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CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation from 05/26/21 - 05/28/21 and 06/01/21-06/02/21. The Wake County Department of Social Services initiated the complaint on 04/30/21.	D 000		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure there were no chronic unpleasant odors in the special care unit (SCU) related to a strong sulfur odor coming from a floor drain in the SCU dining room that permeated from the dining room and into the hallway of the SCU including during meals when residents in the SCU were eating. The findings are: Observation of the special care unit (SCU) entrance on 05/26/21 at 9:38am revealed there was a strong sulfur smell coming from the double doors. Observation of the SCU dining room on 05/26/21 at 9:40am revealed the sulfur smell was coming from a drain on the floor in the middle of the room	D 075		

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and the odor permeated into the hallway of the SCU.

Interview with a personal care aide (PCA) on 05/26/21 at 9:40am revealed:
-The smell in the dining room had been there about 3 or 4 months.
-Management was aware of the smell in the dining room.
-She thought it was because of a "busted sewage pipe".

Interview with the Memory Care Manager (MCM) on 05/26/21 at 10:10am revealed:
-The odor in the SCU dining room was coming from the drain in the floor.
-There was a hopper sink in a storage room that had to be flushed and staff had to put liquid bleach in it to help with the odor.
-If the hopper sink was not flushed, it would "stagnate" and it made an "awful smell" in the dining room.
-The former Maintenance Director had told staff they needed to flush it once or twice a week.
-The odor had been that way since she had worked at the facility for about 3 years.
-The odor would get better when staff flushed the hopper.
-No residents in the SCU had complained to her about the odor which was present at times when the residents ate their meals.

Interview with the Maintenance Manager on 05/26/21 at 2:27pm revealed:
-The smell in the SCU dining room was from when staff did not flush the hopper.
-The smell was sewer gas.
-Staff needed to flush the hopper daily.

Interview with the Administrator on 05/26/21 at

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3:02pm revealed:
-She did not notice the odor in the SCU dining room.
-She was in the SCU daily doing rounds.
-Staff was to flush the hopper weekly with bleach to eliminate the smell.
-Since the facility's former Maintenance Director had changed positions about 3 weeks ago, "it fell through the cracks".
-It would have been her responsibility to make sure the hopper was flushed to prevent the odor.

Interview with the MCM on 05/26/21 at 4:23pm revealed she flushed the hopper and poured some liquid bleach in the drain in the SCU dining room late that morning (05/26/21) to help with the odor.

Observation of the SCU dining room on 05/26/21 at 4:46pm revealed:
-There was a sulfur odor coming from the drain pipe in the floor.
-A resident was sitting in the dining room waiting to be served dinner.

Interview with a resident in the SCU dining room on 05/26/21 at 4:46pm revealed:
-There was a "rotten egg" odor in the dining room at every meal.
-He did not like the odor but it had been that way "a while" (could not specify timeframe).

Observation of the SCU dining room on 05/26/21 at 4:58pm revealed the sulfur odor was coming from a drain on the floor in the middle of the room while the residents were eating dinner.

Interview with a housekeeper on 05/27/21 at 11:05am revealed:
-He noticed a smell in the dining area in the SCU

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D 075	Continued From page 3 at least once a week. -The smell was coming from the floor drain in the middle of the SCU dining area. -He did not know what a hopper was and referred to it as a "big toilet." -He was not instructed on the maintenance protocol for the hopper. Interview with the Administrator on 05/26/21 at 5:03pm revealed: -She could smell the sulfur smell in the SCU dining room. -She would ask the Regional Maintenance Director to look at the hopper tomorrow (05/27/21).	D 075		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations and interviews, the facility failed to ensure the environment was clean and free of hazards related to the cleanliness of residents' rooms and bathrooms in the Special Care Unit (SCU); hazards were accessible to	D 079		

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cognitively impaired residents in 2 residents' rooms and the dining room in the SCU; and there was mold present in a storage room closet in the SCU.

The findings are:

1. Observation of the supply storage closet in the special care unit (SCU) on 05/26/21 at 10:27am revealed:
-The supply storage closet was locked.
-A personal care aide (PCA) had a key to get into the closet.
-The closet contained resident personal care items including incontinence care and hygiene items.

Observation of resident room #420 in the SCU on 05/26/21 at 10:44am revealed:
-The resident was asleep in the bed.
-There was a 500mL bottle of antiseptic mouth rinse on the nightstand that was approximately 75% full.

Observation of resident room #421 in the SCU on 06/02/21 at 9:17am revealed:
-The resident was asleep in the bed.
-There was a 2.4oz tube of denture grip on the bathroom sink.

Observation of the dining room in the SCU on 06/01/21 at 10:37am revealed:
-There was a dining tray with a dirty plate, metal fork, metal knife, and metal spoon sitting on top of the cabinet.
-There was no staff or residents present in the dining room.

Interview with a PCA on 05/26/21 at 10:47am revealed:

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-All hazardous items such as mouthwash should be locked in the storage closet.
-The resident in room #420 was easily agitated when staff tried to take his mouthwash away.
-She was not aware of the resident in room #420 ever attempting to drink his mouthwash.

Interview with the Memory Care Manager (MCM) on 06/01/21 at 10:40am revealed:
-All hazardous items including mouthwash and denture grip should be locked in the storage closet.
-All staff members were responsible to ensure items were stored appropriately.

Interview with the Administrator on 05/26/21 at 3:02pm revealed:
-It was the PCAs responsibility to lock up all hazardous items including mouthwash in the SCU.
-She was not aware that the mouthwash and other items were not being locked in the storage room.

2. Observation of the common bathroom across from room #410 in the special care unit (SCU) on 05/26/21 at 10:22am revealed:
-There was a dead centipede on the floor next to the sink.
-There was debris on top of the clean linen cart cover.
-There was hair, dust, and debris in the bath tub.

Observation of Resident #14's room in the SCU on 05/26/21 at 10:29am revealed:
-The air conditioning unit was pulled apart from the wall and opened to the outside.
-There was dirt and outside debris on the floor next to the resident's bed.

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D 079	Continued From page 6 Observation of resident room #421 in the SCU on 05/26/21 10:44am revealed there was a sticky, red liquid on the floor next to the resident's trash can. Observation of the hallway in the SCU next to the side entrance door on 05/26/21 at 4:39pm revealed there was a large gray trashcan and a small white gallon bucket with dirty water in it. Observation of resident room #409 in the SCU on 05/26/21 at 10:20am revealed: -There was a resident in the bed with covers pulled up to her neck. -There was a black cable cord hanging down about 4 feet form a hole in the ceiling; the cord had to be walked around to prevent the cord from touching the upper body. -There were dark yellow and rust colored stains on the floor around the toilet. -There was dark yellow stains and hair on the toilet seat. -There was a dishpan on the floor turned upside down with pieces of clothing hanging out. -There were 2 metal brackets on a wall without a towel bar. Based on observations, interviews, and record reviews, it was determined the resident in room #409 was not interviewable. Observation of the bathroom in resident room #411 in the SCU on 05/26/21 at 10:30am revealed: -There was dark yellowish orange liquid in the toilet. -There was dirt, debris, and small shreds of toilet paper on the floor around the toilet. -There was an exposed plumbing pipe on the wall behind the toilet with no cover.	D 079		

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-The white round cover to the plumbing pipe was propped up on the hand bar next to the toilet.

Based on observations, interviews, and record reviews, it was determined the resident in room #411 was not interviewable.

Observation of the bathroom in resident room #414 in the SCU on 05/26/21 at 10:46am revealed there was an exposed plumbing pipe on the wall behind the toilet with no cover.

Observation of the men's shower room in the SCU on 05/26/21 at 10:53am revealed:
-The Memory Care Manager (MCM) unlocked the door to the men's shower room.
-The soap dispenser on the wall was loose and only attached on one side.
-The bag of soap for the soap dispenser was laying on a towel on top of the half wall by the shower.
-There was a folded walker and a straight back chair stored in the shower stall.
-There was dirt and debris scattered all over the bathroom floor.

Interview with the MCM on 05/26/21 at 10:53am revealed they did not use this bathroom much anymore because the exhaust fan made such a loud noise and the residents did not like the noise.

Interview with the Maintenance Manager on 05/26/21 at 2:28pm revealed:
-He was the Maintenance Director at a sister facility but he worked as back up as the Maintenance Manager at this facility because their maintenance position was vacant.
-He came to the facility when the Administrator called him and had it cleared with the

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management for the sister facility.
-The exposed areas on the wall behind the toilets in the SCU were plumbing access pipes and just needed to be covered.

Interview with the Administrator on 05/26/21 at 3:06pm revealed:
-She was not aware of the plumbing access pipes being exposed on the wall behind the toilets in the SCU.
-They needed to have covers over them.
-The housekeepers should be cleaning the SCU daily.
-The bathtub in the common bathroom in the SCU should be cleaned daily.

Observation of resident room #409 in the SCU on 05/26/21 at 4:30pm revealed:
-There was a resident sitting up on the bed, clean and dressed.
-There was a black cable cord was hanging down about 4 feet form a hole in the ceiling.
-There was yellow urine in the toilet bowl that had not been flushed.
-There were rust colored stains on the floor around the toilet.
-There was dark yellow stains and hair on the toilet seat.
-There was a dishpan on the floor turned upside down with pieces of clothing hanging out.
-There were 2 metal brackets on a wall without a towel bar.

Observation of the bathroom in resident room #414 in the SCU on 05/26/21 at 4:37pm revealed:
-There was a blue towel on the floor next to the toilet.
-There was an exposed plumbing access pipe on the wall behind the toilet with no cover.

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D 079	Continued From page 9 Observation of the common bathroom across from room #410 in the SCU on 05/26/21 at 4:39pm revealed: -There was a dead centipede on the floor next to the sink. -There was debris on top of the clean linen cart cover. -There was hair, dust, and debris in the bath tub. -The bathroom had not been cleaned. Interview with the MCM on 05/26/21 at 4:39pm revealed: -She did not see housekeeping staff do any cleaning in the SCU today (05/26/21). -The housekeeping staff was supposed to clean in the SCU every day. Interview with a personal care aide (PCA) on 05/26/21 at 4:40pm revealed: -The only time she saw housekeeping staff in the SCU today (05/26/21) was when they mopped and took out the trash in the SCU dining room after breakfast and lunch. -She did not see housekeeping staff do any other cleaning in the SCU today (05/26/21). -The housekeeping staff was supposed to clean in the SCU everyday. Interview with a resident in the SCU on 05/26/21 at 4:44pm revealed housekeeping had not cleaned her room today and it needed sweeping. Interview with the Administrator on 05/26/21 at 3:02pm revealed: -There were two full time housekeepers Monday through Friday, one for the 100 and 200 hallways and one for the 300 and 400 hallways. She expected residents' rooms to be cleaned on a daily basis. -She had not noticed any housekeeping issues	D 079		

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during her daily walks through the facility.

Interview with a housekeeper on 05/27/21 at 11:05am revealed:
-He had cleaned the SCU that morning on 05/27/21.
-He was responsible for cleaning the residents' rooms, bathrooms, and the dining area within the SCU.
-He wiped down the bathrooms, hand rails, and window sills daily in the SCU.
-He also mopped each resident's room and removed their trash.
-There was no cleaning checklist that the housekeepers followed.
-He did not clean the tub in the SCU yesterday, 05/26/21.
-The last time he cleaned the tub in the SCU was last Saturday, 05/15/21.
-The residents typically took showers, so he did not clean the tubs as often.

Interview with the Divisional Vice President Operations (DVPO) on 06/02/21 at 3:00pm revealed:
-She was "very" concerned, "extremely" concerned about the issues identified in the SCU related to the cleanliness of the residents' shower room.
-The residents should be taken care of; this was their "home."

3. Observation of the storage room with the hopper in the special care unit (SCU) on 05/27/21 at 11:25am revealed:
-The storage room was filled with miscellaneous items that were unorganized, laying on top of each other and blocked access to be able to walk around in the storage room or access the hopper sink.

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D 079	Continued From page 11 -There were multiple items in the storage room such as cardboard boxes, a metal bed frame, a walker, a Christmas tree, lamps, a portable heater, bags of clothing, photos, and incontinence supplies. -Half of the ceiling on the left side of the storage room had been replaced with unpainted sheet rock. -There was no light fixture in the ceiling, just the hole with wires hanging down. -There were yellowed dry water stains on the ceiling with multiple area of large patches of black growth on the ceiling. Interview with the Administrator on 05/27/21 at 12:09pm revealed: -She had not seen the storage room in the SCU recently. -They had a leak in the ceiling when she started in December 2019 and the ceiling fell in. -They let it dry out and then drywall was put on the ceiling not longer after it fell. -She thought the reason the light was not reinstalled was because they were concerned it might leak again. -There was no current work order to repair the storage room. -They use the room for storage but she was not aware the room was cluttered and unorganized. -She was not aware there was mold growing on the ceiling but she would check into it. Interview with the Divisional Vice President of Operations (DVPO) on 05/27/21 at 1:08pm revealed a licensed contractor would be coming to the facility this evening to assess the ceiling damage where the mold was growing in the storage room.	D 079		

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D 105	Continued From page 12	D 105		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure a charred electrical outlet located in the residents' dining room was repaired, an exhaust fan in the residents' common bathroom was maintained in operating condition, the air conditioning units were properly installed and maintained in operating condition in the Special Care Unit (SCU), and two toilets were maintained in operating condition in the SCU. The findings are: 1. Observation of the dining room in the SCU on 05/26/21 at 10:08am revealed: -There were 3 air conditioning (AC) units on the lower walls of the dining room. -The front cover of the AC unit on the left wall was lying on the floor in front of the AC unit, exposing the rusted metal vents and inside structure of the AC unit. -The AC unit without the cover was not turned on. -The AC unit on the left side of the back wall was plugged in but not turned on. -There was brown charred discoloration on the wall around the electrical outlet wall plate that the AC unit was plugged into. Interview with a personal care aide (PCA) on	D 105		

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D 105	Continued From page 13 05/26/21 at 10:08am revealed: -The AC unit without the cover on the left wall of the SCU dining room was not turned on because it made a loud noise. -The cover of the AC unit "just falls off". -About 4 months ago, the AC unit on the left side of the back wall "caught on fire". -The fire department was not called because it was actually "sparks" coming out of the electrical outlet that the AC unit was plugged into. -Staff had not been turning on that AC unit because they were afraid it would catch on fire again. -It was reported to the Memory Care Manager (MCM) and she thought the MCM reported it to the Administrator. Interview with the MCM on 05/26/21 at 10:10am revealed: -The AC unit on the left wall in the SCU dining room worked but it was loud and the cover kept falling off of it. -About 3 to 4 months ago, staff reported the AC unit on the left side of the back wall had sparks coming from the electrical outlet it was plugged into. -They had not tried to use that AC unit since the sparks occurred. -The facility's former Maintenance Director looked at the AC unit when it occurred but she did not know why it was not repaired. Observation of resident room #412 in the SCU on 05/26/21 at 10:29am revealed: -The AC unit was pulled away from the wall and the left side of where the unit should have been was open to the outside air. -The AC panel on the wall read "ERR". -The room was warm and the temperature outside was 93 degrees Fahrenheit.	D 105		

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D 105	Continued From page 14 Based on observations, interviews and record reviews, it was determined that the resident in room #412 was not interviewable. Interview with the Maintenance Manager on 05/26/21 at 2:28pm revealed: -He was the Maintenance Director at a sister facility but he worked as back up at this facility as a Maintenance Manager because their maintenance position was vacant. -He came to the facility when the Administrator called him and had it cleared with the management for the sister facility. -He was not made aware of any issues with the AC units in the SCU until today (05/26/21). -If a cord was plugged in and out a lot, it could cause a break in the cord that would affect the circuit breaker and could cause sparks and wires to burn into. -He did not recommend leaving the cord plugged into the damaged electrical outlet as it could still cause sparks if left plugged in and be a safety concern. -He would cut the breaker off and replace the charred electrical out today (05/26/21). -He was not aware the AC unit on the left wall in the SCU dining room was making a loud noise; that had not been reported to him. -He would check that AC unit today also. - The AC unit in resident room #412 was not on his repair list from the Administrator. -The AC unit in resident room #412 room looked like someone must have "snatched on it" and it needed to be reconnected and pushed back into place. -The Regional Maintenance Director was coming to the facility tomorrow (05/27/21) to assist with maintenance issues at the facility.	D 105		

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D 105	Continued From page 15 Interview with the Administrator on 05/26/21 at 3:06pm revealed: -She was not aware of any issues with any AC units in the residents' rooms in the SCU. -She was aware (could not recall when) of the AC unit in the SCU dining room that was making a loud noise but since it was still working, she did not put it on the list for repairs. -As of today (05/26/21), she was aware the electrical outlet for the AC unit in the SCU dining room had a charred area where it had sparked. -The MCM said she notified the Administrator of the charred AC unit on 12/16/20 but she checked her records and could not find any documentation of it. -She was concerned that the AC unit was still plugged in and could spark again. -It should have been left unplugged. -The Regional Maintenance Director was coming to the facility tomorrow and he was bringing new AC units to replace the others. Observation on 05/27/21 at 9:09am revealed: -The Maintenance Manager (from a sister facility) had removed the charred electrical outlet from the wall in the SCU dining room. -The electrical outlet was melted and charred black on one entire side of the outlet. Interview with the Maintenance Manager on 05/27/21 at 9:09am revealed: -The electrical outlet was charred and melted on the inside. -It was "pretty bad". Observation of the SCU dining room on 05/27/21 at 10:21am revealed the charred electrical outlet had been replaced. Observation of the SCU dining room on 05/28/21	D 105		

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at 9:10am revealed the AC unit that had sparked the electrical outlet had been replaced with a new AC unit.

Refer to interview with the Divisional Vice President Operations on 06/02/21 at 3:00pm.

Refer to telephone interview with the Divisional Maintenance Director on 06/02/21 at 3:42pm.

2. Observation of the bathroom in resident room #409 in the SCU on 05/26/21 at 10:20am revealed the toilet in the bathroom had water in the bowl that was continuously swirling around the bowl without stopping.

Based on observations, interviews, and record reviews, it was determined the resident in room #409 was not interviewable.

Interview with the Maintenance Manager on 05/26/21 at 10:23am revealed:
-He was the Maintenance Director at a sister facility but he worked as back up at this facility as a Maintenance Manager because their maintenance position was vacant.
-He was called yesterday (05/25/21) about the toilet running continuously in the bathroom in resident room #409.
-He planned to repair the toilet today in room #409 (05/26/21).

Observation of the bathroom in resident room #414 in the SCU on 05/26/21 at 10:46am revealed:
-There was water leaking around the bottom of the toilet.
-The toilet would not flush.

Interview with the resident in room #414 on

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05/26/21 at 10:46am revealed:
-The toilet had been leaking around the bottom for "a while".
-He last flushed the toilet yesterday (05/25/21).

Interview with the Maintenance Manager on 05/26/21 at 2:28pm revealed:
-He was scheduled to come to the facility today (05/26/21) because he was told there were 4 toilets with problems in the SCU.
-He had repaired 6 toilets in the facility today (05/26/21).

Interview with the Administrator on 05/26/21 at 3:06pm revealed:
-She received a work order from the MCM on 05/19/21 that 2 toilets in the SCU needed repair.
-One of the toilets was flushing continuously and the other one was "running".
-The Maintenance Manager (from a sister facility) was supposed to come from the sister facility on Monday, 05/24/21, to repair the toilets but he got busy at the sister facility and just came today, 05/26/21, to repair the toilets.

Observation of resident room #409 in the SCU on 05/26/21 at 4:30pm revealed there was yellow urine in the toilet but the water was no longer swirling in the bowl.

Observation of the bathroom in resident room #414 in the SCU on 05/26/21 at 4:37pm revealed:
-When the toilet was flushed, water leaked from the handle and flowed down the pipes on the back of the toilet.
-There was a blue towel on the floor next to the toilet.

Refer to interview with the Divisional Vice President Operations on 06/02/21 at 3:00pm.

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D 105	Continued From page 18 Refer to telephone interview with the Divisional Maintenance Director on 06/02/21 at 3:42pm. 3. Observation of the men's shower room in the SCU on 05/26/21 at 10:53am revealed: -The Memory Care Manager (MCM) unlocked the door to the men's shower room. -When the light switch was turned on, there was a continuous loud grinding noise that did not stop until the switch was turned off. Interview with the MCM on 05/26/21 at 10:53am revealed: -They did not use this bathroom much anymore because the exhaust fan made such a loud noise and the residents did not like the noise. -She thought it had been reported but she did not know why it had not been repaired. Interview with the Maintenance Manager on 05/26/21 at 2:28pm revealed: -He was not aware the exhaust fan in the men's shower room in the SCU was making a noise. -Each bathroom needed an exhaust fan that operated properly. Refer to interview with the Divisional Vice President Operations on 06/02/21 at 3:00pm. Refer to telephone interview with the Divisional Maintenance Director on 06/02/21 at 3:42pm. _____ Interview with the Divisional Vice President Operations (DVPO) on 06/02/21 at 3:00pm revealed: -She would visit the facility monthly; her visits were unannounced. -During her monthly visits to the facility, she would walk through both units, the Assisted Living	D 105		

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(AL) section and the Special Care Unit (SCU).
-She would interview the residents about their satisfaction related to the care they received from staff.
-She would talk with staff to confirm if they had any questions/concerns while onsite.
-For any maintenance repairs at the facility, the Administrator could call or email the repair requests to her.
-She would forward the facility's maintenance repair requests to the Divisional Maintenance Director the same day.
-She expected all maintenance repair requests from the facilities to be escalated to her during the weekly divisional call she facilitated with the Administrators from her assigned facilities.
-Additional routes of notifications were by phone or email; all the Administrators had access to her by phone or email 24/7.
-She was not aware of any facility maintenance repair requests submitted from 02/2021 to 05/03/21.
-On 05/03/21, she sent an email to the Divisional Maintenance Director on behalf of the facility to fix non-functioning toilets in the SCU.
-She could not provide an answer why the non-functioning toilets in the SCU were not escalated to her until 05/03/21.
-She was "very" concerned, "extremely" concerned about the issues identified in the SCU related to the the non-functioning toilets, the bathroom exhaust fan, the AC units, and the charred electrical outlet in the dining room.
-The residents should be taken care of; this was their "home."

