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 _____	R 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIVOTAL CARE	303 W FRANKLIN STREET WARRENTON, NC 27589

(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 000}	Initial Comments The Adult Care Licensure Section and the Warren County Department of Social Service conducted a follow-up survey from June 2, 2021 to June 4, 2021 with an exit by telephone on June 4, 2021.	{C 000}		
C 059	10A NCAC 13G .0310 (b) Storage Areas 10A NCAC 13G .0310 Storage Areas (b) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be supervised while in use. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure cleaning products including bleach were stored in a locked area, resulting in hazardous chemicals being accessible to residents in the kitchen, where the unlocked cabinets containing cleaning chemicals were located. The findings are: Observation of the kitchen on 06/02/21 at 8:47am-11:30am revealed: -The Supervisor-in-Charge (SIC) was in and out of the kitchen cleaning. -When the SIC left the kitchen, the door to the kitchen area was not closed. -There were multiple residents moving about the facility. -Several residents took empty cups to the kitchen area. Observation of the kitchen on 06/02/21 between	C 059		

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C 059	Continued From page 1 11:30am-2:00pm revealed the SIC pulled the kitchen door closed twice but did not lock the lock pad attached to the door. Observation of the kitchen on 06/02/21 between 4:00pm-7:00pm revealed the kitchen door was not closed. Observation of the kitchen on 06/02/21 at 5:17pm revealed: -The cabinet under the sink had double doors that were not closed. -The remnants of a lock were attached to the doors but were broken. -There were 3 large containers of bleach. -There was one spray bottle of a cleaner and disinfectant. -There was one large container of antibacterial hand soap. Review of the labels of the chemicals revealed various warnings including avoiding contact with skin and eyes, can be skin and eye irritant, keep out of reach of children and pets, and harmful if swallowed. Interview with the Supervisor in Charge (SIC) on 06/02/21 at 4:41pm revealed: -There was no lock on "that" cabinet. -There had never been a lock on the cabinet where the chemicals were stored. -No one had told her the chemicals needed to be locked. Interview with the Administrator on 06/04/21 at 1:11pm revealed: -She did not know the cleaning products were being stored in the kitchen under the sink. -When staff was not in the kitchen, she expected the kitchen door to be closed and locked.	C 059		

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C 059	Continued From page 2 -She had put a lock on the kitchen door because residents were going into the kitchen taking food. -A named resident recently climbed through the opening in the wall between the kitchen and dining area, over the freezer, to get sugar. -Chemicals were to be locked in a storage area designated for cleaning products and not in the kitchen. -There were residents in the facility that she would be concerned might get into the chemicals.	C 059		
{C 069}	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors had an alarm that was activated and sounded when the doors were opened to alert	{C 069}		

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{C 069}	Continued From page 3 staff for 1 of 1 resident (#1), who had a diagnosis of dementia and was known to wander into the community unsupervised. The findings are: Observations of the facility on 06/02/21 from 8:30am to 7:00pm revealed there was no alarm sounding device when the front door, rear door, or kitchen door to the facility were opened. Observation of the facility on 06/03/21 from 12:43pm-3:56pm revealed there was no alarm sounding device when the front door, rear door, or kitchen door to the facility were opened. Review of Resident #1's current FL-2 dated 03/08/21 revealed: -Diagnoses included dementia, brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension, and hyperlipidemia. -Resident #1 was intermittently disoriented. -Resident #1 had wandering behaviors. Review of Resident #1's Care Plan dated 10/08/20 revealed: -She was sometimes disoriented, forgetful, and needed reminders. -Resident #1 had wandering behaviors. -Resident #1 had disruptive and socially inappropriate behaviors. -Resident #1 had slurred speech. Review of Resident #1's primary care provider's (PCP) visit note dated 03/18/21 revealed Resident #1 should be supervised when leaving the facility for safety reasons. Review of Resident #1's PCP's visit note dated 04/13/21 revealed Resident #1 should be	{C 069}		

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{C 069}	Continued From page 4 supervised when leaving the facility due to recurrent falls. Review of Resident #1's mental health provider's visit summary dated 04/05/21 revealed: -Resident #1 had a tendency to wander off the premises. -There was documentation Resident #1's insight and judgment were poor. Review of staff notes between 04/18/21-05/21/21 revealed Resident #1 left the facility [unsupervised] 18 times. Review of local law enforcement reports revealed there had been 3 missing person reports filed on Resident #1 between 04/18/21-05/31/21. Interview with the Supervisor-in-Charge on 06/02/21 at 6:46pm revealed: -The facility did not have alarms on the doors. -She had never heard an alarm and had not been instructed on what to do with an alarm. -If she was in the back of the house working she would not know if a resident went outside, especially if she was vacuuming. -She thought alarms on the doors would be beneficial because Resident #1 could disappear quickly and she was afraid the resident would fall outside the facility. Telephone interview with the facility's contracted Registered Nurse (RN) on 06/03/21 at 12:06pm revealed she was concerned a door alarm had not been installed at the facility, not just for Resident #1, but for the safety of all the residents. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -She had ordered alarms for the facility on	{C 069}		

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{C 069}	Continued From page 5 04/23/21 and had tried the alarm at her own residence and did not feel the alarm was loud enough to alert the staff when a resident had exited the facility. -She had returned the alarm and had ordered a different alarm "about a week ago." -The alarm had not been delivered as of today, 06/03/21. _____ The facility was provided a plan of protection in accordance with G.S. 131D-34 on 06/03/21 for this violation	{C 069}		
{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 carpeting in the common hallway and sitting area, and the floor in the dining room, walls in the common hallway, a resident bedroom and the kitchen, and windows in the dining room and three resident bedrooms were kept clean and in good repair. The findings are:	{C 074}		

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{C 074}	Continued From page 6 Observation of the dining room on 06/02/21 at 8:45am revealed one of the windows had a 1-inch gap where the windows were open and did not close. Observation of the dining room floor on 06/02/21 at 8:45am and 10:19am revealed: -There was a tear in the linoleum under two of the chairs at the dining room table. -One of the tears was 4 by 4 inches wide and the linoleum was folded back creating a tripping hazard. -The second tear was 6 x 4 inches wide and the linoleum was folded back creating a tripping hazard. Observation of the dining room on 06/02/21 at 8:45am revealed the metal threshold between the linoleum and carpet was not secured to the floor, with part of the metal raised approximately 1 inch from the floor and was a tripping hazard. Observation of the dining room ceiling on 06/02/21 at 8:47am revealed there were large pieces of dust hanging from the textured ceiling over the area where residents' food was served. Observation of the dining room wall on 06/02/21 at 10:19 revealed the wall socket had a brownish substance on it. Observation of the common living room and sitting area on 06/02/21 at 8:40am revealed: -The vent coverings and the area surrounding the vent were covered with dust. -The carpet was stained with a black, hardened substance. -The corner of the wall that led to the hall was stained and scraped.	{C 074}		

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{C 074}	Continued From page 7 Observation of the common hallway on 06/02/21 at 8:56am revealed: -The walls in the hallway were dirty with dried brown and black splatters and drips. -There was a piece of metal, approximately 6 feet in length and 3 feet in height attached to the wall; the corner had pulled loose from the wall creating an area that was approximately 6 inches by 4 inches that was not flush with the wall. Observation of resident bedroom #3 on 06/02/21 at 9:02 revealed: -There was a shower gel bottle used to prop the window up because it wouldn't stay up on its own. -There were three large cobwebs in the corners and along the edge of the ceiling of the room. Interview with a resident who resided in bedroom #3 on 06/02/21 at 9:04am revealed: -He was responsible for sweeping, mopping, and dusting his bedroom. -He had not noticed the cobwebs on the walls. -No staff had cleaned his room. -The window would not stay open without propping it up. -He would get the cobwebs down the next time he cleaned. Observation of resident bedroom #2 on 06/02/21 at 8:46am revealed dust was hanging from the ceiling and ceiling fan. Second observation of resident bedroom #2 on 06/02/21 at 12:21pm revealed: -There was a one-inch hole in the wall at the top of the bed. -There was torn tile at the foot of the bed. -There was a one-inch hole in the wall located near the foot of the bed.	{C 074}		

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{C 074}	Continued From page 8 Observation of the hallway bathroom on 06/02/21 at 8:45am and 10:19am revealed: -There was a piece of wood attached to the wall that had 2 screws with the sharp points exposed outward 2 inches. -The wall behind the commode was covered in a dark brown substance. -Part of the wall had been patched but had not been sanded and painted. -Areas of the floor and the baseboards were covered with a dark brown substance. -There were pieces of tile missing from the floor. -The base of the toilet was dirty. -The floor vent cover had dust between the spaces and rust around it. Observation of resident bedroom #1 on 06/02/21 at 8:46am and 5:56pm revealed: -The window in the bedroom had a 1-inch gap where the window was open and did not close. -There was no screen on the window. -The carpet was stained with a hardened, black substance. -The door would not latch and stay closed. -There was lent hanging from the ceiling. Observation of resident bathroom #1 on 06/02/21 at 8:46am revealed: -There was a hairbrush used to prop the window open. -When the hairbrush was removed, it would take both hands to hold due to the instability of the window. Interview with the resident who resided in bedroom #1 on 06/02/21 at 12:19pm revealed: -She had not noticed the window did not close. -She had not told anyone the window did not close. -She hoped no bugs could come in the opening.	{C 074}		

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{C 074}	Continued From page 9 Observation of bedroom #4 on 06/02/21 at 9:05am revealed there was a patched area on the wall over the bed that was not sanded and painted. Observation of the wall in the kitchen on 06/02/21 8:49am revealed: -There was a 2-inch square hole in the wall above a deep freezer. -There were dried brown drips on the side of the deep-freezer. Interview with Supervisor-in-Charge (SIC) on 06/02/21 at 9:11am revealed: -All staff vacuumed and cleaned. -She vacuumed last on 05/31/21. -The carpet was cleaned last month by an outside cleaning service. -She thought the carpet would be cleaned monthly by the outside cleaning service. -She did not see the outside cleaning service clean the walls or ceiling. -They cleaned the windows seals, windows, and floors. -She had not noticed that the ceiling needed cleaning. -She did not know who was responsible for cleaning the ceiling. -She was responsible for cleaning the floors, the kitchen, and wiping down the furniture. -The third shift staff did the heavy-duty cleaning. -Someone had repaired the holes in the walls, but the hole behind the freezer had been missed. -Someone had repaired the linoleum, but the residents' chairs kept tearing the linoleum. -She had not noticed the threshold not being flush with the floor and thought a resident's chair may have been slid back too hard.	{C 074}		

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{C 074}	Continued From page 10 Interview with a second SIC on 06/02/21 at 6:57pm revealed: -There was a contracted cleaning service that cleaned; they were at the facility two weeks ago. -She knew they cleaned the carpet and wiped down the walls, but she did not know what else they did. -She had not noticed the walls in the hall were dirty with dried brown and black splatters and drips. -She had not noticed resident bedroom #3's walls had spider webs in the corners and around the ceiling. -The windows would not stay opened, so the residents propped them open. -She knew a SIC closed the windows at night in the common areas, but she was not sure if the residents closed their own windows. Telephone interview with the facility's landlord on 06/04/21 at 9:54am revealed: -She was going to replace the windows, but it would be next month before she had the funds to do so. -She was aware of the window being propped open. -She was not responsible for the linoleum repair and thought it continued to get damaged because the chairs needed to be replaced. -The Administrator was responsible for the linoleum repair. -The facility needed a very good cleaning; the facility staff were responsible for cleaning. -The metal was placed on the wall because a previous resident was always damaging the wall with their wheelchair. -She was concerned because a resident could cut their leg on the metal. Telephone interview with Administrator on	{C 074}		

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{C 074}	Continued From page 11 06/04/21 at 1:39pm revealed: -She had contracted a cleaning service to clean the facility in April 2021. -She told the contracted cleaning service not to come in May 2021. -The cleaning services cleaned the ceiling and walls. -The cleaning services repaired the walls and floors. -She did not know why there was a piece of metal attached to the wall and the corner was bent out. -She had not seen the bent metal; "someone must have fallen against it." -She did not know the floor tiles were torn because she had not been to the facility in the past two weeks. -The floor tiles had been replaced multiple times. -Staff should be cleaning the facility in-between the cleaning service.	{C 074}		
{C 100}	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by:	{C 100}		

