STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST GALES ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

(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 March 10-11, 2022 and March 14-16, 2022.	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 1 of 5 sampled staff (Staff D) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: Review of Staff D's, medication aide (MA) personnel record revealed: -Staff D was hired on 07/24/18. -There was no documentation a HCPR check was completed upon hire. Interview with Staff D on 03/16/22 at 11:20am revealed: -She was rehired in December 2020. -She did not know if anyone at the facility completed a HCPR check on her when she was hired. Interview with the Business Office Manager (BOM) on 03/15/22 at 8:35am revealed:	D 137		

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D 137	Continued From page 1 -She could not find a HCPR check in Staff D's' personnel records. -She was just given the password to be able to run HCPR checks in February 2022, every HCPR check before then was completed and filed by the Administrator. -She was now responsible to complete HCPR checks on all new hires. -She had not been told to audit the personnel records for HCPR checks. -She did not know why staff did not have HCPR checks when they were hired. Interview with the Administrator on 03/16/22 at 8:35am revealed: -She knew all staff were all to have HCPR checks before hired. -Until recently, she completed all the HCPR checks for new hires. -She did an HCPR check on Staff D when she was hired but she could not find it in her personnel record. -She did not have an audit system for personnel records to ensure HCPR checks were completed.	D 137		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented	D 167		

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certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months for 6 of 10 sampled staff (Staff A, B, D, F, G and H) for 12 of 42 sampled shifts from 02/28/22 to 03/13/22.

The findings are:

1. Review of Staff A's, personal care aide (PCA), personnel record revealed:
-Staff A was hired on 04/20/18.
-There was no documentation Staff A had training on CPR.

Telephone interview with Staff A on 03/15/22 at 12:15pm revealed she did not have CPR training.

Refer to interview with the Administrator on 03/16/22 at 11:00am.

2. Review of Staff B's, medication aide (MA), personnel record revealed:
-Staff B was hired on 06/10/21.
-There was no documentation Staff B had training on CPR.

Attempted telephone interview with Staff B on

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03/15/22 at 3:36pm was unsuccessful.

Refer to interview with the Administrator on 03/16/22 at 11:00am.

3. Review of Staff D's, medication aide (MA), personnel record revealed:
-Staff D was hired on 07/24/18.
-There was no documentation Staff D had training on CPR.

Interview with Staff D on 03/16/22 at 11:20am revealed:
-She attended a CPR training course in 2021 but could not remember the date and did not have a card.
-She thought she gave the Administrator a copy of her CPR certification for her personnel record.

Refer to interview with the Administrator on 03/16/22 at 11:00am.

4. Review of Staff F's, personal care aide (PCA), personnel record revealed:
-There was no hire date for Staff F.
-There was no documentation Staff F had training on CPR.

Telephone interview with Staff F on 03/16/22 at 4:30pm revealed:
-She attended a CPR training course in the summer of 2021 but could not remember the date and did not have a card.
-She did not give the Administrator a copy because she was never asked for a copy of her CPR certification for her personnel record.

Refer to interview with the Administrator on 03/16/22 at 11:00am.

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5. Review of Staff G's, personal care aide (PCA), personnel record revealed:
-There was no hire date for Staff G.
-There was no documentation Staff G had training on CPR.

Interview with Staff G on 03/16/22 at 9:20am revealed:
-She had worked in the facility about a year but she could not remember the date she was hired.
-She did not have CPR training.

Refer to the interview with the Administrator on 03/16/22 at 11:00am.

6. Review of Staff H's, personal care aide (PCA), personnel record revealed:
-There was no hire date for Staff H.
-There was no documentation Staff H had training on CPR.

Attempted telephone interview with Staff H on 03/16/22 at 3:25pm was unsuccessful.

Refer to interview with the Administrator on 03/16/22 at 11:00am.

Review of personnel records and the punch time detail reports for third shift on 02/28/22 revealed there was no CPR certified staff that worked third shift from 11:00pm-6:52am.