Telephone interview with the Divisional Maintenance Director on 06/02/21 at 3:42pm revealed:
-For any facility maintenance requests, the

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facility's Maintenance Director, the Administrator or the DVPO would submit the request through the facility work order system.
-For any facility maintenance requests which were classified as safety or fire related issues, a contractor would be contacted and there was priority to have the contractor at the facility within 24 hours of the request.
-A safety related maintenance request was defined as a mal-functioning door locking system or a broken window.
-The Divisional Maintenance Director would give directions by phone to the facility's Maintenance Director to provide a temporary repair solution to the maintenance issue until the contractor arrived onsite at the facility.
-A facility rounding form would also automatically generate daily for the facility's Maintenance Director or designee to complete and submit.
-Through a review of the facility work order system from 02/13/21 to 05/26/21, the last facility daily rounding sheet was completed on 05/05/21.
-He was not aware the last facility daily rounding sheet was submitted on 05/05/21.
-He expected the facility daily rounding sheet to be completed and submitted within the facility work order system.
-Through a review of the facility specific work order system from 02/13/21 to 05/26/21, there was no documentation of work orders submitted from the facility for the identified issues in the SCU related to the non- functioning toilets, the AC units, the bathroom exhaust fan, or the electrical outlet in the dining room.
-He had concerns related to the necessary repairs in the SCU, he should have been notified.
-There were resident concerns related to the outlet in the SCU, it was an "electrical safety issue" for the residents.
-He would have expected to be notified

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D 105	Continued From page 21 "immediately." _____ The facility failed to maintain electrical, mechanical, and plumbing equipment in a safe and operating condition in the special care unit (SCU) where 8 residents with dementia resided. There was an air conditioning (AC) unit in the SCU dining room accessible to residents that was plugged into a charred electrical outlet; there was an AC unit in a resident's room that was not working and had been pulled from the wall leaving gaps around it that were open to the outside; there was a toilet in one resident's room that leaked and did not flush and another toilet in a second resident's room that had water continuously swirling in the toilet bowl; and there was an exhaust fan in the residents' common bathroom that made a loud grinding noise when turned on. The facility's failure was detrimental to the heath, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/26/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 12, 2021.	D 105		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F	D 113		

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D 113	Continued From page 22 (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 6 of 16 water fixtures sampled which included 3 fixtures (2 sinks, 1 shower) in the assisted living (AL) side of the facility and 3 fixtures (2 sinks, 1 shower) in the special care unit (SCU) that were used by the residents with hot water temperatures ranging from 75 degrees F to 122 degrees F. The findings are: Review of water temperature logs from 03/01/21 to 05/24/21 revealed: -The entries included the facility name, month/year, and who the water temperature checks were completed by. -The notes section included to check at least 3 rooms per hallway and kitchen, ensure temperatures were not below 100 degrees Fahrenheit (F) and not above 115 degrees F or your state requirement), report any temperatures out of range to the Administrator, create a work order for service, and contact your Divisional Maintenance Director. -There were columns for the location and temperature. -The water temperatures were to be completed Monday, Wednesday, and Friday.	D 113		

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D 113	Continued From page 23 -From 03/01/21 to 03/24/21, the water temperatures ranged from 109.9 to 146.1 degrees F. -There was no documentation of water temperature checks from 03/26/21 through 04/05/21. -From 04/07/21 to 04/14/21, the water temperatures ranged from 109.9 to 144.6 degrees F. -There was no documentation of water temperature checks on 04/16/21. -From 05/03/21 to 05/24/21, the water temperatures ranged from 109.9 to 146.6 degrees F. 1. Observation of the common bathroom across from room #410 in the special care unit (SCU) on 05/26/21 at 10:21am revealed: -The hot water temperature at the sink was 75 degrees Fahrenheit (F). -There was a paper sign next to the sink that read "Caution! Please conduct your 'normal hand' test when using hot water as it may fluctuate before it levels out. Please contact your supervisor-in-charge or your Memory Care Coordinator if water does not feel comfortable to touch. Thank you, Management. " Interview with a personal care aide (PCA) on 05/26/21 at 10:23am revealed: -It was 'normal' for the sink in the SCU common bathroom not to get warm. -Management was aware that the water at the sink did not get warm. Interview with Maintenance Manager on 05/26/21 at 10:44am revealed the reason that the sink in the common bathroom did not get warm was because the regulator on the sink fixture was "bad" and needed replacing.	D 113		

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D 113	Continued From page 24 Observation of the men's shower room in the SCU on 05/26/21 at 10:53am revealed: -The hot water temperature at the sink was 122 degrees F. -No steam was observed. -There was a sign posted near the sink that read "Caution! Please conduct your 'normal hand' test when using hot water as it may fluctuate before it levels out. Please contact your supervisor-in-charge or your Memory Care Coordinator if water does not feel comfortable to touch. Thank you, Management." Interview with the same PCA in the SCU on 05/26/21 at 10:53am revealed: -The residents did not use the bathroom as much as they used to because the exhaust fan made a loud noise. -She had not noticed any problems with the water temperature. Interview with the Memory Care Manager (MCM) on 05/26/21 at 10:53am revealed: -They did not usually use the men's shower room in the SCU for showers because it was small and there was not enough room to move around. -The signed posted near the sink was because of past problems with the water temperatures but she could not recall how long the sign had been posted. Interview with the Maintenance Manager on 05/26/21 at 2:28pm revealed: -He was the Maintenance Director at a sister facility and provided back up maintenance services to this facility as the Maintenance Manager because their maintenance position was vacant. -He adjusted the mixing valve on the hot water	D 113		

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heater in the SCU today (05/26/21) to help with the water being too hot.
-The hot water heater in the SCU was rusted and leaking and needed to be replaced.

Interview with the Administrator on 05/26/21 at 3:06pm revealed:
-She was not aware of any issues with the water temperatures in the SCU.
-The Maintenance Manager (from the sister facility) told her about the regulator not working on the sink in the common bathroom in the SCU today, 05/26/21).
-No staff had reported or complained about the water temperature in the SCU.
-The facility's former Maintenance Director (current Dietary Manager) was still responsible for checking water temperatures weekly.
-If the water temperatures were out of range and the facility's former Maintenance Director could not repair it, he was supposed to notify her.
-No issues with the water temperatures had been reported to her.

Recheck of the common bathroom across from room #410 in the SCU on 05/26/21 at 4:40pm revealed the hot water temperature at the sink was 76 degrees F.

Recheck of the men's shower room in the SCU on 05/27/21 at 8:14am revealed the hot water temperature at the sink was 92 degrees F.

Recheck of the common bathroom across from room #410 in the SCU on 05/27/21 at 8:18am revealed the hot water temperature at the shower was 92 degrees F.

Interview with the Director of Quality of Assurance (DQA) on 05/27/21 at 8:18am revealed the

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Maintenance Manager (from the sister facility) was coming back to the facility today to make more adjustments to the hot water heater in the SCU.

Interview with the same PCA in the SCU on 05/27/21 at 8:21am revealed:
-The hot water temperature in the common bathroom at the shower was not as warm as usual today (05/27/21).
-That morning when she was bathing residents, the water was not as warm but warm enough to bathe the residents.
-The MCM reported the water temperature issue to the Administrator that morning (05/27/21).

Interview with the Maintenance Manager on 05/27/21 at 8:37am revealed:
-When he came in to adjust the hot water heater in the SCU that morning, the thermostat was on 112 degrees F and the hot water heater was leaking.
-A plumber was coming to the facility today (05/27/21) to check the hot water heater.
-A leaking hot water heater usually indicated the hot water heater was "going bad".

Interview with the MCM on 05/27/21 at 8:56am revealed:
-She assisted the PCA with resident showers that morning in the common bathroom across from room #410 in the SCU.
-The water temperature for the first resident they showered was good.
-When they tried to give a shower to the second resident, the water temperature was not warm enough so they washed off the resident "fast" but could not complete a full shower.
-She called the Administrator during the second shower and reported the water temperature.

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-The Administrator said she would call the Maintenance Manager (from the sister facility) to report it.

Based on observations, interviews, and record reviews, it was determined the two residents in the SCU who received showers on the morning of 05/27/21 were not interviewable.

Recheck of the common bathroom across from room #410 in the SCU on 05/27/21 at 10:12am revealed:
-The hot water temperature at the sink was 78 degrees F.
-The hot water temperature at the shower was 104 degrees F.

Recheck of the common bathroom across from room #410 in the SCU on 05/28/21 at 9:16am revealed:
-The hot water temperature at the sink was 106 degrees F.
-The hot water temperature at the shower was 120 degrees F.

Interview with the housekeeper on 05/28/21 at 9:29am revealed:
-No one had reported any issues with the hot water in the SCU today (05/28/21).
-The Maintenance Manager (from the sister facility) was coming back to the facility today (05/28/21).

Interview with another PCA in the SCU on 05/28/21 at 9:31am revealed:
-She assisted 2 residents in the SCU with showers in the common bathroom across from room #410 that morning (05/28/21).
-The water temperature felt "fine" to her when she checked it with her hand.

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-Both residents told her the water was too hot so she adjusted the water temperature so it was more comfortable for the residents.
-The residents were not burned by the hot water.
-She did not report the hot water temperatures to anyone since she was able to adjust the water temperature.

Interview with a resident in the SCU on 05/28/21 at 10:35am revealed:
-Staff in the SCU assisted him with a shower in the common bathroom across from room #410 that morning (05/28/21).
-The water was "too warm" and they had to adjust the water temperature.
-He did not get burned.

Interview with the Administrator on 05/28/21 at 10:18am revealed:
-She was not aware of the hot water temperatures in the SCU that morning (05/28/21).
-She would post warning signs and have the Maintenance Manager (from the sister facility) check the hot water heater when he arrived to the facility.

Recheck of the men's shower room in the SCU on 05/28/21 at 10:26am revealed the hot water temperature at the sink was 120 degrees F.

Interview with the Divisional Vice President of Operations (DVPO) on 05/28/21 at 10:41am revealed:
-Both hot water heaters in the facility, including the hot water heater in the SCU, would be getting replaced.
-She was currently waiting on quotes for getting the hot water heaters replaced.
-She was uncertain when the hot water heaters would be replaced pending the receipt of the

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quotes.

Interview with the Maintenance Manager on 05/28/21 at 11:25am revealed:
-He had adjusted the thermostat on the hot water heater in the SCU again today (05/28/21).
-The hot water heater in the SCU was being replaced today (05/28/21).

Interview with the MCM on 06/02/21 at 4:14pm revealed the hot water heater in the SCU had been replaced on 05/28/21.

Recheck of the men's shower room in the SCU on 06/02/21 at 5:27pm revealed the hot water temperature at the sink was 116 degrees F.

Recheck of the common bathroom across from room #410 in the SCU on 06/02/21 at 5:29pm revealed:
-The hot water temperature at the sink was 108 degrees F.
-The hot water temperature at the shower was 114 degrees F.

Refer to interview with the Maintenance Manager on 05/26/21 at 2:28pm.

Refer to interview with the Dietary Manager/Former Maintenance Director on 06/02/21 at 2:18pm

Refer to interview with the Administrator on 05/28/21 at 11:30am.

Refer to interview with the plumber on 05/27/21 at 12:27pm.

Refer to telephone interview with the Regional Maintenance Director on 06/02/21 at 3:42pm.

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D 113	Continued From page 30 2. Observation of the shared bathroom between resident rooms #201 and #203 in the assisted living (AL) side of the facility on 05/26/21 at 9:45am revealed: -The hot water temperature at the sink was 118.4 degrees Fahrenheit (F). -There was visible steam from the running water that fogged the mirror. Observation of the men's common bathroom (the only bathroom used for showering for men) on the corner of the 100 and 200 halls in the AL side of the facility on 05/26/21 at 10:08am revealed the hot water temperature at the shower was 116.6 degrees F. Observation of the shared bathroom between resident rooms #302 and #304 in the AL side of the facility on 05/26/21 at 10:25am revealed the hot water temperature at the sink was 86 degrees F. Interview with the resident residing in room #302 on 05/26/21 at 10:30am revealed: -He had no problems with the water being too hot or too cold as he was able to adjust it. -He would like a better shower head in the men's common shower room, as this was the only shower for the men on the AL to use. -He would like the water in his sink to be warmer to help with shaving. Second observation of the shared bathroom between resident rooms # 201 and #203 in the AL side of the facility on 05/28/21 at 10:30am revealed the hot water temperature at the sink was 108.5 degrees F. Second observation of the shared bathroom	D 113		

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between resident rooms #302 and #304 in the AL side of the facility on 05/28/21 at 10:30am revealed the hot water temperature at the sink remained 86 degrees F.

Interview with a personal care aide (PCA) on 05/26/21 at 10:47am revealed:
-She had not had anyone complain of the water being too hot or too cold.
-She had not noticed the water being too hot or too cold since she would adjust it to a comfortable temperature.

Refer to interview with the Maintenance Manager on 05/26/21 at 2:28pm.

Refer to interview with the Dietary Manager/Former Maintenance Director on 06/02/21 at 2:18pm

Refer to interview with the Administrator on 05/28/21 at 11:30am.

Refer to interview with the plumber on 05/27/21 at 12:27pm.

Refer to telephone interview with the Regional Maintenance Director on 06/02/21 at 3:42pm.

_____

Interview with the Maintenance Manager on 05/26/21 at 2:28pm revealed:
-He worked for a sister facility and was "on loan" to this facility since they did not have a maintenance person on staff at this time.
-He adjusted the water temperatures on the hot water heaters that morning on 05/26/21.
-He was not aware of the current issues with the hot water temperatures prior to today, 05/26/21.

Interview the Dietary Manager/Former

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Maintenance Director on 06/02/21 at 2:18pm revealed:
-He was the facility's Maintenance Director from 05/04/20 until around 04/02/21 when he became the Dietary Manager.
-He still performed some of the maintenance duties as needed.
-He checked the water temperature and completed the logs on Monday, Wednesday and Friday.
-If the hot water temperature was below 100 degrees F, it was too cold.
-If the hot water temperature was over 116 degrees F, it was too hot.
-He would adjust the mixer valve to keep the temperatures between 100 degrees F and 114 degrees F.
-When he was the facility's Maintenance Director, the logs were kept in his office but now they were kept in the Administrator's office.
-From 04/14/21 to 05/03/21 when no water temperatures were checked, he was in training for the Dietary Manager's position.
-He was not sure who would have been responsible during that time, but the Administrator would know.

Interview with the Administrator on 05/28/21 at 11:30am revealed:
-The facility did not have a Maintenance Director at this time.
-The Maintenance Manager (from a sister facility) filled in as needed.
-If water temperatures were out of compliance, she would be notified and then she would notify the Divisional Vice President of Operations (DVPO) and the Regional Maintenance Director (RMD) as needed.
-The Dietary Manager was the facility's Maintenance Director from 05/04/20 until around

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04/02/21 when he became the Dietary Manager.
-He still performed some maintenance duties as needed.
-She had not been notified by anyone that the hot water temperatures were out of range.
-She would be concerned about hot water temperatures that were too high since it could cause burns to the residents.

Interview with the plumber on 05/27/21 at 12:27pm revealed:
-He had never been to the facility until today, 05/27/21.
-The purpose of his visit to the facility today was diagnostic.
-There were 4 water heaters located in the facility.
-There was 1 in the boiler room, 1 in the kitchen, 1 in the Special Care Unit (SCU), and 1 in the laundry room.
-The water heater in the SCU was leaking based on his observations today.
-His recommendations were to replace the water heaters in the boiler room and in the SCU and replace the thermal expansion tanks in the other 2 units within the kitchen and laundry room.
-The thermal expansion tanks were nonfunctional.
-The thermal expansion tanks protected the life of the water heater and if not fixed could shorten the life of water heater.

Telephone interview with the Regional Maintenance Director (RMD) on 06/02/21 at 3:42pm revealed:
-For any facility maintenance requests, the facility's Maintenance Director, the Administrator or the Divisional Vice President Operations (DVPO) would submit the request through the facility work order system.
-For any facility maintenance requests which

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were classified as safety or fire related issues, a contractor would be contacted and there was priority to have the contractor at the facility within 24 hours of the request.
-A safety related maintenance request was defined as a mal-functioning door locking system or a broken window.
-The Divisional Maintenance Director would give directions by phone to the facility's Maintenance Director to provide a temporary repair solution to the maintenance issue until the contractor arrived onsite at the facility.
-Through a review of the facility work order system from 02/13/21 to 05/26/21, weekly water temperatures were completed at the facility during the weeks of 03/10/21, 03/17/21, and 03/24/21.
-There was no documentation within the facility work order system of the completion of water temperatures after the week of 03/24/21.
-He was not aware there were no water temperatures submitted from the facility after the week of 03/24/21.
-He expected the water temperatures checks to be completed weekly at the facility.
-He expected when the water temperature checks were completed there were at least 3 rooms per hallway and kitchen to be checked by the facility's Maintenance Director or Designee to ensure temperatures were not below 100 degrees Fahrenheit (F) and above 115 degrees F.
-He expected the facility's Maintenance Director or Designee to report any temperatures out of range to the Administrator and a work order be created.
-Through a review of the facility specific work order system from 02/13/21 to 05/26/21, there was no documentation of work orders submitted from the facility for the identified issues in the SCU related to the abnormal water temperatures.

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D 113	Continued From page 35 -He had concerns related to the necessary repairs in the SCU; he should have been notified. -There were resident concerns related to the abnormal water temperatures; if the water was too hot, it was a "safety" concern for the residents at the facility. _____ The facility failed to ensure hot water temperatures for 6 of 16 fixtures in the facility including 4 sinks and 2 showers that were used by the residents, including residents with dementia in the special care unit (SCU) were maintained between 100 - 116 degrees F. The water temperatures ranged from 75 degrees F to 122 degrees F. A water temperature of 120 degrees F could result in a first degree burn in 8 minutes and a second degree burn in 10 minutes. A water temperature of 124 degrees F could result in a first degree burn in 2 minutes and a second degree burn in 4.2 minutes. This failure of the facility was detrimental to the safety, health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 5/28/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 12, 2021.	D 113		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs,	D 270		

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D 270	Continued From page 36 care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 4 of 4 residents sampled (#6, #7, #8, #9) related to residents smoking in their bathrooms (#6 and #7). The findings are: Review of the tobacco use section from the resident handbook revealed: -All facility buildings were non-smoking buildings. -Residents must use smoking materials in a safe manner. -A resident may only smoke outside the building and in designated smoking areas. -Residents who use smokeless tobacco must use a means of disposal approved by the Director. -In any case, the facility reserved the right to confiscate smoking materials and tobacco products in the interests of fire safety and sanitation. -The resident's use of smoking materials in an unauthorized area, such as the resident's room, was cause for immediate discharge. Review of the smoking and alcohol policy from the residency agreement revealed: -The smoking and alcohol policy was effective 05/23/16. -To protect the health and safety of the residents and employees, the facility was a smoking and	D 270		

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alcohol restricted environment.
-Smoking use may occur in designated areas and in accordance with State law and the requirements (if any) set in the resident's service plan.

1. Review of Resident #6's current FL-2 dated 02/16/21 revealed:
-Diagnosis included traumatic hematoma of buttock.
-The disoriented and inappropriate behavior sections were blank.
-He was semi-ambulatory and was wheelchair bound.
-He required the assistance of 1-person when out of bed.

Review of Resident #6's care plan dated 07/10/20 revealed:
-His mental, health, and social history included wandering, he was verbally abusive, he had disruptive behavior, and he was socially inappropriate.
-He had a wheelchair.
-He was sometimes disoriented.
-He required limited assistance with ambulation, bathing, and transferring.

Observation of the bathroom in resident room #303 on 05/27/21 at 9:16am revealed:
-There were no residents currently residing in room #303.
-There was an odor of cigarette smoke in the bathroom in resident room #303.
-The toilet seat was up and there were cigarette ashes on the rim of the toilet and inside the toilet bowl.

Review of Resident #6's smoking assessment dated 09/26/20 revealed:

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-His short- and long-term memories were not intact.
-He was not free from weakness or paralysis in his upper/lower limbs.
-He was not free from any medication(s) which would alter his alertness.
-He did not demonstrate a safe technique for putting out matches/lighter and disposal of ashes.
-He had a history of smoking outside of the designated smoking areas.
- "Safe smoker" was checked "No."

Review of Resident #6's progress notes dated 02/25/21 at 1:30pm revealed Resident #6 was seen putting a cigarette out in the bathroom, before the Supervisor could take a picture of the cigarette in the toilet the resident flushed the cigarette down the toilet.

Review of Resident #6's progress notes dated 03/08/21 at 10:10am revealed Resident #6 was caught in the bathroom smoking cigarettes while on the toilet.

Interview with Resident #6 on 06/02/21 at 2:24pm revealed:
-He kept his own cigarettes and lighters in his room.
-He had smoked in his bathroom in the past when he could not find a staff member to take him outside to the smoking area.

Telephone interview with a former staff on 06/02/21 at 9:38am revealed:
-Sometime after Christmas 2020, she knocked on Resident #6's bathroom door because she could smell cigarette smoke but the resident flushed the cigarette down the toilet.
-She reported it to the Administrator but nothing was done about it to her knowledge.

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-Staff was not instructed to supervise Resident #6 any more frequently than the routine 2-hour checks.