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{C 100}	Continued From page 12 Based on observations, interviews, and record reviews, the facility failed to ensure at least four fire drills were performed each year. The findings are: Review of the fire and disaster drill log revealed the last documented fire drill was conducted on 10/22/20 at 1:00pm and six residents took three minutes to evacuate the facility. Interview with a resident on 06/02/21 at 7:30pm revealed they had not had a fire drill in so long she could not remember the last time one was done. Interview with the Supervisor-in-Charge (SIC) on 06/021/21 at 9:11am revealed: -She had not been trained on fire safety. -She was not trained on how to perform fire drills and did not know how to complete a fire drill. -She asked the Administrator if someone could do a fire drill and let her observe so she would know what to do and she had not heard anything further. -She had not had training on the use of a fire extinguisher. Telephone interview with the facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed: -Fire drills had been an ongoing issue. -It had been ages since a fire drill had been done. -If there was an actual fire, the SIC would have to provide a lot of assistance to the residents. -It was concerning because there were multiple residents who smoked, and one resident was known to smoke in his room. -Another resident who had dementia, had been caught with a lighter and cigarettes in her room multiple times.	{C 100}		

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{C 100}	Continued From page 13 Telephone interview with the Administrator on 06/04/21 at 2:45pm revealed: -Fire drills were supposed to be conducted once a month and documented. -She had instructed the SIC where to go in case of a fire but had not taught the SIC how to perform fire drills.	{C 100}		
{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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to ensure 3 of 3 staff sampled (Staff A, B, C) were tested for tuberculosis (TB) disease	{C 140}		

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{C 140}	Continued From page 14 in compliance with control measures adopted by the Commission for Health Services upon hire. The findings are: 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 02/04/21. -There was no documentation Staff A had a TB skin test administered. . Interview with Staff A on 06/02/21 at 12:21pm revealed: -She had a TB skin test in February 2021. -She gave the TB skin test results to the Administrator. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -Everyone should have had their TB skin test. -Staff A "came in the door with one." -The TB skin test results should be in the personnel record at the facility. Documentation of Staff A's TB test was requested on 06/02/21 but was not provided by survey exit. 2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: -There was documentation Staff B had a TB skin test administered on 09/14/20 and read as negative on 09/17/20. -There was documentation Staff B had a second TB skin test administered by a Registered Nurse (RN) on 10/02/20 and read as negative on 10/05/20. -There was no documentation of any other TB skin test results. Telephone interview with Staff B on 06/04/21 at	{C 140}		

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{C 140}	Continued From page 15 10:26am revealed: -She had been working at the facility as a medication aide for a "little over a year." -She had not had a TB test in September 2020 or October 2020 but she had a TB test a couple of months ago. -She did not recall the date of the TB test. Telephone interview with the facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed she had administered Staff B's TB skin test on 04/04/21 and the test was read as negative. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -Everyone should have had their TB skin test. -Staff B's TB skin test results should be in the personnel record at the facility. Documentation of Staff B's TB test was requested on 06/02/21 but was not provided by survey exit. 3. Review of the facility's personnel records revealed there was no record for Staff C, Supervisor-in-Charge (SIC) in the facility. Interview with Staff C on 06/02/21 at 5:40pm revealed: -She had been working at the facility as a medication aide (MA) for about 3-4 weeks (she did not recall her start date). -She had not had a TB test since she started to work at the facility, but she had one a "couple" of months ago while she was an employee at another adult care home. -The Administrator was supposed to obtain copies of her TB test from her previous employer. Telephone interview with the facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed she	{C 140}		

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{C 140}	Continued From page 16 had not administered a TB skin test on Staff C. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -Everyone should have had their TB skin test. -Staff C's TB skin test results should be in the personnel record at the facility. Documentation of Staff C's TB test was requested on 06/02/21 but was not provided by survey exit. _____ The facility failed to ensure 3 of 3 staff had a negative TB skin tests and the results were on file at the facility which placed the residents at increased risk for exposure to and transmission of tuberculosis disease. The facility's failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type Unabated B Violation. _____ A plan of protection was provided to the facility on 06/03/21.	{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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B	{C 145}		

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{C 145}	Continued From page 17 Violation was abated. Noncompliance continues. Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of the facility's personnel records revealed there was no record for Staff C, Supervisor-in-Charge (SIC) in the facility. Interview with Staff C on 06/02/21 at 5:40pm revealed: -She had been working at the facility as a SIC for about 3-4 weeks (she did not recall her start date). -She did not know what a HCPR was or if one had been completed on her. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -Staff C's HCPR results should be in the personnel file at the facility. -She absolutely checked Staff C's HCPR. Documentation of Staff C's HCPR was requested on 06/02/21 but was not provided by survey exit.	{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.	{C 147}		

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{C 147}	Continued From page 18 131D-40; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 sampled staff (Staff C) completed a statewide criminal background check prior to hire. The findings are: Review of the facility's personnel records revealed there was no record for Staff C, Supervisor-in-Charge (SIC) in the facility. Interview with Staff C on 06/02/21 at 5:40pm revealed: -She had been working at the facility as a SIC for about 3-4 weeks (she did not recall her start date). -She did not know if a criminal background had been completed on her. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -Staff C's criminal background results should be in the personnel record at the facility. -She completed a background check on Staff C. Documentation of Staff C's background check was requested on 06/02/21 but was not provided by survey exit.	{C 147}		
{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	{C 185}		

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{C 185}	Continued From page 19 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: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules for family care homes related to infection prevention, supervision, health care; outside entrances and exits, test for tuberculosis, and adult care home medication aide training and competency evaluation requirements. The findings are: Interview with a resident on 06/02/21 at 9:04am revealed she had not seen the Administrator since last month when the Administrator accompanied her to a court appointment. Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 9:28am revealed: -The Administrator was usually at the facility once a month.	{C 185}		

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{C 185}	Continued From page 20 -The Administrator had been at the facility in May 2021 to take a resident to a court appointment; she had not seen the Administrator since then. Interview with a second SIC on 06/02/21 at 5:40pm revealed she had been working at the facility for 3-4 weeks and had never met the Administrator. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -She had not been to the facility for a couple of weeks because she had been sick. -Prior to that, she had been going to the facility weekly. -She went usually on weekdays, and it may be in the morning or nights, whenever her scheduled allowed her to go. Noncompliance was identified at violation level in the following rule areas: 1. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors had an alarm that was activated and sounded when the doors were opened to alert staff for 1 of 1 resident (#1), who had a diagnosis of dementia and was known to wander into the community unsupervised. [Refer to tag C0069, 10A NCAC 13G. 0312(g) Outside Entrances and Exits. (Unabated Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure 3 of 3 staff sampled (Staff A, B, C) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services upon hire. [Refer to tag C0140, 10A NCAC 13G. 0405(a) Test for Tuberculosis (Unabated Type B Violation)].	{C 185}		

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{C 185}	Continued From page 21 3. Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 staff sampled (Staff C) who administered medications had completed the medication clinical skills competency validation prior to administering medications and 3 of 3 sampled staff had successfully completed the required state examination (Staff A, B, C). [Refer to tag C935, G.S. 131D-21 4.5B(b) Adult Care Home Medication Aide Training and Competency (Continuing Unabated Type B Violation)]. 4. Based on interviews and record reviews, the facility failed to ensure the primary care provider (PCP) and mental health provider was notified for 1 of 3 sampled residents related to multiple missed medications including blood pressure medication, diabetic medication, and psychiatric medication (#1) and not scheduling a follow-up appointment with the primary care provider for 2 of 3 sampled residents. [Refer to tag 246 10A NCAC 13G .0902 (b) Healthcare (Type B Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 2 of 2 sampled residents (Resident #1 and Resident #2) with orders for finger stick blood sugar (FSBS) checks twice daily (#1, #2); and monthly BP checks (#2) . [Refer to tag 249 10A NCAC 13G .0902 (c)(3-4) Healthcare (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for	{C 185}		

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{C 185}	Continued From page 22 2 of 2 sampled diabetic residents (#1, #2) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. [Refer to Tag D932, G.S. 131D-4.4A(b)(1) Adult Care Home Infection Prevention Requirements (Type A2 Violation)]. 7. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs and current symptoms for 2 of 3 sampled residents (Residents #1, #4) related to Resident #1 who was reported missing to local law enforcement and was known to leave the facility unsupervised to go into the community who had a history of falls and was known to seek rides, food, money, and cigarettes from unknown individuals (#1) and a resident who was smoking inside the facility (#4).[Refer to tag C0243, 10A NCAC 13G. 0901(b) Personal Care and Supervision (Unabated Type A2 Violation)]. _____ The Administrator failed to ensure the overall management, operations, and policies of the facility were implemented by failing to ensure Resident #1, who wandered and was adjudicated incompetent, leaving the facility unsupervised on multiple occasions without staff knowing her whereabouts; outside entrances had an alarm that was activated and sounded when opened to alert staff that Resident #1 had left the facility; and a medication who had no been validated on the medication clinical skills checklist and medication aides who were administering medications had not passed the written medication test; not assuring the facility had supplies for the residents to have their blood pressure (BP) checked and finger stick blood sugar (FSBS) checked, resulting in staff sharing glucometers and BP's not being checked, not	{C 185}		

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{C 185}	Continued From page 23 assuring the primary care provider (PCP) and mental health provider were aware of a residents refusals of medications and missed follow-up appointments; and staff qualifications related to testing for tuberculosis and were completed upon hire for staff. This failure of the Administrator resulted in substantial risk for serious physical harm and neglect of the residents' which constitutes a Unabated Type A2 Violation. _____ The facility was provided a plan of protection in accordance with G.S. 131D-34 on 06/03/21 for this violation.	{C 185}		
{C 243}	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs and current symptoms for 2 of 3 sampled residents (Residents #1, #4) related to Resident #1 who was reported missing to local law enforcement and was known to leave the facility unsupervised to go into the community who had a history of falls and was known to seek rides, food, money, and cigarettes from unknown individuals	{C 243}		

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{C 243}	Continued From page 24	{C 243}		

(#1) and a resident who was smoking inside the facility (#4).

The findings are:

1. Review of Resident #1's current FL-2 dated 03/08/21 revealed:
-Diagnoses included dementia, brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension, and hyperlipidemia.
-Resident #1 was intermittently disoriented.
-Resident #1 was a wanderer.

Review of Resident #1's Resident Register revealed:
-There was an admission date of 09/23/20.
-Resident #1 had a guardian.

Review of Resident #1's Care Plan dated 10/08/20 revealed:
-She was sometimes disoriented, forgetful, and needed reminders.
-Resident #1 had wandering, disruptive, and socially inappropriate behaviors.
-Resident #1 had slurred speech.
-There were no interventions to address behaviors or supervision needs.

Review of Resident #1's primary care physician's (PCP)'s visit note dated 03/18/21 revealed Resident #1 should be supervised when leaving the facility for safety reasons.

Review of Resident #1's PCP's visit note dated 04/13/21 revealed Resident #1 should be supervised when leaving the facility due to recurrent falls.

