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SUNRISE AT NORTH HILLS	615 SPRING FOREST ROAD RALEIGH, NC 27609

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 08/25/21 to 08/27/21 with an exit conference via telephone on 08/27/21.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 5 of 6 sampled staff (Staff A, B, C, D, E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff A's, Medication Aide (MA) personnel record revealed: -There was a hire date of 07/01/21. -There was no documentation Staff A had a HCPR check upon hire. Refer to interview with the Executive Director (ED) on 08/26/21 at 4:02pm and 5:00pm. Refer to telephone interview with the ED on 08/27/21 at 11:26am. 2. Review of Staff B's, Medication Aide (MA) personnel record revealed: -There was a hire date of 10/14/09.	D 137		

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D 137	Continued From page 1 -There was no documentation Staff B had a HCPR check upon hire. Refer to interview with the Executive Director (ED) on 08/26/21 at 4:02pm and 5:00pm. Refer to telephone interview with the ED on 08/27/21 at 11:26am. 3. Review of Staff C's, Medication Aide (MA) personnel record revealed: -There was a hire date of 09/02/16. -There was no documentation Staff C had a HCPR check upon hire. Refer to interview with the Executive Director (ED) on 08/26/21 at 4:02pm and 5:00pm. Refer to telephone interview with the ED on 08/27/21 at 11:26am. 4. Review of Staff D's, Medication Aide (MA) personnel record revealed: -There was a hire date of 01/30/16. -There was no documentation Staff D had a HCPR check upon hire. Refer to interview with the Executive Director (ED) on 08/26/21 at 4:02pm and 5:00pm. Refer to telephone interview with the ED on 08/27/21 at 11:26am. 5. Review of Staff E's, Medication Aide (MA) personnel record revealed: -There was a hire date of 12/11/15. -There was no documentation Staff E had a HCPR check upon hire. Refer to interview with the Executive Director	D 137		

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D 137	Continued From page 2 (ED) on 08/26/21 at 4:02pm and 5:00pm. Refer to telephone interview with the ED on 08/27/21 at 11:26am. _____ Interview with the Executive Director (ED) on 08/26/21 at 4:02pm and 5:00pm revealed: -The former business office manager was responsible for the personnel records. -She did not know what was in the personnel records or what was missing, but she suspected some documents would be missing. -She had not had a chance to review or audit the personnel records for missing documentation because she was new to the facility and she was "taking care of other things first". Telephone interview with the ED on 08/27/21 at 11:26am revealed: -She had not located the HCPR checks in the personnel records, but she would continue to look for the documents. -If she could not locate the HCPR checks for the staff she would run them that day, 08/27/21.	D 137		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 270		

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Based on observation, interviews and record review, the facility failed to provide supervision for 1 of 7 residents sampled who had 6 falls, one of which resulted in a fracture to her right arm, sutures to her left arm and staples to her head (#5).

The findings are:

Review of the Fall Management Program for the facility dated 01/19 revealed:
-When a resident was found on the floor, a fall was considered to have occurred; facility was obligated to complete an investigation and put interventions in place to prevent another fall.
-A licensed nurse would complete a focused assessment of the resident when a new fall occurred.
-An individualized service plan would be developed to decrease the risk of falls that would include the date the plan was initiated, a list of individualized interventions, the disciplines responsible for carrying out the interventions and the date on which each goal would be reviewed.

Review of Resident #5's current FL2 dated 06/30/21 revealed:
-Diagnoses included age-related osteoporosis, cervical spondylosis, chronic pain, glaucoma, macular degeneration, physical deconditioning, gait instability and a history of right total knee arthroplasty.
-Resident #5 was semi-ambulatory and intermittently disoriented.
-Resident #5 had functional limitations with sight and hearing.
-Resident #5 was incontinent of bowel and bladder.
-The section for personal care assistance was blank and there was no indication of an assistive

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device.

Review of Resident #5's Resident Register revealed:
-The resident was admitted on 06/30/21.
-Resident #5 required assistance with dressing, bathing, ambulation, getting in and out of bed and toileting.
-Resident #5 was forgetful and needed reminders.
-Resident #5 needed a walker.

Review of Resident #5's current care plan dated 08/18/21 revealed:
-Resident #5 was hard of hearing and had decreased vision.
-Resident #5 was incontinent and required assistance with toileting, grooming, dressing and bathing.
-Resident #5 was at risk for falls and fell on 07/23/21 and 08/07/21.
-Resident #5 was independent with mobility and transferring.

Observation of Resident #5 on 08/25/21 at 9:26am revealed:
-There were 2 walkers and a rollator in the room.
-Resident #5 had a brace on her right forearm.
-There were stitches on her left forearm.

Interview with Resident #5 on 08/25/21 at 9:26am revealed she had fallen and was taken to the local emergency room but she did not remember what the date was.

Review of a Fall Investigation Worksheet for Resident #5 signed by a Nurse on 07/06/21 revealed:
-Resident #5 fell in her room on 07/02/21 at 12:00pm.

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-The position of Resident #5 prior to the fall was blank.
-The activity the resident was doing at the time of the fall was documented as sitting and there were no environmental factors identified.
-Resident #5 had on shoes at the time of the fall.
-Equipment was left blank in the area to indicate footwear and equipment at the time of the fall.
-A walker was listed as the assistive device used by the resident.
-The section regarding room and resident check after a fall indicated the resident was continent.
-The areas for history of prior falls, how long since last voiding, timeframe between last meal and last fall and activity level prior to fall were blank.
-The section for the resident's description of the fall was blank.
-The section to list immediate interventions that were initiated after the fall was blank.
-The section for evaluation and intervention to indicate the resident care team's determination of the cause of the fall was blank.
-Recommendations to prevent further falls section was blank and dated 07/23/21.

Review of a Fall Investigation Worksheet for Resident #5 signed by a Nurse on 07/12/21 revealed:
-Resident #5 fell in her room on 07/10/21 at 5:15am.
-Resident #5's position prior to the fall was given as lying and the activity was unknown.
-There were no environmental factors identified and the resident was wearing socks at the time of the fall.
-Walker, cane and wheelchair were marked "no" in the footwear and equipment at the time of fall section.
-A walker was listed as the assistive device used

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by the resident.
-The resident described that she was trying to roll over in bed and rolled onto the floor.
-The section regarding room and resident check after a fall indicated the resident was continent, call bell was functioning and within reach with bed in a low position.
-The area for history of prior falls was marked "no".
-The areas for how long since last voiding, timeframe between last meal and last fall and activity level prior to fall were blank.
-The section to list immediate interventions that were initiated after the fall was blank.
-The evaluation and intervention section indicated the fall was related to perception by the resident care team.
-Recommendations to prevent further falls section stated to continue to work with physical therapy/occupational therapy and was dated 07/12/21.

Review of a progress note dated 07/14/21 at 8:16am revealed:
-Resident #5 was found on the floor during rounds.
-Resident #5 had reported that she has attempted to sit when she slipped and fell.
-There was a skin tear to Resident #5's elbow.

Review of a progress note dated 07/15/21 at 6:17pm revealed Resident #5 was 1 day post fall and had been observed walking in the hall with a slow, steady gait using a walker.

Review of a form for the reporting of accidents and injury to the local county Department of Social Services dated 07/22/21 revealed:
-Resident #5 was found on the floor of her apartment on 07/21/21 at 1:45pm and was calling

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for help.
-She had a laceration to her head and was admitted to the hospital for observation.

Review of a progress note dated 07/21/21 at 3:42pm revealed Resident #5 was observed on the floor of her apartment yelling out for help.

Review of a progress note dated 07/21/21 at 3:40pm revealed Resident #5 was set out to a local hospital due to a head bleed after the resident fell and hit her head on a bedside table.

Review of a discharge summary from a local hospital for Resident #5 dated 07/23/21 revealed:
-Resident #5 was admitted on 07/21/21 for a fall with injury to the head.
-Resident #5 received a displaced comminuted fracture of the right ulnar and a splint was placed with instructions for no weight bearing until followed up by orthopedic in 4 weeks.
-There was a skin tear on her left arm.

Review of a progress note dated 07/23/21 at 3:40pm revealed Resident #5 returned to the facility from the local hospital with 3 staples in the back of her head, sutures to the left forearm and a brace to her right arm.

Review of a Fall Investigation Worksheet for Resident #5 signed by a Nurse on 07/28/21 revealed:
-Resident #5 fell in her room on 07/23/21 and the time was left blank.
-The position and the activity of Resident #5 at the time of the fall was unknown.
-Resident #5 had on socks at the time of the fall.
-Equipment was left blank in the area to indicate footwear and equipment at the time of the fall.
-Wheelchair was listed as the assistive device

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used by the resident.
-Resident #5 reported that she was coming from the bathroom when she fell.
-Resident's history of prior falls was as marked as "Yes".
-The section to list immediate interventions that were initiated after the fall was blank.
-The evaluation and intervention section indicated the fall was related to perception by the resident care team.
-Recommendations to prevent further falls section was blank and dated 07/23/21.

