroom using a urine specimen cup. -She completed a drug screen on Staff B in the facility's employee bathroom. 3. Review of Staff C's Supervisor-in-Charge (SIC), personnel record revealed: -Staff C was hired on 08/30/20. -There was documentation on a named company form titled Toxicology Screen, Staff C completed the examination and screen for the presence of controlled substance on 08/27/20. Interview with Staff C on 11/27/20 at 8:12am revealed: -He had not completed a screening for controlled substances completed at the facility. -He had not used a urine specimen cup provided by the Administrator to complete a drug screen. Telephone interview with a provider at the named	C992		

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C992	Continued From page 170	C992		

toxicology screening company on 10/26/20 at 1:35pm revealed:
-His company did not do drug screens for facilities.
-He did not know why there would be documentation on his agency's form on file at the facility.
-He did not know how someone had obtained a form from his agency to use.
-He did not know Staff C, and had not performed a drug screen on Staff C.

Telephone interview with the Administrator on 10/20/2020 at 3:31pm and 10/21/20 at 12:06pm revealed:
-She had requested assistance to give her staff drug test from a friend who was a doctor.
-The doctor used an online program to verify drug screening.

Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed:
-She completed drug screenings on all new hires.
-Drug screens were completed in the facility's employee bathroom using a urine specimen cup.
-She completed a drug screen on Staff C in the facility's employee bathroom.

4. Review of the facility's personnel records revealed Staff D did not have a personnel record.

Telephone interview with Staff D on 11/04/20 at 12:04pm revealed she had not had a screening for controlled substances on her since she began working at the facility.

Telephone interview with the Administrator on 10/26/20 at 1:14pm revealed:
-Staff D did not have a personnel record.
-Staff D was a "fill-in" who worked at a "peer's

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C992	Continued From page 171 facility." -Staff D had been a long-term employee at the peer's facility and had a personnel record at the peer's facility. _____ The facility failed to ensure an examination and screening for the presence of controlled substances was performed for 4 of 4 sampled staff (C and D) hired after 10/01/13. This failure was detrimental to the health, safety, and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/28/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 19, 2020.	C992		