Interview with the Administrator on 05/27/21 at 9:16am revealed:
-Resident #6 was moved out of room #303 yesterday (05/26/21) across the hall to another room.
-Resident #6's former roommate for room #303 was moved out of the room about one week ago but he was not a smoker.
-The room that shared a bathroom with room #303 was currently vacant.
-She was not aware of the cigarette ashes in Resident #6's bathroom in room #303.
-Resident #6 was a smoker and staff had found evidence of the resident smoking, like smelling smoke, in his bathroom "a few months ago".
-Staff started keeping Resident #6's cigarettes and lighter/matches but Resident #6 would get cigarettes from other residents.
-She was unable to indicate any supervision put in place for the resident smoking in the facility.

Telephone interview with Resident #6's primary care provider (PCP) on 06/02/21 at 1:30pm revealed:
-Resident #6's judgement was poor.
-He would repeatedly stand up and not lock his wheelchair.
-He needed to supervised closely for smoking.

Refer to the interview with a housekeeper on 05/27/21 at 11:05am.

Refer to the telephone interview with a former staff on 06/02/21 at 9:38am.

Refer to the telephone interview with the

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Administrator on 05/28/21 at 11:22am.

Refer to the telephone with Resident #6's PCP on 06/02/21 at 1:30pm.

2. Review of Resident #7's current FL-2 dated 06/02/19 revealed:
-Diagnosis included fever.
-The disoriented, inappropriate behavior, and personal care sections were blank.

Review of Resident #7's care plan dated 08/20/20 revealed:
-Her mental, health, and social history included she was verbally and physically abusive, and she had disruptive behavior, and she was socially inappropriate.
-She had a wheelchair.
-She was forgetful needed reminders.

Observation of Resident #7's bathroom on 05/26/21 at 11:00am revealed a gray powdery ash residue was on the sink.

Observation of the two residents' adjoining rooms to the bathroom on 05/26/21 at 11:02am revealed Resident #7 occupied room 307 and room 309 was unoccupied by any resident.

Review of Resident #7's smoking assessment dated 05/28/21 revealed:
-She was not free from weakness or paralysis in her upper/lower limbs.
-She did not a history of smoking outside of the designated smoking area.

Telephone interview with a former staff on 06/02/21 at 9:38am revealed:
-She had observed cigarette ashes in a cup at Resident #7's bedside; she could not recall the

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date.
-She reported it to the Administrator but nothing was done about it to her knowledge.

Interview with the Administrator on 05/26/21 at 3:06pm revealed:
-Resident #7 had been caught smoking before and the resident's cigarettes were taken away for staff to keep.
-It was a few months ago or may have been up to 6 months ago.
-She could not recall when but a progress note should have been documented in the resident's record.
-The resident's cigarettes were returned (could not recall when) because the resident promised she would not smoke in the facility again.
-The resident was not put on any supervision checks when she was caught smoking or after she received her cigarettes back.
-No staff, including housekeepers, had reported finding and cleaning up any cigarette ashes in Resident #7's room or bathroom.
-Facility staff should report any evidence of smoking in the facility such as ashes or smelling smoke to her.

Attempted interviews with Resident #7 on 05/26/21 at 11:00am and 06/02/21 at 2:15pm were unsuccessful.

Refer to the interview with a housekeeper on 05/27/21 at 11:05am.

Refer to the telephone interview with a former staff on 06/02/21 at 9:38am.

Refer to the telephone interview with the Administrator on 05/28/21 at 11:22am.

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D 270	Continued From page 42 Refer to the telephone interview with the primary care provider on 06/02/21 at 1:30pm. 3. Review of Resident #8's current FL-2 dated 05/18/21 revealed: -Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, dermatitis, essential hypertension, constipation, and gastroesophageal reflux disease. -She was intermittently disoriented. -She was ambulatory without an assistive device. Review of Resident #8's care plan dated 03/23/21 revealed: -She resisted care. -She had a history of developmental disabilities. -She was sometimes disoriented. Review of Resident #8's medical record revealed there was no smoking assessment completed. Resident #8's smoking assessment was requested on 05/28/21 at 12:00pm and was not received prior to survey exit on 06/02/21. Interview with Resident #8 on 06/02/21 at 3:06pm revealed: -The housekeeper let them out into the smoking area today (06/02/21). -She and other residents knew the lock pad code to get into the smoking area. -There were not assigned smoking times before COVID-19 restrictions. Refer to the interview with a housekeeper on 05/27/21 at 11:05am. Refer to the telephone interview with a former staff on 06/02/21 at 9:38am.	D 270		

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Refer to the telephone interview with the Administrator on 05/28/21 at 11:22am.

Refer to the telephone interview with the primary care provider on 06/02/21 at 1:30pm.

4. Review of Resident #9's current FL-2 dated 04/27/21 revealed:
-Diagnoses included muscle weakness, acute kidney failure, and bacteremia.
-The disoriented section was blank.
-He used a powerchair.

Review of Resident #9's care plan dated 10/29/20 revealed his mental, health, and social history included wandering, he was verbally and physically abusive, had disruptive behavior, and he was socially inappropriate.

Review of Resident #9's smoking assessment dated 10/29/20 revealed "safe smoker" was checked "No."

Interview with a housekeeper on 05/27/21 at 11:05am revealed:
-Resident #9 "always" smoked in his room.
-He knew Resident #9 smoked in his room because he could smell cigarette smoke coming from his room.
-He could not recall the last time he smelled cigarette smoke coming from Resident #9's room.
-When he smelled cigarette smoke coming from a resident's room, he would report it directly to the Administrator.

Telephone interview with a former staff on 06/02/21 at 9:38am revealed:
-She had walked in Resident #9's room and observed him spraying air freshener in his

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bathroom.
-She smelled a combination of air freshener and cigarette smoke within his bathroom; she could not recall the date.

Interview with Resident #9 on 06/02/21 at 2:18pm revealed:
-There facility had specific times that residents were allowed to go out to smoke which were 9:00am, 3:00pm, 6:00pm, and 9:00pm since COVID-19 restrictions were put into place in January of 2021.
-It was difficult to find a staff member that was willing to go out with the residents at 6:00pm.
-He kept his own cigarettes and lighters in his room.
-If he could not find a staff member when he wanted a cigarette, he signed himself out of the facility and would go to the front porch.
-Residents were not allowed to smoke in their room but he knew some residents were frustrated not being able to find someone to take them out to smoke.

Refer to the interview with a housekeeper on 05/27/21 at 11:05am.

Refer to the telephone interview with a former staff on 06/02/21 at 09:38am.

Refer to the telephone interview with the Administrator on 05/28/21 at 11:22am.

Refer to the telephone interview with the primary care provider on 06/02/21 at 1:30pm.

_____

Interview with a housekeeper on 05/27/21 at 11:05am revealed:
-Residents #6 #7, #8, and #9 were identified as smokers.

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D 270	Continued From page 45 -He was not sure if the residents who were identified as smokers received increase supervision from staff. Telephone interview with a former staff on 06/02/21 at 9:38am revealed: -Residents' cigarettes used to be kept at the facility's nurses' station but this ended after 03/2021; she was not sure why this process changed. -Staff were "never" instructed to supervise residents more than the routine 2- hour checks who were identified as smokers at the facility. Interview with the Administrator on 05/28/21 at 11:22am revealed: -She expected staff to report any observations of a resident actively smoking cigarettes outside of a designated smoking area or any cigarette smell coming from a resident's room to her the day of occurrence. -Staff could notify her by phone or leave her a note. -The next step would be for her to discuss the facility's smoking policy with the resident. -If there was a direct observation of resident actively smoking cigarettes outside of a designated smoking area, the resident would not be allowed to keep their cigarettes within their possession. -Resident(s) who smoked within their rooms was a "safety" hazard, it was a fire hazard. -Residents who smoked cigarettes outside of a designated smoking area could cause health issues for other residents who had underlying lung issues. -She had concerns for residents who had oxygen within their room. -She had not received any staff notifications about observations or smelling smoke for	D 270		

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D 270	Continued From page 46 Residents #6, 7, 8, and 9. -Current supervision in place was routine 2-hour checks. Telephone interview with the primary care provider for Residents #6, 7, 8, and 9 on 06/02/21 at 1:30pm revealed: -She expected all residents who were identified as smokers to be "supervised" they were only smoking in the facility's outdoor designated smoking areas. -She had "safety" concerns for all residents living at the facility when residents smoked cigarettes within their rooms. -If a resident was smoking within their room or bathroom, it could "burn" the building down. -A fire could occur if there was oxygen present or if the resident could not safely put out matches or cigarettes. -Residents lived at the facility because they required assistance with activities of daily living and she expected staff to supervise them to keep them safe.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION. Based on these findings, the previous Type A2 Violation was not abated. Based on record reviews and interviews, the	D 273		

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facility failed to ensure referral and follow-up to meet the health care needs for 4 of 5 residents sampled (#1, #2, #3, #4) including a speech therapy consult (#3), follow-up appointment post-cataract surgery (#2), follow-up lab work and urinalysis (#4, #5) and weight gain (#5).

The findings are:

1. Review of Resident #3's current FL-2 dated 10/30/20 revealed diagnoses included vascular dementia without behaviors, hypoxia, dysphagia, and airway aspiration.

Review of Resident #3's care plan dated 02/16/21 revealed he required supervision at meal times due to increased risk for choking.

Review of Resident #3's resident progress notes revealed there was no progress note documented on 04/12/21 or 04/13/21.

Review of Resident #3's physician order dated 04/12/21 revealed:
-Resident #3 was choking on thin liquids and mechanical soft foods.
-There was an order for speech therapy to evaluate Resident #3's swallowing.
-There was an order to start nectar thick liquids.
-There was an order to discontinue mechanical soft diet and start pureed diet.

Review of Resident #3's consultation note on 04/13/21 revealed:
-Resident had an episode of dysphagia.
-He was to start nectar thick liquids and a pureed diet.
-He was to receive a speech therapy evaluation.
-Staff was to monitor closely for signs/symptoms of aspiration.

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D 273	Continued From page 48 -The primary care provider (PCP) discussed safety with the resident and instructed him to notify staff promptly if he developed chest pressure, chest pain, cough, wheezing, shortness of breath or difficulty breathing. Interview with the facility's Director of Quality Assurance on 06/01/21 at 3:10pm revealed Resident #3's speech evaluation ordered 04/12/21 was not completed. Interview with the Memory Care Manager (MCM) on 06/02/21 at 1:14pm revealed: -She was responsible for scheduling Resident #3's speech evaluation. -She received the order for Resident #3's speech evaluation on 04/12/21. -She sent an email to a home health company about the referral but did not follow up on it. -She was not able to recall when she sent the email to the home health agency. -Resident #3's speech therapy consult was not done because it "fell through the cracks". -She did not notify the PCP that the consult was not completed. Interview with the Administrator on 06/02/21 at 4:08pm revealed: -It was the Care Manager's responsibility to ensure that consults were done. -She was not aware that Resident #3's speech therapy consult wasn't completed. -Care Managers reported new consults in the daily stand-up meetings and she did not recall the MCM discussing Resident #3's speech therapy consult. -She expected consults to be scheduled immediately because there was a risk for further aspiration.	D 273		

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Telephone interview with Resident #3's PCP on 06/02/21 at 1:20pm revealed:
-She expected referrals to be called right away or at least within 24 hours.
-She was not aware that Resident #3 did not receive a speech therapy evaluation as ordered on 04/12/21.
-Resident #3 could experience further risk for aspiration by not receiving the speech therapy evaluation which could result in infection.
-She changed Resident #3's diet after the incident on 04/12/21 but she was expecting the speech therapy consult to be completed to determine if the resident was on the appropriate type of diet.

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

2. Review of Resident #2's current FL-2 dated 02/11/21 revealed:
-Diagnoses included left great toe amputation secondary to osteoarthritis, peripheral vascular disease, type 2 diabetes mellitus, coronary artery disease, hypertension, hyperlipidemia, diffuse alveolar damage, and a history of cerebrovascular accident.

Review of Resident #2's progress note dated 12/17/20 revealed:
-Resident #2 was at her ophthalmologist surgeon's office.
-She had new orders for Prednisolone, Ofloxacin, and Ketorolac to start today when she returned to the facility. (Prednisolone acetate eye drops are used to reduce the irritation, redness, burning, and swelling of eye inflammation after eye surgery. Ofloxacin eye drops are used to treat eye infections. Ketorolac eye drops are used to treat itchy eyes caused by allergies and treatment

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of swelling and redness that can occur after cataract surgery).
-There were no signed orders with her discharge package.
-She had a follow-up appointment, 12/18/20.
-Her ophthalmologist surgeon's office would give clarification on new orders then.
-No issues to report concerning her left eye currently.

Review of Resident #2's progress notes from 12/17/20-05/10/21 revealed there was no documentation Resident #2 had any follow-up visits at her ophthalmologist surgeon's office after 12/17/20.

Review of Resident #2's medical record revealed there was no physician visit notes from Resident #2's ophthalmologist surgeon's office or the discharge package dated 12/17/20.

Telephone interview with an eye technician at Resident #2's ophthalmologist's office on 06/02/21 at 1:37pm revealed:
-On 12/17/20, Resident #2 had cataract surgery on her left eye.
-She did not come to the eye care center on 12/18/20 for her post-operative visit related to her left eye cataract surgery.
-Her right eye cataract surgery was scheduled for 12/21/20.
-She did not come to the eye care center on 12/21/20 for her right eye cataract surgery.
-She had 2 post-operative visits scheduled for 02/18/21 and 03/09/21.
-Both post-operative visits were canceled, no additional details provided.
-It was important Resident #2 completed both steps of her recommended cataract surgery for both of her eyes to improve her vision.

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D 273	Continued From page 51 -Resident #2 not showing up to her scheduled right cataract eye surgery at the eye care center on 12/21/20 was she "hanging in the balance" with only one of her recommended eye surgeries completed. -Resident #2 did not come to the eye center for her post-operative visit on 12/18/20. -Resident #2 not showing up to her post-operative appointments at the eye care center on 12/18/20, 02/18/21, and 03/09/21, were she never received her follow-up instructions, her ophthalmologist could not assess her for any signs or symptoms for infection or complications from her left eye cataract surgery, without any follow-up post-operative instructions her prescribed post-operative eye drops could be extended past the recommended period, and she was pending new prescription eye glasses based on the outcome of her cataract surgery. Interview with the Administrator on 06/02/21 at 2:47pm revealed: -It was the responsibility of the facility's scheduler to schedule all the resident's appointments and follow-up appointments. -During the daily morning round up at the facility, the scheduler would update the facility management team on the resident appointments which were pending. -The residents who were pending appointment dates were noted on a white board at the facility. -The Administrator would confirm residents' appointments were made by the scheduler when the resident's name was no longer listed on the white board. -The facility's scheduler who worked at the facility from 12/2020 to 03/2021, no longer worked at the facility. -The facility's new scheduler and the new Resident Care Coordinator started their new	D 273		

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positions at the facility on 05/17/21.
-She was not aware of Resident #2's right eye cataract surgery scheduled for 12/21/20 and post-operative visits scheduled for 12/18/20, 02/18/21, and 03/09/21.
-She was not sure why Resident #2's right eye cataract surgery scheduled for 12/21/20 and post-operative visits scheduled for 12/18/20, 02/18/21, and 03/09/21 did not happen.
-Resident #2 had surgery the middle of 01/2021 and was in rehab through the middle of 02/2021 as a possible explanation for the follow-up cancellations.
-She expected Resident #2 to attend her post-operative visits scheduled for 02/18/21 and 03/09/21 because she did return to facility from rehab on 02/12/21.
-She expected the Care Managers which included the Memory Care Manager and the Resident Care Coordinator to review all resident's medical documentation.
-The Care Managers would notify the scheduler of the need to schedule a resident's appointment.
-She expected all the resident's appointments and follow-up appointments to be scheduled within 24-48 orders of the order.

Attempted telephone interviews with Resident #2's primary care provider on 06/01/21 at 10:54am and on 06/02/21 at 2:19pm were unsuccessful.

3. Review of Resident #5's current FL-2 dated 05/21/21 revealed diagnoses included vascular dementia, a virus that attacks the body's immune system, epilepsy, hypothyroidism, hyperlipidemia, constipation, and insomnia.

a. Review of Resident #5's mental health provider (MHP) visit note dated 03/18/21 revealed:

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-The Resident Care Coordinator (RCC) reported the resident was restless and his dementia seemed to be progressively worsening.
-The resident had been harder to redirect and often told staff to "shut up".
-The MHP ordered a full panel of labs and urinalysis with culture and sensitivity (U/A with C&S) to rule out urinary tract infection (UTI) as a possible cause of agitated behaviors.
-The panel of labs ordered by the MHP included: fasting lipids, complete metabolic panel (CMP), complete blood count (CBC) with differential, hemoglobin A1C, and thyroid stimulating hormone (TSH).

Review of Resident #5's MHP visit note dated 04/15/21 revealed:
-The facility staff reported no acute concerns with the resident at this time.
-The resident was in his room, had confusion, and denied depression.
-A full panel of labs and U/A with C & S to rule out UTI as possible cause of agitated behaviors were ordered last visit but "not performed".
-The MHP reordered the labs and U/A to be done.

Review of Resident #5's labwork revealed:
-There was no documentation of any labwork being completed that was ordered by the resident's MHP on 03/18/21 and again on 04/15/21.
-There was no documentation of any U/A with C & S being completed for the resident.
-There was a CMP and CBC with differential ordered by the PCP completed on 04/13/21.
-There was a TSH level ordered by the PCP that was completed on 03/09/21, prior to the orders by the MHP on 03/18/21 and 04/15/21.
-The resident's TSH level was 1.62 (reference range 0.40 - 4.50) on 03/09/21.

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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
D 273	Continued From page 54 -There was no documentation of any fasting lipids or hemoglobin A1C. Interview with the Memory Care Manager (MCM) on 06/02/21 at 3:40pm revealed: -Resident #5's MHP used their own lab company who came to the facility to draw and collect labwork. -She failed to see the orders on Resident #5's MHP visits on 03/18/21 and 04/18/21 to have labwork and a U/A completed for the resident. -She filed the MHP visit notes without reading the information because she thought the MHP would document any orders on a separate form. -She contacted the MHP today, 06/02/21, and the lab company would be coming to the facility tomorrow (06/03/21) to draw blood for the labwork and they would get a U/A for the resident. -She was responsible for following up on lab orders and if no response in 3 days, she would call the MHP to see if results had been received. -For U/A orders processed by the MHP's lab company, the lab company would come to the facility when they received the order. -The lab company would ask the MAs to get a urine sample while the lab was on-site and the lab company would take the sample that same day for processing. -Resident #5 had not complained of any symptoms of a UTI to her knowledge. -Resident #5 was at his baseline and had not been agitated to her knowledge. Interview with the Administrator on 06/02/21 at 4:25pm revealed: -The RCC or MCM were responsible for coordinating any lab orders for residents. -She was not sure what the facility's system was for implementing lab orders from the MHP. -Resident #5's labwork should have been	D 273		

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completed as ordered in March 2021.
-The facility kept a supply of urine specimen cups in the medication room and the MAs were responsible for collecting urine samples for U/A orders.
-There was a lab phone number on the urine specimen bags and the MAs were responsible for calling the number to coordinate with the lab to pick up the specimens.
-The RCC and MCM were responsible for following up to make sure U/A orders were completed.
-She was not aware Resident #5's MHP ordered a U/A with C&S on 03/18/21 and again on 04/15/21.
-Resident #5's U/A should have been done as ordered.
-The MHP's lab company would be at the facility tomorrow (06/03/21) to draw blood and obtain a urine specimen for Resident #5.

Interview with Resident #5 on 06/02/21 at 4:14pm revealed:
-He could not recall if he had any blood drawn for labwork while at the facility.
-No one had asked to collect a urine sample at the facility but his urine had been checked at the hospital but he could not recall when.
-He had trouble trying to urinate that morning on 06/02/21 but he had not reported it to anyone.
-He denied burning or urinary frequency.

Attempted telephone interview with Resident #5's MHP on 06/02/21 at 1:47pm was unsuccessful.

b. Review of Resident #5's physician's order dated 03/16/21 revealed an order to check weight weekly and notify the primary care provider (PCP) if weight gain greater than (>) 2 pounds in one week.

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D 273	Continued From page 56 Review of Resident #5's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry to check weight weekly and notify the PCP if weight gain > 2 pounds in one week. -The resident's weight was documented as checked between 10:00am - 2:00pm once a week on Wednesdays. -The resident was documented as weighing 176.8 pounds on 03/03/21 and 179.9 pounds on 03/10/21, a weight gain of 3.1 pounds. -There was no documentation of the PCP being notified of the weight gain > 2 pounds on 03/10/21 as ordered. Review of Resident #5's April 2021 eMAR revealed: -There was an entry to check weight weekly and notify the PCP if weight gain > 2 pounds in one week. -The resident's weight was documented as checked between 10:00am - 2:00pm once a week on Wednesdays. -The resident was documented as weighing 180.7 pounds on 04/21/21 and 183.6 pounds on 04/28/21, a weight gain of 2.9 pounds. -There was no documentation of the PCP being notified of the weight gain > 2 pounds on 04/28/21 as ordered. Review of Resident #5's May 2021 eMAR revealed: -There was an entry to check weight weekly and notify the PCP if weight gain > 2 pounds in one week. -The resident's weight was documented as checked between 10:00am - 2:00pm once a week on Wednesdays.	D 273		

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D 273	Continued From page 57 -The resident was documented as weighing 183.6 pounds on 04/28/21 and 187.5 pounds on 05/05/21, a weight gain of 3.9 pounds. -There was no documentation of the PCP being notified of the weight gain > 2 pounds on 05/05/21 as ordered. Interview with the Memory Care Manager (MCM) on 06/02/21 at 3:40pm revealed: -The MAs were supposed to use fax sheets to notify Resident #5's PCP of any weight gains as ordered. -She printed a weight report for the PCP to review and sign for weights for the last 6 months on 05/17/21. -She expected the MAs to notify the PCP at the time the weight gain occurred as ordered by the PCP. Interview with the Administrator on 06/02/21 at 4:25pm revealed: -The MCM was responsible for notifying the PCP of weight changes as ordered and documenting it in the progress notes. -Resident #5's PCP should have been notified of the weight gain at the time it occurred. Interview with Resident #5's PCP on 06/02/21 at 1:22pm revealed: -The facility did not contact her regarding Resident #5's weight gain of > 2 pounds in March 2021, April 2021, or May 2021 to her knowledge. -She expected staff to follow the order to contact the PCP for weight gain. -The resident was taking a medication for fluid retention so weight gain could indicate an exacerbation of congestive heart failure symptoms which could lead to fluid in the lungs and more heart issues that could require hospitalization.	D 273		

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4. Review of Resident #4's current FL-2 dated 02/26/21 revealed diagnoses included bi-polar anxiety, fibromyalgia, vitamin B deficiency, gastric ulcer, hypertension, status post cerebrovascular accident, and depression.