Review of Resident #1's mental health provider's visit summary dated 04/05/21 revealed:

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{C 243}	Continued From page 25 -Chief complaint for the visit was behaviors and falls. -Resident #1 was in the emergency department at the local hospital due to falls. -Resident #1 had a tendency to wander off the premises. -It was not clear if Resident #1 was confused or disoriented or if it was manipulative behavior. -Resident #1's insight and judgment were poor. Review of Resident #1's licensed health professional support (LHPS) review and evaluation report dated 05/03/21 revealed: -Resident #1 had a decline in her cognition and had engaged in several unsafe incidents since the last assessment. -Resident #1 was at local stores or the neighbors. -The police were called on several occasions and were asked to look for the resident and return the resident to the facility for her safety. -Resident #1 had left the home and fallen on several occasions. -Resident #1 had a documented 17 falls since the last evaluation on 01/12/21. Review of staff notes dated April 2021 and May 2021 revealed: -On 04/18/21, Resident #1 was not at the facility when she arrived to work. The resident came back about 5:30pm there was no documentation as to what time she left the facility. -On 04/26/21, Resident #1 "walked off" at 7:00pm and returned with a lighter and cigarettes. The lighter was removed but the resident still had the cigarettes. -On 04/30/21, Resident #1 left the facility without permission after lunch. -On 05/01/21, Resident #1 left the facility twice without permission there was no documentation as to what time she left the facility.	{C 243}		

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{C 243}	Continued From page 26 -On 05/05/21, Resident #1 left the facility at 2:50pm and the Administrator was notified. Resident #1 returned at 3:30pm with food. -On 05/08/21, Resident #1 left the facility twice to go to the house next door. -On 05/10/21, Resident #1 left the facility without permission twice and the Administrator was notified. -On 05/10/21, Resident #1 was out of the facility when the MA arrived and did not return until 8:00pm (the time was not documented). -On 05/15/21, Resident #1 was gone all day and refused to have her temperature checked when she returned and left again. The Administrator instructed the medication aide (MA) to not allow Resident #1 back into the facility until she agreed to have her temperature checked. -On 05/19/21, Resident #1 had been missing for a while (the time was not documented). -On 05/19/21, Resident #1 left the facility and did not eat dinner (the time was not documented). -On 05/26/21, Resident #1 was gone from 7:20am-12:00pm, and the police were notified. She returned, stayed about 30 minutes, and left again for a "few hours." -On 05/26/21, Resident #1 left the facility twice but came "right back." and then left again around 7:00pm and did not return until after 9:00pm. Resident #1 fell out of the bed and emergency medical services (EMS) was called to the facility. -On 05/28/21, Resident #1 returned to the facility after 8:00pm and was gone since he arrived at the facility for his shift (the time was not documented). -On 05/29/21, the police were called because Resident #1 left the facility (the time was not documented). -On 05/29/21, Resident #1 returned to the facility at 7:00pm and was gone since he arrived at the facility for his shift. (the time was not	{C 243}		

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documented).
-On 05/31/21, Resident #1 returned to the facility at 5:30pm; there was no documentation as to what time she left the facility.

Review of local law enforcement reports revealed:
-On 04/30/21, the police were called at 1:57pm for a missing person. The resident had been gone for two hours. She was located next door on the neighbor's porch at 2:03pm.
-On 05/26/21, the police were called at 11:00am for a missing person. The resident had been gone since 7:15am. The resident returned to the facility on her own at 11:45am.
On 05/26/21, the police were called at 9:09pm for a missing person who had been gone for over an hour. The resident returned during the 911 call.

Review of the facility's sign in and out log revealed:
-On 04/30/21, Resident #1 signed out of the facility at 3:00pm with destination documented as next door. There was no return time listed.
-On 05/01/21, Resident #1 signed out of the facility at 12:33pm with destination documented as next door. The return time was 1:00pm.
-On 05/01/21, Resident #1 signed out of the facility at 6:40pm with destination documented as next door. The return time was 7:00pm.
-There was no other documentation Resident #1 signed out of the facility in April 2021 and May 2021.

Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 9:11am revealed:
-She received a call at the facility from a local store on 05/31/21 that Resident #1 was begging other patrons for money.
-Resident #1 had memory problems that "comes

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and goes."
-The local police department was familiar with Resident #1.
-She had been told by the Administrator if Resident #1 was gone for more than an hour to call the police.
-She was concerned about Resident #1 being unsupervised in the community.
-She had witnessed Resident #1 flag cars down in the street in front of the facility.
-Resident #1 would not respond when trying to get her to stop this behavior.
-Resident #1 came back to the facility with money all the time.
-Resident #1 got into cars with people she did not know.
-The local police department had advised Resident #1 to not go to a neighbor's house because it was known for illicit activity.
-Resident #1 needed to be watched constantly but it was hard because the other residents had needs as well.
-She was concerned about who Resident #1 was with and what she was doing.

Interview with Resident #1 on 06/02/21 at 5:41pm revealed:
-She left the facility because she was bored.
-She liked to go shopping and would leave the facility to go to named local stores.
-The Administrator would tell her she would take her shopping, but she never did.
-She had not been to the neighbor's house lately because "Jesus told me not to because the neighbor was not my friend."
-The local police were at the facility about a week ago because she had left the facility at 8:30am and did not return until 3:00pm.
-She was at the local stores shopping and ate lunch at a store that had hot dogs and Chinese

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food.
-She fell coming from the neighbor's house (in the last couple of days) and had sustained a bruise on the inner thigh of her right leg, but she did not tell anyone at the facility about the fall.

Review of the Adult Home Specialist (AHS) with the Department of Social Services (DSS) reports revealed:
-On 4/19/21 at 8:42am, the AHS received a telephone call from the DSS on-call worker that a call was received on 04/17/21 reporting Resident #1 was walking in the middle of the road trying to flag cars down.
-On 05/24/21 at 12:39pm, the AHS received a call from a community resident with concerns regarding resident #1. The caller picked Resident #1 walking and took her to the laundromat.
-On 05/28/21 at 8:15am, the AHS was approached by another DSS employee who had observed Resident #1 walking from the facility; she was walking unsteadily and shaking really bad.

Telephone interview with the facility's contracted Registered Nurse (RN) on 06/03/21 at 12:06pm revealed:
-She completed Resident #1's LHPS assessment on 05/03/21.
-Resident #1 was not able to safely leave the facility unsupervised because of her mental and physical condition.
-Resident #1 could hurt herself because she did not comprehend danger or safety.
-If Resident #1 was out of the facility for more than an hour the police were to be notified as directed by the Administrator.
-The Administrator was aware of her concerns about Resident #1 leaving the facility unsupervised.

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{C 243}	Continued From page 30 Telephone interview with Resident #1's PCP on 06/04/21 at 12:30pm revealed: -Resident #1 needed to be supervised at all times because she was at risk for falling or becoming hyperglycemic (high blood sugar) or hypoglycemic (low blood sugar). -Resident #1 could "fall in harm's way" if she was not supervised. -If Resident #1 was out of the facility in the community she needed to be supervised. Telephone interview with Resident #1's mental health provider on 06/04/21 at 11:31am revealed: -Resident #1 had poor insight and poor judgment that could put the resident in danger. -Resident #1 had also had recent falls. -Resident #1 needed to be supervised at all times. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -The staff were supposed to call 911 and report Resident #1 as missing when she was gone for one hour and had not returned. -Resident #1 "wants to do what she wants to do." -The local police department had not been helpful in trying to keep Resident #1 from leaving the home because they could not enforce the facility rules. -She told Resident #1 she did not want the police to "lock her up" and she explained the dangers of Resident #1's behaviors to her. -She provided the facility staff with guidance on what to do if Resident #1 wanted to leave the facility such as to try to redirect Resident #1 if she wanted to leave. -She could not impede Resident #1's rights. -She asked the neighbors to not entertain "her residents."	{C 243}		

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{C 243}	Continued From page 31 -Resident #1 got in cars with strangers and went to other people's homes in the neighborhood that she should not go to. -She was concerned Resident #1 did not recognize situations as being unsafe. Attempted telephone interview with Resident #1's guardian on 06/04/21 at 8:52am was unsuccessful. 2. Review of Resident #4's FL-2 dated 02/09/21 revealed diagnoses included schizophrenia, diabetes mellitus, hypertension, nicotine dependency, depression, glaucoma, Bell's palsy, and a communicable blood borne pathogen. Review of Resident #4's Care Plan dated 02/19/20 revealed: -He had social and mental health history and substance abuse rehabilitation in 2008. -He had been clean and sober since 2010. Review of a document in Resident' #4's record titled Use of Tobacco dated 03/01/17 revealed: -Resident must smoke in designated areas. -No smoking was allowed in the facility -First occurrence of smoking in the facility was a verbal warning. -Second occurrence of smoking in the facility was a written warning. -Third occurrence of smoking in the facility would be a 30-day notice of discharge. -The document was not signed by Resident #4. Review of Resident #4's Smoker's Agreement dated 01/01/18 revealed: -The document was signed by Resident #4. -There would be a two-dollar fine for smoking inside the facility. -There was a statement that read it was against	{C 243}		

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{C 243}	Continued From page 32 the law to smoke in the facility. Review of a document in Resident #4's record titled Warning and Breaking the [House] rules protocol dated 03/01/17 revealed: -Resident #4 did not sign the document. -The first offense for breaking house rules was a verbal warning, the second offense was a written warning and upon the third offense the resident would be given a 30-day discharge notice. Review of Resident #4's care notes revealed Resident #4 was still smoking in the building; smoke could be smelled in the hallway. Observation on 06/02/21 at 8:46am revealed: -Resident #4 could be heard coughing behind the closed door of his room. -There was a strong smell of something burning or smoke at Resident #4's door, which was closed. -Upon entrance, Resident #4 was in the room alone. -He was seated slightly up on the bed with a fleece cover pulled up to his neck. -The room had a strong scent of smoke as if something was burning. Interview with Resident #4 on 06/02/21 at 8:47am revealed he had not been smoking in his room because residents were not allowed to smoke in the facility. Interview with a Supervisor-in-Charge (SIC) on 06/02/21 at 8:49am revealed: -Residents were not allowed to smoke in their rooms. -Resident #4 was caught smoking in his room frequently. -Staff documented and called the Administrator	{C 243}		

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{C 243}	Continued From page 33 each time Resident #4 was caught smoking in his room. -The Administrator talked to Resident #4 about each occurrence. -Resident #4 had not had any substance abuse treatments since employment. Observation of Resident #4 on 06/02/21 at 12:20pm revealed: -Resident #4 left the dining room table from lunch and walked to his room -Resident #4 was heard coughing behind the closed bedroom door. -There was a strong smell of cigarette smoke coming from Resident #4's room. -Resident #4's room was filled with cigarette smoke with a strong smell. -Resident was seated in front of the window that was down. Interview with a second SIC on 06/02/21 at 4:21pm and 4:51pm revealed: -Resident #4 smoked in his room. -She smelled smoke from Resident #4's room. -Someone had called the facility before to ask why there was a man hanging out the window (she did not recall the date); Resident #4 was hanging out the window. -She documented each smoking occurrence and notified the Administrator. -The Administrator would talk to Resident #4 after each occurrence. Interview with a third SIC on 06/02/21 at 5:40pm revealed: -She often smelled smoke in the hallway. -She had not observed Resident #4 smoking in his room. -No Resident was allowed to have smoking paraphernalia in their room.	{C 243}		

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{C 243}	Continued From page 34 -She would contact the Administrator if she caught anyone smoking. Telephone interview with the facility's contracted Registered Nurse (RN) on 06/03/21 at 12:06pm revealed: -She heard about Resident #4. -She knew Resident #4 signed some documents about not smoking in the facility. -Her biggest concern was there was another resident whose room was located in close proximity to Resident #4, who had asthma, and the smoke could affect the resident's breathing. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -She was not aware Resident #4 had been smoking in his room lately. -She routinely checked the staff's daily documentation to see if Resident #4 had been reported as smoking in the facility. -She had not read any notes about Resident #4 smoking in the facility, but she had not been to the facility in the past two weeks. -In the past, she reminded and redirected Resident #4 about not smoking in the facility. -She spoke to Resident #4 on the telephone a "couple of days ago" and when she asked him if he had been smoking in the facility and he denied it. Refer to Tag C011 10A NCAC 13G .0316 Fire Safety and Disaster Plan _____ The facility failed to provide supervision to Resident #1 who was adjudicated incompetent and appointed a guardian, had a diagnosis of schizophrenia, was intermittently disoriented, and had a history of wandering behaviors resulting in the resident leaving the facility unsupervised on	{C 243}		

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{C 243}	Continued From page 35 multiple occasions to wander in the community 18 times in 33 days without staff knowing her whereabouts for as long as six hours; Resident #4 who had a history of smoking inside the facility, unsupervised in his bedroom, had multiple times noted that the resident continued to smoke in the facility and his room was observed filled with smoke on 06/02/21. The facility did not practice fire drills and there was a resident with asthma whose room was in close proximity to the resident who smoked. These failures placed the residents at substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ A plan of protection was provided to the facility in accordance with G.S. 131D-34 on 06/03/21 for this violation.	{C 243}		
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 B VIOLATION Based on interviews and record reviews, the facility failed to ensure the primary care provider (PCP) and mental health provider was notified for 1 of 3 sampled residents related to multiple missed medications including blood pressure medication, diabetic medication, and psychiatric medication (#1) and not scheduling a follow-up appointment with the primary care provider for 2 of 3 sampled residents.	C 246		

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C 246	Continued From page 36 The findings are: Review of the facility's medication administration policy and procedure manual revealed if a resident was routinely refused medication the prescribing provider should be notified. 1. Review of Resident #1's current FL-2 dated 03/02/21 revealed diagnoses included dementia, brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension, and hyperlipidemia. a. Review of Resident #1's mental health provider's orders revealed: -There was an order dated 04/05/21 for Amantadine (used to treat tremors) 100mg twice daily. -There was an order dated 04/05/21 for Divalproex 500mg (used for bipolar disorder) 500mg twice daily -There was an order dated 04/09/21 Haloperidol (a medication used to treat symptoms of psychosis) 2mg twice daily. -There was an order dated 03/02/21 for Citalopram (used to treat depression) 20mg daily. Review of Resident #1's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Amantadine 100mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was an entry for Divalproex 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was an entry for Haloperidol 2mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was an entry for Citalopram 20mg daily	C 246		

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with a scheduled administration time of 8:00am.
-There was documentation Resident #1 refused Amantadine 100mg, Divalproex 500mg, Citalopram 20mg, and Haloperidol 2mg at 8:00am on 05/03/21, 05/09/21, 05/14/21, 05/15/21, 05/23/21, 05/25/21, 05/26/21, 05/27/21, and 05/31/21.