Review of fax confirmation sheet dated 08/07/21 at 2:35pm revealed that Resident #5's primary care provider (PCP) was notified of a fall without injury.

Review of a progress note dated 08/07/21 at 2:54pm revealed that staff found the resident sitting on the floor and she stated she had lost her balance and fell.

Interview with medication aide (MA) on 08/26/21 at 8:20am revealed:
-Resident #5 had a lot of falls.
-Nurses or the personal care aides (PCA) at the facility monitored a resident for 3 days after a fall.
-There were no increased monitoring checks done by the MAs or the PCAs during this time.
-Resident #5 had difficulties with her vision and efforts were made to use brighter objects in the resident's room.

Interview with a Wellness Nurse on 08/26/21 at 10:03am revealed:
-A nurse would meet with a resident daily for 3 days following a fall and would document in a progress note.
-A fall investigation was completed after each fall

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to identify the cause of the fall and interventions that may be helpful to prevent future falls.
-Interventions should be placed on the care plan.
-The Assisted Living Supervisor was responsible for updating care plans.

Interview with the Resident Care Director (RCD) on 08/26/21 at 10:33am revealed:
-The resident's care plan should be updated after each fall and include interventions put into place.
-The assisted living supervisor was responsible for updating care plans following a fall.
-Interventions that were put into place should be included in the updated care plan for the resident.
-She did not know if interventions had been put into place following the falls for Resident #5.

A second interview with the RCD on 08/26/21 at 6:50pm revealed:
-There was an intervention guide on the fall investigation worksheet that was non-specific.
-There was a box were interventions should be handwritten on the worksheet and those interventions should be added to the care plan for the resident by the assisted living supervisors.

Interview with the ED on 08/26/21 at 6:10pm revealed:
-A Fall Investigation Worksheet and an accident and Injury report was to be completed after each fall.
-Interventions were to be listed on the back of the investigation worksheet and added to the resident's care plan by the RCD.
-The RCD was responsible for updating the care plan with interventions following a fall.
-She did not know Resident #5 had 6 falls and did not know what interventions were put into place after each fall.

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D 270	Continued From page 10 Attempted telephone interview with the primary care provider for Resident #5 on 08/26/21 at 9:30am was unsuccessful. The Assisted Living Supervisor was not available for interview on 08/26/21. Attempted telephone interview with the power of attorney for Resident #5 on 08/26/21 at 9:23am was unsuccessful. The Nurse that complete the fall worksheet investigation was not available for interview during the survey. _____ The facility failed to provide supervision for 1 of 7 residents (#5) that had 6 falls resulting in a laceration to the head requiring staples, a laceration to her left arm that required sutures and a fracture of the right arm. The failure of the facility to provide supervision resulted in substantial risk of neglect and serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/27/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED September 26, 2021	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.	D 273		

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This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to notify the primary care provider (PCP) for 1 of 7 sampled residents regarding a medication used to treat anxiety and behaviors not being available and not notifying the primary care provider (PCP) for refusing to wear anti-embolism stockings (Resident #1) .

The findings are:

Review of Resident #1's current FL2 dated 06/10/21 revealed diagnoses included dementia with behavior disturbance, major depressive disorder, and hypertension.

Review of Resident #1's current FL2 dated 06/10/21 revealed there was an order for Zyprexa (used to treat agitation) 2.5mg twice a day.

Review of Resident #1's eMAR for June 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.
-There was documentation all doses had been administered for 9:00am and 9:00pm from 06/01/21 to 06/30/21 at 9:00am.

Review of Resident #1's eMAR for July 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.
-There was documentation on 07/31/21 at 9:00pm, the dose was documented as medication pending delivery.

Review of Resident #1's eMAR for August 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.

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-There was documentation on 08/01/21 at 9:00am and 9:00pm, the dose was documented as medication pending delivery.
-There was documentation on 08/02/21 at 9:00pm, the dose was documented as medication pending delivery.
-There was documentation on 08/23/21 and 08/24/21 at 9:00pm that medication was not administered; see progress note.
-There was not enough medication dispensed for doses of Zyprexa to be administered on 08/01/21 at 9:00am.

Observation of Resident #1's medication on hand on 08/25/21 at 5:20pm revealed there was no Zyprexa available to administered to the resident.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/26/21 at 9:33am revealed:
-Resident #1 had difficulty obtaining Zyprexa 2.5mg due to insurance issues.
-Insurance would not pay for Zyprexa 2.5mg tablets so the pharmacy could only send a 5 day supply to ensure the medication was paid for by the resident or family per the contract with the facility.
-The pharmacy representative had faxed notices to the PCP and the facility of Resident #1's insurance issues.
-Based on the amount dispensed, Resident #1 did not have enough medication to administer twice daily as ordered.
-There was not enough medication dispensed for doses of Zyprexa to be administered from 06/09/21 at 9:00pm through 06/11/21 at 9:00am and from 06/16/21 through 06/30/21 at 9:00pm.
-There was not enough medication dispensed for doses of Zyprexa to be administered from 07/01/21 at 9:00am through 07/06/21 at 9:00am

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and from 07/11/21 through 07/31/21 at 9:00pm.
-There was not enough medication dispensed for doses of Zyprexa to be administered on 08/01/21 at 9:00am.

Telephone interview with a Nurse Practitioner (NP) for Resident #1's Primary Care Provider (PCP) on 08/26/21 at 9:53am revealed:
-She did not know Resident #1 had difficulty with the co-pay for the Zyprexa that had been ordered since May 2021.
-The facility nor the pharmacy made the PCP aware that insurance would not cover Resident #1's Zyprexa if it were the 2.5mg tablets instead of the 5mg tablets.
-The pharmacy always says they sent information to the PCP they we never receive anything from them.
-At the beginning of August, a wellness nurse from the facility notified her that Resident #1 needed a new prescription for Zyprexa.
-A new prescription was written on 08/04/21.
-Had she been made aware of the situation back in June she could have written a new prescription at that time.

Interview with a medication aide (MA) on 08/26/21 at 6:10pm revealed:
-Resident #1 was on Zyprexa twice daily.
-There was a time Resident #1 was out of Zyprexa.
-She notified the pharmacy and they said she did not have any.
She was out of Zyprexa at the beginning of August and currently out.
-MAs can call the pharmacy to request refills on medications.
-Faxes regarding medications were sent to the Wellness Nurses.
-There were 5 days she did not administer

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Resident #1's Zyprexa due to it was pending delivery from the pharmacy and that was 07/31/21-08/02/21 and 08/23/21-08/24/01.
-MAs were responsible to notify the pharmacy when refills were needed.

-Interview with a second MA on 08/27/21 at 11:48am revealed:
-She knew Resident #1 had issues obtaining Zyprexa from the pharmacy.
-On 08/23/21 -08/25/01, Resident #1 did not have any Zyprexa available, so she used a deceased residents Zyprexa which was the same dose as Resident #1's Zyprexa.
-She had tried to call the pharmacy but was not able to get the medication because it was not time for a refill.

Interview with a Wellness Nurse on 08/26/21 at 10:12am revealed:
-She did not know there was a problem with insurance paying for Resident #1's Zyprexa.
-She did not know who was supposed to pay for a resident's medication when insurance would not pay for it.
-The Wellness Nurses did not know about any problems with medications unless someone let them know.
-The MAs and the Wellness Nurses were responsible for ensuring the PCP was notified of any problems obtaining medications.

Interview with a second Wellness Nurse on 08/26/21 at 10:32am revealed:
-She did not know there was a problem with insurance paying for Resident #1's Zyprexa until the beginning of August.
-The pharmacy had faxed a form to the facility at the beginning of August stating that insurance would not pay for Zyprexa 2.5mg but it would pay

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for a 5mg tablet cut in half.
-The insurance form was placed in the PCP's folder.
-The PCP wrote an order to change the Zyprexa to 5mg cut in half twice a day at the beginning of August.
-The MAs were responsible for reporting problems with obtaining medications to the Wellness Nurses.

Interview with the Resident Care Director (RCD) on 08/26/21 at 10:48am revealed:
-She did not know there was a problem with insurance paying for Resident #1's Zyprexa.
-The MAs were responsible for letting the Wellness Nurses know when they needed a refill for a prescription.
-The Wellness Nurses were responsible for informing the PCP of any problems of obtaining medications and obtaining new orders.