Review of Resident #4's Primary Care Provider (PCP) orders revealed:
-There was an order for a urinalysis (U/A) dated 03/02/21. (A U/A is a urine test to detect urinary tract infections).
-There was an order dated 03/02/21 to start Cephalexin (an antibiotic used to treat bacterial infections such as UTI's) capsule 500 mg 1 capsule by mouth every 12 hours for 7 days.

Review of Resident #4's laboratory results revealed there were no results for any urine collected on 04/01/21, on 04/20/21 nor on 04/22/21.

Review of Resident #4's PCP visit note dated 04/01/21 revealed:
-The resident was seen for confusion and a urine sample would be obtained to rule out a urinary tract infection (UTI).
-There was an order for a U/A dated 04/01/21.

Review of Resident #4's PCP visit note dated 04/06/21 revealed:
-The resident was being seen for confusion and a urine sample would be obtained to rule out a urinary tract infection (UTI).
-There was an entry for acute cystitis.
-There was an entry that the resident was recently treated for a UTI so a broad spectrum and treat for possible resistance with Augmentin (an antibiotic used to treat bacterial infections such as UTI's) 500 mg twice a day for 7 days.

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D 273	Continued From page 59 -There was an entry that it was unclear if resident's acute confusion was related to a UTI or other issues. Review of Resident #4's PCP visit note dated 04/20/21 revealed: -There was an entry that the possible unresolved UTI was causing current presentation of hallucinations/delusions and behavioral changes. -There was an order for a U/A dated 04/20/21. -The staff were requested to collect an UA and send as soon as possible (ASAP). -The U/A should be sent out that day (04/20/21). -There was an entry as update: As of 04/23/21 the U/A was still not collected nor sent to the lab. -The PCP treated the resident for a presumptive UTI as symptoms were ongoing and concerning. Review of Resident #4's PCP visit note dated 04/22/21 revealed: -An entry regarding the resident's confusion and dizziness and the need for the staff to obtain a urine sample. -There was an order for a U/A dated 04/22/21. Review of Resident #4's Primary Care Provider orders dated 04/23/21 revealed there was an order to start Cipro (an antibiotic used to treat bacterial infections such as UTI's) 500 mg 1 capsule by mouth twice a day for 3 days. Review of Resident #4's PCP visit note dated 04/27/21 revealed: -There was an entry UTI: UA was never collected however the resident had symptomatically improved following completion of treatment with Cipro. -The UTI was at least a likely contributing factor to the confusion and hallucinations.	D 273		

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D 273	Continued From page 60 Telephone interview with a former medication aide (MA) on 06/02/21 at 9:37am revealed: -She normally collected the residents UA's when they were ordered. -Resident #4 was an easy resident to collect a UA. -Resident #4 was able to urinate in the "hat" on the toilet and she would let me know when she was done. -She did not remember having had any UA orders that were not completed when she worked with Resident #4. Interview with a medication aide (MA) on 06/02/21 at 3:15pm revealed: -Resident #4 was an easy resident to collect a UA as she could do it herself. -She did not remember having had orders for anything related to UA's only orders related to her complaints about her stomach. Interview with the Memory Care Manager (MCM) on 06/01/21 at 10:52am revealed: -The medication aide (MA) would have been responsible to get the UA collection. -She had the PCPs sign order on Tuesday and Friday when they came to the facility to see the residents. -The PCPs left any orders on her desk to be carried out. -When a resident had a change in status the MA would have been responsible to contact the PCP immediately. -There should have been documentation by the MA if contact was made with Resident #4's PCP regarding being unable to get the UA completed. -She expected orders to be carried out as soon as possible once the order was received. -She was unaware of the missed orders for the	D 273		

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D 273	Continued From page 61 UA's on Resident #4. Interview with the Administrator on 05/27/21 at 1:47pm and 06/02/21 at 4:09pm revealed: -The Care Managers (CM) were responsible for faxing new orders to the pharmacy. -The CMs were responsible for ensuring orders were correct and carried out. -Any new orders were discussed in the "stand-up" meetings that were done every morning in her office with all the managers. -The CMs would leave a note at the medication desk for the needed lab and date to be done. -The UA collection cups and specimen bags were available and well stocked. -The MA was responsible for collecting the specimen and calling the lab for pick up. -The CMs were responsible to follow up to make sure the labs were done. -The CMs were responsible to complete PCP orders and follow up on all visit notes from providers. Interview with Resident #4's PCP on 05/28/21 at 9:31am revealed: -She had not be notified that the ordered U/As had not been collected. -Missing or overlooked orders were common especially with the short staffing and turnover in staff. -She treated suspected UTI's prophylactically for that reason. -She expected all orders including any laboratory orders given for the resident to be completed as ordered. Interview with Resident #4's second PCP on 06/01/21 at 1:36pm revealed: -She had known orders to "disappear" (never followed through and no one knows what	D 273		

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D 273	Continued From page 62 happened to the order, it went missing). -She handed them directly to the MCM or the Administrator now. -She expected all orders including any laboratory orders given for the resident to be completed as ordered. _____ The facility failed to ensure a resident who had a history of aspiration had a speech therapy consult completed (Resident #3) placing the resident at risk for further aspiration and potential infection; failed to ensure Resident #2 had a follow up appointment as ordered after cataract surgery; failed to complete a urinalysis resulting in the primary care provider (PCP) starting prophylactic antibiotics without ordered lab results (Resident #4); failed to notify Resident #5's PCP of a weight gain as ordered on 3 occasions and to have lab work and a urinalysis completed as ordered by Resident #5's mental health provider. The facility's failure placed the residents at risk for serious physical harm and neglect and constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/02/21 for this violation.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30	D 280		

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D 280	Continued From page 63 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a quarterly Licensed Health Professional Support (LHPS) evaluation was completed for 2 of 5 sampled residents (Residents #4 & #3) with LHPS task of positioning and applying a brace and use of suppositories (#4) and transferring of a semi-ambulatory resident (#3). The findings are: 1. Review of Resident #4's current FL-2 dated 02/26/21 revealed: -Diagnoses included bi-polar anxiety, fibromyalgia, vitamin B deficiency, gastric ulcer, hypertension, status post cerebrovascular accident, and depression. -Her ambulatory status was not listed on the FL-2.	D 280		

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D 280	Continued From page 64 Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation dated 08/22/20 revealed: -There was documentation that included the tasks of an ankle foot orthosis (AFO) brace and rectal suppository. -There was no documentation of additional LHPS tasks listed. -Resident #4's documented physical assessment noted she ambulated with rolling walker. -There was documentation to continue current plan of care and there was no documented recommendation. -There was no documentation for quarterly LHPS reviews and evaluations after 06/22/20. Interview with a personal care aide (PCA) on 05/26/21 at 4:58pm revealed: -Resident #4 transferred without assistance from her bed to walker. -Resident #4 was able to self-propel with her rolling walker. -She required assistance to apply the AFO brace. Refer to interview with the Memory Care Manager (MCM) on 06/01/21 at 10:35am. Refer to interview with the Administrator on 06/01/21 at 12:30pm. Attempted interview with Resident #4 on 06/01/21 was unsuccessful as she was out of the facility. 2. Review of Resident #3's current FL-2 dated 10/30/20 revealed: -Diagnoses included vascular dementia without behaviors, hypoxia, dysphagia, and airway aspiration. -He was semi-ambulatory with a wheelchair.	D 280		

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D 280	Continued From page 65 Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation revealed: -There was documentation of a LHPS evaluation dated 08/17/20 that included the task of any other prescribed physical or occupational therapy. -There was no documentation of additional LHPS tasks listed. -Resident #3's documented physical assessment noted he ambulated with wheelchair and/or walker. -There was documentation to continue current plan of care and there was no documented recommendation. -There was no documentation for quarterly LHPS reviews and evaluations from 08/17/20 to 06/02/21. Interview with a personal care aide (PCA) on 05/26/21 at 4:58pm revealed: -Resident #3 transferred with assistance from his bed to wheelchair. -Resident #3 was able to self-propel in the wheelchair. Based on observations, interviews and record reviews, it was determined that Resident #3 was not interviewable. Refer to interview with the Memory Care Manager (MCM) on 06/01/21 at 10:35am. Refer to interview with the Administrator on 06/01/21 at 12:30pm. _____ Interview with the Memory Care Manager (MCM) on 06/01/21 at 10:35am revealed: -The facility's LHPS nurse transitioned from full time to part time in October of 2020. -The LHPS nurse only came to the facility to see	D 280		

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D 280	Continued From page 66 a handful of residents at a time for LHPS review when she was available. -There was a new LHPS nurse that was starting in a few weeks and all the residents would be evaluated then. Interview with the Administrator on 06/01/21 at 12:30pm revealed: -The facility did not currently have a LHPS nurse, but they hired one that will start the week of 06/07/21. -The previous LHPS nurse was part time and did only a few evaluations at a time. -Care Managers were responsible for ensuring that quarterly evaluations were completed. -She did not realize Resident #1 and Resident #3 did not have a current quarterly evaluation completed until the survey staff brought it to her attention.	D 280		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the kitchen and food storage areas were clean and free of contamination related to a build-up of a black substance on the floor, a partially smoked cigarette in a clear plastic bin that contained	D 282		

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individual salt packets, a brownish substance on the floor of the refrigerator, stainless-steel baking pans and other assorted pans stored on a wire rack in front of a large hole in the sheetrock, bowls and plates stored upright and not covered on the top shelf of a stainless-steel storage rack, no paper towels at the hand washing sink, missing and loose floor tiles, an ice scoop left uncovered on the ice machine, a brownish substance throughout the food warmer used to transport plates of food, and food items stored in the refrigerator that were expired, and food items stored in the refrigerator and dry storage area that were opened but not dated or labeled.

The findings are:

Review of the local Environmental Health Inspection report for the kitchen dated 04/23/21 revealed an inspection score of 98.5.

Observation on 05/27/21 at 7:35am revealed a partially smoked cigarette in a clear plastic bin that contained individual salt packets on a shelf near the kitchen door from the dining room.

Observation on 05/27/21 at 7:36am revealed food items (sour cream and ranch dressing) stored in the refrigerator that were expired and had dried food substances on the outside of the containers (ranch dressing) and food that had been opened (sour cream) but did not have dates when it was opened.

Observation on 05/27/21 at 7:37am revealed an unwrapped meat patty lying on the floor of the refrigerator.

Observation of the walk-in refrigerator on 05/27/21 at 7:38am revealed there was a

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stainless-steel bowl that contained sliced oranges that was partially covered and not dated and labeled.

Observation of the dry storage area on 05/27/21 at 7:42am revealed:
-There were cans of spinach and collard greens sitting on the floor.
-The plastic containers used for storage for oatmeal, grits and cereal were not labeled with an open date for when the products were placed in the containers.
-There was cornmeal (wrapped in plastic), vanilla wafer cookies (wrapped in plastic), chocolate pudding mix (wrapped in plastic), rice crispy cereal (wrapped in plastic), mashed potato mix (wrapped in plastic), and noodles (wrapped in plastic) but none were labeled and dated.

Observation of the pan storage area in the kitchen on 05/27/21 at 7:42am revealed there were stainless-steel baking pans and other assorted pans stored on a wire rack in front of a large hole in the sheetrock of the kitchen wall.

Observation of the dish storage area in the kitchen on 05/27/21 at 7:43am revealed bowls and plates stored upright and not covered on the top shelf of a stainless-steel storage rack.

Observation of the hand washing sink in the kitchen on 05/27/21 at 7:44am revealed there were no paper towels at the hand washing sink.

Observation of the kitchen floor near the ice machine on 05/27/21 at 7:44am revealed missing and loose flooring tiles with build-up of a black sticky substance.

Observation of the ice machine on 05/27/21 at

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D 282	Continued From page 69 7:44am revealed the ice scoop was left uncovered on the ice machine. Observation of the food warmer on 05/27/21 at 7:44am revealed a dried brownish substance throughout the bottom and sides of the food warmer used to transport plates of food to the special care unit. Observation of the food warmer cart on 05/27/21 at 8:08am revealed: -The cook rolled the cart out into the dining room. -The Administrator pushed the cart out of the dining room towards the special care unit and instructed the dietary aide to help get the trays passed out to the residents seated in the dining room. Interview with the Dietary Manager (DM) on 06/01/21 at 10:25am revealed: -He had started as the DM in April 2021. -The dietary staff was short staffed and had not done a deep clean since he started. -The food deliveries came in on Tuesday and Friday. -The cleaning supplies and sanitizer chemicals came in once a month. -The kitchen staff were taught to clean as they go. -There was a cleaning schedule, but the staff did not always sign off on it. -He cleaned the ice machine daily -The dietary aides were responsible for stocking the dry goods and were expected to clean their area as they stocked it. -The cleaning schedule listed the items that were to be cleaned weekly. -The cleaning schedule was requested from the DM and was not received by the time of exit. -The kitchen staff was to label and date food	D 282		

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D 282	Continued From page 70 items as they opened them for use. -They had planned a deep cleaning to be done that weekend. Interview with the Administrator on 05/28/21 at 11:23am revealed: -The DM had been working in the kitchen as the DM since around April 2021. -The DM also still helped with some of the maintenance issues at times. -She would help get trays out as needed since they were short staffed in the kitchen. -The refrigerator, freezers and dry storage should be cleaned before the food delivery came. -The DM would be responsible to make sure the areas of the kitchen were cleaned. -She was not aware of how long the floor tiles had been broken.	D 282		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 3 of 5 residents (#2, #3, #4) sampled received their nutritional supplements as ordered.	D 310		

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D 310	Continued From page 71 1. Review of Resident #3's current FL-2 dated 10/30/20 revealed diagnoses included vascular dementia without behaviors, hypoxia, dysphagia III, and aspiration into airway. Review of Resident #3's physician order dated 01/20/21 revealed an order to start nutritional supplemental shakes, 1 bottle three times a day with meals. Observation of Resident #3 in the Special Care Unit (SCU) dining room on 05/26/21 at 5:03pm revealed no supplement was served or offered to the resident during the dinner meal. Review of Resident #3's May 2021 electronic medication administration record (eMAR) revealed on 05/26/21 revealed: -There was an entry for nutritional supplemental shake, three times a day, drink 118mL with meals. -The nutritional supplemental shakes were scheduled for administration at 8:00am, 12:00pm, and 5:00pm. -The nutritional supplemental shake was documented as administered on 05/26/21 at 5:00pm. Observation of Resident #3 in the SCU dining room on 05/27/21 at 12:27pm revealed no supplement was served or offered to the resident during the lunch meal. Observation of Resident #3 in the special care unit (SCU) dining room on 05/28/21 at 12:32pm revealed: -The resident had eaten approximately 80% of his lunch meal. -There was a cup of thickened water and tea beside the resident's lunch plate.	D 310		

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-The resident drank all of the water and tea.
-There was no supplement on the table with the resident's lunch meal.
-No supplement was served or offered to the resident during the lunch meal.

Interview with the personal care aide (PCA) on 05/28/21 at 12:34pm revealed:
-No supplements came on the food cart in the SCU to pass out.
-No residents in the SCU, including Resident #3, received any supplements during any meals.
-She thought the medication aides (MAs) passed out supplements during the medication passes.

Interview with the Memory Care Manager (MCM) on 06/01/21 at 10:40am revealed:
-It was the medication aides (MA) responsibility to get the supplements from the kitchen for the residents.
-The MA was responsible for signing the eMAR when the resident received the supplement.
-Resident #3 enjoyed the strawberry flavored nutritional supplemental shake and never refused it when offered.
-It "depended on who the MA was" as to whether or not Resident #3 received his shake.

Interview with Resident #3's primary care provider (PCP) on 06/01/21 at 1:35pm revealed:
-She expected staff to offer the residents supplements as ordered.
-She was not aware that Resident #3 was not receiving his supplement as ordered and was not offered his supplement as ordered.
-She expected staff to encourage Resident #3 to take his supplement.

Refer to observation of the freezer on 06/02/21 at 2:50pm.

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D 310	Continued From page 73 Refer to interview with Dietary Manager on 06/02/21 at 2:46pm Refer to interview with Administrator on 06/01/21 at 12:30pm. 2. Review of Resident #1's current FL-2 dated 02/19/21 revealed: -Diagnoses included vascular dementia, altered mental status, hypertension, bilateral hydronephrosis, chronic indwelling catheter, chronic kidney disease, and acute cystitis with hematuria. -He was constantly disoriented. Review of Resident #1's FL-2 Medication Clarification dated 02/19/21 revealed an order for nutritional supplemental shakes, 1 can three times a day between meals. Review of Resident #1's May 2021 electronic medication administration record (eMAR) revealed: -There was an electronic entry for nutritional supplemental shakes to be given three times a day to drink one can between meals at 9:00am, 2:00pm, and 8:00pm. -There was an electronic entry for nutritional supplemental shake being administered at 2:00pm. Observation of Resident #1 on 05/26/21 at 2:10 pm and 3:05pm revealed he was resting quietly in bed and no nutritional supplemental shake was served. Observation of Resident #1 on 05/27/21 at 7:30am - 9:08am revealed he was not served a nutritional supplemental shake at or after his	D 310		

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breakfast meal.

Observation of Resident #1 on 05/27/21 at 12:30pm revealed he was not served a nutritional supplemental shake at or after his lunch meal.

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

Refer to observation of the freezer on 06/02/21 at 2:50pm.

Refer to interview with Dietary Manager on 06/02/21 at 2:46pm.

Refer to interview with Administrator on 06/01/21 at 12:30pm.

3. Review of Resident #2's current FL-2 dated 02/11/21 revealed:
-Diagnoses included left great toe amputation secondary to osteoarthritis, peripheral vascular disease, type 2 diabetes mellitus, coronary artery disease, hypertension, hyperlipidemia, diffuse alveolar damage, and a history of a cerebrovascular accident.
-She required personal care assistance with bathing and dressing.
-She had a wheelchair.
-She was on a regular diet with a nutritional supplement.

Review of Resident #2's eMARs for March 2021, April 2021, and May 2021 revealed there were no entries for a nutritional supplement.

Observation of Resident #2 on 05/27/21 at 7:30am - 9:08am revealed she was not served an nutritional supplement at her breakfast meal.

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D 310	Continued From page 75 Interview with Resident #2's on 06/02/21 at 10:49am revealed she had never been offered an nutritional supplement during meal times since she became a resident at the facility. Attempted telephone interviews with Resident #2's primary care provider on 06/01/21 at 10:54am and on 06/02/21 at 2:19pm were unsuccessful. _____ Observation of the freezer on 06/02/21 at 2:50pm revealed an unopened case of nutritional supplement shakes which contained 75 shakes per the label. Interview with Dietary Manager on 06/02/21 at 2:46pm revealed: -He kept nutritional supplemental shakes in the freezer in the kitchen. -He did not stock the nutritional supplement for Resident #2. -He did not know he needed to order any other nutritional supplements for any residents. -If he needed to order them, he could order them today (06/02/21) and have them in by Friday (06/05/21). -The medication aides were responsible to come to the kitchen to pick up any needed supplements for the residents. Interview with the Administrator on 06/01/21 at 12:30pm revealed: -She expected staff to offer supplements to the residents as ordered. -It was the MA's responsibility to get the residents their supplements as ordered.	D 310		

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D 315	Continued From page 76	D 315		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews and review of the facility's activity calendar, the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Observation on 05/26/21 at 9:27am during the initial tour of the facility revealed there were activity calendars posted in the assisted living (AL) and special care unit (SCU) hallways of the facility. Observation on 05/26/21 during the initial tour of the facility revealed there were October 2020 activity calendars posted in several of the residents' rooms on the AL side. Review of the May 2021 Activity Calendar on 05/26/21 at 9:27am posted on a bulletin board in AL hallway revealed: -There were at least fourteen hours of activities scheduled weekly on the calendar. -Alternate and one on one activities were always	D 315		

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D 315	Continued From page 77 available upon request and to ask staff to schedule. Observations on 05/26/21 at 10:00am-11:00am, 1:00-2:00pm and 4:00-5:00pm revealed: -There were no activities being conducted on AL. -The activity of resident council meeting was scheduled on 05/26/21 10:00-11:00am. -The activity of Badminton was scheduled on 05/26/21 1:00-2:00pm. -The activity Tie Dye bandanas was scheduled on 05/26/21 4:00-5:00pm. Interview with a resident on 05/26/21 at 10:11am revealed: -There were not any activities. -They played Bingo some time ago (could not remember exact date). -They did not play the entire scheduled time (could not remember why it was cut short). Observations on 05/26/21 at 10:00-11:00am, 1:00-2:00pm and 4:00-5:00pm revealed: -There were no activities being conducted in the SCU. -The activity of resident council meeting was scheduled on 05/26/21 10:00-11:00am. -The activity of Badminton was scheduled on 05/26/21 1:00-2:00pm. -The activity Tie Dye bandanas was scheduled on 05/26/21 4:00-5:00pm. Interview with a resident in the SCU dining room on 05/26/21 at 4:41pm revealed: -She saw on the Activity Calendar that there was Tie-Dye Bandanas scheduled at 4:00pm but no staff ever came to do the activity. -They didn't have very many activities anymore. -She missed having activities and loved playing bingo.	D 315		

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D 315	Continued From page 78 -There was no Activities Director (AD) since before Thanksgiving of 2020. Interview with a medication aide (MA) on 05/26/21 at 9:47am revealed: -The facility's former AD left around October 2020. -The AD position was still vacant. -There were currently no activities being done in the SCU except they listened to music on the radio sometimes when the residents were eating their meals. -They were not doing activities in the SCU because there was no AD. Interview with a second resident in the SCU on 05/26/21 at 10:39am revealed: -There were no activities in the SCU. -He sometimes went to the AL side of the facility and played bingo about once a week. -He was bored and would like to have some church activities. Another interview with the second resident in the SCU on 06/02/21 at 4:14pm revealed: -There were no activities to do in the SCU. -He was laying in his bed with "nothing to do" and he was "bored". Interview with the Administrator on 06/02/21 at 4:09pm revealed: -There was not a current activity director. -The last time there had been an activity director was in October 2020. -The business office manager (BOM) would do activities as her availability allowed. -An AD at a sister facility made the activities calendar. -Resident were not receiving 14 hours of activities a week.	D 315		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 3 residents (#10, #11, #12) observed during the medication passes including errors with a medication used to treat seasonal allergies, a medication used to treat gastric reflux, and an inhaler for shortness of breath and wheezing (#10), a mild pain reliever patch (#11), and medication used to treat high blood pressure (#12); and for 3 of 6 residents sampled (#2, #5, #13) for record review including errors with medications for underactive thyroid, fluid retention, and high blood pressure (#5); errors with crushing extended release medications for high blood pressure, low potassium levels, and acid reflux (#13); and errors with a laxative (#2). The findings are: 1. The medication error rate was 17% as evidenced by the observation of 5 errors out of 28	D 358		

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opportunities during the 7:00 to 9:00am medication pass on 05/27/21.

a. Review of Resident #10's current FL-2 dated 03/02/21 revealed:
-Diagnoses included type 2 diabetes, hypertension, bipolar disorder, osteoarthritis, syncope and history of falls.
-There was an order for Claritin 10mg 1 tablet daily. (Claritin is used to treat allergies.)