Interview with a Supervisor-in-Charge on 06/02/21 at 3:24pm revealed:
-She was on a virtual visit with Resident #1 and her mental health provider about 1.5 months ago.
-She reported to the mental health provider Resident #1 had been refusing to take her medication.

Telephone interview with Resident #1's mental health provider on 06/04/21 at 11:31am revealed:
-She was not aware Resident #1 was refusing her medications.
-The concerns for refusing these medications would be safety decompensation, stopping the medication abruptly.
-Without proper administration of medication, Resident #1 would be at risk for increased aggression, disruptive sleep pattern, and labile mood (rapid, often exaggerated changes in mood).
-It would be difficult to determine the effectiveness of the medication if Resident #1 was taking not the medication as prescribed.
-If Resident #1 continued to refuse her oral medication she would need to consider doing an injection instead.

Interview with the same Supervisor-in-Charge (SIC) on 06/02/21 at 3:24pm revealed:
-She told the Administrator when Resident #1 refused to take her medication.
-She had not called the PCP or mental health

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C 246	Continued From page 38 provider and was never told she should call the PCP or mental health provider to report when Resident #1 refused to take her medications. Interview with Resident #1 on 06/02/21 at 5:41pm revealed: -She did not refuse to take her medication. -Her medication was scheduled for 8:00am and she was asleep at 8:00am. -When she got up, usually between 11:00am-12:00pm, she would ask for her medication but the SIC would tell her it was too late to take the medication. -She did not know if her PCP or mental health provider knew she was missing her medications or not. Telephone interview with the facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed: -She had been "told a couple of times" that Resident #1 had refused to take her medications, but it was usually once a month. -She was not aware Resident #1 had refused her medications multiple times. -If Resident #1 refused her medications 2-3 days in a row the PCP or mental health provider should have been notified. -If she had known Resident #1 refused her medications, she would have notified the PCP or mental health provider herself or directed the SIC to notify the PCP or mental health provider. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -She was notified of Resident #1's refusals and it was documented on the eMAR. -She would tell the SIC to try every 15 minutes up to one hour to administer Resident #1's medications. -Resident #1's PCP or mental health provider	C 246		

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would be notified of the resident's "next appointment."
-The RN would be responsible for notifying the PCP or mental health provider at the appointment.
-The RN should have notified Resident #1's PCP or mental health provider.

b. Review of Resident #1's primary care provider's orders revealed:
-There was an order dated 03/02/21 for Amlodipine (used to treat blood pressure) 5mg daily.
-There was an order dated 03/02/21 for Aspirin (used to promote heart health) 81mg daily.
-There was an order dated 03/02/21 for Fluticasone (used to treat allergies) spray 1 spray in both nostrils twice daily.
-There was an order dated 03/20/21 for Glipizide (used to treat diabetes) 10mg daily.
-There was an order dated 04/01/21 for Lispro (used to treat diabetes) 100 unit pen to be used with the following sliding scale; check finger stick blood sugar (FSBS) twice a day and cover with a sliding scale of 150-200=2 units (u), 201-250=6u, 251-300=8u, 301-350=10u, >351=call PCP.
-There was an order dated 04/01/21 for Metformin ER (used to treat diabetes) 500mg twice daily.
-There was an order dated 01/05/21 for Metoprolol ER (used to treat high blood pressure) 50mg daily.

Review of Resident #1's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine 5mg daily with a scheduled administration time of 8:00am.
-There was an entry for Aspirin 81mg daily with a scheduled administration time of 8:00am

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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 40 -There was an entry for Fluticasone twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was an entry for Glipizide 10mg daily with a scheduled administration time of 8:00am. -There was an entry for Lispro twice daily with a sliding scale of 150-200=2u, 201-250=6u, 251-300=8u, 301-350=10u, >351=call PCP with a scheduled administration time of 8:00am and 8:00pm. -There was an entry for Metformin ER 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was an entry for Metoprolol ER 50mg daily with a scheduled administration time of 8:00am. -There was documentation Resident #1 refused her Amlodipine 5mg, Aspirin 81mg, Fluticasone, Glipizide 10mg, Metformin 500mg, and Metoprolol 50mg at 8:00am on 05/03/21, 05/09/21, 05/14/21, 05/15/21, 05/23/21, 05/25/21, 05/26/21, 05/27/21, and 05/31/21. -There was documentation Resident #1 refused her Lispro and FSBS at 8:00am on 05/01/21-05/03/21, 05/06/21-05/07/21, 05/09/21, 05/11/21-05/31/21 and 8:00pm on 05/02/21, 05/10/21-05/11/21, 05/14/21-05/16/21, 05/18/21-05/26/21, 05/28/21-05/31/21. Telephone interview with Resident #1's PCP's medical assistant on 06/03/21 at 9:43am revealed: -The PCP had not been notified of Resident #1's medication refusals. -If Resident #1 was refusing to take her medications as ordered, the PCP would have wanted to know why she was refusing and would figure out a way to get the resident back in compliance with her medication. -The PCP was always concerned when a resident refused medication.	C 246		

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C 246	Continued From page 41 -There was concern Resident #1 was refusing to take her medications because the resident had a history of high blood pressure and diabetes and if she was not taking her medication, she was at risk for strokes, hypoglycemia, and hyperglycemia, as well as the long term effects on the resident's kidneys. Review of Resident #1's progress notes for May 2021 revealed there was no documentation the PCP had been notified of Resident #1's medication and treatment refusals. Interview with a Supervisor-in-Charge (SIC) on 06/02/21 at 3:24pm revealed: -She told the Administrator when Resident #1 refused to take her medication. -She had not called the PCP or mental health provider and was never told she should call the PCP or mental health provider to report when Resident #1 refused to take her medications. Interview with Resident #1 on 06/02/21 at 5:41pm revealed: -She did not refuse to take her medication. -Her medication was scheduled for 8:00am and she was asleep at 8:00am. -When she got up, usually between 11:00am-12:00pm, she would ask for her medication but the SIC would tell her it was too late to take the medication. -She did not know if her PCP or mental health provider knew she was missing her medications or not. Telephone interview with the facility's contracted Registered Nurse (RN) on 06/03/21 at 12:06pm revealed: -She had been "told a couple of times" that Resident #1 had refused to take her medications,	C 246		

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but it was usually once a month.
-She was not aware Resident #1 had refused her medications multiple times.
-If Resident #1 refused her medications 2-3 days in a row, the PCP or mental health provider should have been notified.
-If she had known Resident #1 refused her medications, she would have notified the PCP or mental health provider herself or directed the SIC to notify the PCP or mental health provider.

Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed:
-She was notified of Resident #1's refusals and it was documented on the eMAR.
-She would tell the SIC to try every 15 minutes up to one hour to administer Resident #1's medications.
-Resident #1's PCP or mental health provider would be notified at the resident's "next appointment."
-The RN would be responsible for notifying the PCP or mental health provider at the appointment.
-The RN should have notified Resident #1's PCP or mental health provider.

c. Review of Resident #1's primary care provider's (PCP) visit summary dated 04/13/21 revealed Resident #1 was to follow-up in one month.

Review of Resident #1's emergency services (EMS) reports revealed:
-Resident #1 had a fall on 04/16/21 and was transported to the emergency department (ED).
-Resident #1 had a fall on 05/10/21 and was not noted to have any injuries and refused transport to the ED.
-Resident #1 had a fall on 05/13/21, had a blood

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pressure reading of 162/102 and a second blood pressure reading of 140/100, but refused transport to the ED.
-Resident #1 had a fall on 05/26/21, and was not noted to have any injuries and refused transport to the ED.

Interview with Resident #1 on 06/02/21 at 5:41pm revealed she did not recall when she last saw her PCP or mental health provider or when she was supposed to see the PCP or mental health provider again.

Telephone interview with Resident #1's PCP medical assistant on 06/03/21 at 9:43am revealed:
-Resident #1 was seen by the PCP on 04/13/21 for a follow-up after an ED visit and multiple changes in the resident's condition including falls, weakness, ambulation, and increased lethargy.
-Resident #1 was supposed to have a follow-up visit with the PCP in one month.
-Resident #1 had not been in to see the PCP since 04/13/21.
-Staff at the facility were responsible for scheduling all follow-up visits with the PCP.
-It was concerning Resident #1 had not had a follow-up with the PCP because the resident had multiple problems that needed to be monitored including multiple falls and ED visits.

Telephone interview with the facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed:
-She did not know what happened to Resident #1's follow-up with her PCP.
-She had been "running up and down the road" for five weeks straight taking Resident #1 to appointments.
-If the visit summary for a follow-up was not in Resident #1's record, then "it did not happen."

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C 246	Continued From page 44 Telephone interview with the Administrator on 06/04/21 at 2:45pm revealed: -She was not aware Resident #1 should have had a one-month follow-up with her PCP. -The RN was responsible for scheduling appointments. Review of Resident #2's FL 2 dated 12/30/21 revealed diagnosis of major depressive disorder, Myasthenia gravis,diaphoresis, dyspnea on exertion (Asthma), hypertension, Hypothyroidism, diabetes mellitus. 2. Review of Resident #2's primary care provider's (PCP) visit summary dated 04/09/21 revealed: -Resident #2 was seen by the PCP on 04/09/21 for diabetic management. -Resident #2 was to return for follow-up appointment in two weeks for diabetic management and review of fingerstick blood sugar (FSBS) log. -Resident #2 hemoglobin A1C is 7.9. (a blood test that measures the proteins in your blood that are coated with sugar, normal is less than 5.7) -Resident #2 was instructed to lose weight. -Resident #2 was encouraged to monitor her FSBS and keep a log of readings. -Resident #2 was started on Glipizide (used to decrease blood glucose levels) 10mg by mouth every day and Metformin ER 500mg two tablets by mouth every morning and two tablets by mouth at night. -Resident #2 was to check her FSBS twice a day. Review of Resident #2's emergency medical services (EMS) report dated 04/19/21 revealed: -She was transported to the emergency department (ED) on 04/19/21. -Resident #2 complained of nausea, vomiting,	C 246		

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C 246	Continued From page 45 and abdominal pain. -She was vomiting. Review of Resident #2's ED report dated 04/19/21 revealed: -She was diagnosed with urinary tract infection (UTI) and was to follow-up with the PCP in one to two days. -She was started on Cephalexin (antibiotic used to treat infections) 500mg four times a day for ten days. -She was prescribed Ondansetron (used to treat nausea and vomiting) 8mg three times a day as needed for nausea and vomiting. Review of Resident' #2's PCP visit summary dated 05/04/21 revealed: -Resident #2 was seen by PCP for nausea and vomiting as a follow-up to the ED visit. -Resident #2 continued to have stomach pain, nausea, and vomiting. -Resident #2 complained of pain in her stomach that was worse after she ate. -Resident #2 was referred to GI for a consult and the appointment was scheduled for 06/04/21. -Resident #2 was prescribed Ondansetron (used to treat nausea and vomiting) 4mg tablets, take one tablet by mouth four times a day. -Resident #2 was prescribed Protonix (used to treat reflux) 40mg, take one tablet by mouth daily. Interview with Resident's #2 on 06/02/21 at 9:05am revealed: -She has had nausea and vomiting for several months. -She did not remember when she saw the PCP last. Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 9:30am revealed:	C 246		