Interview with the Administrator on 08/26/21 at 12:28 revealed:
-She did not know there had been any issues with insurance not paying for Resident #1's Zyprexa.
-The RCD was responsible to ensure all medications were available.
-When a MA noticed a medication was not available, they should inform the wellness nurses or contact the pharmacy.
-The Wellness Nurses were responsible for making the PCP aware of any problems with medications and obtaining new orders.

Attempted telephone interview with Resident #1's family member on 08/26/21 at 10:05am was unsuccessful.

Based on observations, interview, and record review, it was determined that Resident #1 was

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D 273	Continued From page 16 not interviewable.	D 273		
D 281	10A NCAC 13F .0903 (d) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure follow up on recommendations written by the Licensed Health Support Professional (LHPS) nurse for 1 of 7 sampled residents (#4) related to a continuous positive air pressure device (CPAP) machine was used nightly as ordered. The findings are: Review of Resident #4's current FL2 dated 03/08/21 revealed diagnoses included obstructive sleep apnea, chronic sinusitis, and hypertension. Review of Resident #4's physician's orders dated 03/08/21 revealed an order for a continuous positive air pressure device (CPAP) nightly with an entry the resident managed the CPAP on his own.	D 281		

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Review of Resident #4's electronic medication administration records (eMAR) for June 2021, July 2021, and August 2021 revealed there was no entry or documentation related to Resident #4's CPAP machine.

Review of Resident #4's Licensed Health Professional Support (LHPS) review dated 06/23/21 revealed:
-Resident #4 had an LHPS task of monitoring the resident's CPAP.
-There was an entry to assist the resident to apply and remove the CPAP mask each night.

Interview with Resident #4 on 08/25/21 at 10:06am revealed:
-He had not used his CPAP machine in over a month because his headgear was not working correctly.
-He asked staff at the facility to assist him with his CPAP because it was not working, and no one had helped him.
-He thought no one had helped him because they did not know anything about a CPAP machine.
-He had suffered headaches and was "just not feeling well" because he had not been wearing his CPAP machine.

Second interview with Resident #4 on 08/25/21 at 4:23pm revealed:
-He had asked, "over and over" and no one knew what to do.
-He asked the "nurses" at the facility, but he did not know their names.
-He did not know if anyone had talked to his primary care provider (PCP) about the CPAP machine.
-He first asked someone about the CPAP machine, about 6-8 weeks ago.
-He did not know the last time he had talked to

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anyone about needing assistance with the CPAP machine.

Interview with a medication aide (MA) on 08/25/21 at 4:20pm revealed:
-She usually worked from 2:00pm-10:00pm.
-Resident #4 had never asked her to assist him with his CPAP machine.
-Resident #4 was usually still sitting up in his chair when she made her final rounds before leaving her shift.

Interview with a personal care assistant (PCA) on 08/25/21 at 4:51pm revealed:
-The only thing she had ever assisted Resident #4 with was opening a nutritional supplement.
-As far as she knew Resident #4 was self-sufficient.
-She had not assisted Resident #4 with his CPAP machine.

Observation of Resident #4 on 08/26/21 at 8:32am revealed the resident was sitting in a chair, slumped over to the right side, asleep.

Interview with Resident #4 on 08/26/21 at 8:32am revealed:
-He did not sleep well last night.
-He had asked for a Tylenol (used to treat pain) because he had a headache.
-He had new straps for his headgear, but he did not know how to attach the straps to the face mask.
-The headgear that was attached was not working correctly.
-He had tried to fix the straps, but he "got worn out" just trying.
-He had a sleep study completed because he had been having headaches.
-He started using the CPAP machine after the

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sleep study was completed.
-His headaches had improved after he started using the CPAP machine at night.
-His headaches had been "bad" lately.
-He would get up during the night to go to the bathroom and his head hurt so bad he could not fall back asleep.
-He sometimes tried to "wait it out" but sometimes a headache would hurt so bad he would have to ask for Tylenol.
-He thought his headaches were getting "worse and worse."
-The staff knew he was having headaches because he had complained of headaches when he asked for the Tylenol.

Observation of Resident #4's CPAP machine, mask, and headgear on 08/26/21 at 8:49am revealed:
-The CPAP machine was located on a metal file cabinet beside the resident's bed.
-There was one face mask and headgear connected to the CPAP machine.
-There was a second set of headgear located beside the CPAP machine.

Observation of Resident #4 on 08/26/21 at 8:49am revealed:
-Resident #4 attempted to put the CPAP mask and headgear on to demonstrate how it was supposed to be worn.
-The straps of the headgear were twisted and would not attach correctly to the mask once the resident had the mask in place.
-The resident became fatigued while trying to straighten the straps and connect them to the mask as evidenced by, he dropped his hands several times and said he needed to rest and then would try again.
-He dropped his hands and in a frustrated tone

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stated, "I cannot make this work correctly."
-The surveyor untwisted the straps for the resident.
-The resident was then able to demonstrate how the CPAP machine was worn and stated it "now" fit correctly.

Telephone interview with a technician with Resident #4's CPAP supply company on 08/26/21 at 8:45am revealed Resident #4's CPAP supplies were sent out on 04/26/21, including tubing, face mask and headgear.

Telephone interview with a Nurse Practitioner (NP) on 08/26/21 at 9:19am revealed:
-She saw Resident #4 once a month as part of a Veteran's Administration home-based care program.
-She had not seen Resident #4 in twelve weeks but prior to that, she always made sure the resident's CPAP machine was working correctly when she visited Resident #4 monthly.
-She had asked the facility's nursing staff to assist Resident #4 with his CPAP machine during one of her previous visits.
-She had asked the facility's nursing staff to assist the resident to make sure he was putting the mask on and off appropriately.
-She had offered to show both a medication aide (MA) and a nurse how to use the resident's CPAP machine, but no one went with her for her to demonstrate.
-She had reviewed care notes written by a colleague that had seen Resident #4 in her absence, and it appeared his memory was not as good, and he required more assistance.
-The resident's memory decline could be related to his sleep apnea.
-It was concerning to her Resident #4 had issues with his CPAP and no one assisted him.

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-Resident #4 not wearing his CPAP machine as ordered, could contribute to headaches, daytime sleep, and increase his blood pressure.
-The resident's last blood pressure reading recorded by her colleague was 130/64.

Interview with the facility's contracted LHPS nurse on 08/26/21 at 11:52am revealed:
-Facility staff usually assisted residents with their CPAP machines.
-She expected the staff to make sure Resident #4 was using his CPAP machine correctly, including putting the mask on and making sure the mask fit and if the mask did not fit, they should call someone about the mask.
-If Resident #4 was not using his CPAP machine correctly it would contribute to dizziness, fatigue, and altered mental status.

Interview with a second PCA on 08/26/21 at 6:34pm revealed:
-She worked at the facility through a staffing agency.
-She had worked with Resident #4 since May 2021.
-She had woken Resident #4 up multiple times and had never seen him wear the CPAP machine.

Interview with the facility's Wellness Nurse on 08/26/21 at 11:57am revealed:
-She was not familiar with Resident #4 and his CPAP machine.
-No one had mentioned to her anything about Resident #4 and his CPAP machine.
-She knew Resident #4 was mostly independent with his care.

Interview with another facility Wellness Nurse on 08/26/21 at 12:01pm revealed:

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-She was not familiar with Resident #4 and his CPAP machine.
-No one had mentioned to her anything about Resident #4 and his CPAP machine.
-If Resident #4 had a CPAP machine, and even if he used it independently, the task should have been on Resident #4's eMAR.
-Personal care assistants (PCA) made rounds with all the residents and she would have expected the PCA to have made sure Resident #4 was wearing his CPAP machine.
-If Resident #4 was not wearing his CPAP machine, she would have expected the PCA to encourage him to wear it and to notify the Wellness Nurse if there were any issues.

Second interview with this Wellness Nurse on 08/26/21 at 12:39pm revealed:
-She had seen Resident #4 on 07/12/21 during her monthly visit.
-She completed Resident #4's vitals, asked how he was doing overall, and assessed for any pain or wounds.
-Resident #4 did not mention anything about his CPAP machine during the visit.

Interview with the facility's Resident Care Director (RCD) on 08/26/21 at 12:10pm revealed:
-She knew Resident #4 wore a CPAP machine.
-She was under the impression Resident #4 managed the CPAP machine on his own.
-The facility staff would not do anything with the CPAP machine if Resident #3 self-managed it.
-She had not reviewed the LHPS recommendations for Resident #4 because she was new at the facility and had been in training from 07/13/21-08/21/21.
-As the Resident Care Director, she would be responsible for reviewing the LHPS recommendations and ensuring any

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recommendations were implemented.
- Resident #4's LHPS review dated 06/23/21 was a recommendation related to assisting Resident #4 with putting the CPAP on and removing, and not an order, so if she had seen it she would have discussed it with the Administrator and obtained an order if needed.