Observation of the morning medication pass on 05/27/21 revealed Claritin 10mg was not administered or offered to Resident #10 when she received her other morning medications at 7:54am.

Review of Resident #10's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Claritin 10 mg, take 1 tablet every morning for allergies, scheduled for administration at 7:00am.
-Claritin 10mg was documented as administered on 5/27/21 at 7:00am.

Observation of Resident #10's medications on hand on 05/27/21 at 12:49pm revealed:
-There was a blister pack of Claritin 10mg tablets dispensed on 05/18/21.
-There were 8 tablets remaining of the 9 tablets dispensed on 05/18/21.
-The medication label read Claritin 10mg with instructions to take 1 tablet every morning for allergies.

Interview with the medication aide (MA) on 05/27/21 at 12:45pm revealed:
-She only gave Resident #10 the Claritin when the resident complained of allergies.

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-She read the instructions on the eMAR for Claritin to be an "as needed" medication.
-She did not ask Resident #10 if she had allergy symptoms this morning during the medication pass.

Interview with Resident #10 on 05/27/21 at 3:45pm revealed:
-She had a continuous runny nose because of her allergies.
-She did not recall staff asking her about any allergy symptoms.
-She could not remember if she got a Claritin tablet every day with her morning medications.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/21 8:45pm revealed:
-The pharmacy dispensed 9 Claritin 10mg tablets for Resident #10 on 05/18/21.
-Starting on 05/24/21, Resident #10's Claritin would be added into her multi-dose medication packs for weekly refill.

Interview with the Resident Care Coordinator (RCC) on 05/27/21 at 1:38pm revealed she expected Resident #10 to receive Claritin daily as ordered.

Interview with the Administrator on 05/27/21 at 1:47pm revealed she expected staff to administer Resident #10's Claritin daily as ordered.

Attempted telephone interview with Resident #10's primary care provider (PCP) on 06/01/21 at 10:28am and 06/02/21 at 1:39pm was unsuccessful.

b. Review of Resident #10's current FL-2 dated 03/02/21 revealed an order for Omeprazole

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D 358	Continued From page 82 20mg, take 1 capsule daily. (Omeprazole is used in the treatment of gastroesophageal reflux disease.) Observation of the 8:00am medication pass on 05/27/21 revealed: -The medication aide (MA) said she had forgotten to administer a medication to Resident #10 during the 8:00am medication pass. -The MA administered Omeprazole 20mg to Resident #10 at 8:58am. Review of Resident #10's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Omeprazole 20mg, take one capsule by mouth on an empty stomach, scheduled for administration at 6:00am. -Omeprazole 20mg was documented as administered at 6:00am on 05/27/21 by the 3rd shift MA. Observation of Resident #10's medications on hand on 05/27/21 at 12:49pm revealed: -There were 30 of 30 Omeprazole 20mg capsules with a dispense date of 05/25/21. -The Omeprazole capsule was a white color. Interview with the MA who performed the 8:00am medication pass on 05/27/21 at 12:45pm revealed: -She was used to administering Resident #10 the Omeprazole with her morning medications, but the scheduled times had changed recently for morning medications from 7:00am to 8:00am. -She did not check the eMAR to see if Resident #10's Omeprazole was due on 05/27/21; she was used to giving it out of habit during the 8:00am medication pass. -She should have checked the eMAR before	D 358		

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administering Resident #10's Omeprazole.

Telephone interview with the third shift MA on 05/27/21 at 8:30pm revealed she administered Resident #10's Omeprazole that was scheduled for administration on 05/27/21 at 6:00am.

Interview with Resident #10 on 05/27/21 at 3:45pm revealed:
-The third shift MA gave her one white capsule in the morning before the MA left around 6:00am.
-She could not recall how long the third shift MA had been giving her the morning medication.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/21 at 8:45am revealed:
-The pharmacy last dispensed 30 Omeprazole 20mg capsules to Resident #10 on 05/25/21 in a blister pack.
-Prior to the last dispense date of 05/25/21, the pharmacy dispensed 30 Omeprazole 20mg capsules on 04/30/21 for Resident #10.

Interview with the Resident Care Coordinator (RCC) on 05/27/21 at 1:38pm revealed:
-She expected staff to review the eMAR prior to administering medications.
-She expected staff to administer Resident #10's Omeprazole as ordered.

Interview with the Administrator on 05/27/21 at 1:47pm revealed she expected staff to administer Resident #10's Omeprazole as ordered.

Attempted telephone interview with Resident #10's primary care provider (PCP) on 06/01/21 at 10:28am and 06/02/21 at 1:39pm was unsuccessful.

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D 358	Continued From page 84 c. Review of Resident #10's physician order dated 05/18/21 revealed an order for Xopenex 45mcg inhaler, two puffs in the morning and two puffs in the evening for shortness of breath and wheezing. (Xopenex is used to treat wheezing and shortness of breath.) Observation of the morning medication pass on 05/27/21 revealed Xopenex inhaler was not administered or offered to Resident #10 when she received her other morning medications at 7:54am. Review of Resident #10's May 2021 electronic medication administration record (eMAR) revealed there was an entry for Xopenex inhaler, 45mcg inhale two puffs in the morning, scheduled for administration at 7:00am. Interview with the medication aide (MA) on 05/27/21 at 7:55am revealed she called the pharmacy yesterday to request Resident #10's Xopenex inhaler because it was a new order. Observation of Resident #10's medications on hand on 05/27/21 at 12:49pm revealed there was no Xopenex inhaler available for administration. Interview with Resident #10 on 05/27/21 at 3:45pm revealed: -She had not yet received her new inhaler from when she saw her primary care provider (PCP) on 05/18/21. -She was still short of breath with activity. -She had an inhaler in the past that helped with her wheezing and she was looking forward to getting the new inhaler. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/21 at	D 358		

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D 358	Continued From page 85 8:45am revealed: -Resident #10's Xopenex inhaler order was received at the pharmacy on 05/18/21. -The pharmacy contacted the facility and the PCP a total of 14 times regarding an issue with insurance over the last two weeks. -The facility had yet to respond to the pharmacy's request. -The pharmacy had entered the order into the eMAR system but the medication had not been dispensed yet. Interview with the Resident Care Coordinator (RCC) on 05/27/21 at 1:38pm revealed: -She was not aware that Resident #10 did not have the Xopenex inhaler available for administration. -She expected staff to notify her if they were not able to obtain a resident's medication for administration. Interview with the Administrator on 05/27/21 at 1:47pm revealed: -The RCC or Memory Care Manager (MCM) were responsible for faxing new orders to the pharmacy. -The RCC or MCM were responsible for ensuring orders were correct on the eMAR and medications were available for administration. -She expected medications to be available in the facility for administration. Attempted telephone interview with Resident #10's primary care provider (PCP) on 06/01/21 at 10:28am and 06/02/21 at 1:39pm was unsuccessful. d. Review of Resident #11's current FL-2 dated 02/26/21 revealed: -Diagnoses included Alzheimer's disease,	D 358		

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osteoarthritis, gait impairment, hyperlipidemia, hypothyroidism, hypertension, and gastroesophageal reflux disorder.
-There was an order for Lidocaine 4% patch apply 1 patch to left lateral flank every morning and remove every evening. (Lidocaine is a pain reliever.)

Observation of the 8:00am medication pass on 05/27/21 revealed Lidocaine 4% patch was not administered or offered to Resident #11 when she received her other morning medications at 8:04am.

Review of Resident #11's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Lidocaine 4% adhesive patch with instructions to apply 1 patch to left lateral flank every morning and remove every evening, scheduled for administration at 7:00am.
-Lidocaine 4% patch was documented as administered on 5/27/21 at 7:00am.

Interview with Resident #11 on 05/27/21 at 12:30pm revealed:
-The Lidocaine patch was to help with chronic back pain.
-Staff was "hit or miss" as to when they would apply the patch.
-Staff was responsible for applying and removing the patch.
-Staff had not placed the patch in a while, at least not the last three days.
-She could not remember when the last time staff had put on the Lidocaine patch.

Observation of Resident #11's medications on hand on 05/27/21 at 12:25pm revealed there were no Lidocaine 4% patches available for

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administration.

Interview with the medication aide (MA) on 05/27/21 at 12:45pm revealed:
-She could not locate Resident #11's Lidocaine patches in the medication cart.
-She was going to fax a request for a medication refill to the pharmacy today.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/21 at 8:45am revealed:
-The pharmacy received a faxed refill request on 05/28/21 and filled the request with 30 patches sent to the facility on 05/28/21.
-Prior to the request on 05/28/21, the Lidocaine 4% patch had not been filled since 12/08/20 when they dispensed 30 patches.

Interview with the Resident Care Coordinator (RCC) on 05/27/21 at 1:38pm revealed:
-She expected staff to administer Resident#11's Lidocaine patch daily as ordered.
-She had just received cart audit form from the night shift MA that noted Resident #11's Lidocaine patch was available on the cart.
-The cart audit completed on 05/26/21 was the first audit that had been done since she started two weeks earlier.

A second interview with the RCC on 05/27/21 at 1:55pm revealed:
-The Lidocaine 4% patches were not unavailable and had been found.
-Resident #11's Lidocaine 4% patches were located in the medication cart underneath a package of dressing supplies.

A second observation of Resident #11's medication on hand on 05/27/21 at 3:57pm

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revealed four Lidocaine 4% patches with a dispense date of 12/08/20.

Interview with the Administrator on 05/27/21 at 1:47pm revealed she expected Resident #11 to receive her Lidocaine 4% patch daily as ordered.

Interview with Resident #11's primary care provider (PCP) on 06/01/21 at 1:35pm revealed:
-She expected Resident #11's Lidocaine patch to be administered as ordered.
-If Resident #11 did not receive the Lidocaine patch as ordered, she could experience increased back pain.

e. Review of Resident #12's current FL-2 dated 03/09/21 revealed:
-Diagnoses included dementia with behavioral disturbances, hypertension, chronic kidney disease, delusions, and benign prostatic hypertrophy.
-There was an order for Losartan-Hydrochlorothiazide 50-12.5mg (combination) with instructions to take 1 tablet daily. (Losartan-Hydrochlorothiazide is used to treat high blood pressure.)

Review of Resident #12's physician orders dated 05/07/21 revealed:
-There was an order to discontinue Hydrochlorothiazide.
-There was no order to discontinue Losartan.

Observation of the 9:00am medication pass on 05/27/21 revealed Losartan 50mg was not administered or offered to Resident #12 during the morning medication pass.

Review of Resident #12's May 2021 electronic medication administration record (eMAR) on

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05/27/21 at 12:48pm revealed:
-There was no entry for Losartan 50mg daily.
-There was an entry for Losartan-Hydrochlorothiazide 50-12.5mg take 1 tablet daily, that was discontinued on 05/07/21.

Review of Resident #12's May 2021 vital signs revealed:
-Resident #12's blood pressure (BP) on 05/05/21 was documented as 138/74.
-Resident #12's BP on 05/12/21 was documented as 138/74.
-Resident #12's BP on 05/19/21 was documented as 128/67.
-Resident #12's BP on 05/27/21 was documented as 140/77.

Observation of Resident #12's medications on hand on 05/27/21 at 12:15pm revealed there was no Losartan 50mg available for administration.

Interview with the medication aide (MA) performing the morning medication pass on 05/27/21 at 12:45pm revealed she did not administer Resident #12's Losartan because it was not on the eMAR.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/21 at 8:45am revealed:
-The facility staff entered discontinue orders into the eMAR system.
-The pharmacy had Losartan 50mg on Resident #12's profile dated 05/07/21.
-The pharmacy had not received a request to fill the Losartan 50mg prior to 05/28/21.

Interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm revealed the Administrator discontinued the Losartan-Hydrochlorothiazide

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from the eMAR on 05/07/21.

Interview with the Administrator on 05/27/21 at 1:47pm revealed:
-She thought the discontinue Hydrochlorothiazide order from 05/07/21 meant to discontinue the Losartan-Hydrochlorothiazide.
-She deleted the Losartan-Hydrochlorothiazide from Resident #12's eMAR on 05/07/21.

A second interview with the Administrator on 05/27/21 at 4:50pm revealed:
-She called Resident #12's primary care provider (PCP) today (05/27/21) for instruction on the Losartan.
-The PCP told the Administrator to take Resident #12's blood pressure and place him on the list to be seen by the provider tomorrow (05/28/21).
-The Losartan was not to be discontinued.

Interview with Resident #12's PCP on 06/01/21 at 1:35pm revealed:
-The order on 05/07/21 was to discontinue Hydrochlorothiazide, not the Losartan.
-She expected if staff had a question about the order they should have called and clarified.
-Resident #12 should be receiving Losartan 50mg daily as ordered.
-If Resident #12 did not receive Losartan as ordered he could experience increased blood pressure placing him at an increased risk for stroke or falls.

Based on observations, interviews, and record reviews, it was determined Resident #12 was not interviewable.

2. Review of Resident #5's current FL-2 dated 05/21/21 revealed diagnoses included vascular dementia, a virus that attacks the body's immune

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system, epilepsy, hypothyroidism, hyperlipidemia, constipation, and insomnia.

a. Review of Resident #5's physician's order dated 09/22/20 revealed an order for Levothyroxine 112mcg 1 tablet daily before breakfast, hold for heart rate (HR) below 60.

Review of Resident #5's primary care provider (PCP) visit note dated 12/22/20 revealed:
-The resident's Thyroid Stimulating Hormone (TSH) lab level was low. (TSH is used to diagnose thyroid conditions.)
-The resident's hyperthyroid state could have contributed to his recent seizure although there was a low likelihood of significant contribution.
-There was an order to stop Levothyroxine 112mcg and start Levothyroxine 100mcg 1 tablet in the morning on an empty stomach.

Review of Resident #5's PCP visit note dated 12/29/20 revealed:
-There was an order to continue Levothyroxine 100mcg 1 tablet in the morning on an empty stomach.
-The medication was recently adjusted due to low TSH; will monitor labs for need of further adjustment.

Review of Resident #5's PCP visit note dated 02/16/21 revealed:
-There was an order to continue Levothyroxine 100mcg 1 tablet in the morning on an empty stomach.
-The last TSH was 0.35 (reference range 0.40 - 4.50) and the medication was adjusted at that time.
-Hyperthyroid state could possibly be contributing to recent weight loss; continue to monitor.

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Review of Resident #5's PCP visit note dated 03/16/21 revealed:
-There was an order to continue Levothyroxine 100mcg 1 tablet in the morning on an empty stomach.
-The last TSH was 0.35 and the medication was adjusted at that time; continue to monitor for need of further adjustments.
-The resident's appetite had returned to baseline.

Review of Resident #5's PCP visit note dated 05/18/21 revealed:
-The resident's hypothyroidism was currently managed on Levothyroxine 100mcg.
-The resident denied temperature intolerance, weight fluctuation, changes in appetite, diarrhea, and constipation.
-No current complications noted; continue Levothyroxine 100mcg daily.

Review of Resident #5's December 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 112mcg 1 tablet every day scheduled for 6:00am.
-Levothyroxine 112mcg was documented as administered daily at 6:00am from 12/01/20 - 12/18/20.
-There was a second entry for Levothyroxine 112mcg 1 tablet in the morning on an empty stomach once a day scheduled for 9:00am.
-Levothyroxine 112mcg was documented as not administered from 12/19/20 - 12/21/20 due to "on hold, pharmacy will deliver later".
-Levothyroxine 112mcg was documented as administered daily at 9:00am from 12/22/20 - 12/23/20.
-There was a third entry for Levothyroxine 112mcg 1 tablet in the morning on an empty stomach once a day scheduled for 6:00am.

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D 358	Continued From page 93 -Levothyroxine 112mcg was documented as administered daily at 6:00am from 12/24/20 - 12/31/20. -There was no entry for Levothyroxine 100mcg every morning on an empty stomach as ordered on 12/22/20. Review of Resident #5's January 2021 eMAR revealed: -There was an entry for Levothyroxine 112mcg 1 tablet in the morning on an empty stomach once a day scheduled for 6:00am. -Levothyroxine 112mcg was documented as administered daily at 6:00am from 01/01/21 - 01/31/21 except on 01/25/21 when the medication was unavailable. -There was no entry for Levothyroxine 100mcg every morning on an empty stomach as ordered on 12/22/20. Review of Resident #5's February 2021 eMAR revealed: -There was an entry for Levothyroxine 112mcg 1 tablet in the morning on an empty stomach once a day scheduled for 6:00am. -Levothyroxine 112mcg was documented as administered daily at 6:00am from 02/01/21 - 02/28/21. -There was no entry for Levothyroxine 100mcg every morning on an empty stomach as ordered on 12/22/20. Review of Resident #5's March 2021 eMAR revealed: -There was an entry for Levothyroxine 112mcg 1 tablet in the morning on an empty stomach once a day scheduled for 6:00am. -Levothyroxine 112mcg was documented as administered daily at 6:00am from 03/01/21 - 03/31/21.	D 358		

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-There was no entry for Levothyroxine 100mcg every morning on an empty stomach as ordered on 12/22/20.

Review of Resident #5's April 2021 eMAR revealed:
-There was an entry for Levothyroxine 112mcg 1 tablet in the morning on an empty stomach once a day scheduled for 6:00am.
-Levothyroxine 112mcg was documented as administered daily at 6:00am from 04/01/21 - 04/30/21 except on 04/25/21 when it was documented as being on hold.
-There was no entry for Levothyroxine 100mcg every morning on an empty stomach as ordered on 12/22/20.

Review of Resident #5's May 2021 eMAR revealed:
-There was an entry for Levothyroxine 112mcg 1 tablet in the morning on an empty stomach once a day scheduled for 6:00am.
-Levothyroxine 112mcg was documented as administered daily at 6:00am from 05/01/21 - 05/26/21 except on 05/05/21 when the resident was unavailable.
-There was no entry for Levothyroxine 100mcg every morning on an empty stomach as ordered on 12/22/20.

Observation of Resident #5's medications on hand on 06/01/21 at 5:30pm revealed:
-There was a bubble card with 2 of 30 Levothyroxine 112mcg tablets remaining that were dispensed on 04/24/21.
-There was a second bubble card with 30 of 30 Levothyroxine 112mcg tablets remaining that were dispensed on 05/24/21.

Telephone interview with a pharmacy technician

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at the facility's contracted pharmacy on 06/02/21 at 1:50pm revealed:
-The last order the pharmacy had on file for Resident #5's Levothyroxine was dated 12/18/20 and was for Levothyroxine 112mcg daily.
-They never received an order dated 12/22/20 for Levothyroxine 100mcg and never dispensed Levothyroxine 100mcg for Resident #5.
-They dispensed 30 Levothyroxine 112mcg tablets each on 12/20/20, 01/30/21, 03/13/21, 04/24/21, and 05/24/21.

Interview with the Memory Care Manager (MCM) on 06/01/21 at 5:30pm revealed:
-Resident #5 had always received Levothyroxine 112mcg daily.
-She did not recall the order change on 12/22/20.
-The pharmacy usually entered medication orders into the eMAR system.
-Either she or the Resident Care Coordinator (RCC) or the Administrator had access to approve orders once the orders were entered into the eMAR system.
-The facility had to approve orders in the eMAR system so the orders would become active on the eMAR.
-She did not know why the order for Levothyroxine was never implemented.
-The order must have been "overlooked".

Review of Resident #5's lab results dated 03/03/21 revealed the resident's TSH level was 1.62 (reference range 0.40 - 4.50).

Interviews with Resident #5's PCP on 06/01/21 at 1:35pm and 06/02/21 at 1:22pm revealed:
-She expected staff to administer Levothyroxine 100mcg as ordered on 12/22/20 to the resident.
-She was not aware the order for Levothyroxine 100mcg was never implemented.