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C 246	Continued From page 46 -Resident #2 went to the ED a few weeks ago. -Resident #2 returned with a diagnosis of UTI. -Resident #2 continued to complain of nausea and vomiting. Interview with the facility's contracted Registered Nurse on 06/03/21 at 12:06 revealed: -She was not aware of a follow-up visit for Resident #2 with PCP in two weeks of 04/09/21. -She did not know why Resident #2 did not follow up with PCP. -She was not responsible for taking residents to physician appointments. Observation of Resident' #2 on 06/02/21 at between 12:00pm and 6:00pm. -She did not want to eat lunch. -She ate lunch with the encouragement of staff. -She complained of nausea and vomiting. Telephone interview with Resident #2's PCP medical assistant on 06/03/21 at 9:43am revealed: -Resident #2 was seen by the PCP on 05/04/21 for a follow-up after an ED visit on 04/19/21 due to nausea, vomiting, and abdominal pain. -Resident #2 did not have a follow-up visit with the PCP in one to two days after the visit to the ED on 04/19/21. -Resident #2 did not have a follow-up visit with the PCP in two weeks following the physician's appointment on 04/09/21. -Staff at the facility were responsible for scheduling all follow-up visits with the PCP. -She was concerned Resident #2 had not had a follow-up with the PCP because the resident had uncontrolled diabetes from the 04/09/21 visit and abdominal pain, nausea, vomiting, and UTI from the ED visit on 04/19/21 that needed to be monitored.	C 246		

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C 246	Continued From page 47 Telephone interview with Administrator on 06/04/2021 at 2:45pm revealed: -She was not aware Resident #2 should have had a follow-up in two weeks with her PCP. -The RN was responsible for making the follow-up appointments. _____ The facility failed to ensure physician notification Resident #1's refused psychiatric medications to the mental health provider and missed blood pressure medications and diabetic medications to the primary care provider (PCP) and did not schedule a follow up appointment with the PCP after the resident had four falls and elevated blood pressures; and did not schedule a follow up appointment in 1-2 days with the PCP for Resident #2, who had uncontrolled diabetes and a ED visit for a UTI and nausea and vomiting. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ A plan of protection was provided to the facility in accordance with G.S. 131D-34 on 06/03/21 for this violation.	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.	C 249		

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C 249	Continued From page 48 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 2 of 2 sampled residents (Resident #1 and Resident #2) with orders for finger stick blood sugar (FSBS) checks twice daily (#1, #2); and monthly BP checks (#2) . The findings are: 1. Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included dementia, brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension, and hyperlipidemia. Review of Resident #1's physician's order dated 04/01/21 revealed an order to check Resident #1's finger stick blood sugar (FSBS) twice a day and administer Lispro (used to lower glucose levels) 100 unit pen to be used with the following sliding scale; 150-200=2 units (u), 201-250=6u, 251-300=8u, 301-350=10u, >351=call the primary care provider (PCP). Review of Resident #1's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Lispro twice daily with a sliding scale of 150-200=2u, 201-250=6u, 251-300=8u, 301-350=10u, >351=call PCP with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Resident #1 refused her Lispro and FSBS at 8:00am on 05/01/21-05/03/21, 05/06/21-05/07/21, 05/09/21,	C 249		

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C 249	Continued From page 49 05/11/21-05/31/21 and 8:00pm on 05/02/21, 05/10/21-05/11/21, 05/14/21-05/16/21, 05/18/21-05/26/21, 05/28/21-05/31/21. -There was no documentation Resident #1 needed FSBS supplies. Observation of Resident #1's glucometer's memory revealed there had been no FSBS checks since 05/17/21. Interview with Resident #1 on 06/02/21 at 2:59pm revealed she had not had her FSBS checked in about a month because she did not have any glucometer strips. Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 3:24pm revealed: -Resident #1 had been out of strips for her glucometer for over a week. -She did not use the last glucometer strip, but she had noticed there were no strips available to check Resident #1's FSBS. -She had never ordered FSBS and did not know how to. -She notified the Administrator and the facility's Registered Nurse (RN). Telephone interview with the facility's RN on 06/03/21 at 12:06pm revealed: -She was not aware Resident #1 was out of strips for her glucometer. -The SIC was responsible for ordering supplies. -There would be no way of knowing if Resident #1 needed to be administered insulin if the FSBS were not being checked as ordered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/03/21 at 1:30pm revealed: -A box of 100 strips had been dispensed to the	C 249		

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facility for Resident #1 on 03/18/21.
-There had been no other test strips dispensed.
-She was currently working on a request received today (06/03/21) to refill Resident #1's glucometer strips.

Telephone interview with Resident #1's PCP on 06/04/21 at 12:15pm revealed:
-He was not aware Resident #1's FSBS were not being checked as ordered.
-He expected Resident #1's FSBS to be checked as ordered.
-If Resident #1's FSBS was not checked, the SIC would not know whether the resident's FSBS was high or low and whether to take Lisinopril insulin or not.
-Resident #1's FSBS could go very high or very low and it was important to know whether she needed insulin or not.

Telephone interview with the Administrator on 05/03/21 at 5:09pm revealed:
-No one should run out of supplies.
-She recalled being told a resident was out of strips for the glucometer and she thought it was Resident #1.
-The SIC reported to her the RN had been notified the residents needed strips for their glucometers.
-It was extremely concerning Resident #1 had diabetes and her FSBS was not being checked as ordered due to being out of glucometer supplies.

2. Review of Resident #2's current FL-2 dated 12/30/20 revealed diagnosis of hypertension, diabetes mellitus, hypothyroidism, major depressive disorder, myasthenia gravis, diaphoresis, dyspnea on exertion (asthma).

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C 249	Continued From page 51 a. Review of Resident #2's FL-2 dated 12/30/20 revealed an order for finger stick blood sugar (FSBS) checks weekly. Review of Resident #2's Primary Care Provider (PCP) visit summary dated 04/09/21 revealed: -There was an order for FSBS checks twice a day. -There was an order to document FSBS and bring report of findings to PCP on follow up visit in two weeks. -There was an order to start Glipizide (a medication used to lower blood glucose levels) daily. -There was an order to start Metformin ER (a medication used to lower blood glucose levels) 500mg, two tablets every morning and two tablets every evening. Review of Resident #2's electronic treatment administration record (eTAR) dated April 2021 revealed: -There was an entry to check FSBS weekly. -The weekly FSBS ordered was discontinued on 04/09/21. -There was no documentation of a FSBS from 04/01/21-04/09/21. -There was an entry to check FSBS twice a day started 04/10/21. -There was documentation FSBS were checked 23 out of 42 times from 04/10/21-04/30/21. Review of Resident #2's eTAR dated May 2021 revealed: -There was an entry to check FSBS twice a day. -There was documentation FSBS were checked 22 out of 62 times from 05/01/21-05/31/21. Review of Resident #2's eTAR dated June 2021 revealed:	C 249		

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C 249	Continued From page 52 -There was an entry to check FSBS twice a day. -There was no documentation of a FSBS from 06/01/21-06/02/21. Interview with Resident' #2 on 06/02/21 at 9:05 am revealed she usually had her FSBS checked twice a day. Interview with the Supervisor in Charge (SIC) on 06/02/21 at 11:25am revealed: -Glucometer strips had been out for a couple of weeks. -She told the facility's Registered Nurse (RN) who ordered strips. Telephone interview with facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed: -She was never told they needed glucometer strips for Resident #2. -She was not responsible for ordering glucometer supplies for Resident #2. -The staff should call the pharmacy to order glucometer supplies for Resident #2. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/03/21 at 10:08am revealed: -She had never sent glucometer strips for Resident #2. -She could send them if she had an order. -She sent a box of lancets, 100 count, on 05/26/21 for Resident #2. Telephone interview with the Pharmacist at the previous contracted pharmacy on 06/04/21 at 10:22am revealed: -The last time diabetic supplies were shipped to the facility for Resident #2 was on 09/10/2020. -The glucometer and 50 strips were shipped to facility for Resident #2 on 09/10/20.	C 249		

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C 249	Continued From page 53 -The Pharmacy had not provided services for the facility since 09/10/20. Telephone interview with Resident #2's PCP on 06/04/21 at 12:15 revealed: -He would like FSBS log kept in the facility and brought into office on the visits. -He was concerned about hyperglycemia and hypoglycemia when the FSBS were not being checked. -He would have liked to have known FSBS were not being checked as ordered. Telephone interview with Administrator on 06/03/21 at 5:10pm revealed: -She was unaware that Resident #2 had no glucometer strips. -Staff was to let the RN know they were out of strips so she could order them from the pharmacy. -The facility should never run out of glucometer strips. b. Review of Resident #2's FL-2 dated 12/30/20 revealed an order for monthly blood pressure (BP) checks. Review of Resident #2's PCP visit summary dated 04/09/21 revealed ordered blood pressure monitoring was encouraged. Review of Resident #2's electronic medication administration record (eMAR) dated April 2021 revealed: -There was an entry for a monthly BP. -There was no documented BP reading. Review of Resident #2's eMAR dated May 2021 revealed: -There was an entry for a monthly BP.	C 249		

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C 249	Continued From page 54 -There was no documented BP reading. Interview with a MA on 06/02/21 at 6:30pm revealed there was no working BP cuff in the facility. Telephone interview with the facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed: -She was unaware that there was no working BP cuff in the facility. -The SIC should have known where a working BP cuff was located. -Staff was aware that Resident #2's BP should be obtained. Telephone interview with Resident #2's PCP on 06/04/21 at 12:15pm revealed: -Resident #2 was on BP medication daily. -A record of Resident #2's BP should be kept in the facility. -He had not been notified Resident #2's BP had not been obtained as ordered. Telephone interview with Administrator on 06/03/21 at 5:10pm revealed: -If there was an order for BP to be obtained then the staff should be checking it. -She bought two manual BP cuffs. -She was not aware the BP cuffs were broken. _____ The facility failed to implement orders for FSBS for a resident who had diabetes and was on a sliding scale insulin (#1) and a resident who had uncontrolled diabetes and had physician's orders to take her FSBS twice daily and document the readings (#2); and a resident (#2) who had a diagnosis of hypertension and an order for monthly blood pressure and the facility did not have a working BP cuff. The failure of the facility was detrimental to the health and safety of the	C 249		

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C 249	Continued From page 55 residents and constitutes a Type B Violation. _____ A plan of protection was provided to the facility in accordance with G.S. 131D-34 on 06/03/21 for this violation.	C 249		
{C 270}	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 1 of 2 sampled residents (#1) with physician orders for a diabetic diet. The findings are: Review of Resident #1's current FL-2 dated 03/08/21 revealed: -Diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension, and hyperlipidemia. -Resident #1 did not have a diet ordered. Review of a hospital discharge summary dated 03/29/21 revealed Resident #1 was on a restrictive diabetic diet. Review of Resident #1's primary care provider's (PCP) visit summary dated 04/13/21 revealed:	{C 270}		

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{C 270}	Continued From page 56	{C 270}		

-Please monitor Resident #1's diet.
-Resident #1 should not be allowed to keep snacks in her room because of the new onset of adult diabetes.

Review of Resident #1's neurologist's visit summary dated 04/15/21 revealed:
-Due to the resident's body mass index, educational materials were provided to the resident about healthy eating.
Resident #1 was advised to exercise and lose weight.

Review of Resident #1's mental health provider's visit summary dated 04/29/21 revealed healthy lifestyle practices were discussed with Resident #1 including a healthy diet and regular physical activity.

Observation of the lunch meal service on 06/02/21 at 12:14pm-12:16pm revealed:
-Resident #1 was served approximately one and a half cups of a beef and noodle dish.
-Resident #1 brought her own beverage to lunch.
-Resident #1 are 100% of her meal.

Interview with Resident #1 on 06/02/21 at 12:18pm revealed she was drinking a diet drink.

Observation of Resident #1's room on 06/02/21 at 12:18pm revealed an empty bottle of a diet drink.