Interview with Resident #4's PCP on 08/26/21 at 1:02pm revealed:
-She saw Resident #4 today, 08/26/21.
-Resident #4 complained of headaches to her and that was an indication he had not been wearing his CPAP machine.
-Resident #4 was able to demonstrate he could use his CPAP machine appropriately to her since the straps had been fixed earlier today, 08/26/21.

Telephone interview with the Assisted Living Supervisor on 08/26/21 at 1:17pm revealed:
-The facility staff did not manage Resident #4's CPAP machine.
-Resident #4 had spoken to the interim RCD about his CPAP machine about 2 months ago.
-She did not know what the issue was with Resident #4's CPAP but thought the CPAP needed a piece for the machine.
-She did not know what the interim RCD did about the CPAP, because she was not involved and just remembered "hearing about it."
-The PCAs checked on Resident #4 daily during rounds.
-The PCA's did not document checks on residents unless there was an issue.

Interview with a PCA on 08/26/21 at 6:34pm revealed:
-She was a contracted PCA through a staffing agency and had worked with Resident #4 since May 2021.

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-She had been in to wake Resident #4 up for breakfast and had never seen him with the CPAP machine on, the CPAP mask was always laying on the bedside table.
-No one had ever told her to do anything with Resident #4's CPAP machine.
-She did not know if Resident #4 put his CPAP machine on and off by himself and had already removed it before she came into the room.
-She had never talked to anyone about Resident #4's CPAP machine because she did not know she needed to.

Interview with the Executive Director on 08/26/21 at 5:49pm revealed:
-The staff the resident saw most often was the PCAs and she would have expected the PCA to let whatever department know if there was an issue and to also let their supervisor know.
-If the LHPS documented Resident #4 needed assistance with his CPAP machine, assistance should have been provided.
-Resident #4's CPAP machine should have been entered into the eMAR.
-When Resident #4 asked for assistance with his CPAP machine, she expected that person to have done whatever needed to be done to resolve the issue.
-She was concerned Resident #4 did not get the assistance he should have received.

_____

The facility failed to ensure 1 of 7 sampled resident (#4) had received the assistance that was needed to ensure his CPAP machine was working correctly. Because the resident had not received the assistance he had requested, he did not wear his CPAP machine for 6-8 weeks, and during that time he had increased frequency of headaches, increased fatigue, and complained of "just not feeling well all over." This failure was

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D 281	Continued From page 25 detrimental to the welfare of the resident which constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/20/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 11, 2021.	D 281		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews it was determined the facility failed to ensure the residents were served in the dining room for all three meals. Observation of the breakfast meal on the Assisted Living (AL) floors of the facility on 08/26/21 from 7:00am to 8:00am revealed: -There were two floors in the facility that the AL residents resided in; the second floor and the third floor. -The kitchen was on the second floor of the facility. -There was a large dining room on the second floor that was adjacent to the kitchen. -There was a cook in the kitchen and two kitchen staff; the same two kitchen staff were observed serving the residents their breakfast meals in their rooms on the floors.	D 338		

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-The dining room was empty.
-There was one kitchen staff assigned to each floor to serve the residents the breakfast meal in their rooms.
-The breakfast meal including beverages were served in disposable containers.

Observation of lunch meal in the AL dining room on 08/26/21 at 11:53am to 12:30pm revealed:
-There was an activities staff serving beverages and assisting the residents.
-There were two kitchen staff serving food to the residents.
-There were two personal care aides (PCAs) helping to serve residents their lunch meals.

Observation of two resident in their rooms on 08/25/21 at 7:38am and 7:40am revealed:
-One resident was eating breakfast from a plate sitting on her lap.
-The second resident was eating her breakfast that had been placed on her bedside table.

Interview with one of the residents on 08/25/21 at 7:38am revealed she preferred to eat in the dining room, "it was easier to eat at the [dining room] table."

Interview with a second resident on 08/25/21 at 7:42am revealed:
-He was looking forward to going back to the dining room for meals.
-He was told by staff he could not have his breakfast and dinner meals in the dining room right now because of lack of help.

Interview with six residents on 08/25/21 from 9:20am to 10:15am revealed:
-The food was better when they were able to eat in the dining room.

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-Since they had been eating in their rooms they were served ham sandwiches, turkey sandwiches, and hot dogs "over and over."
-They went to the dining room for lunch Monday-Friday and all other meals they ate in their room.
-One resident did not have a table to eat her lunch, but put napkins in her lap and "made do."
-Another resident preferred to eat in the dining room because he did not like to eat alone.
-One resident was looking forward to eating a hot pancake with syrup; she ate toast every day because it was easier to eat because it was not messy.
-They preferred to eat meals in the dining room.
-It was frustrating that the meals and beverages and condiments were not served at the same time; he had to wait as long as 20 minutes before to get his drink and silverware to eat.
-One resident was told she had to eat in her room because the pandemic was "going around" again.
-She would prefer to eat all her meals in the dining room because she liked to see everyone.
-The food was better when served in the dining room; she felt like she was eating "picnic" style food when she ate in her room.
-All the residents wanted to eat breakfast and dinner, not just lunch, in the dining room.

Interview with a dietary aide on 08/26/21 at 7:27am revealed:
-She could only think of one resident who did not have a tray or table to eat their meal.
-No one had complained to her about eating breakfast and dinner in their rooms.
-The residents were looking forward to being able to eat in the dining room because the residents liked to eat with other residents.

Interview with a second dietary aide on 08/26/21

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D 338	Continued From page 28 at 7:49am revealed: -The residents were served the breakfast and dinner meals in their rooms and the lunch meal was served in the dining room. -She served the residents' their breakfast meals on one floor and the other kitchen staff served on another floor. -At lunch time they both served the lunch meal in the dining room. -She knew they were short a staff to wash dishes in the kitchen in the morning and the PCAs were helping to get residents up in the morning so there was not enough staff to help in the dining room in the morning. -She did not work during the dinner meal, so she did not know what staff was "short" in the evening. -The residents had been eating their breakfast and dinner meals in their rooms since the pandemic. Interview with two cooks on 08/26/21 at 5:38pm revealed: -One cook had worked at the facility for over five years and one cook had only worked at the facility for a few weeks and was being trained by the first cook for the dinner meal. -The dinner meal was not served to the residents in the dining room but was served in their rooms because there was only one kitchen staff to serve resident meals. -When the dinner meal had been served in the dining room there had were two kitchen staff to serve the dinner meal, one kitchen staff to wash dishes and four PCAs to help serve the residents in the dining room. -The PCAs and the kitchen staff had been short of staff for a few months. -They did not know if the residents preferred to eat in the dining room.	D 338		

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-The presentation of the food was better when it was served in the dining room because it was served on a plate and not in a disposable container.
-The first cook thought it was better for the residents to eat in the dining room because they could get exactly what they wanted and any request for any food or additional items could be met quickly.
-He also thought the food was hotter when it was served in the dining room.
-They did not know if the residents complained about eating in their rooms verses the dining rooms.

Interview with the Kitchen Manager (KM) on 08/25/21 at 3:14pm revealed:
-He had been the KM for three months.
-The residents who resided in the AL ate their lunch meal in dining room and all other meals were served in the resident's rooms.
-Lunch was only served in the dining room Monday through Friday.
-There was a shortage of kitchen staff in the mornings and in the evenings.
-There should have been a cook, one kitchen staff to wash dishes and two kitchen staff to serve the food in the dining room for each meal.
-There was only a cook and one staff to serve food in the evening.
-There was not a kitchen staff to wash dishes at all during any of the meals.
-He worked when he could to help but there still was not enough kitchen staff to work in the department.
-There was enough staff during the day to serve the lunch meal in the dining room because the PCAs and an activities staff helped.
-The residents did not complain to him about eating in their rooms, but they did often ask him

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when they would be eating all their meals in the dining room again.
-He had at least one resident ask once a week when they were going to be able to eat [all meals] in the dining room again.

Interview with the KM on 08/26/21 at 11:18am revealed:
-There needed to be four staff in the dining room to serve the residents that resided in the AL at the facility.
-There should have been two kitchen staff and two PCAs to help at each meal served in the dining room.
-The facility had been short staffed in all the departments for a while and had resorted to hiring agency labor.
-The residents were not served lunch in the dining rooms on the weekends because a lot of the agency staff called off on the weekends.
-The kitchen used agency help and had staff call off on the weekends.

Interview with the Executive Director (ED) on 08/25/21 at 10:31am revealed:
-The residents who lived on the AL side of the facility ate their lunch meals in the dining room; they ate their breakfast and their dinner meals in their rooms.
-The kitchen did not have enough staff to serve the residents in the AL for breakfast and dinner in the dining room.