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-She had not changed the order for Levothyroxine 100mcg daily.
-The facility had problems in the past (no time specified) with misplacing orders so she currently emailed or handed orders to the MCM and the orders in her PCP notes were electronically signed.
-Not decreasing the Levothyroxine when ordered, could have perpetuated the resident's hyperthyroid state (symptoms may include weight loss, appetite changes, temperature intolerance, rapid and irregular heartbeat, nervousness, anxiety, and irritability).
-She would leave the resident on Levothyroxine 112mcg since the resident was stable now but she would recheck the TSH level to determine if any changes needed to be made.

b. Review of Resident #5's physician's orders dated 09/22/20 and 03/16/21 revealed an order for Hydrochlorothiazide (HCTZ) 25mg 1 tablet every day. (HCTZ is a diuretic used to treat swelling and fluid retention and can lower blood pressure.)

Review of Resident #5's primary care provider (PCP) visit note dated 05/18/21 revealed:
-The resident was being seen for follow-up to a recent emergency room visit (05/05/21) with complaint of chest pain.
-The resident's blood pressure upon exam by the PCP was "somewhat low" at 100/60 on 05/18/21.
-The PCP noted she would discontinue the resident's HCTZ as the medication was not ideal for the resident due to the risk of dehydration, electrolyte depletion, elevated glucose, and falls risk.

Review of Resident #5's PCP order dated 05/21/21 revealed an order to discontinue the

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D 358	Continued From page 97 HCTZ. Review of Resident #5's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for HCTZ 25mg 1 tablet every day scheduled for administration at 8:00am. -HCTZ was documented as administered at 8:00am from 05/01/21 - 05/24/21. -The HCTZ was documented as discontinued on 05/24/21. -The resident continued to receive HCTZ for 3 days after it was discontinued on 05/21/21. -The resident's BP ranged from 132/68 - 148/65 from 05/05/21 - 05/08/21 when the resident was under 72-hour monitoring after a hospital visit. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/02/21 at 1:50pm revealed: -The pharmacy received Resident #5's order to discontinue HCTZ on 05/21/21 at 5:20pm. -The pharmacy entered orders, including discontinue orders, into the eMAR system. -The facility was responsible for approving the orders entered into the eMAR system. -The HCTZ order would remain active in the eMAR system until facility staff approved the order. Interview with the Memory Care Manager (MCM) on 06/01/21 at 5:30pm revealed: -The pharmacy usually entered medication orders, including discontinue orders, into the eMAR system. -Either she or the Resident Care Coordinator (RCC) or the Administrator had access to accept orders once the orders were entered into the eMAR system.	D 358		

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-She did not get a copy of the discontinue order for the HCTZ dated 05/21/21 (Friday) until she returned to work on Monday, 05/24/21.
-She accepted the discontinue order in the eMAR system on 05/24/21.
-The HCTZ order would have remained active in the eMAR system until she accepted it on 05/24/21.

Interview with the Administrator on 06/02/21 at 4:25pm revealed:
-The eMARs should accurately reflect current medication orders.
-If a medication was discontinued, it should be removed from the eMAR.
-She and the RCC and the MCM had remote access to the eMAR system and could log in at any time to review and accept or enter orders if needed.
-The MAs were responsible for letting she or the RCC or the MCM know if orders were received that needed to be reviewed and accepted.
-Resident #5's HCTZ should have been discontinued when it was ordered on 05/21/21.

Interview with Resident #5's PCP on 06/01/21 at 1:35pm revealed:
-She discontinued Resident #5's HCTZ because his blood pressure had been running low.
-She expected the HCTZ to be stopped when the discontinue order was written.
-Continuing to administer the HCTZ could put the resident at risk for low blood pressures which could cause dizziness and lightheadedness and could put the resident at risk for falls.

c. Review of Resident #5's current FL-2 dated 05/21/21 revealed there was an order for Metoprolol 25mg take ½ tablet (12.5mg) twice daily as needed for systolic blood pressure (SBP)

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above 180 or diastolic blood pressure (DBP) above 100; hold for heart rate (HR) below 80, if BP is "high 180/110" wait 5 minutes, recheck before giving this medication. (Metoprolol is used to lower blood pressure and heart rate.)

Review of Resident #5's previous physician's order dated 09/22/20 revealed an order for Metoprolol 25mg take ½ tablet (12.5mg) twice daily as needed for SBP above 180 or DBP above 100; hold for HR below 80.

Review of Resident #5's physician's order dated 03/16/21 revealed an order Metoprolol 25mg take ½ tablet (12.5mg) twice daily as needed for SBP above 180 or DBP above 100; hold for HR below 80, if BP is "high 180/110" wait 5 minutes, recheck before giving this medication.

Review of Resident #5's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol 25mg take ½ tablet (12.5mg) twice daily as needed for SBP above 180 or DBP above 100; hold for HR below 80 - If BP is "high 180/110" wait 5 minutes, recheck before giving this medication.
-There were no scheduled times listed for this medication.
-There were two rows each to document the resident's BP and HR.
-There were no BPs or HRs documented for the parameters for administration of the Metoprolol or for holding the Metoprolol from 03/01/21 - 03/31/21.
-No Metoprolol was documented as administered from 03/01/21 - 03/31/21.
-It could not be determined if Metoprolol should have been administered or held without the parameters of the BP and HR being checked

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twice a day as ordered.
-There was an entry for 72-hour monitoring for the resident from 03/12/21 - 03/15/21 with documented BPs and HRs for each shift.
-The resident's BP ranged from 125/78 - 142/59 and the HR ranged from 67 - 80 from 03/12/21 - 03/15/21.

Review of Resident #5's April 2021 eMAR revealed:
-There was an entry for Metoprolol 25mg take ½ tablet (12.5mg) twice daily as needed for SBP above 180 or DBP above 100; hold for HR below 80 - If BP is high 180/110 wait 5 minutes, recheck before giving this medication.
-There were no scheduled times listed for this medication.
-There were two rows each to document the resident's BP and HR.
-There were no BPs or HRs documented for the parameters for administration of the Metoprolol or for holding the Metoprolol from 04/01/21 - 04/30/21.
-No Metoprolol was documented as administered from 04/01/21 - 04/30/21.
-It could not be determined if Metoprolol should have been administered or held without the parameters of the BP and HR being checked twice a day as ordered.

Review of Resident #5's May 2021 eMAR revealed:
-There was an entry for Metoprolol 25mg take ½ tablet (12.5mg) twice daily as needed for SBP above 180 or DBP above 100; hold for HR below 80 - If BP is high 180/110 wait 5 minutes, recheck before giving this medication.
-There were no scheduled times listed for this medication.
-There were two rows each to document the

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resident's BP and HR.
-There were no BPs or HRs documented for the parameters for administration of the Metoprolol or for holding the Metoprolol from 05/01/21 - 05/26/21.
-No Metoprolol was documented as administered from 05/01/21 - 05/26/21.
-It could not be determined if Metoprolol should have been administered or held without the parameters of the BP and HR being checked twice a day as ordered.
-There was an entry for 72-hour monitoring for the resident from 05/05/21 - 05/08/21 with documented BPs and HRs for each shift.
-The resident's BP ranged from 132/68 - 148/65 and the HR ranged from 68 - 77 from 05/05/21 - 05/08/21.

Observation of Resident #5's medications on hand on 06/01/21 at 5:30pm revealed:
-There was a bubble card of Metoprolol 25mg tablets dispensed on 09/21/20.
-There were a total of 20 half tablets (12.5mg) dispensed.
-There were 12 of the 20 half tablets of Metoprolol remaining.

Interview with the Memory Care Manager (MCM) on 06/01/21 at 5:30pm revealed:
-She had not noticed Resident #5's BP and HR were not being checked twice a day to determine if Metoprolol should be administered or held.
-The order did not automatically "pop up" on the eMAR for staff to administer because it was entered as an as needed (prn) medication.
-The resident's BP and HR should be checked twice a day so the MAs would know whether to administer or hold the Metoprolol.
-She was checking with the PCP today about the Metoprolol order.

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Interview with Resident #5's PCP on 06/01/21 at 1:35pm revealed:
-She expected the facility staff to check Resident #5's BP and HR twice a day to determine if the Metoprolol should be administered or held.
-She was not concerned that the resident had not received any Metoprolol because the resident recently had low BPs.

3. Review of Resident #13's current FL-2 dated 11/24/20 revealed:
-Diagnoses included traumatic brain injury, intellectual disability, hyperlipidemia, blindness, edema, anxiety, dysphagia, subdural hematoma, gastroesophageal reflux disease (GERD), dysarthria, asthenia, and agitation.
-There was an order for Metoprolol ER 25mg take ½ tablet (12.5mg) every morning, do not crush. (Metoprolol ER is an extended release medication used to lower blood pressure.)
-There was an order for Potassium Chloride ER 20mEq take 1 tablet once daily, do not crush. (Potassium Chloride ER is an extended release medication used to treat low potassium levels.)
-There was an order for Protonix 20mg take 1 tablet daily for GERD. (Protonix is a delayed release medication used to treat acid reflux.)

Review of Resident #5's physician order dated 12/18/20 revealed an order to crush medication: all medication may be crushed, check Do Not Crush (DNC) list, and placed in applesauce or pudding unless otherwise noted.

Observation of the medication aide (MA) on 05/28/21 at 9:56am revealed:
-The MA started preparing morning medications for Resident #13.
-The MA crushed all medications and put them in

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pudding and administered to the resident at 10:01am.

Review of the facility's DNC list revealed:
-Potassium Chloride ER should not be crushed due to being a slow-release formulation.
-Metoprolol ER should not be crushed due to being a slow-release formulation.
-Protonix should not be crushed due to being a slow-release formulation.

Review of Resident #13's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol ER 25mg take ½ tablet (12.5mg) every morning, "do not crush" scheduled for administration at 8:00am.
-There was an entry for Protonix 20mg take 1 table every day for GERD, "do not crush" scheduled for administration at 9:00am.
-There was an entry for Potassium Chloride ER 20mEq take 1 tablet every day, "do not crush" scheduled at 8:00am.

Observation of Resident #13's medications on hand on 05/28/21 at 2:33pm revealed:
-There was a supply of Metoprolol ER 25mg tablets dispensed on 05/25/21 with instructions that included "not to be crushed or chewed".
-There was a supply of Potassium Chloride ER 20mEq tablets dispensed on 05/25/21 with instructions that included "not to be crushed or chewed".
-There was a supply of Protonix 20mg tablets dispensed on 04/10/21 with instructions that included "do not chew/crush, swallow whole".

Interview with the MA on 05/28/21 at 2:33pm revealed:
-She always crushed all of Resident #13's

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medications, including Metoprolol ER, Potassium Chloride ER, and Protonix because the resident would not swallow the medications if they were not crushed.
-She was not aware Metoprolol ER, Potassium Chloride ER, and Protonix were not supposed to be crushed.
-She thought the medications could be crushed because the facility had standing orders to crush medications if needed.
-She did not know if the facility had a DNC list.
-She had not noticed the instructions on the medication labels or the eMAR to not crush those 3 medications.

Interview with the Resident Care Coordinator (RCC) on 05/28/21 at 2:39pm revealed:
-She was not aware Resident #13's medications were being crushed.
-The MAs were supposed to check the medication label and the eMAR instructions which should indicate if a medication should be crushed.
-She was not sure if the facility had a DNC list.
-Extended release medications should not be crushed.
-If a medication could not be crushed, the MAs should let her know so she would contact the PCP for alternative formulations.

Interview with Resident #13's PCP on 06/01/21 at 1:35pm revealed:
-She expected staff to only crush medications that were appropriate to crush for Resident #13.
-Resident #13's Metoprolol ER, Potassium Chloride ER, and Protonix should not be crushed.
-She was not aware these medications were being crushed for Resident #13.
-Crushing medications that were extended release would cause the medication to be

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released too fast and prevent the medications from working appropriately.
-Crushing Metoprolol ER could cause too much medication to be released at one time and could put the resident at risk for low blood pressure.
-Crushing Potassium Chloride ER tablets could irritate the resident's esophagus.

Based on observations, interviews, and record reviews, it was determined Resident #13 was not interviewable.

3. Review of Resident #2's current FL-2 dated 02/11/21 revealed:
-Diagnoses included left great toe amputation secondary to osteoarthritis, peripheral vascular disease, type 2 diabetes mellitus, coronary artery disease, hypertension, hyperlipidemia, diffuse alveolar damage, and a history of cerebrovascular accident.

Review of Resident #2's physician order report dated 02/25/21 revealed there was an order for Polyethylene glycol 3350 17grams daily. (Polyethylene glycol is a laxative solution used to stimulate bowel movements.)

Observation of medications on-hand on 06/01/21 at 11:20am revealed Resident #2's Polyethylene Glycol 3350 was not available for administration.

Review of Resident #2's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Polyethylene Glycol 3350 take 1 packet (17grams) daily mix in 4 ounces of water scheduled to be administered at 9:00am from 03/01/21 to 03/22/21 and scheduled to be administered at 7:00am from 03/23/21 to 03/31/21.

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D 358	Continued From page 106 -From 03/01/21 starting at 9:00am to 03/22/21 at 9:00am, it was documented Polyethylene Glycol was administered. -From 03/23/21 starting at 7:00am to 03/31/21 at 7:00am, it was documented Polyethylene Glycol was administered. Review of Resident #2's April 2021 eMAR revealed: -There was an entry for Polyethylene Glycol 3350 take 1 packet (17grams) daily mix in 4 ounces of water scheduled to be administered at 7:00am. -From 04/01/21 starting at 7:00am to 04/30/21 at 7:00am, it was documented Polyethylene Glycol was administered. Review of Resident #2's May 2021 eMAR revealed: -There was an entry for Polyethylene Glycol 3350 take 1 packet (17grams) daily mix in 4 ounces of water scheduled to be administered at 7:00am. -From 05/01/21 starting at 7:00am to 05/19/21 at 7:00am, it was documented Polyethylene Glycol was administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/01/21 at 11:42 revealed: -Resident #2's Polyethylene Glycol 3350 was last dispensed to the facility on 10/14/20 for a 30-day supply. -Resident #2's Polyethylene Glycol 3350 became an inactive order on 02/12/21. -Resident #2's Polyethylene Glycol 3350 became an active order on 02/25/21. Interview with the Pharmacist at the facility's contracted pharmacy on 06/01/21 at 12:00pm revealed: -He was not aware Resident #2's Polyethylene	D 358		

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D 358	Continued From page 107 Glycol 3350 had not been dispensed to facility since 10/14/20. -He was not sure if this was overlooked by the pharmacy, but he expected the facility to notify the pharmacy for missing medications or refill requests for residents. Interview with the Administrator on 06/02/21 at 4:00pm revealed: -She was not aware Resident #2's Polyethylene Glycol 3350 had not been dispensed to facility since 10/14/20. -She was not aware Resident #2's Polyethylene Glycol 3350 was not on the medication cart. -She expected the medication carts to be audited by the medication aides weekly and issues with medications on hand be brought to the attention of the Care Managers, Resident Care Coordinator or the Memory Care Manager. Attempted telephone interviews with Resident #2's primary care provider on 06/01/21 at 10:54am and on 06/02/21 at 2:19pm were unsuccessful. _____ The facility failed to ensure medications were administered as ordered for 3 residents observed during the medication pass and for 2 residents sampled. The facility did not administer medication that was ordered to treat chronic back pain resulting in continued pain for Resident #11. Resident #5 had a physician's order dated 12/22/20 to decrease Levothyroxine which was never implemented resulting in the resident continuing to receive the higher dose and placing the resident at risk for overactive thyroid symptoms such as weight loss, appetite changes, temperature intolerance, rapid and irregular heartbeat, nervousness, anxiety, and irritability. Resident #3 received a diuretic used to treat high	D 358		

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D 358	Continued From page 108 blood pressure for 3 days after it was discontinued due to the resident having low blood pressure which put the resident at risk of further low blood pressures that could cause dizziness, lightheadedness, and risk for falls. Resident #13 was administered medications in crushed form including 3 extended release medications that should not have been crushed putting the resident at risk for low blood pressure and an irritated esophagus. The facility's failure to administer medication as ordered was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/28/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 17, 2021.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications	D 364		

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D 364	Continued From page 109	D 364		

were administered within one hour before or after the prescribed or scheduled times for 5 of 5 residents observed (#3, #5, #14, #15, #16) in the special care unit (SCU) on 05/27/21 and 3 of 3 residents observed (#1, #13, #17) on the assisted living (AL) side of the facility on 05/28/21 resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time.

The findings are:

Review of the facility's Medication Management Clinical Standard Operating Procedure dated 07/20 revealed:
-Medications must be administered within a two-hour time frame defined as; one hour before and one hour after the scheduled medication time as per state rules and regulations.
-Medication shall not be administered two hours before or two hours after the scheduled time.
-All medications shall be reviewed that are ordered for specific times to ensure actual administration times are compliant with physician orders.

Review of the facility's census on 05/27/21 revealed there were 31 residents in the assisted living (AL) side and 8 residents in the special care unit (SCU).

1. Observation of the special care unit (SCU) on 05/27/21 from 10:45am to 11:21am revealed:
-There was one medication aide (MA) on the medication cart passing medications.
-The Administrator and Memory Care Manager (MCM) were on the SCU.

Interview with the MA on 05/27/21 at 11:18am revealed:

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D 364	Continued From page 110 -She still needed to give one resident their morning medication on SCU. -She had not been offered any help from other staff. -She had not asked for any assistance today because management could see that she was behind because they were in the hallways and aware of the two emergency incidents. -She was the only MA for the whole facility. -She normally finished her morning medication pass by 9:30am but she had two emergencies that took her away from the medication cart this morning (05/27/21). -She had reported to management that it was too much for one MA to pass the morning medications to all 39 residents in the facility. Observation of the resident in room #304 on 05/27/21 from 9:05am to 9:37am revealed the MA assisted with an emergency incident involving a resident until the emergency medical services arrived. Observation of the hallway in the SCU on 05/27/21 at 10:39am revealed: -There was a second emergency incident with a resident in the hallway and the Administrator came to assist the resident. -The MA continued to administer medications for her morning medication pass. a. Review of Resident #16's current FL-2 dated 05/21/21 revealed diagnoses included vascular dementia, hypertension, partial gastrectomy, seizure disorder, anxiety with depression, osteoarthritis, gastroesophageal reflex disease, and seasonal allergies. Review of Resident #16's May 2021 electronic medication administration record (eMAR)	D 364		

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D 364	Continued From page 111 revealed: -There were 3 medications scheduled to be administered at 8:00am. -There was 1 medication scheduled twice a day at 8:00am and 8:00pm. -There was an entry for Tylenol 500 mg 3 times a day and it was scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. (Tylenol is a mild pain reliever.) -There was an entry for Buspirone 10mg 3 times a day and it was scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. (Buspirone is used for the treatment of anxiety disorders.) -There was no documentation of time medications were actually administered on 05/27/21 listed on the eMAR. Observation of the medication aide (MA) administering morning medications on 05/27/21 revealed she entered Resident #16's room with her medications scheduled for 8:00am at 11:18am and exited at 11:21am. Based on observations, interviews, and record reviews, it was determined Resident #16 was not interviewable. Refer to the interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm. Refer to the interview with the Administrator on 05/27/21 at 4:50pm. Refer to interview with a contracted primary care provider (PCP) for the facility on 05/28/21 at 10:08am. Refer to interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm.	D 364		

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D 364	Continued From page 112 b. Review of Resident #5's current FL-2 dated 05/21/21 revealed diagnoses included vascular dementia, virus transmitted by blood and body fluids, epilepsy, hypothyroidism, hyperlipidemia, constipation, and insomnia. Review of Resident #5's May 2021 electronic medication administration record (eMAR) revealed: -There were 8 medications scheduled to be administered at 8:00am. -There was an entry for Keppra 1,000mg take 2 tablets twice daily scheduled for 8:00am and 8:00pm. (Keppra is used to treat seizures.) -Keppra was documented as administered late on 5 occasions from 05/01/21 - 05/27/21 ranging from 38 minutes up to 3 hours and 1 minute after the allowed timeframe. -There was no documentation of time medications were actually administered on 05/27/21 listed on the eMAR. Observation of the medication aide (MA) administering morning medications on 05/27/21 revealed she entered Resident #5's room with his medications that were scheduled for 8:00am at 11:08am and exited at 11:10am. Refer to the interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm. Refer to the interview with the Administrator on 05/27/21 at 4:50pm. Refer to interview with a contracted primary care provider (PCP) for the facility on 05/28/21 at 10:08am. Refer to interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm.	D 364		

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D 364	Continued From page 113 c. Review of Resident #3's current FL-2 dated 10/30/20 revealed diagnoses included vascular dementia without behaviors, hypoxia, dysphagia, and airway aspiration. Review of Resident #3's May 2021 electronic medication administration record (eMAR) revealed: -There were 3 medications scheduled to be administered at 8:00am. -There was an entry for Gabapentin 300mg take 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm. (Gabapentin is used to treat neuropathy.) -Gabapentin was documented as administered late on 5 occasions from 05/01/21 - 05/27/21 ranging from 44 minutes up to 2 hours and 7 minutes after the allowed timeframe. -There was no documentation of time medications were actually administered on 05/27/21 listed on the eMAR. Observation of the medication aide (MA) administering morning medications on 05/27/21 revealed she entered the dining room at 11:06am and administered Resident #3's medications that were scheduled for 8:00am. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Refer to the interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm. Refer to the interview with the Administrator on 05/27/21 at 4:50pm. Refer to interview with a contracted primary care	D 364		

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provider (PCP) for the facility on 05/28/21 at 10:08am.

Refer to interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm.

d. Review of Resident #15's current FL-2 dated 05/26/21 revealed diagnoses included dementia with behaviors, bipolar, history of urinary retention, and neuropathy.