Observation of the dinner meal service on 06/02/21 at 5:30pm revealed:
-Resident #1 ate approximately 6 ounces of meat, 1.5 cups of breaded and fried okra, and 1.5 cups of pinto beans.
-Resident #1 had approximately 8 ounces of flavored drink.
-Resident #1 ate approximately 1.5 cups of okra

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{C 270}	Continued From page 57 off another resident's plate. Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 5:45pm revealed: -She did not make the flavored drink, so she did not know how much sugar had been added. -When she made tea, she usually used 2 cups of sugar. Observation of the flavored drink packet revealed the packet would make 2-quarts and sweeten to taste. Interview with Resident #1 on 06/02/21 at 5:41pm revealed: -She was supposed to be on a diabetic diet. -She did not know what a diabetic diet was. -Her PCP told her she needed to lose weight in her belly. Interview with the SIC on 06/02/21 at 12:21pm revealed: -Resident #1 was not supposed to have anything with added sugar. -Sugar-free juices had been offered to Resident #1, but she refused to drink the juices. Interview with the facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed. -Resident #1 was supposed to be on a low sodium and diabetic diet. -Resident #1 was diabetic and had high cholesterol. Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed: -Resident #1 was the only resident on a restricted diet. -Resident #1 was supposed to be on a low sodium and a "low something," she thought it was	{C 270}		

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{C 270}	Continued From page 58 NAS (NAS is no added salt). Interview with the SIC on 06/02/21 at 9:11am and 12:21pm revealed: -All the residents ate the same meal. -She prepared lunch and dinner when she worked. -She prepared meals based on what was available in the facility. -She had not seen a list of residents on therapeutic diets. -She was not aware of a menu at the facility. Interview with a second SIC on 06/02/21 at 5:30pm revealed: -She cooked whatever was available to be cooked. -No one told her to follow a menu. Interview with the facility's Registered Nurse (RN) on 06/03/21 at 12:06pm revealed. -It was impossible to prepare meals for different diets so the SIC's were supposed to prepare meals that were low sodium, low sugar and low fat. -The SICs had to feed the residents what was available in the facility. Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed: -There was only one resident on a restrictive diet. -There should be a therapeutic menu posted at the facility. -She thought there was a therapeutic diet list posted at the facility. -The SICs were responsible for keeping the therapeutic diet list updated.	{C 270}		

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{C 288}	Continued From page 59	{C 288}		
{C 288}	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to develop and implement an activity program that promoted active involvement for the residents who resided in the facility. The findings are: Observations of the facility on 06/02/21 between 8:30am-7:00pm revealed: -There was not an activities calendar posted. -No residents were observed participating in activities. -One resident walked around inside and outside the facility with headphones on listening to music. -One resident worked on various puzzle books in her room. -One resident was in her bed except when she went to meals. -The television was on in the living room and several residents watched the television at various times. -One resident sat in the chairs near the dining room and watched the surveyors. Interview with a resident on 06/02/21 at 11:00am revealed: -The male residents liked to smoke and play cards. -The female resident did not do anything. -She did not remember the last time she	{C 288}		

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{C 288}	Continued From page 60	{C 288}		

participated in an activity at the facility.
-She would like to play bingo and arts and crafts.
-She spent her days doing word books, watching television and taking walks.
-There were no group activities.

Interview with a second resident on 06/02/21 at 5:41pm revealed:
-She had never seen an activities calendar at the facility.
-She liked to do activities like play bingo and coloring.
-She would like to have things to do.
-She left the facility because she was bored.

Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 5:40pm revealed:
-She had not been told to encourage residents to participate in activities.
-She thought the residents needed "something to do."

Interview with a second SIC on 06/02/21 at 5:40pm revealed:
-She had not observed any activities going on in the facility.
-Residents had cards, dominos, pictures, and checkers but they did not engage.
-Residents watched television and sat outside.
-One of the residents would sit at the dining room table and play with his cards.
-One resident listened to music and walked inside and outside.
-One resident watched television and worked on crossword puzzles.
-The staff did not offer activities to the residents.

Interview with the Administrator on 06/04/21 at 1:39pm revealed:
-She had an activity calendar.

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{C 288}	Continued From page 61 -The calendar was completed by an Activity Director (AD) at another facility. -The AD had similar residents in her facility. -The AD developed books for coloring and word games. -She had not taken the calendar or books to the facility because she thought the facility was going to be closed and she had found out four days ago the facility was not going to be closed and she had not had time to take the items to the facility.	{C 288}		
{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: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#1), related to a medication used to treat diabetes (#1). The findings are: Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension, and hyperlipidemia.	{C 330}		

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{C 330}	Continued From page 62 Review of Resident #1's physician's order dated 04/01/21 revealed an order to check Resident #1's finger stick blood sugar (FSBS) twice a day and administer Lispro (used to treat diabetes) 100 unit pen to be used with the following sliding scale; 150-200=2u, 201-250=6u, 251-300=8u, 301-350=10u, >351=call the primary care provider (PCP). Review of Resident #1's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Lispro twice daily with a sliding scale of 150-200=2u, 201-250=6u, 251-300=8u, 301-350=10u, >351=call PCP with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Resident #1 refused her Lispro and FSBS at 8:00am on 05/01/21-05/03/21, 05/06/21-05/07/21, 05/09/21, 05/11/21-05/31/21 and 8:00pm on 05/02/21, 05/10/21-05/11/21, 05/14/21-05/16/21, 05/18/21-05/26/21, 05/28/21-05/31/21. Observation of Resident #1's medication on hand on 06/02/21 at 8:45am revealed: -There was a box that contained four Lispro 100 unit pens in a refrigerator; the pens had a dispense date of 03/29/21. -There was one insulin pen laying loose on a shelf in the refrigerator labeled with Resident #1's name; there was no open date or discard date on the pen. Review of Resident #1's glucometer revealed there had been no FSBS checks since 05/17/21. Without FSBS being obtained as ordered, it was unable to determine if Resident #1's Lispro was	{C 330}		

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{C 330}	Continued From page 63 to be administered resulting in a medication error. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/03/21 at 2:12pm revealed five 3 milliliter (ml) Lispro pens were dispensed on 03/29/21; there were no other dispensing dates. Interview with Resident #1 on 06/02/21 at 2:59pm and 5:41pm revealed: -She did not have her FSBS checked every day. -Sometimes her FSBS was checked in the mornings, sometimes in the evenings, and sometimes not at all. -She had not had a shot in a long time (she did not recall how long). -She had not refused to take her medication. -Her medication was scheduled for 8:00am and she was asleep at 8:00am. -When she got up, usually between 11:00am-12:00pm, she would ask for her medication but the Supervisor-in-Charge (SIC) would tell her it was too late to take the medication. -She had not had her FSBS checked in about a month because she did not have any glucometer strips. Interview with the SIC on 06/02/21 at 3:24pm revealed: -Resident #1 had been out of strips for her glucometer for over a week. -Without checking Resident #1's FSBS she would not know if Resident #1 needed to be administered insulin. Telephone interview with Resident #1's primary care provider (PCP) on 06/04/21 at 12:15pm revealed: -If Resident #1's FSBS were not being checked	{C 330}		

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{C 330}	Continued From page 64 as ordered, the SIC would not know whether to administer Resident #1's sliding scale insulin or not. -He expected Resident #1's SSI to be administered as ordered, depending on FSBS results. Telephone interview with the facility's contracted Registered Nurse (RN) on 06/021/21 at 12:06pm revealed: -Resident #1 had an order for SSI insulin and FSBS checks twice daily. -There would be no way of knowing if the Lispro SSI was being administered to Resident #1 as ordered if the FSBS were not being done as ordered. -She expected Resident #1's FSBS to be checked and Lispro administered as ordered. Interview with the Administrator on 06/03/21 at 5:09pm revealed: -The SICs had reported to her Resident #1 refused her medications. -She would tell the SIC to try every 15 minutes up to one hour to administer Resident #1's medications. -She expected Resident #1's FSBS to be checked and Lispro to be administered as ordered. -She was concerned Resident #1's Lispro was not administered as ordered because the FSBS were not being done.	{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	{C 342}		

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{C 342}	Continued From page 65 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the medication administration records were accurate for 2 of 2 sampled residents. 1. Review of Resident #1's current FL-2 dated 03/02/21 revealed diagnoses included dementia, brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension, and hyperlipidemia. Review of Resident #1's April 2021 and May 2021 electronic medication administration records (eMAR) revealed: -The Administrators initials were documented as administering medication 13 out of 30 days in April 2021. -The Administrators initials were documented as	{C 342}		

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{C 342}	Continued From page 66 administering medication 12 out of 31 days in May 2021. Refer to the observation of the medication cart on 06/02/21 at 6:08pm. Refer to the interview with Staff C on 06/02/21 at 6:02pm. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 06/02/21 at 2:45pm. Refer to the observation of the medication cart on 06/02/21 at 6:08pm. Refer to the interview with Staff C on 06/02/21 at 6:02pm. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 06/02/21 at 2:45pm. Refer to the telephone interview with the Administrator on 06/04/21 at 2:45pm. 2. Review of Resident #2's currect FL 2 dated 12/30/2021 revealed diagnosis of major depressiveve disorder, myasthenia gravis, diaphoresis, dyspnea on exertion (asthma), hypertension, hypothyroidism, diabetes mellitus. Review of Resident #2's April 2021 and May 2021 electronic medication adminsitration record (eMAR) revealed: -The Administrators initials were documented as administering medications 8 of 30 days in April 2021. -The Administrators initials were documented as admnistering medications 16 of 31 days in May	{C 342}		

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{C 342}	Continued From page 67 2021. Refer to the observation of the medication cart on 06/02/21 at 6:08pm. Refer to the interview with Staff C on 06/02/21 at 6:02pm. Refer to the telephone interview with the Account Manager from the facility's contracted pharmacy on 06/02/21 at 2:45pm. Refer to the telephone interview with the Administrator on 06/04/21 at 2:45pm. _____ Observation of the medication cart on 06/02/21 at 6:08pm revealed: -The electronic medication administration record (eMAR) program was open with the Administrator as the signed-in medication aide (MA). -The Supervisor-in-Charge (SIC) went through the process of pulling up a resident, popping the pill from the bubble pack, and administering the medication to the resident. Interview with Staff C on 06/02/21 at 6:02pm revealed: -She was not able to document when medication had been administered using her initials because the Administrator had not added her as a user in the eMAR system. -The Administrator had instructed her to use the Administrators initials when she administered medication. Telephone interview with the Account Manager from the facility's contracted pharmacy on 06/02/21 at 2:45pm revealed: -She was not aware there were SICs at the facility who were using other staff's eMAR sign-in to	{C 342}		

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{C 342}	Continued From page 68 administer medications. -It was not acceptable to sign in under another SIC and administer medications. Telephone interview with the Administrator on 06/04/21 at 2:45pm revealed: -She had not administered medication at the facility but acknowledged her initials were documented on the eMAR. -There were SICs who had not been trained and had not been set up in the eMAR system. -The new SIC's would not be able to sign in with her own initials until they were trained. -She was not physically at the facility but was observing the medication pass with new SIC's remotely.	{C 342}		
C 346	10A NCAC 13G .1004(n) Medication Administration 10A NCAC 13G .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to maintain medication in a way that prevented contamination realted to multiple loose pills in the medication drawers with other Resident's medication. The findings are: Observation of the medication cart on 06/02/21 at 3:30pm revealed there were 6 pills of various colors and shapes lying loose in the medication	C 346		

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C 346	Continued From page 69 drawer. Review of medication punch cards on 06/02/21 at 3:30pm revealed: -There was a punch card labeled Aspirin EC 81mg that contained a round, yellow tablet that appeared to be the loose pill. -There was a punch card labeled Propranolol 20mg that contained a round, blue tablet that appeared to be the loose pill. -There was a punch card labeled Ibuprofen 800mg that contained an oval, white tablet that appeared to be the loose pill. -There was a punch card labeled Ferrous Sulfate 325mg that contained a round, red tablet that appeared to be the loose pill. -There was a punch card labeled Bupropion XL 10mg that contained a round, white tablet that appeared to be the loose pill. -There was a punch card labeled Memantine 10mg that contained an oblong, grey tablet that appeared to be the loose pill. Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 3:30pm revealed: -She had noticed loose tablets in the medication drawer. -She had not mentioned it to the Administrator. -The facility's Registered Nurse (RN) went through the medication cart. -The facility RN was at the facility "about" every other day. Telephone interview with facility's RN on 06/03/21 at 12:06pm revealed: -She was told to do medication cart audits by the pharmacy's contracted RN . -Loose tablets should be thrown into the sharp's container. -She told one SIC not to use the loose tablets and	C 346		