Interview with the ED on 08/26/21 at 11:26am revealed:
-The facility had a COVID-19 outbreak in December 2020 and had tried to ease back into serving meals to the residents in the dining room in March 2021.
-They began with the lunch meal first, but they

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D 338	Continued From page 31 were only able to serve the lunch meal in the dining room Monday through Friday. -There was a large amount of staff that would call off on the weekend so they could not serve lunch meals in the dining room on the weekends. -There was a combination of four staff in the dining room at lunch time; 2 kitchen staff, one PCA and one staff from activities to pour beverages. -The kitchen staff were short one staff to wash dishes and one staff to serve meals in the evening. -The PCAs were getting residents up in the mornings, toileting, bathing and dressing them so they were not available to help serve the breakfast meal in the dining room. -There was a group of residents that preferred not to eat the breakfast meal in the dining room prior to the pandemic. -There was still a large group of residents that did not want to eat breakfast in the dining room. -The residents asked her "here and there" when they could eat all their meals in the dining room again. -She planned on resuming meals in the dining room again in the next couple of weeks because she had found agency with kitchen staff to work in the kitchen and she had hired staff for the kitchen and the PCAs.	D 338		
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	D 358		

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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 for 4 of 7 sampled residents (#1, #4, #6, #7) including a medication to help reduce fluid overload in relation to weight gain (#7), and a medication used to treat allergies (Resident #6), a medication used to help decrease agitation associated with dementia (#1), and a medication used to treat a rash and a medication used to open the airway (Resident #4).

The findings are:

1. Review of Resident #7's current FL2 dated 04/27/21 revealed:
-Diagnoses included congested heart failure, hypertension, atrial fibrillation, obstructive sleep apnea
-He was non-ambulatory
-He was transferred to the wheelchair with assistance of two facility staff and a hoyer lift.
-He required total assistance for bathing, dressing, ambulation, transfers and toileting.

Review of Resident #7's hospital discharge summary dated 04/27/21 revealed:
-There was an order for furosemide (used to treat high blood pressure and heart failure by reducing fluid) 20mg daily.
-There was an order for furosemide 40mg twice daily for two days for weight gain greater than 5 pounds in one week or greater than 3 pounds in

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two days.
-There was documented weight of 220 pounds 11.2 ounces upon discharge from the hospital.
-He had a scheduled appointment with the Cardiologist on 05/03/21 at 1:15pm related to abnormal electrocardiogram (a test that records the timing and strength of the electrical signals that make the heart beat).

Review of signed physician orders dated 06/23/21 revealed:
-There was an order for furosemide 20mg daily.
-There was an order for furosemide 40mg twice daily for two days for weight gain greater than 5 pounds in one week or greater than 3 pounds in two days.

Review of Resident #7's electronic medication administration record (eMAR) for June 2021 revealed:
-There was an entry for furosemide 20mg daily.
-There was an entry for furosemide 40mg twice daily for two days for weight gain greater than 5 pounds in one week or greater than 3 pounds in two days.

Review of Resident #7's eMAR for July 2021 revealed:
-There was an entry for furosemide 20mg daily.
-There was an entry for furosemide 40mg twice daily for two days for weight gain greater than 5 pounds in one week or greater than 3 pounds in two days.

Review of Resident #7's eMAR for August 2021 revealed:
-There was an entry for furosemide 20mg daily.
-There was an entry for furosemide 40mg twice daily for two days for weight gain greater than 5 pounds in one week or greater than 3 pounds in

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two days.

Review of Resident #7's weight summary record for June 2021 revealed there was a documented weight on 06/01/21 at 12:37pm of 246.8 pounds.

Review of Resident #7's weight summary record for July 2021 revealed there was a documented weight recorded on 07/01/21 at 7:19am of 238.8 pounds.

Review of Resident #7's weight summary record for August 2021 revealed there was a documented weight on 08/04/21 at 8:54am of 247 pounds.

Observation of weight obtained on 08/27/21 at 11:30am revealed a weight of 239.6 pounds.

Review of Resident #7's physicians visit form dated 08/20/21 revealed:
-He had dyspnea with minimal exertion during visit.
-There was an order to add an extra 20mg of furosemide in addition to the daily dose furosemide 20mg for the next three days, 08/21/21 to 08/23/21.

Review of Resident #7's Primary Care Provider's (PCP) report dated 08/23/21 revealed the facility staff was not checking daily weights to determine if additional dose of furosemide was needed.

Review of facility weights policy revealed:
-The resident's weight would be obtained as ordered by PCP.
-The resident's weight would be recorded in the resident's eMAR.
-The resident would be re-weighed for significant changes from previous weight and reported to the

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D 358	Continued From page 35 licensed nurse. Interview with Resident #7 on 08/26/21 at 10:20am revealed: -He was weighed in his wheelchair the first week of each month. -He was weighed monthly. -He had shortness of breath with exertion. -He had shortness of breath "several times a week". -He knew he was administered a fluid medication daily. -He did not know if the fluid medication was doing what it was intended to do. -He received an extra dose of the fluid medication for three days "about a week ago". Interview with the Medication Aide (MA) on 08/26/21 at 10:25am revealed: -The personal care assistants (PCA) were responsible for obtaining weights. -Resident weights were obtained the first three days of the month. -Resident weights were documented on the eMAR by the MA. -Resident #7 complained of shortness of breath "at times" when maneuvering his wheelchair, dressing, bathing and toileting. -She knew furosemide was a fluid medication. -She had not noticed the order to administer additional furosemide related to Resident #7's weight gain of 5 pounds in one week or 3 pounds in two days. -Resident #7's weight should have been obtained and recorded daily. -An additional dose of furosemide should have been given based on Resident #7's weights. -She had not weighed Resident #7 every day. -She had not administered additional furosemide based on weight.	D 358		

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-The only additional furosemide the MA had administered was on 08/21/21 to 08/23/21.

Interview with the Resident Care Director (RCD) on 08/26/21 at 9:40am and 5:03pm revealed:
-Monthly weights were obtained by the case managers.
-The Assisted Living Coordinator supervised the PCA's.
-The MA should have Resident #7's weight checked and recorded daily.
-The MA should check the weight to see if additional furosemide was needed.
-She did not know if Resident #7 went to the Cardiologist appointment on 05/03/21 as scheduled.

Interview with Wellness Nurse on 08/26/21 at 10:45am revealed:
-Monthly weights were obtained by the case manager.
-The MA documented the weights in the eMAR.
-The MA was responsible for obtaining Resident #7's weight "at least" every 2 days to know if additional furosemide was needed.
-Furosemide was a fluid medication to "pull fluid off".
-Resident #7 was taking furosemide because of shortness of breath related to fluid.
-Resident #7 was admitted to Hospice "about a month ago".
-She did not know if Resident #7 went to the Cardiologist appointment on 05/03/21.

Telephone interview with Assisted Living Supervisor on 08/26/21 at 10:05am revealed:
-She supervised the PCA's.
-Monthly weights were obtained the first three days of each month.
-The PCA's were responsible for obtaining the

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residents' monthly weights.
-The MA was responsible for recording the monthly weight in the eMAR.
-The MA would obtain weights when ordered more frequently than monthly and record the reading in the eMAR.
-The MA was responsible for obtaining the weight when associated with a medication.

Interview with Executive Director on 08/26/27 at 5:11pm revealed:
-The Assisted Living Supervisor was responsible for having the monthly weights obtained.
-The MA was responsible for additional weights obtained during the month.
-The MA was responsible for administering additional furosemide related to resident's weight.
-The MA was expected to follow the PCPs orders.

Telephone interview with a personal for hospice on 08/26/21 at 4:38pm revealed:
-Resident #7 was admitted to hospice services on 07/21/21.
-Referral for hospice for Resident #7 was made after a visit to the emergency department on 07/19/21.

Telephone interview with a personal at the Cardiologist office on 08/27/21 at 9:27am revealed:
-Resident #7 did not show up for his appointment on 05/03/21 at 1:15pm.
-Resident #7 had never been seen at the Cardiology office.

Attempted telephone interview with the PCP on 08/26/21 at 3:15pm and on 08/27/21 at 9:38pm was unsuccessful.

2. Review of Resident #6's FL2 dated 3/8/21

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revealed an order for Claritin (used to treat seasonal allergies) 10mg daily.

Review of Resident #6's physician orders signed 07/26/21 revealed an order for Claritin 10mg daily.

Review of Resident #6's quarterly pharmacy consultation report dated 07/24/21 revealed:
-Diagnosis included seasonal allergic rhinitis.
-Resident #6 had received Claritin 10mg daily since 03/29/18.
-The pharmacist recommended discontinuing Claritin or changing to as needed.
-The Primary Care Provider (PCP) signed the pharmacy consultation report on 08/09/21 and agreed with the Pharmacist recommendation.
-Rationale for recommendation was administration should be limited to allergy season in order to avoid adverse events attributed to daily long-term use.