Review of Resident #15's May 2021 electronic medication administration record (eMAR) revealed:
-There were 4 medications scheduled to be administered at 8:00am.
-There were 3 medications scheduled twice a day at 8:00am and 8:00pm.
-There was no documentation of time medications were actually administered on 05/27/21 listed on the eMAR.

Observation of the medication aide (MA) administering morning medications on 05/27/21 revealed she entered Resident #15's room with her medications that were scheduled for 8:00am at 11:03am and exited at 11:06am.

Refer to the interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm.

Refer to the interview with the Administrator on 05/27/21 at 4:50pm.

Refer to interview with a contracted primary care provider (PCP) for the facility on 05/28/21 at 10:08am.

Refer to interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm.

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D 364	Continued From page 115 e. Review of Resident #14's current FL-2 dated 03/09/21 revealed diagnoses included dementia with behavioral disturbances, hypertension, constipation, hypothyroidism, and dysfunction of gait. Review of Resident #14's May 2021 electronic medication administration record (eMAR) revealed: -There were at 6 medications scheduled to be administered at 8:00am. -There were at 3 medications scheduled twice a day at 8:00am and 8:00pm. -There was no documentation of time medications were actually administered on 05/27/21 listed on the eMAR. Observation of the medication aide (MA) administering morning medications on 05/27/21 revealed she entered Resident #14's room with her medications that were scheduled for 8:00am at 11:12am and exited at 11:14am. Based on observations, interviews, and record reviews, it was determined Resident #14 was not interviewable. Refer to the interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm. Refer to the interview with the Administrator on 05/27/21 at 4:50pm. Refer to interview with a contracted primary care provider (PCP) for the facility on 05/28/21 at 10:08am. Refer to interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm.	D 364		

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D 364	Continued From page 116 2. Observation of the assisted living (AL) side of the facility on 05/28/21 from 9:35am - 10:03am: -There was one medication aide (MA) on the medication cart passing medications. -The MA prepared and administered medications to 3 residents starting at 9:35am and she came out of the third resident's room at 10:03am. -At 10:01am, the Resident Care Coordinator (RCC) came to the medication cart and told the MA there was a resident going on a leave of absence who would need to take their medications with them. -The RCC did not ask the MA if she had any more residents to administer medications to or if she needed any assistance. -The RCC left the medication cart and went down the hall. Interview with the MA on 05/28/21 at 9:35am revealed: -She was the only MA administering morning medications on first shift to the residents in the special care unit (SCU) and the AL side of the facility. -She had finished administering morning medications in the SCU but she still had 3 residents on the AL side to administer morning medications to. A second interview with the MA on 05/28/21 at 9:56am revealed: -She was running late with the medications this morning (05/28/21). -The MAs were not allowed to administer any medications to residents while they were in the dining room. -If she did not have time to administer a resident's medication prior to the resident going into the dining room to eat breakfast, she had to wait until	D 364		

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they came out of the dining room.
-If the meals were late being served, it also made her late with administering the medications and the breakfast meal was served 10 to 15 minutes late that morning (05/28/21).

Observation on 05/28/21 revealed the MA finished the morning medication pass (medications scheduled for 7:00am and 8:00am) on the AL side of the facility at 10:03am.

Interview with the RCC on 05/28/21 at 2:39pm revealed:
-She was not aware some morning medications were administered late on the AL side of the facility that morning (05/28/21).
-There were no emergencies this morning (05/28/21) that would have caused the medication pass to be late.
-The MA did not report to the RCC that she was late administering medications for the morning medication pass.
-The MA should have reported to the RCC that she was late administering the morning medications on 05/28/21.
-When she went to the medication cart to tell the MA about a resident going on a leave of absence that morning (05/28/21), she did not notice the MA was still administering medications.
-She was new to the facility and was not sure about the facility's policy for administering medications to residents while in the dining room.
-The MAs should let her know they were late with administering medications so she could provide assistance or get someone else to assist them with finishing the medication pass.

Interview with the Administrator on 05/28/21 at 2:56pm revealed:
-She was not aware some morning medications

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on the AL side of the facility were administered late that morning (05/28/21).
-The MAs should let the RCC or MCM know if they were late with a medication pass so they could get assistance finishing it.
-She preferred for the MAs not to administer medications while resident were in the dining room because it may be a "dignity issue" with the residents trying to enjoy their meal.

Review of the May 2021 electronic medication administration records (eMARs) on the AL side revealed:
-One of the 3 residents observed had morning medications scheduled for 7:00am.
-Two of the 3 residents observed had morning medications scheduled for 8:00am.
-Two of the 3 residents observed had medications ordered twice a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.]

a. Review of Resident #1's current FL-2 dated 02/19/21 revealed diagnoses included vascular dementia, altered mental status, hypertension, bilateral hydronephrosis, chronic indwelling catheter, chronic kidney disease, and acute cystitis with hematuria.

Observation of the medication pass on 05/28/21 from 9:35am - 9:47am revealed:
-The medication aide (MA) started preparing Resident #1's morning medications (scheduled for 8:00am) at 9:35am.
-At 9:44am, the MA went into Resident #1's room and administered his medications.
-At 9:46am, the MA went back in the room and checked the resident's blood pressure and then returned to the medication cart at 9:47am.

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D 364	Continued From page 119 Review of Resident #1's May 2021 eMAR revealed: -There were 6 medications scheduled to be administered once a day at 8:00am. -There was an entry for Brimonidine 0.2% eye drops instill 1 drop in both eyes twice daily. (Brimonidine is used to treat glaucoma.) -Brimonidine was documented as administered late on 4 occasions from 05/01/21 - 05/28/21 ranging from 47 minutes up to 1 hour and 47 minutes after the allowed timeframe. -There was an entry for Docusate Sodium 100mg twice daily. (Docusate Sodium is a stool softener.) -Docusate Sodium was documented as administered late on 3 occasions from 05/01/21 - 05/28/21 ranging from 1 hour and 8 minutes up to 1 hour and 47 minutes after the allowed timeframe. -There was an entry for Dorzolamide 2% eye drops instill 1 drop in both eyes twice daily. (Dorzolamide is used to treat glaucoma.) -Dorzolamide was documented as administered late on 4 occasions from 05/01/21 - 05/28/21 ranging from 47 minutes up to 1 hour and 47 minutes after the allowed timeframe. -There was an entry for Metoprolol Tartrate 25mg 1 tablet twice daily. (Metoprolol is used to treat high blood pressure.) -Metoprolol Tartrate was documented as administered late on 4 occasions from 05/01/21 - 05/28/21 ranging from 23 minutes up to 1 hour and 50 minutes after the allowed timeframe. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Refer to the interview with the Memory Care	D 364		

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Manager (MCM) on 05/27/21 at 4:25pm.

Refer to the interview with the Administrator on 05/27/21 at 4:50pm.

Refer to interview with a contracted primary care provider (PCP) for the facility on 05/28/21 at 10:08am.

Refer to interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm.

b. Review of Resident #13's current FL-2 dated 11/24/20 revealed diagnoses included traumatic brain injury, intellectual disability, hyperlipidemia, blindness, edema, anxiety, dysphagia, subdural hematoma, gastroesophageal reflux disease, dysarthria, asthenia, and agitation.

Observation of the medication pass on 05/28/21 from 9:56am - 10:03am revealed:
-The medication aide (MA) started preparing Resident #13's morning medications at 9:56am.
-At 10:01am, the MA went into the resident's room and administered his morning (scheduled for 7:00am) medications.
-At 10:03am, the MA came out of the resident's room.

Review of Resident #13's May 2021 electronic medication administration record (eMAR) revealed:
-There were 7 medications scheduled to be administered once daily at 7:00am.
-There was an entry for Colestipol 5gm packet mix 1 packet in 3 ounces of liquid and drink twice daily. (Colestipol is used to lower cholesterol.)
-Colestipol was documented as administered late on 4 occasions from 05/01/21 - 05/28/21 ranging from 27 minutes up to 2 hours and 1 minute after

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the allowed timeframe.
-There was an entry for Enulose 10gm/15ml take 15ml twice daily. (Enulose is a laxative.)
-Enulose was documented as administered late on 5 occasions from 05/01/21 - 05/28/21 ranging from 27 minutes up to 2 hours and 1 minute after the allowed timeframe.

Based on observations, interviews, and record reviews, it was determined Resident #13 was not interviewable.

Refer to the interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm.

Refer to the interview with the Administrator on 05/27/21 at 4:50pm.

Refer to interview with a contracted primary care provider (PCP) for the facility on 05/28/21 at 10:08am.

Refer to interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm.

c. Review of Resident #17's current FL-2 dated 06/09/20 revealed diagnoses included seizure disorder, hemiplegia, hypokalemia, hypertension, history of pulmonary embolism, and traumatic brain injury.

Observation of the medication pass on 05/28/21 from 9:49am - 9:55am revealed:
-The medication aide (MA) started preparing Resident #17's morning medications at 9:49am.
-At 9:50am, the MA went into the resident's room and administered his morning medications.
-At 9:50am, the MA came back to the medication cart.

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D 364	Continued From page 122 Review of Resident #17's May 2021 eMAR revealed: -There were 4 medications scheduled to be administered once daily at 8:00am. -The 8:00am medications included Lasix (a diuretic), Potassium Chloride ER (for low potassium levels), Flonase Nasal Spray (for seasonal allergies), and Vitamin D3 (for low Vitamin D levels). Based on observations, interviews, and record reviews, it was determined Resident #17 was not interviewable. Refer to the interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm. Refer to the interview with the Administrator on 05/27/21 at 4:50pm. Refer to interview with a contracted primary care provider (PCP) for the facility on 05/28/21 at 10:08am. Refer to interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm. _____ Interview with the Memory Care Manager (MCM) on 05/27/21 at 4:25pm revealed: -About 2 weeks ago, the decision was made by the Administrator to have one medication aide (MA) administer medications to the whole facility. -She had never seen it take the MA until 11:20am to complete the morning medication pass. -She would have expected the MA to ask for assistance if she didn't think she could complete the medication pass within the required timeframe of one hour prior and one hour after the scheduled time.	D 364		

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D 364	Continued From page 123 Interview with the Administrator on 05/27/21 at 4:50pm revealed: -She expected the MA to be able pass morning medications including oral medications, inhalers, lotions, powders, and insulin injections for 39 residents by 9:00am. -The Administrator and the MCM were able to pass morning medications within the allotted time frame of 1 hour before the scheduled time and 1 hour after. -The MA potentially could have been delayed because of training a new employee on 05/27/21. -The Resident Care Coordinator (RCC) should have taken over the emergency situation on the Assisted Living side of the building so that the MA could continue with her medication pass on 05/27/21. -The MCM reviewed a weekly report with administration times and there were no concerns with late medications. Interview with a contracted primary care provider (PCP) for the facility on 05/28/21 at 10:08am revealed: -The facility did not usually notify her if medications were administered late. -Her concern for late medications was some medications with multiple administration times could be administered too close together. -For example, administering blood pressure medications too close together could cause low blood pressures or anxiety medications too close could cause increased somnolence and increase risk for falls. -Some medications needed to be administered about the same time everyday to be the most effective. Interview with a second contracted PCP for the facility on 06/01/21 at 1:35pm revealed:	D 364		

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D 364	Continued From page 124 -Medication administration at the facility was "always running late". -The facility was under-staffed with only one MA for the morning administration. -She thought it was "completely impractical" for one MA to administer all of the facility's morning medication in a timely manner. -She was concerned about residents receiving medications that were scheduled for three times a day being administered too close together including blood pressure medications and psychiatric medications causing increased risk for adverse reactions.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication 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).	D 367		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the electronic medication administration records (eMARs) for 4 of 8 sampled residents (#2,# 4, #10, #11) related to inaccurate documentation of three ophthalmic drops (#2), a sedative, an anti-tremor medication, an anti-convulsant medication, and an antidepressant (#4), antihistamine and an inhaler used to treat wheezing and shortness of breath (#10), and a mild pain reliever (#11).

The findings are:

1. Review of Resident #2's current FL-2 dated 02/11/21 revealed:
-Diagnoses included left great toe amputation secondary to osteoarthritis, peripheral vascular disease, type 2 diabetes mellitus, coronary artery disease, hypertension, hyperlipidemia, diffuse alveolar damage, and a history of cerebrovascular accident.

Observation of medications on-hand on 06/01/21 at 11:20am revealed Resident #2's Ketorolac 0.4% ophthalmic drops, Ofloxacin 0.3% ophthalmic drops, and Prednisolone Acetate 0.1% ophthalmic drops were not available to administer.

a. Review of Resident #2's ophthalmologist's order dated 12/18/20 revealed:
-There was an order for Ketorolac 0.4% ophthalmic 1 drop (gtt) into the left eye four times daily for 90 days (Ketorolac eye drops are used to treat itchy eyes caused by allergies and treatment of swelling and redness that can occur after

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cataract surgery).
-The start date was 12/18/20 and the end date was 03/18/21.

Review of Resident #2's current FL-2 dated 02/11/21 revealed there was not an order for Ketorolac gtts.

Review of Resident #2's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Ketorolac 0.4% ophthalmic 1 drop (gtt) into left eye four times daily, start after surgery scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-From 03/01/21 to 03/03/21, Ketorolac gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm on 03/01/21 and 03/02/21 and documented as administered at 8:00am and 12:00pm on 03/03/21.
-From 03/05/21 to 03/06/21, Ketorolac gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm on 03/05/21 and documented as administered at 8:00am on 03/06/21.
-On 03/07/21 and 03/23/21, Ketorolac gtts were documented as administered at 8:00am.
-On 03/09/21, Ketorolac gtts were documented as administered at 8:00am and at 8:00pm.
-On 03/13/21 to 03/14/21, Ketorolac gtts were documented as administered at 8:00am.
-On 03/17/21, 03/18/21, and 03/26/21, Ketorolac gtts were documented as administered at 4:00pm and at 8:00pm.
-On 03/19/21, Ketorolac gtts were documented as administered at 8:00pm.
-On 03/27/21, 03/28/21, and 03/31/21, Ketorolac gtts were documented as administered at 8:00am and at 12:00pm.

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D 367	Continued From page 127 Review of Resident #2's April 2021 eMAR revealed: -There was an entry for Ketorolac 0.4% ophthalmic 1 gtt into left eye four times daily, start after surgery scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -From 04/02/21 to 04/05/21, Ketorolac gtts were documented as administered at 4:00pm and at 8:00pm on 04/02/21, and administered at 8:00am, at 12:00pm, at 4:00pm, and at 8:00pm from 04/03/21 to 04/05/21. -On 04/06/21, 04/08/21, 04/21/21, 04/22/21, and 04/25/21, Ketorolac gtts were documented as administered at 8:00am and at 12:00pm. -On 04/16/21, Ketorolac gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm, and at 8:00pm. -On 04/23/21, Ketorolac gtts were documented as administered at 4:00pm and at 8:00pm. -On 04/24/21, 04/26/21, and 04/30/21, Ketorolac gtts were documented as administered at 8:00am, at 12:00pm and at 8:00pm. Review of Resident #2's May 2021 eMAR revealed: -There was an entry for Ketorolac 0.4% ophthalmic 1 gtt into left eye four times daily, start after surgery scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -On 05/01/21, Ketorolac gtts were documented as administered at 8:00am and at 12:00pm. -On 05/02/21 and 05/06/21, Ketorolac gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm, and at 8:00pm. -On 05/03/21, Ketorolac gtts were documented as administered at 4:00pm and at 8:00pm. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/01/21 at 11:42 revealed:	D 367		

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-Resident #2's Ketorolac 0.4% gtts were last dispensed to the facility on 01/14/21 for a 30-day supply.
-Resident #2's Ketorolac 0.4% gtts became an inactive order on 02/12/21.
-She was not sure why the entry for Resident #2's Ketorolac 0.4% gtts were still on the eMAR.
-The authorized users of the eMAR at the facility had to accept discontinued medication orders for the medications to be removed from the eMAR.
-The eMARs referenced by the facility staff when administering medications were not visible to the pharmacy staff.

Interview with the Administrator on 06/02/21 at 4:00pm revealed:
-She was not aware the entry for Resident #2's Ketorolac 0.4% gtts still appeared on the eMAR even though the order became inactive on 02/12/21.
-She expected any discontinued medications be removed from a resident's eMAR the day the medications were discontinued by the Care Managers, Resident Care Coordinator or the Memory Care Manager.

Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/01/21 at 12:00pm.

Attempted telephone interviews with Resident #2's ophthalmologist on 06/01/21 at 10:54am was unsuccessful.

Attempted telephone interviews with Resident #2's primary care provider on 06/01/21 at 10:54am and on 06/02/21 at 2:19pm were unsuccessful.

b. Review of Resident #2's ophthalmologist's

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D 367	Continued From page 129 order dated 12/18/20 revealed: -There was an order for Ofloxacin 0.3% ophthalmic instill 1 drop (gtt) into the left eye start after surgery for 30 days (Ofloxacin eye drops are used to treat bacterial infections of the eye). -The start date was 12/18/20 and the end date was 01/17/21. Review of Resident #2's current FL-2 dated 02/11/21 revealed there was not an order for Ofloxacin gtts. Review of Resident #2's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Ofloxacin 0.3% ophthalmic 1 gtt into left eye four times daily scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -On 03/01/21, 03/02/21, and 03/05/21, Ofloxacin gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm, and at 8:00pm. -On 03/03/21, 03/27/21, 03/28/21, and 03/31/21, Ofloxacin gtts were documented as administered at 8:00am and at 12:00pm. -On 03/06/21, 03/09/21, 03/13/21, 03/14/21, and 03/23/21, Ofloxacin gtts were documented as administered at 8:00am. -On 03/17/21, 03/18/21, and 03/26/21, Ofloxacin gtts were documented as administered at 4:00pm and at 8:00pm. Review of Resident #2's April 2021 eMAR revealed: -There was an entry for Ofloxacin 0.3% ophthalmic 1 gtt into left eye four times daily scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -On 04/02/21 and 04/26/21, Ofloxacin gtts were documented as administered at 4:00pm and at	D 367		

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D 367	Continued From page 130 8:00pm. -On 04/03/21, 04/05/21, and 04/16/21, Ofloxacin gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm, and at 8:00pm. -On 04/06/21, 04/21/21, 04/22/21, and 04/25/21, Ofloxacin gtts were documented as administered at 8:00am and at 12:00pm. -On 04/19/21, Ofloxacin gtts were documented as administered at 8:00am. -On 04/24/21, Ofloxacin gtts were documented as administered at 8:00am, at 12:00pm, and at 8:00pm. -On 04/30/21, Ofloxacin gtts were documented as administered at 8:00am, at 4:00pm, and at 8:00pm. Review of Resident #2's May 2021 eMAR revealed: -There was an entry for Ofloxacin 0.3% ophthalmic 1 gtt into left eye four times daily scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -On 05/01/21, Ofloxacin gtts were documented as administered at 8:00am and at 12:00pm. -On 05/02/21 and 05/06/21, Ofloxacin gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm, and at 8:00pm. -On 05/03/21, Ofloxacin gtts were documented as administered at 4:00pm and at 8:00pm. -On 05/07/21, Ofloxacin gtts were documented as administered at 8:00am. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/01/21 at 11:42 revealed: -Resident #2's Ofloxacin 0.3% gtts were last dispensed to the facility on 01/15/21 for a 30-day supply. -Resident #2's Ofloxacin 0.3% gtts became an inactive order on 02/12/21.	D 367		

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D 367	Continued From page 131 -She was not sure why the entry for Resident #2's Ofloxacin 0.3% gtts were still on the eMAR. -The authorized users of the eMAR at the facility had to accept discontinued medication orders for the medications to be removed from the eMAR. -The eMARs referenced by the facility staff when administering medications were not visible to the pharmacy staff. Interview with the Administrator on 06/02/21 at 4:00pm revealed: -She was not aware the entry for Resident #2's Ofloxacin 0.3% gtts still appeared on the eMAR even though the order became inactive on 02/12/21. -She expected any discontinued medications be removed from a resident's eMAR the day the medications were discontinued by the Care Managers, Resident Care Coordinator or the Memory Care Manager. Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/01/21 at 12:00pm. Attempted telephone interviews with Resident #2's ophthalmologist on 06/01/21 at 10:54am was unsuccessful. Attempted telephone interviews with Resident #2's primary care provider on 06/01/21 at 10:54am and on 06/02/21 at 2:19pm were unsuccessful. c. Review of Resident #2's ophthalmologist's order dated 12/18/20 revealed: -There was an order for Prednisolone Acetate 1% ophthalmic instill 1 drop (gtt) into the left eye four times daily, start after surgery (Prednisolone Acetate eye drops were used to reduce the	D 367		

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irritation, redness, burning and swelling after eye surgery).
-The start date was 12/18/20 and the end date was 01/17/21.

Review of Resident #2's current FL-2 dated 02/11/21 revealed there was not an order for Prednisolone Acetate gtts.

Review of Resident #2's March 2021 eMAR revealed:
-There was an entry for Prednisolone Acetate 0.1% ophthalmic 1 gtt into left eye four times daily, start after surgery scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-On 03/01/21, 03/02/21, and 03/05/21, Prednisolone Acetate gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm, and at 8:00pm.
-On 03/03/21, 03/27/21, 03/28/21, and 03/31/21, Prednisolone Acetate gtts were documented as administered at 8:00am and at 12:00pm.
-On 03/06/21, 03/09/21, 03/13/21, 03/14/21, and 03/23/21, Prednisolone Acetate gtts were documented as administered at 8:00am.
-On 03/17/21, 03/18/21, and 03/26/21, Prednisolone Acetate gtts were documented as administered at 4:00pm and at 8:00pm.
-On 03/22/21, Prednisolone Acetate gtts were documented as administered at 8:00pm.

Review of Resident #2's April 2021 eMAR revealed:
-There was an entry for Prednisolone Acetate 0.1% ophthalmic 1 gtt into left eye four times daily, start after surgery scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-On 04/02/21, Prednisolone Acetate gtts were documented as administered at 4:00pm and at 8:00pm.