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C 346	Continued From page 70 to discard the tablets. -She had observed loose tablets in the medication cart drawers in March 2021 and April 2021. -She had instructed the SIC to dispose of the medication because the medication was contaminated. -She talked to the SIC to try to determine why there continued to be loose tablets in the medication cart. -She expected the SIC to "pass on" the information to other SICs. Telephone interview with the Account Manager from the facility's contracted pharmacy on 06/02/21 at 2:45pm revealed: -When she was at the facility, she looked through the medication cart. -She looked specifically for loose tablets because she had noted them previous in medication cart. -She informed thd SIC of the loose tablets in the cart in April 2021 and May 2021. -The contracted pharmacy partnered with the facility to provide education and training. Telephone interview with the RN from the facility's contracted pharmacy on 06/03/21 at 3:45pm revealed: -She gave instructions on how to pop tablets from the medication punch cards. -She was informed monthly medication cart audits were being completed, however she suggested weekly medication cart audits.	C 346		
{C 353}	10A NCAC 13G .1006(b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those	{C 353}		

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{C 353}	Continued From page 71 requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure a resident's insulin pens were maintained safely under locked security. The findings are: Observation of a small refrigerator on 06/02/21 between 8:20am-7:00pm revealed: -There was a small refrigerator located in the resident's dining room. -The refrigerator was not locked. -There was one insulin pen laying loose on a shelf in the refrigerator labeled with Resident #1's name. -There were four insulin pens in a box inside the refrigerator; the box was labeled with a sticker that read refrigerate. -There was a container sitting on top of the refrigerator with a spout. -A resident went to the container multiple times, unscrewed the top to the container, and poured water into a cup. -The Supervisor-in-Charge (SIC) refilled the container of water and returned the container to the top of the refrigerator. -The residents ate breakfast, lunch, and dinner at the table beside the refrigerator. Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 6:47pm revealed: -Insulin was kept in the refrigerator in the dining room.	{C 353}		

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{C 353}	Continued From page 72 -The insulin had never been in a locked box in the refrigerator. -It had been "like that since she started." -She did not know the medication needed to be locked and secured; no one had ever told her that. Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed: -Insulin should be stored in the small refrigerator in the dining room. -The refrigerator was not locked, but the insulin should be placed inside a "tackle box with a little lock" and placed inside the refrigerator. -The tackle box had been at the facility for this purpose for as long as she could remember. -She had instructed the SIC to put the insulin in the tackle box but that SIC was no longer employed at the facility. -She had not looked in the refrigerator to make sure the insulin was in a locked box. -She was concerned anyone could get the medication and that was why the medication should be locked.	{C 353}		
{C 444}	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid.	{C 444}		

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{C 444}	Continued From page 73 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure accident and incident reports were sent to the Department of Social Services (DSS) within 48 hours for 1 of 1 sampled resident (#1) who experienced a fall with an injury that required emergency medical treatment. The findings are: Review of Resident #1's current FL-2 dated 03/08/21 revealed: -Diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension, and hyperlipidemia. -Resident #1 was intermittently disoriented. Interview with the Supervisor-in-Charge (SIC) on 06/02/21 at 9:28am revealed: -Resident #1 had a fall last month and was transported to the emergency department (ED). -She notified the Administrator when Resident #1 would have a fall or when she called 911 for Resident #1. Interview with the Adult Home Specialist (AHS) with the local county DSS office on 06/02/21 at 8:30am revealed she had not received an Accident/Incident Report for Resident #1 for the fall that occurred on 04/16/21 with transport to the local hospital. Review of Resident #1's emergency management services (EMS) reports revealed Resident #1 was transported to the ED on 04/16/21 at 1:11pm secondary to a fall.	{C 444}		

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{C 444}	Continued From page 74 Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed: -When Resident #1 had a fall with injuries, the staff called 911. -Resident #1 had several falls. -She was responsible for submitting an incident report to the local county DSS. -She knew Resident #1 had a fall and was transported to the ED on 04/15/21 and probably did not return to the facility until 04/16/21. -She did not recall EMS transporting Resident #1 on 04/16/21 from the facility at 1:11pm. -She would provide a copy of the incident report he completed on Resident #1's most recent fall, 04/16/21. Review of Resident #1's incident report provided by the Administrator on 06/04/21 at 1:15pm revealed Resident #1 had a fall at 7:50pm and was transported to the ED on 04/15/21. Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed she did not know why she did not have an incident report for the fall on 04/16/21.	{C 444}		
{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 ensure every resident had the right to receive care and	{C 912}		

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{C 912}	Continued From page 75 services which are adequate, appropriate, and in compliance with rules and regulations as related to outside entrances and exits, test for tuberculosis, other staff qualifications, and adult care home medication aides training and competency evaluation requirements. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors had an alarm that was activated and sounded when the doors were opened to alert staff for 1 of 1 resident (#1), who had a diagnosis of dementia and was known to wander into the community unsupervised. [Refer to tag C0069, 10A NCAC 13G. 0312(g) Outside Entrances and Exits. (Unabated Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure 3 of 3 staff sampled (Staff A, B, C) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services upon hire. [Refer to tag C0140, 10A NCAC 13G. 0405(a) Test for Tuberculosis (Unabated Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 staff sampled (Staff C) who administered medications had completed the medication clinical skills competency validation prior to administering medications and 3 of 3 sampled staff had successfully completed the required state examination (Staff A, B, C). [Refer to tag C935, G.S. 131D-21 4.5B(b) Adult Care Home Medication Aide Training and Competency (Continuing Unabated Type B Violation)].	{C 912}		

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{C 912}	Continued From page 76 4. Based on interviews and record reviews, the facility failed to ensure the primary care provider (PCP) and mental health provider was notified for 1 of 3 sampled residents related to multiple missed medications including blood pressure medication, diabetic medication, and psychiatric medication (#1) and not scheduling a follow-up appointment with the primary care provider for 2 of 3 sampled residents. [Refer to tag 246 10A NCAC 13G .0902 (b) Healthcare (Type B Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 2 of 2 sampled residents (Resident #1 and Resident #2) with orders for finger stick blood sugar (FSBS) checks twice daily (#1, #2); and monthly BP checks (#2) . [Refer to tag 249 10A NCAC 13G .0902 (c)(3-4) Healthcare (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 2 of 2 sampled diabetic residents (#1, #2) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. [Refer to Tag D932, G.S. 131D-4.4A(b)(1) Adult Care Home Infection Prevention Requirements (Type A2 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.	{C 914}		

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{C 914}	Continued From page 77 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 management and other staff and personal care and supervision. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs and current symptoms for 2 of 3 sampled residents (Residents #1, #4) related to Resident #1 who was reported missing to local law enforcement and was known to leave the facility unsupervised to go into the community who had a history of falls and was known to seek rides, food, money, and cigarettes from unknown individuals (#1) and a resident who was smoking inside the facility (#4). [Refer to tag C0243, 10A NCAC 13G. 0901(b) Personal Care and Supervision (Unabated Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules for family care homes related to infection prevention, supervision, health care; outside entrances and exits, test for tuberculosis, and adult care home medication aide training and competency evaluation requirements.[Refer to tag C0185, 10A NCAC 13G. 0601(a) Management and Other Staff (Unabated Type A2 Violation)].	{C 914}		

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C 932	Continued From page 78	C 932		
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV,	C 932		

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C 932	Continued From page 79 hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 2 of 2 sampled diabetic residents (#1, #2) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the Center for Disease Control and Prevention (CDC) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the facility's diabetic testing policy and procedure revealed: -Whenever possible, glucometers should be assigned to an individual person and not be shared. -If glucometers must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. -If the manufacturer did not specify how the device should be cleaned and disinfected then	C 932		

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C 932	Continued From page 80 the glucometer should not be shared. Observation of the facility's medication treatment cart on 06/02/21 at 3:19pm revealed: -There was one hard-sided glucometer case that contained a glucometer (Brand A). -The case and glucometer were not labeled. -There was a second glucometer that was in a soft sided zippered case (Brand B). -The case was not labeled with the residents name; the glucometer was labeled with a residents name. Review of the manufacturer's manual for Brand A glucometer revealed Brand A was a single-use glucometer and should not be used between multiple residents. Review of the manufacturers manual for Brand B glucometer revealed: -The meter is for single patient use. -Do not share the glucometer with anyone including other family members. -Do not use the glucometer on multiple patients. -All parts of the glucometer were considered biohazardous and could potentially transmit infectious diseases, even after cleaning and disinfection. 1. Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included type II diabetes, brain aneurysm, dementia, hypertension, obesity, schizophrenia, and hyperlipidemia. Review of Resident #1's physician orders dated 04/01/21 revealed there was an order for fingerstick blood sugar (FSBS) twice a day. Review of Resident #1's mental health physician's	C 932		

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C 932	Continued From page 81 summary dated 04/05/21 revealed: -There was a heading for communicable diseases. -There was documentation Resident #1 was positive for a communicable blood borne pathogen. -There was no date listed. -Resident #1 was a carrier and had received treatment in the past. Review of the memory for Resident #1's Brand A glucometer on 06/02/21 at 3:23pm revealed: -The date on the glucometer was 06/02/21 and the time was 3:19pm. -The glucometer reading on 05/17/21 at 7:50pm was 125. -The glucometer reading on 05/15/21 at 8:08pm was 104. -The glucometer reading on 05/14/21 at 7:46pm was 137. -The glucometer reading on 05/13/21 at 8:19pm was 190. -The glucometer reading on 05/12/21 at 8:22pm was 116. -The glucometer reading on 05/11/21 at 6:58pm was 148. -The glucometer reading on 05/06/21 at 7:06pm was 106. -The glucometer reading on 05/01/21 at 8:15am was 122. -The glucometer reading on 04/26/21 at 7:17pm was 157. -The glucometer reading on 04/24/21 at 7:11pm was 66. -The glucometer reading on 04/20/21 at 6:40pm was 162. -The glucometer reading on 04/18/21 at 7:17pm was 127. -These twelve FSBS readings were not documented in Resident #1's electronic	C 932		

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C 932	Continued From page 82	C 932		

medication administration record (eMAR); four of the twelve were documented in another residents eMAR for the same date and time.

Review of Resident #1's eMAR 04/17/21-04/30/21 and 05/01/21-05/27/21 FSBS readings revealed:
-A FSBS reading of 96 on 05/27/21 at 8:00pm.
-A FSBS reading of 122 on 05/13/21 at 8:00pm.
-A FSBS reading of 119 on 05/06/21 at 8:00pm.
-A FSBS reading of 100 on 04/19/21 at 8:00pm.
-A FSBS reading of 120 on 04/18/21 at 8:00am
-These six readings were not in Resident #1's Brand A glucometer's memory.

Interview with Resident #1 on 06/02/21 at 2:59pm revealed:
-She sometimes had her FSBS checked in the mornings and night, and sometimes not at all.
-She did not have her FSBS checked every day.
-She had not had her FSBS checked for "a while."

Interview with a medication aide (MA) on 06/02/21 at 3:30pm revealed:
-Resident #1's had not had glucometer strips for over a week.
-She reported Resident #1 needed glucometer strips to the facility's contracted Registered Nurse (RN).