Review of Resident #6's electronic medication administration record (eMAR) for August 2021 revealed:
-There was an entry for Claritin 10mg daily.
-The medication aide (MA) had documented administration of Claritin 10mg daily from 08/01/21 to 08/26/21 at 8:00am.

Telephone interview with facility contracted pharmacist on 08/27/21 at 9:00am revealed:
-Claritin was used for seasonal allergies.
-Adverse events for long term usage of Claritin included increased muscle cramps, increased dementia, increased fatigue, increased dizziness and dehydration.
-The facility staff was responsible for faxing signed pharmacy consultation report to the pharmacy once the PCP signed the report.

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-The facility staff would enter the new order into eMAR if the PCP agreed.
-The pharmacy did not have record that the pharmacy consultation report was faxed to them once the PCP signed the report.

Interview with Wellness Nurse on 08/26/21 at 12:30pm revealed:
-The PCP would review the pharmacy consultation report.
-The PCP would sign the report, and agree or disagree, with recommendations.
-She faxed the pharmacy consultation report to the pharmacy.
-She entered new orders into the eMAR.
-She did not know why this order was not discontinued in the eMAR.
-The orders were filed by the third shift MA after they were entered in the eMAR.
-The order could have been filed in the resident's record before faxing to the pharmacy.
-All orders were entered in the eMAR by facility staff.

Interview with the Executive Director on 08/26/21 at 5:11am revealed:
-The Resident Care Director (RCD) was responsible for the pharmacy consultation report follow-up.
-The RCD was responsible for faxing the pharmacy consultation report to the PCP or placing in the PCP's folder for review.
-The RCD would fax the pharmacy consultation report to the pharmacy once the PCP reviewed and signed the report.
-The RCD was responsible for implementing any new orders the PCP agreed with on the report.
-The staff could not continue to let medication orders "slip through" without implementation.

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Attempted telephone interview with the PCP on 08/26/21 at 3:15pm and on 08/27/21 at 9:38am was unsuccessful.

3. Review of Resident #1's current FL2 dated 06/10/21 revealed:
-Diagnoses included dementia with behavior disturbance, major depressive disorder, and hypertension.
-There was an order for Zyprexa (used to treat agitation) 2.5mg twice a day.

Review of Resident #1's eMAR for June 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.
-There was documentation all doses had been administered for 9:00am and 9:00pm from 06/01/21 to 06/30/21.

Review of Resident #1's eMAR for July 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.
-There was documentation all doses had been administered for 9:00am and 9:00pm from 07/01/21 to 07/31/21 at 9:00am.
-There was documentation on 07/31/21 at 9:00pm, the dose was documented as medication pending delivery.

Review of Resident #1's eMAR for August 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.
-There was documentation all doses had been administered for 9:00am and 9:00pm from 08/03/21 to 08/25/21 at 9:00am.
-There was documentation on 08/01/21 at 9:00am and 9:00pm, the dose was documented

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as medication pending delivery.
-There was documentation on 08/02/21 at 9:00am that the dose had been administered.
-There was documentation on 08/02/21 at 9:00pm, the dose was documented as medication pending delivery.
-There was documentation on 08/23/21 and 08/24/21 at 9:00pm that medication was not administered; see progress note which said the resident ran out of zyprexa and it was not time to reorder medication.

Observation of Resident #1's medication on hand on 08/25/21 at 5:20pm revealed there was no Zyprexa available to administer to the resident.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/26/21 at 9:33am revealed:
-Zyprexa 5mg tablets were dispensed as half tablets on 05/05/21 with the original order for Zyprexa with instructions to administer ½ tablet twice daily; 30 tablets were dispensed and would last 30 days when administered as ordered.
-On 06/03/21, 06/11/21, 07/06/21, 08/01/21, Zyprexa 2.5mg tablets were dispensed with instructions to administer 1 tablet twice daily; 10 tablets were dispensed and would last 5 days when administered as ordered.
-Insurance would not pay for zyprexa 2.5mg tablets so the pharmacy could only send a 5 day supply to ensure the medication was paid for by the resident or family per the contract with the facility.
On 08/04/21, Zyprexa was switched back to the 5mg tablets so that insurance would pay for the medication; 30 tablets were dispensed and would last 30 days when administered as ordered.
-Resident #1 had difficulty obtaining Zyprexa 2.5mg due to insurance issues.

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-The pharmacy representative had faxed notices to the primary care provider (PCP) and the facility of Resident #1's insurance issues.
-Based on the amount dispensed, Resident #1 did not have enough medication to administer twice daily as ordered.
-There was not enough medication dispensed for doses of Zyprexa to be administered from 06/09/21 at 9:00pm through 06/11/21 at 9:00am and from 06/16/21 through 06/30/21 at 9:00pm.
-There was not enough medication dispensed for doses of Zyprexa to be administered from 07/01/21 at 9:00am through 07/06/21 at 9:00am and from 07/11/21 through 07/31/21 at 9:00pm.
-There was not enough medication dispensed for doses of Zyprexa to be administered on 08/01/21 at 9:00am.

Telephone interview with a Nurse Practitioner (NP) for Resident #1's PCP on 08/26/21 at 9:53am revealed:
-She did not know Resident #1 had difficulty with the co-pay for the Zyprexa that had been ordered.
-The PCP ordered Zyprexa to treat Resident #1's anxiety, agitation, and behaviors associated with dementia.
-Not receiving the Zyprexa as ordered could cause an increase in anxiety, agitation, and behaviors in Resident #1.

Interview with a medication aide (MA) on 08/26/21 at 6:10pm revealed:
-She worked regularly with Resident #1 and administered her medications.
-Resident #1 was on Zyprexa twice daily.
-There was a time Resident #1 was out of Zyprexa.
-The pharmacy said the prescription could not be refilled at that time due to insurance not paying.
-MAs could call the pharmacy to request refills on

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medications.
-Faxes regarding medications were sent to the wellness nurses as the fax machine was in their office.
-There were not any times that she documented the medication as being administered when the medication was not available.
-There were 5 days she did not administer Resident #1's Zyprexa due to it was pending delivery from the pharmacy and that was 07/31/21-08/02/21 and 08/23/21-08/24/01.
-MAs were responsible to notify the pharmacy when refills were needed.

Interview with a second MA on 08/27/21 at 11:48am revealed:
-She knew Resident #1 had issues obtaining Zyprexa from the pharmacy due to insurance not paying for it.
-On 08/23/21-08/25/21, Resident #1 did not have any Zyprexa available, so she used a deceased residents Zyprexa which was the same dose as Resident #1's Zyprexa.
-She did not want the resident to be without her medication.
-She had tried to call the pharmacy but was not able to get the medication as it was too soon for a refill.

Interview with a Wellness Nurse on 08/26/21 at 10:12am revealed:
-She did not know there was a problem with insurance paying for Resident #1's Zyprexa.
-She did not know who was supposed to pay for a resident's medication when insurance would not pay for it.
-The Wellness Nurses did not know about any problems with medications unless someone let them know.
-Wellness Nurses did not do cart audits because

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the MAs were supposed to do them every 30 days.
-When MAs audited the medication carts, they looked for expired medications and ensured all medications were on the medication carts.
-She did not know if the MAs documented cart audits anywhere.
-The MAs were responsible to ensure medications were administered as ordered.
-The MAs and the Wellness Nurses were responsible for ensuring the PCP was notified of any problems obtaining medications.

Interview with a second Wellness Nurse on 08/26/21 at 10:32am revealed:
-The pharmacy faxed a form to the facility at the beginning of August 2021 stating that insurance would not pay for Zyprexa 2.5mg but it would pay for a 5mg tablet cut in half.
-The insurance form was placed in the PCP's folder when she received it.
-The PCP wrote an order to change the Zyprexa to 5mg cut in half twice a day on 08/05/21.
-If the pharmacy needed an order the MA could pull a record and fax them the current FL2 as it was good for 6 months.
-The resident's family member was responsible for paying for medication when insurance did not pay for it.
-There had not been any medication cart audits since she worked started at the facility.

Interview with the Resident Care Director (RCD) on 08/26/21 at 10:48am revealed:
-She did not know about any missed medications.
-Missed medications should have shown up on the missed medication report.
-When insurance did not pay for a medication, she assumed the family would be responsible for paying the bill.

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-The MAs were responsible for letting the Wellness Nurses know when they needed a refill for a prescription.
-She did not know if anyone had been doing medication cart audits to ensure medications were available.