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D 367	Continued From page 133 -On 04/03/21, 04/04/21, 04/05/21, and 04/16/21, Prednisolone Acetate gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm, and at 8:00pm. -On 04/06/21, 04/21/21, 04/22/21, and 04/25/21, Prednisolone Acetate gtts were documented as administered at 8:00am and at 12:00pm. -On 04/13/21, Prednisolone Acetate gtts were documented as administered at 8:00am. -On 04/18/21, 04/19/21, and 04/26/21, Prednisolone Acetate gtts were documented as administered at 4:00pm and at 8:00pm. -On 04/24/21, Prednisolone Acetate gtts were documented as administered at 8:00am, at 12:00pm, and at 8:00pm. -On 04/30/21, Prednisolone Acetate gtts were documented as administered at 8:00am, at 4:00pm, and at 8:00pm. Review of Resident #2's May 2021 eMAR revealed: -There was an entry for Prednisolone Acetate 0.1% ophthalmic 1 gtt into left eye four times daily, start after surgery scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -On 05/01/21 and 05/07/21, Prednisolone Acetate gtts were documented as administered at 8:00am and at 12:00pm. -On 05/02/21 and 05/06/21, Prednisolone Acetate gtts were documented as administered at 8:00am, at 12:00pm, at 4:00pm, and at 12:00pm. -On 05/03/21, Prednisolone Acetate gtts were documented as administered at 4:00pm and at 8:00pm. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/01/21 at 11:42 revealed: -Resident #2's Prednisolone Acetate gtts were last dispensed to the facility on 01/14/21 for a	D 367		

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30-day supply.
-Resident #2's Prednisolone Acetate 0.1% gtts became an inactive order on 02/12/21.
-She was not sure why the entry for Resident #2's Prednisolone Acetate gtts were still on the eMAR.
-The authorized users of the eMAR at the facility had to accept discontinued medication orders for the medications to be removed from the eMAR.
-The eMARs referenced by the facility staff when administering medications were not visible to the pharmacy staff.

Interview with the Administrator on 06/02/21 at 4:00pm revealed:
-She was not aware the entry for Resident #2's Prednisolone Acetate 0.1% gtts still appeared on the eMAR even though the order became inactive on 02/12/21.
-She expected any discontinued medications be removed from a resident's eMAR the day the medications were discontinued by the Care Managers, Resident Care Coordinator or the Memory Care Manager.

Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/01/21 at 12:00pm.

Attempted telephone interviews with Resident #2's ophthalmologist on 06/01/21 at 10:54am was unsuccessful.

Attempted telephone interviews with Resident #2's primary care provider on 06/01/21 at 10:54am and on 06/02/21 at 2:19pm were unsuccessful.

2. Review of Resident #4's current FL-2 dated 02/26/21 revealed:
-Diagnoses included bi-polar anxiety,

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D 367	Continued From page 135 fibromyalgia, vitamin B deficiency, gastric ulcer, hypertension, status post cerebrovascular accident, and depression. -Her current medication list was attached and signed by the Primary Care Provider (PCP). -There was a medication order for Benztropine (used to treat anxiety and agitation) 0.5mg take one tablet by mouth at bedtime. -There was a medication order for Clonazepam (used to treat panic disorder and anxiety) 0.5mg take one by mouth daily. -There was a medication order for Lamotrigine (Lamictal) (used to treat bipolar disorder) 25mg take one by mouth twice a day. -There was a medication order for Trazodone (used to treat depression) 50mg take one table by mouth at bedtime. Review of Resident #4's PCP's physician electronic visit note dated 04/06/21 revealed: -Resident #4's MAR was reviewed. -Trazodone (used to treat depression), Lamictal (used to treat bipolar disorder) and Benztropine (used to treat anxiety and agitation)all remained on the MAR at that time. -These were all originally discontinued in January 2021, but they were still being administered. -The mental health provider stated the combination of all of the above medications could have explained the confusion Resident #4 had been experiencing. -These medications were discontinued on 04/03/21 by the mental health provider. -The PCP spoke with the Administrator and discussed getting the Benztropine, Lamictal and Trazodone orders discontinued. -There was an order to continue the Clonazepam at this time and would readdress when the acute confusion had resolved.	D 367		

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a. Review of Resident #4's physician electronic visit note dated 02/26/21 revealed there was a medication order for Benztropine 0.5mg take one tablet by mouth at bedtime.

Review of Resident #4's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Benztropine 0.5mg take one tablet by mouth at bedtime.
-There was documentation the Benztropine 0.5mg was administered from 03/01/21 to 03/22/21 at 8:00pm.
-There was documentation the Benztropine 0.5mg was administered from 03/23/21 to 03/28/21 and 03/30/21 and 03/31/21 at 7:00pm.
-There was no documentation that Benztropine 0.5mg was administered on 03/29/21.

Review of Resident #4's April 2021 eMAR revealed:
-There was an entry for Benztropine 0.5mg take one tablet by mouth at bedtime.
-There was documentation the Benztropine 0.5mg was administered from 04/01/21 to 04/06/21 at 7:00pm.
-There was documentation the Benztropine 0.5mg on 04/07/21 at 7:00pm was not administered as it was discontinued.

b. Review of Resident #4's physician electronic visit note dated 02/26/21 revealed there was medication order for Clonazepam 0.5mg take one by mouth daily scheduled at 7:00pm and 1/2 tablet by mouth daily as needed for anxiety.

Review of Resident #4's physician electronic visit note dated 03/02/21 revealed:
-The Clonazepam was refilled at last visit, however there was an issue with packaging that

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the insurance would not cover dual dosing if written in 2 separate entries; it had to be in one order.
-The PCP discussed the Clonazepam orders with the Memory Care Manager who fixed the issue.

Review of Resident #4's physician electronic visit note dated 04/13/21 revealed:
-Resident #4 was alert and oriented x 3 on assessment.
-Resident #4's Clonazepam would be discontinued with her consent.
-There was an order to discontinue Clonazepam both scheduled and prn.

Review of Resident #4's physician electronic visit note dated 04/16/21 revealed:
-There was a medication order for Clonazepam 0.5 mg one tablet between 7-8pm orally once a day for 30 days.
-There was a medication order to decrease Clonazepam 0.5 mg one tablet po daily scheduled and ½ tablet (0.25mg) twice a day for anxiety.
-Resident #4 was on Clonazepam scheduled at bedtime and would change it too as needed.

Review of Resident #4's physician electronic visit note dated 04/20/21 revealed:
-There was a medication order to stop Clonazepam 0.5 mg one tablet between 7-8pm orally once a day.
-There was a medication order to stop Clonazepam 0.5 mg one tablet po daily scheduled and ½ tablet (0.25mg) twice a day for anxiety.

Review of Resident #4's March 2021 electronic medication administration record (eMAR) revealed:

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-There was an entry for Clonazepam 0.5mg take one tablet by mouth once a day - take ½ tablet by mouth as needed (PRN) for anxiety.
-There was an entry for Clonazepam 0.5mg take one tablet by mouth once a day as scheduled.
-There was no documentation Clonazepam 0.5mg was administered from 03/01/21 - 03/26/21 at 9:00am.
-There was documentation that the Clonazepam 0.5mg was administered at 9:00am from 03/27/21 to 03/31/21.
-There was an entry for Clonazepam 0.5mg take one tablet by mouth once a day at bedtime.
-There was documentation that the Clonazepam 0.5mg was administered at 9:00pm.from 03/01/21 to 03/24/21.
-There was no documentation Clonazepam 0.5mg was administered on 03/25/21 or 03/26/21at 9:00pm.
-There was documentation that the Clonazepam 0.5mg was administered from 03/27/21 to 03/31/21 at 9:00pm.
-There was an entry for Clonazepam 0.5mg take ½ tablet by mouth as needed for anxiety.
-There were no entries that the PRN Clonazepam was administered in the month of March.

Review of Resident #4's April 2021 eMAR revealed:
-There was an entry for Clonazepam 0.5mg take one tablet by mouth once a day as scheduled every day.
-There was an entry for Clonazepam 0.5mg take one tablet by mouth once a day as scheduled at bedtime.
-There was an entry for Clonazepam 0.5mg - take ½ tablet by mouth as needed (PRN) for anxiety.
-There was documentation that the Clonazepam 0.5mg was administered on 04/01/21 at 8:00am.

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D 367	Continued From page 139 -There was an entry for Clonazepam 0.5mg take one tablet by mouth once a day at 9:00pm. -There was documentation that the Clonazepam 0.5mg was administered at 9:00pm from 04/02/21 to 04/13/21. -There was no documentation Clonazepam 0.5mg was administered on 04/14/21 to 04/30/21 at 9:00pm. -There was an entry for Clonazepam 0.5mg take ½ tablet by mouth as needed for anxiety. Review of Resident #4's May 2021 eMAR revealed there were no electronic entries for Clonazepam. c. Review of Resident #4's physician electronic visit note dated 02/26/21 revealed there was a medication order for Lamotrigine (Lamictal) 25mg take one by mouth twice a day at 7:00am and 7:00pm Review of Resident #4's physician electronic visit note dated 03/02/21 revealed there was an entry to continue Lamictal tablet 25mg 1 tablet orally twice a day. Review of Resident #4's March 2021 eMAR revealed: -There was an entry for Lamotrigine 25mg take one tablet by mouth twice daily at 7:00am and 7:00pm. -There was documentation that the Lamotrigine 25mg was administered daily at 7:00am from 03/01/21 to 03/29/21. -There was documentation that the Lamotrigine 25mg was administered daily at 8:00am from 03/30/21 to 03/31/21. -There was documentation that the Lamotrigine 25mg was administered daily at 7:00pm from 03/01/21 to 03/28/21.	D 367		

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D 367	Continued From page 140 -There was documentation that the Lamotrigine 25mg was administered daily at 8:00pm from 03/29/21 to 03/31/21. Review of Resident #4's April 2021 eMAR revealed: -There was an entry for Lamotrigine 25mg take one tablet by mouth twice daily at 8:00am and 8:00pm. -There was documentation that the Lamotrigine 25mg was administered daily at 8:00am from 04/01/21 to 04/06/21. -There was documentation that the Lamotrigine 25mg was administered daily at 8:00pm from 04/01/21 to 04/05/21. -There was documentation that the Lamotrigine 25mg on 04/07/21 and 04/08/21 at 8:00am was not administered as it was discontinued. -There was documentation that the Lamotrigine 25mg on 04/06/21 and 04/07/21 at 8:00pm was not administered as it was discontinued. d. Review of Resident #4's physician electronic visit note dated 02/26/21 revealed there was medication order for Trazodone 50mg take one tablet by mouth at bedtime at 8:00pm. Review of Resident #4's March 2021 eMAR revealed: -There was an entry for Trazodone 50mg take one tablet by mouth at bedtime. -There was documentation that the Trazodone 50mg was administered daily at 8:00pm from 03/01/21 to 03/22/21. -There was documentation that the Trazodone 50mg was administered daily at 7:00pm from 03/23/21 to 03/31/21. Review of Resident #4's April 2021 eMAR revealed:	D 367		

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-There was an entry for Trazodone 50mg take one tablet by mouth at bedtime.
-There was documentation that the Trazodone 50mg was administered daily at 7:00pm from 04/01/21 to 04/06/21.
-There was documentation that the Trazodone 50mg was not administered at 7:00pm on 04/07/21 as it was discontinued.

Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/01/21 at 11:42am.

Refer to interview with the Administrator on 06/02/21 at 4:00pm.

Refer to interview with the Pharmacist at the facility's contracted pharmacy on 06/01/21 at 12:00pm.

3. Review of Resident #10's current FL-2 dated 03/02/21 revealed:
-Diagnoses included type 2 diabetes, hypertension, bipolar disorder, osteoarthritis, syncope and history of falls.

a. Review of Resident #10's current FL-2 dated 03/02/21 revealed there was an order for Claritin 10mg 1 tablet daily. (Claritin is used to treat allergies.)

Review of Resident #10's May 2021 electronic medication administration record (eMAR) revealed there was an entry for Claritin 10 mg, take 1 tablet every morning for allergies, scheduled for administration at 7:00am.

Observation of the morning medication pass on 05/27/21 revealed Claritin 10mg was not administered or offered to Resident #10 when

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she received her other morning medications at 7:54am.

Review of Resident #10's May 2021 eMAR on 05/27/21 at 12:40pm revealed Claritin 10mg was documented as administered on 5/27/21 at 7:00am.

Observation of Resident #10's medications on hand on 05/27/21 at 12:49pm revealed:
-There was a blister pack of Claritin 10mg tablets dispensed on 05/18/21.
-There were 8 tablets remaining of the 9 tablets dispensed on 05/18/21.
-The medication label read Claritin 10mg with instructions to take 1 tablet every morning for allergies.

Interview with the medication aide (MA) on 05/27/21 at 12:45pm revealed:
-She only gave Resident #10 the Claritin when the resident complained of allergies.
-She read the instructions on the eMAR for Claritin to be an 'as needed' medication.
-She did not mean to document as administered on 05/27/21 because the resident did not receive the medication.

Interview with Resident #10 on 05/27/21 at 3:45pm revealed:
-She had a continuous runny nose because of her allergies.
-She did not recall staff asking her about any allergy symptoms.
-She could not remember if she got a Claritin tablet every day with her morning medications.

Interview with the Resident Care Coordinator (RCC) on 05/27/21 at 1:38pm revealed she expected the eMAR to correctly reflect if Resident

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D 367	Continued From page 143 #10 did not receive Claritin on 05/27/21. Interview with the Administrator on 05/27/1 at 1:47pm revealed she expected staff to document correctly on the eMAR. Attempted telephone interviews with Resident #10's primary care provider (PCP) on 06/01/21 at 10:28am and 06/02/21 at 1:39pm were unsuccessful. b. Review of Resident #10's physician order dated 05/18/21 revealed an order for Xopenex 45mcg inhaler, two puffs in the morning and two puffs in the evening for shortness of breath and wheezing. (Xopenex is used to treat wheezing and shortness of breath.) Review of Resident #10's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Xopenex inhaler, 45mcg inhale two puffs in the morning, scheduled for administration at 7:00am. -Xopenex inhaler was documented as administered from 05/22/21 to 05/25/21 at 7:00am. -There was an entry for Xopenex inhaler, 45mcg inhale two puffs in the evening, scheduled for administration at 5:00pm. -Xopenex was documented as administered from 05/19/21 to 05/26/21 at 5:00pm. Observation of Resident #10's medications on hand on 05/27/21 at 12:49pm revealed there was no Xopenex aerosol inhaler available for administration. Interview with Resident #10 on 05/27/21 at 3:45pm revealed she had not yet received her	D 367		

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D 367	Continued From page 144	D 367		

new inhaler from when she saw her primary care provider (PCP) on 05/18/21.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/01/21 at 8:45am revealed Resident #10's Xopenex inhaler order was received at the pharmacy on 05/18/21 but the prescription had not been dispensed yet.

Interview with the Resident Care Coordinator (RCC) on 05/27/21 at 1:38pm revealed she expected the eMAR to correctly reflect if Resident #10 did not receive her Xopenex.

Interview with the Administrator on 05/27/21 at 1:47pm revealed:
-If a medication was not available for administration, she expected staff to document that on the eMAR.
-Staff should not have documented that Xopenex was administered when it wasn't even in the building.

Attempted telephone interviews with Resident #10's primary care provider (PCP) on 06/01/21 at 10:28am and 06/02/21 at 1:39pm were unsuccessful.

4. Review of Resident #11's current FL-2 dated 02/26/21 revealed:
-Diagnoses included Alzheimer's disease, osteoarthritis, gait impairment, hyperlipidemia, hypothyroidism, hypertension, and gastroesophageal reflux disorder.
-There was an order for Lidocaine 4% patch apply 1 patch to left lateral flank every morning and remove every evening. (Lidocaine is a mild pain reliever.)

Review of Resident #11's May 2021 electronic

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D 367	Continued From page 145 Medication Administration Record (eMAR) revealed there was an entry for Lidocaine 4% patch, apply 1 patch to left lateral flank every morning and remove every evening, scheduled for administration at 7:00am. Observation of the 8:00am medication pass on 05/27/21 revealed Lidocaine 4% patch was not administered or offered to Resident #11 when she received her other morning medications at 8:04am. Review of Resident #11's May 2021 electronic Medication Administration Record (eMAR) revealed Lidocaine 4% patch was documented as administered on 05/27/21 at 7:00am. Interview with Resident #11 on 05/27/21 at 12:30pm revealed: -She did not receive a Lidocaine patch on 05/27/21. -The Lidocaine patch was to help with chronic back pain. -Staff was responsible for applying and removing the patch. Observation of Resident #11's medication on hand on 05/27/21 at 3:57pm revealed four Lidocaine 4% patches with a dispense date of 12/08/20 with instructions on the medication label to apply to left flank every morning and remove every evening. Interview with the medication aide (MA) on 05/27/21 at 12:45pm revealed: -She could not locate Resident #11's Lidocaine patches in the medication cart today (05/27/21). -She did not mean to document administered on the eMAR. -She meant to document not given, with the	D 367		

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D 367	Continued From page 146 reason as 'medication not available.' Interview with the Resident Care Coordinator (RCC) on 05/27/21 at 1:38pm revealed: -She expected staff to administer Resident#11's Lidocaine patch daily as ordered. -She had just received a medication cart audit form from the night shift MA that noted Resident #11's Lidocaine patch was available on the medication cart. Interview with Resident #11's primary care provider (PCP) on 06/01/21 at 1:35pm revealed: -She expected the eMAR to match what was administered. -It was "dangerous" when the eMAR doesn't match what was administered because some treatment decisions were made off of inaccurate documentation. -She had come to learn not to 'trust' the eMAR documentation. -She suspected the eMAR frequently was inaccurate because oriented residents report not receiving medication that was documented as administered. -She had brought her concerns about inaccurate eMAR documentation to the Administrator on multiple occasions and it has not improved. _____ Interview with the Pharmacist at the facility's contracted pharmacy on 06/01/21 at 12:00pm revealed: -Per the pharmacy's contract with the facility, if a resident was gone from the facility more than 7 days the resident's medication profile was wiped cleaned. -The authorized users at facility had to accept discontinued medication orders for the medications to be removed from the eMAR. -The eMARs referenced by the facility staff when	D 367		

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D 367	Continued From page 147 administering medications were not visible to the pharmacy staff.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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 the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to other requirements, health care, and medication administration. The findings are: 1. Based on observations and interviews, the facility failed to ensure a charred electrical outlet located in the residents' dining room was repaired, an exhaust fan in the residents' common bathroom was maintained in operating condition, the air conditioning units were properly installed and maintained in operating condition in the Special Care Unit (SCU), and two toilets were maintained in operating condition in the SCU. [Refer to Tag D105, 10A NCAC 13F .0311(a) Other Requirements (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of	D912		

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D912	Continued From page 148 116°F for 6 of 16 water fixtures sampled which included 3 fixtures (2 sinks, 1 shower) in the assisted living (AL) side of the facility and 3 fixtures (2 sinks, 1 shower) in the special care unit (SCU) that were used by the residents with hot water temperatures ranging from 75 degrees F to 122 degrees F. [Refer to Tag D113, 10A NCAC 13F .311(d) Other Requirements (Type B Violation)]. 3. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 4 of 5 residents sampled (#1, #2, #3, #4) including a speech therapy consult (#3), follow-up appointment post-cataract surgery (#2), follow-up lab work and urinalysis (#4, #5) and weight gain (#5). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Unabated Type A2 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 3 residents (#10, #11, #12) observed during the medication passes including errors with a medication used to treat seasonal allergies, a medication used to treat gastric reflux, and an inhaler for shortness of breath and wheezing (#10), a mild pain reliever patch (#11), and medication used to treat high blood pressure (#12); and for 3 of 6 residents sampled (#2, #5, #13) for record review including errors with medications for underactive thyroid, fluid retention, and high blood pressure (#5); errors with crushing extended release medications for high blood pressure, low potassium levels, and acid reflux (#13); and errors with a laxative (#2). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		

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D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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D935	Continued From page 150 b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) who administered medications had completed the 5, 10, or 15-hour medication administration training course. The findings are: Review of Staff C's, medication aide's (MA) personnel record revealed: -Staff C was hired on 02/23/17. -There was documentation Staff C passed the written MA exam on 04/04/03. -There was documentation of a Medication Clinical Skills Competency Validation dated 03/10/17. -There was no documentation Staff C completed the 5, 10, or 15-hour medication administration training course. -Section 3 of the Facility Medication Aide Verification form was not completed. -There was no verification of employment prior to 2016. Review of a resident's May 2021 electronic medication administration record (eMAR) revealed Staff C documented the administration of medications 12 days in May 2021. Interview with Staff C on 06/02/21 at 3:50pm revealed: -She had worked at the facility since 2017 as a MA on second and third shift. -She administered medications independently. -She had not received the 5, 10, or 15-hour	D935		

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D935	Continued From page 151 medication aide training. -She did not know she needed to complete the 5, 10, or 15-hours of medication aide training and no one had told her she needed the MA training. Interview with the Business Office Manager (BOM) on 06/02/21 at 1:10pm revealed: -She and the Administrator were responsible for ensuring all personnel records were complete. -She did not know that all of Section 3 on the Facility Medication Aide Verification form had to be completed for Staff C in order to exempt her from the 5, 10, or 15-hour medication aide training. Interview with the Administrator on 06/02/21 at 4:08pm revealed: -Staff C was a MA and independently administered medications to the residents. -The BOM and the Administrator were responsible for ensuring all personnel records were complete. -She had never seen the Facility Medication Aide Verification form and did not know it was not completed on Staff C. -She did not know Staff C had not completed the 5, 10, or 15-hour medication aide training. -The BOM completed an audit of all staff personnel records in February of 2021.	D935		