Interview with a second MA on 06/02/21 at 6:37pm revealed:
-There were two residents who had their FSBS checked twice daily.
-Each resident had their own glucometer, lancets, and strips.
-She had never shared a glucometer between the residents.
-She could not explain why the FSBS readings

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C 932	Continued From page 83 from one resident were documented in another resident's record. Interview with a third MA on 06/02/21 at 6:30pm revealed: -She checked Resident #1's FSBS on her shift. -Resident #1 had her own glucometer, sticks, needles, and strips. -Resident #1's glucometer was kept with her medications. -She had never shared a glucometer. Telephone interview with the facility's contracted RN on 06/03/21 at 12:06 revealed no one had reported to her Resident #1 needed strips for her glucometer. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/03/21 at 1:30pm revealed 100 FSBS test strips had been dispensed to Resident #1 on 03/18/21; no other FSBS test strips were dispensed. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed there were no residents who were positive for a communicable blood borne pathogen. Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed she was aware that Resident #1 had tested positive for a communicable blood borne pathogen, but it had been resolved. Refer to the telephone interview with a MA on 06/03/21 at 8:04am. Refer to the telephone interview with the facility's contracted RN on 06/03/21 at 12:06pm.	C 932		

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C 932	Continued From page 84 Refer to the telephone interview with the Administrator on 06/03/21 at 5:09pm. Refer to the telephone interview with the facility's primary care provider on 06/04/21 at 12:30pm. 2. Review of Resident #2's current FL-2 dated 12/30/20 revealed: -Diagnosis of major depressive disorder, myasthenia gravis, diaphoresis, dyspnea on exertion (asthma), hypertension, hypothyroidism, diabetes mellitus. -There was an order for fingerstick blood sugar (FSBS) weekly. Review of Resident #2 Primary care provider's (PCP) visit summary dated 04/09/21 revealed: -Check Resident #2's FSBS two times a day and keep a FSBS log. -Follow up with PCP in two weeks with FSBS log. Review of Resident #2's Brand B glucometer memory on 06/04/21 at 11:25am revealed: -The date on the glucometer was 11/08/20 and the time was 5:07pm -The actual date and time were 06/04/21 at 11:25am. -There were two readings recorded in the glucometer for 11/08/20 between 4:54am and 5:07pm. -The 4:54am reading was 61 and the 5:07pm reading was 128. Review of Resident #2's electronic medication administration record (eMAR) FSBS readings for 5/10/21 revealed: -The 5:07pm reading of 128 was documented on Resident #2's eMAR on 05/10/21 as 8:00am reading. -The 4:54am reading of 161 was documented on	C 932		

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C 932	Continued From page 85 Resident #2's eMAR on 05/09/21 as 8:00pm reading. -On 05/12/21 at 8:00pm of a FSBS reading of 116. -On 05/13/21 at 8:00am of a FSBS reading of 191. -On 05/14/21 at 8:00pm of a FSBS reading of 137 -On 05/15/21 at 8:00pm of a FSBS reading of 114. -On 05/16/21 at 8:00pm of a FSBS reading of 120. -On 05/17/21 at 8:00pm of a FSBS reading of 125. -On 05/19/21 at 8:00pm of a FSBS reading of 126. -On 05/27/21 at 8:00pm of a FSBS reading of 123. -Four of the readings matched the FSBS memory in another residents glucometer. Interview with Resident #2 on 06/02/2021 at 9:05am revealed: -Her FSBSs were usually checked twice a day. -Her FSBS was not checked this morning. -She could not recall the last time her FSBS was checked. Interview with a medication aide (MA) on 06/02/21 at 3:30pm revealed: -Resident #2's glucometer strips had been out for over a week. -She reported Resident #2 needed glucometer strips to the facility's contracted Registered Nurse (RN). Interview with a second MA on 06/02/21 at 6:30pm revealed: -FSBS were obtained twice on her shift. -Resident #2 had her own glucometer, lancets, needles and strips.	C 932		

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C 932	Continued From page 86 -Glucometers were kept with their medications. -She never shared a glucometer. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/04/21 at 10:10am revealed the pharmacy had never dispensed glucometer strips to Resident #2. Telephone interview with a pharmacist at the facility's previous contracted pharmacy on 06/04/21 at 10:22am revealed the pharmacy had never dispensed glucometer strips to Resident #2. Telephone interview with the facility's contracted RN on 06/03/21 at 12:06 revealed no one had reported to her Resident #2 needed strips for her glucometer. Refer to the telephone interview with a MA on 06/03/21 at 8:04am. Refer to the telephone interview with the facility's contracted RN on 06/03/21 at 12:06pm. Refer to the telephone interview with the Administrator on 06/03/21 at 5:09pm. Refer to the telephone interview with the facility's primary care provider on 06/04/21 at 12:30pm. _____ Telephone interview with a MA on 06/03/21 at 8:04am revealed: -There were two residents who each had their FSBS checked twice daily. -She had shared a glucometer between the two residents when one of the residents was out of glucometer strips. -She had shared the glucometer "about a month ago."	C 932		

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C 932	Continued From page 87 -She did not know she should not share glucometers; no one had told her not to share glucometers. Telephone interview with the facility's contracted RN on 06/03/21 at 12:06pm revealed: -Her last day of employment with the facility was on 05/31/21. -The first shift staff was responsible for ordering supplies. -Staff should never share glucometers, even if the other resident was out of supplies. -Staff were trained and knew they should never share resident's glucometers. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -She was not aware staff had shared glucometers. -No one should run out of supplies but if they did staff should not share glucometers. -Glucometers should not be shared because of the risk of cross-contamination, exposure to blood-borne pathogens, and infection control. -Sharing glucometers was "not acceptable." Telephone with the facility's primary care provider on 06/04/21 at 12:30pm revealed there was no reason to share glucometers between residents. _____ The facility failed to ensure CDC guidelines and facility procedures were maintained for glucometers and lancing devices for 2 of 2 diabetic residents sampled with orders for finger stick blood sugar testing, resulting in shared glucometers among the diabetic residents, including one resident with a diagnosis of a bloodborne virus. The sharing of the glucometers placed the residents at risk for transmission and development of bloodborne infectious diseases.	C 932		

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C 932	Continued From page 88 The facility's failure placed the residents at substantial risk for serious physical harm which constitutes a Type A2 Violation. _____ The facility was provided with a plan of protection in accordance with G.S. 131D-34 on 06/03/21 for this violation.	C 932		
{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	{C935}		

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{C935}	Continued From page 89 training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previous Unabated Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 staff sampled (Staff C) who administered medications had completed the medication clinical skills competency validation prior to administering medications and 3 of 3 sampled staff had successfully completed the required state examination (Staff A, B, C). The findings are: Review of the facility's medication administration policy and procedure manual revealed: -Prior to administering medications all medication staff must complete the 5 hours (or 15 hours) training program and the clinical skills validation using the standardized skills competency checklist. -Within 60 days of hire all medication staff must successfully complete the additional 10-hour	{C935}		

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{C935}	Continued From page 90 training program and pass the written medication exam for adult care homes. 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 02/04/21. -There was documentation signed by a Registered Nurse (RN) Staff A had completed the 15-hour medication training on 02/05/21. -There was documentation Staff A completed the medication clinical skills competency validation on 02/25/21. -There was no documentation Staff A had passed the written medication aide (MA) exam. Interview with Staff A on 06/02/21 at 4:35pm revealed: -She had not taken the state-required MA exam. -The Administrator "just mentioned to her yesterday" about taking the written MA exam. -The Administrator told her she was going to see when the classes were available. -She had not signed up to take the test. -She had administered medications to the residents since she started working in the facility. Review of a resident's electronic medication administration record (eMAR) for April 2021 revealed Staff A had administered medication 15 days in April 2021. Review of a resident's eMAR for May 2021 revealed Staff A had administered medications 9 days in May 2021. Review of a resident's eMAR for June 2021 revealed Staff A had administered medications 2 of 2 days in June 2021. Telephone interview with the Administrator on	{C935}		

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{C935}	Continued From page 91 06/03/21 at 5:09pm revealed: -There were no test dates available for Staff A to take the written MA exam until late June 2021. -She had been looking for a test date for Staff A to take the written MA exam for over a month. 2. Review of Staff B'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 an RN on 09/16/20. -There was no documentation Staff A had passed the written medication aide (MA) exam. Telephone interview with Staff B on 06/04/21 at 10:26am revealed: -She had been working at the facility as a MA for a "little over a year." -She had not taken the written MA exam because she did not have transportation to a testing site, and she did not have the funds to take the exam. -She had told the Administrator why she had not taken the MA exam and the Administrator told her to try to "get down there" as soon as possible. Review of a resident's electronic medication administration record (eMAR) for April 2021 revealed Staff B had administered medications 18 days in April 2021. Review of a resident's eMAR for May 2021 revealed Staff B had administered medications 8 days in May 2021. Telephone interview with the Administrator on	{C935}		

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{C935}	Continued From page 92 06/03/21 at 5:09pm revealed: -She knew Staff B should have taken the written MA exam "a while ago." -She had not started the process with Staff B taking the written MA exam. -She had not had time to work on some of the things that needed to be done. 3. Review of the facility's personnel records revealed there was no record for Staff C, Supervisor-in-Charge (SIC) in the facility. Interview with Staff C on 06/02/21 at 5:40pm revealed: -She started working 3-4 weeks ago (she did not know the exact date). -She worked on Monday, Wednesday, and Fridays from 5:00pm-11:00pm and Saturday 8:00am-5:00pm. -She had not had MA training at the facility but had training at her previous facility. -She thought the Administrator was obtaining copies of required documents from her previous employer. Observation of the medication cart on 06/02/21 at 6:08pm revealed: -The electronic medication administration record (eMAR) program was open with the Administrator signed-in as the MA. -Staff C went through the process of pulling up a resident's medication, popping the tab let from the bubble pack, and administering the medication to the resident. Interview with Staff C on 06/02/21 at 6:02pm revealed: -She was not able to document when medication had been administered using her initials because the Administrator had not added her as a user in	{C935}		

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{C935}	Continued From page 93 the eMAR system. -The Administrator had instructed her to use the Administrator's initials when she administered medication. Review of a resident's eMAR for May 2021 revealed Staff C's initials were not on the resident's eMAR; the Administrators initials were documented as administering medication 11 days in May 2021. Interview with the pharmacy's contracted Registered Nurse (RN) on 06/03/21 at 3:45pm revealed: -She provided training to the facility's staff. -She had not been to the facility to do training since February 2021. -She was supposed to do a class on her last visit to the facility (February 2021) but no one showed up. Telephone interview with the Administrator on 06/03/21 at 5:09pm revealed: -Staff C's personnel record should be on file at the facility. -She had the information that had been faxed to her by Staff C to create the personnel record and would provide that information. Telephone interview with the Administrator on 06/04/21 at 2:45pm revealed: -She had not administered medication at the facility but acknowledged her initials were documented on the eMAR. -She was not physically at the facility but was observing the medication pass with Staff C remotely. -Staff C would not be able to sign in with her own initials until she was trained. -Staff C was not signed up for the written	{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 _____	R 06/04/2021

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{C935}	Continued From page 94 medication test. Documentation of Staff C's medication clinical skills checklist and 15-hour training certificate was requested on 06/02/21 but was not provided by survey exit. _____ Refer to Tag C330 10A NCAC 13G .1004(a) Medication Administration. Refer to Tag C342 10A NCAC 13G .1004(j) Medication Administration. Refer to Tag 353 10A NCAC 13G .1006 Medication Storage. Refer to Tag C0932 G.S 131D-4.4A Adult Care Home Infection Prevention Requirements. _____	{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	{C992}		

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{C992}	Continued From page 95 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 and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 3 of 3 sampled staff (Staff A, B, C) prior to hire. The findings are: 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff A was hired on 02/04/21. -There was a picture of an empty urine sample collection cup. -Staff A's name was written on the empty cup. -There was a piece of paper placed under the cup with the Administrator's signature on the paper. -There were no images of the readings on the cup after a urine sample was provided.	{C992}		

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{C992}	Continued From page 96 Interview with Staff A on 06/02/21 at 12:47pm revealed: -She had been working at the facility since February 2021. -She had taken a drug test at the facility using a urine sample cup. -The Administrator was present the day the urine sample was provided. Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed: -Staff A had a drug screen and the results should be in her personnel record. -She would provide a picture of completed drug screens. Documentation of staff drug screenings was requested on 06/02/21 but no further information was provided prior to the survey exit on 06/04/21. 2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: -Staff B was hired on 09/23/20. -There was a form signed on 09/17/20 indicating Staff B had a toxicology screen completed. -There was no other documentation a drug screen had been completed. Telephone interview with Staff B on 06/04/21 at 6:26am revealed she had not had a drug test since she started working at the facility. Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed: -Staff B had a drug screen and the results should be in her personnel record. -She would provide a picture of completed drug screens. Review of the picture provided by the	{C992}		

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{C992}	Continued From page 97 Administrator on 06/04/21 at 1:15pm revealed: -There was a urine sample cup, with a light brown liquid inside the cup. -The cup was sitting on a piece of paper with Staff B's name written on the paper, dated 12/20/20 and the paper was signed by the Administrator. 3. Review of the facility's personnel records revealed there was no record for Staff C (Supervisor-in-Charge) in the facility. Interview with Staff C on 06/02/21 at 5:40pm and 6:37pm revealed: -She had been working at the facility for 3-4 weeks. -She had not had a drug test. Telephone interview with the Administrator on 06/04/21 at 1:11pm revealed: -Staff C had a drug screen and the results should be in her personnel record. -She would provide a picture of completed drug screens. Documentation of staff drug screenings was requested on 06/02/21 but no further information was provided prior to the survey exit on 06/04/21.	{C992}		