Interview with the Administrator on 08/26/21 at 12:28 revealed:
-She did not know there had been any issues with insurance not paying for Resident #1's Zyprexa.
-She did not know Resident #1 did not have enough Zyprexa dispensed so it could be administered as ordered.
-The RCD was responsible to ensure all medications were available.
-When a MA noticed a medication was not available, they should inform the Wellness Nurses or contact the pharmacy.
-The residents were responsible for paying for any medication that their insurance did not pay for.
-Missed medications were reviewed during the daily stand-up meeting.
-The RCD was responsible for following up with missed medication.
-Monthly cart audits were completed by the contracted pharmacy to ensure all medications were on the medication cart.

Attempted telephone interview with Resident #1's family member on 08/26/21 at 10:05am was unsuccessful.

Based on observations, interview, and record review, it was determined that Resident #1 was not interviewable.

4. Review of Resident #4's current FL-2 dated 03/08/21 revealed diagnoses included obstructive

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sleep apnea, chronic sinusitis, and hypertension.

a. Review of Resident #4's FL-2 dated 03/08/21 revealed an order for Atrovent 17mcg, inhale two puffs twice daily for sleep apnea. (Atrovent is used to open up the medium and large airways in the lungs).

Review of Resident #4's June 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Atrovent 17mcg inhale two puffs twice a day with a scheduled administration time of 8:00am and 8:00pm.
-Atrovent 17mcg was documented as administered twice daily at 8:00am and 8:00pm from 06/01/21-06/30/21.
-There were no exceptions documented.

Review of Resident #4's July 2021 eMAR revealed:
-There was an entry for Atrovent 17mcg inhale two puffs twice a day with a scheduled administration time of 8:00am and 8:00pm.
-Atrovent 17mcg was documented as administered twice daily at 8:00am and 8:00pm from 07/01/21-07/30/21.
-There were no exceptions documented.

Review of Resident #4's August 2021 eMAR revealed:
-There was an entry for Atrovent 17mcg inhale two puffs twice a day with a scheduled administration time of 8:00am and 8:00pm.
-Atrovent 17mcg was documented as administered twice daily at 8:00am and 8:00pm from 08/01/21-08/25/21 and at 8:00am on 08/26/21.
-There were no exceptions documented.

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D 358	Continued From page 47 Observation of Resident #4's medication on hand on 08/25/21 at 4:14pm revealed: -There was a box labeled for Atrovent 17mcg. -The directions were to inhale 2 puffs by mouth twice daily for diagnosis of sleep apnea. -The pharmacy label showed a dispensed date of 06/20/21. -There was a handwritten entry on the label of 06/22/21. -The Atrovent inhaler's count display was red and had the number zero visible. Interview with a medication aide (MA) on 08/25/21 at 4:20pm revealed: -She administered Resident #4's 8:00pm dose of Atrovent. -Dates written on labels were the date the item was opened to be administered. Interview with Resident #4 on 08/25/21 at 4:23pm revealed: -The MA brought his inhaler in when she brought his morning and evening medications. -The MA handed him the inhaler to administer. -When he pushed the inhaler down, he thought he could feel air coming from the inhaler and thought it was the medication. -He had not experienced any shortness of breath. -He was not sure why he had been prescribed the Atrovent inhaler. Observation of Resident #4's medication on hand on 08/26/21 at 7:39am revealed: -There was a box labeled for Atrovent 17mcg. -The directions were to inhale 2 puffs by mouth twice daily for diagnosis of sleep apnea. -The pharmacy label showed a dispensed date of 06/20/21. -There was a handwritten entry on the label of 06/22/21.	D 358		

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-The Atrovent inhalers count display was red and had the number zero visible.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/26/21 at 9:00am revealed:
-Resident #4's Atrovent was last dispensed on 06/20/21 for a 30-day supply.
-On 08/17/21, an Atrovent inhaler was filled and was delivered to the facility on 08/18/21.
-The Atrovent inhaler contained 120 inhalations, which was a thirty-day supply based on the order for two inhalations twice a day.
-An electronic request had been received today, 08/26/21, to refill Resident #4's Atrovent inhaler.
-There was no name listed on the request to indicate who had initiated the refill.

Observation of Resident #2's medications on hand on 08/26/21 at 11:00am revealed Resident #2's Atrovent inhaler, dated 06/20/21, was in the medication drawer and was presented when requested to see Resident #4's inhaler that was administered today, 08/26/21.

Interview with a MA on 08/26/21 at 11:00am revealed when asked if Resident #2 had any other inhalers, a new, unopened Atrovent box, with a dispensed date of 08/17/21, was provided.

Telephone interview with a Nurse Practitioner (NP) on 08/26/21 at 9:19am revealed:
-She saw Resident #4 once a month as part of a Veteran's Administration (VA) home-based care program.
-Resident #4 had been receiving Atrovent inhalations but when she reviewed his record, she could not see any reason to continue the medication and it was "on hold" in the VA system and could not be filled in the VA system.

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D 358	Continued From page 49 -She was not sure when she put Resident #4's Atrovent "on hold" but it was in 2021. -If Resident #4 was continuing to use the Atrovent inhaler, the order must have come from the facility's contracted providers and filled at the facility's contracted pharmacy. Interview with a MA on 08/26/21 at 11:01am revealed: -She administered Resident #4's Atrovent today, 08/26/21. -She thought the line beside the zero in the count display meant there was one inhalation left in the inhaler and that she had administered the last inhalation this morning. -She did not know the zero in the count display meant there were no inhalations left to be administered had been visible on 08/25/21. Interview with the facility's Resident Care Director (RCD) on 08/26/21 at 5:19pm revealed: -She did not know Resident #4's Atrovent inhaler was being administered when there was no medication to be administered. -She was concerned the medication had not been administered as ordered because the medication was used to open the resident's bronchioles up. -If Resident #4 had not been administered the Atrovent, the resident may not have been able to breathe as well and would not get a good quality night of sleep. -The Atrovent was dated, and the MAs should have known when the medication was running low and replaced before it was empty. Interview with the Executive Director on 08/26/21 at 5:49pm revealed: -She did not know Resident #4's Atrovent inhaler was being administered when the count indicated the inhaler was empty.	D 358		

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-She would have expected the MAs to monitor the count on the inhaler and know when the medication needed to be refilled.
-She expected Resident #4's Atrovent to have been administered as ordered.
-Cart audits were completed by the facility's contracted pharmacy and were completed in June 2021.

Attempted telephone interview with the facility's primary care provider on 08/26/21 at 10:59am and 4:39pm was unsuccessful.

b. Review of a message communication form dated 07/07/21 revealed:
-The message was written on 07/07/21 by one of the facility's Wellness Nurses.
-The message was regarding Resident #4 had a red rash in his groin area and upper thigh on the resident's right leg and had complained of the rash itching.
-She had requested the resident be assessed by the facility's contracted primary care provider (PCP).
-Resident #4 was seen by the PCP on 07/12/21 and Triamcinolone 0.1% cream was ordered with the directions to apply to rash/itchy areas on the thighs, groin and waistline topically twice a day for 14 days.

Review of Resident #4's July 2021 eMAR revealed:
-There was an entry for Triamcinolone Cream 0.1% apply to back, arms, legs, topically as needed for dry skin.
-The medication could be kept in the resident's room for unsupervised self-administration as needed.
-There was no entry for Triamcinolone cream twice daily to be administered for 14 days.

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D 358	Continued From page 51 -There was no documentation Triamcinolone cream had been administered. Observation of Resident #4's medication on hand on 08/25/21 at 4:14pm revealed there was no Triamcinolone cream available to be administered. Interview with the MA on 08/25/21 at 4:20pm revealed she had not administered any creams for Resident #4. Interview with Resident #4 on 08/25/21 at 4:23pm revealed: -He had a rash and it was itching. -He thought his adult briefs were causing irritation to the skin and caused the rash. -The rash "comes and goes" and was "okay" right now. -No one had applied any creams to the rash. -No one had given him a cream to apply to the rash. -He had a bottle of lotion for itching he applied to the rash and it "seemed to help." Observation of Resident #4's room on 08/25/21 at 4:30pm revealed: -There was no Triamcinolone cream available to be administered. -There was an anti-itch concentrated bottle of lotion located on the resident's bathroom counter. Interview with another MA on 08/26/21 at 7:45am and 11:01am revealed: -Resident #4's creams were only as needed and there was none on the medication cart. -She thought Resident #4's creams were kept in his room. -Resident #4 had an order for scheduled Triamcinolone cream "last year" but it had been	D 358		

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discontinued.
-Resident #4 had not asked for Triamcinolone cream to be applied.
-She could not recall the last time she had applied Resident #4's Triamcinolone cream, but she knew she had not applied the cream in 2021.

Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 08/26/21 at 9:09am revealed:
-Resident #4's Triamcinolone cream was last dispensed in 2019.
-Resident #4's Triamcinolone cream had not been dispensed in 2021.
-No order was received for Triamcinolone cream to be administered twice daily for 14-days for Resident #4.

Telephone interview with a customer care representative at Resident #4's VA pharmacy on 08/26/21 at 9:45am revealed Triamcinolone had not been dispensed by the VA pharmacy.

Interview with the facility's Wellness Nurse on 08/26/21 at 12:55pm revealed:
-The message communication form was used to communicate with the resident's providers.
-The PCP entered orders onto the form, and the form would be faxed to the facility.
-Either she or the other Wellness Nurse would enter the order into the eMAR.
-She did not know if the order for Resident #4's Triamcinolone cream had been faxed to the pharmacy.

Interview with another Wellness Nurse on 08/26/21 at 4:41pm revealed:
-The home health nurse had reported to her Resident #4 had a rash.
-She looked at the rash, and the skin looked

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irritated.
-She initiated the message communication form for the PCP to assess Resident #4.
-Just because she wrote the note, did not mean she was the one who entered the order for the Triamcinolone cream.
-Resident #4 was already on Triamcinolone as needed and maybe that was why the order was not entered on the eMAR.
-The order for Triamcinolone twice a day for 14-days should have been entered on the eMAR.

Interview with the facility's Resident Care Director (RCD) on 08/26/21 at 5:19pm revealed:
-All orders should be given to the Wellness Nurse who was responsible for faxing the orders to the pharmacy.
-The orders should not be filed in the resident's record until confirmation was received from the pharmacy the order had been received.
-Resident #4's Triamcinolone should have been faxed to the pharmacy to be ordered and should have been applied by the MAs as ordered.
-She was concerned Resident #4 was not getting his medications as ordered.

Interview with the Executive Director on 08/26/21 at 5:49pm revealed:
-The Wellness Nurses were responsible for making sure orders were filled.
-After 14-days she would have expected the Wellness Nurse to assess Resident #4's skin to make sure the rash had improved, and if not contact the PCP to re-order the Triamcinolone.
-She expected Resident #4 to have received his medication as ordered.

Attempted telephone interview with the facility's primary care provider on 08/26/21 at 10:59am and 4:39pm was unsuccessful..

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D 358	Continued From page 54 The facility failed to administer medications as ordered including a resident who had an order for furosemide to be administered as ordered for a weight gain of five pounds in one week or three pounds in two days. Because the resident had not been weighed and medication administered accordingly, he continued with shortness of breath related to fluid overload (#7); the staff failed to make sure an inhaler contained medication prior to administering as evidenced by administering medications for two days when the medication count was zero. The resident also had complained of a rash, and the PCP ordered a cream to be applied for fourteen days and the medication was never ordered or applied (#4); and a resident whose diagnosis included dementia with behavior disturbance and was ordered an antipsychotic medication that was not administered (#1); and a resident was administered a seasonal allergy medication that had been discontinued because the PCP felt the medication should be limited to allergy season in order to avoid adverse events attributed to daily long-term use which included increased muscle cramps, increased dementia, increased fatigue, increased dizziness and dehydration (#6). This failure was detrimental to the welfare of the resident which constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/20/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 11, 2021.	D 358		

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D 367	Continued From page 55	D 367		
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). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 7 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 06/10/21 revealed: -Diagnoses included dementia with behavior disturbance, major depressive disorder, and hypertension. -There was an order for Zyprexa (used to treat	D 367		

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agitation) 2.5mg twice a day.

Review of Resident #1's eMAR for June 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.
-There was documentation all doses had been administered for 9:00am and 9:00pm from 06/01/21 to 06/30/21.

Review of Resident #1's eMAR for July 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.
-There was documentation all doses had been administered for 9:00am and 9:00pm from 07/01/21 to 07/31/21 at 9:00am.
-There was documentation on 07/31/21 at 9:00pm, the dose was documented as medication pending delivery.

Review of Resident #1's eMAR for August 2021 revealed:
-There was an entry for Zyprexa 2.5mg twice a day scheduled for 9:00am and 9:00pm.
-There was documentation on 08/01/21 at 9:00am and 9:00pm, the dose was documented as medication pending delivery.
-There was documentation on 08/02/21 at 9:00am that the dose had been administered.
-There was documentation on 08/02/21 at 9:00pm, the dose was documented as medication pending delivery.
-There was documentation all doses had been administered for 9:00am and 9:00pm from 08/03/21 to 08/25/21 at 9:00am.
-There was documentation on 08/23/21 and 08/24/21 at 9:00pm that medication was not administered; see progress note.

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Observation of Resident #1's medication on hand on 08/25/21 at 5:20pm revealed there was no Zyprexa available to administer to the resident.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/26/21 at 9:33am revealed:
-Zyprexa 5mg tablets were dispensed as half tablets on 05/05/21 with the original order for Zyprexa with instructions to administer ½ tablet twice daily; 30 tablets were dispensed and would last 30 days when administered as ordered.
-On 06/03/21, 06/11/21, 07/06/21, 08/01/21, Zyprexa 2.5mg tablets were dispensed with instructions to administer 1 tablet twice daily; 10 tablets were dispensed and would last 5 days when administered as ordered.
On 08/04/21, Zyprexa was switched back to the 5mg tablets so that insurance would pay for the medication; 30 tablets were dispensed and would last 30 days when administered as ordered.
-Based on the amount dispensed, Resident #1 did not have enough medication to administer twice daily as ordered.

Interview with a MA on 08/26/21 at 6:10pm revealed:
-She worked regularly with Resident #1 and administered her medications.
-Resident #1 was on Zyprexa twice daily.
-There was a time Resident #1 was out of Zyprexa.
-The pharmacy said she did not have any.
-She believed the eMAR was accurate even though Resident #1 did not have enough medication to administer twice a day as ordered.

Interview with a second MA on 08/27/21 at 11:48am revealed:
-She believed the eMAR was accurate even

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D 367	Continued From page 58	D 367		

though Resident #1 did not have enough medication to administer twice a day as ordered.
-On 08/23/21 -08/25/01, Resident #1 did not have any Zyprexa available, so she used a deceased residents Zyprexa which was the same dose as Resident #1's Zyprexa.
-She did not want the resident to be without her medication.

Interview with a Wellness Nurse on 08/26/21 at 10:12am revealed:
-The Wellness Nurses did not know about any problems with medications unless someone let them know.
-Wellness nurses did not complete eMAR audits because the MAs were supposed to do them every 30 days.
-When MAs audited the eMARs, they looked to ensure all medications on the medication carts matched the eMAR.
-She did not know if the MAs documented audits anywhere.
-The MAs were responsible to ensure eMARs were accurate.

Interview with a second Wellness Nurse on 08/26/21 at 10:32am revealed:
-She did not know Resident #1's eMARs were not accurate
-There had not been any eMAR audits since she started at the facility.

Interview with the Resident Care Director (RCD) on 08/26/21 at 10:48am revealed:
-She did not know about any missed medications or the eMAR being inaccurate.
-Missed medications should have shown up on her missed medication report.
-The MAs were responsible for letting the Wellness Nurses know when they needed a refill

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D 367	Continued From page 59 for a prescription. -She did not know if anyone had been doing medication cart audits to ensure medications were available. Interview with the Administrator on 08/26/21 at 12:28 revealed: -She did not know Resident #1 did not have enough Zyprexa dispensed so it could be administered as ordered. She did not know Resident #1's eMAR was inaccurate. -The RCD was responsible to ensure all medications were available. -When a MA noticed a medication was not available, they should inform the Wellness Nurses or contact the pharmacy. -Monthly cart audits were completed by the contracted pharmacy to ensure all medications were on the medication cart. -She expected eMARs to be accurate and reflect what was administered to the resident and if something was not administered it should have been documented as not administered.	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, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate,	D912		

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appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision, Licensed Health Professional Support, and medication administration.

The findings are:

1. Based on observations, interviews and record review, the facility failed to ensure 1 or 7 sampled residents (#5) was supervised in accordance with each resident's assessed needs, care plan and current symptoms related to falls with injury. The failure of the facility to provide supervision resulted in serious neglect and serious physical harm. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]

2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 7 sampled residents (#1, #4, #6, #7) including a medication to help reduce fluid overload in relation to weight gain (#7), and a medication used to treat allergies (Resident #6), a medication used to help decrease agitation associated with dementia (#1), and a medication used to treat a rash and a medication used to open the airway (Resident #4). [Refer to Tag 358, 10A NCAC 13F .1004a Medication Administration (Type B Violation)]

3. Based on interviews and record reviews, the facility failed to ensure follow up on recommendations written by the Licensed Health Professional Support (LHPS) nurse for 1 of 7 sampled residents (#4) related to a continuous positive air pressure device (CPAP) machine was used nightly as ordered. [Refer to Tag 281, 10A NCAC 13F .0903d Licensed Health Professional

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D912	Continued From page 61 Support (Type B Violation)]	D912		