Review of personnel records and the punch time detail reports for third shift dated 03/01/22 revealed there was no CPR certified staff that worked third shift from 11:00pm - 7:00am.

Review of personnel records and the punch time detail reports for second and third shift dated 03/02/22 revealed:

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D 167	Continued From page 5 -There was no CPR certified staff that worked second shift from 8:00pm-11:00pm. -There was no CPR certified staff that worked third shift from 11:00pm - 7:00am. Review of personnel records and the punch time detail reports for third shift dated 03/03/22 revealed there was no CPR certified staff that worked third shift from 11:27pm-7:00am. Review of personnel records and the punch time detail reports for third shift dated 03/04/22 revealed there was no CPR certified staff that worked third shift from 1:45am-7:00am. Review of personnel records and the punch time detail reports for second and third shift dated 03/07/22 revealed: -There was no CPR certified staff that worked second shift from 5:19pm-11:00pm. -There was no CPR certified staff that worked third shift from 11:00pm - 7:00am. Review of personnel records and the punch time detail reports for third shift dated 03/08/22 revealed there was no CPR certified staff that worked third shift from 11:00pm - 7:00am. Review of personnel records and the punch time detail reports for second and third shift dated 03/09/22 revealed: -There was no CPR certified staff that worked second shift from 5:37pm-11:00pm. -There was no CPR certified staff that worked third shift from 11:00pm - 7:00am. Review of personnel records and the punch time detail reports for third shift dated 03/12/22 revealed there was no CPR certified staff that worked third shift from 11:00pm-6:07am.	D 167		

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D 167	Continued From page 6 Interview with the Administrator on 03/16/22 at 11:00am revealed: -She identified only 4 staff with CPR certification who worked at the facility. -She was responsible to schedule a CPR certified staff on every shift. -It was not the facility's policy that all staff were CPR certified. -The MAs and PCAs volunteered for CPR training or already had it when they were hired. -She made the schedule from memory of staff she thought had CPR. -The schedule would be covered with CPR certified staff until staff called off work or did not show up for work. -Staff calling off and not showing up for work happened more frequently in the past several months leaving shifts uncovered if she was not able to fill in on the floor. The facility failed to ensure there was staff on duty who had training on CPR and choking management in the last 24 months on second and third shifts for 12 of 42 shifts sampled resulting in no staff available to perform lifesaving measures in the event of an emergency. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2022.	D 167		

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D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility	D 188		

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is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, record reviews and interviews, the facility failed to ensure the required aide hours for 23 of 42 shifts sampled from 02/28/22 to 03/13/22.

The findings are:

Review of the facility's 2022 license revealed the facility had a licensed capacity of 60 residents.

Review of the facility's daily census report (DCR) dated 02/28/22 revealed there was a census of 56 residents, which required 32 aide hours on second shift.

Review of staff timecards dated 02/28/22 revealed there was a total of 26.25 aide hours provided on second shift leaving a shortage of 5.75 aide hours.

Review of the facility's DCR dated 03/01/22 revealed there was a census of 56 residents, which required 32 aide hours on first shift.

Review of staff timecards dated 03/01/22 revealed there was a total of 22.75 aide hours provided on second shift leaving a shortage of 9.25 aide hours.

Review of the facility's DCR dated 03/02/22 revealed there was a census of 56 residents,

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which required 32 aide hours on first shift.

Review of staff timecards dated 03/02/22 revealed there was a total of 23.5 aide hours provided on first shift leaving a shortage of 8.5 aide hours.

Review of the facility's DCR dated 03/03/22 revealed there was a census of 56 residents, which required 32 aide hours on second shift.

Review of staff timecards dated 03/03/22 revealed there was a total of 20.75 aide hours provided on second shift leaving a shortage of 11.25 aide hours.

Review of the facility's DCR dated 03/04/22 revealed there was a census of 56 residents, which required 32 aide hours on second shift and 16 aide hours on third shift.

Review of staff timecards dated 03/04/22 revealed:
-There was a total of 26.5 aide hours provided on second shift leaving a shortage of 5.5 aide hours.
-There was a total of 11.75 aide hours provided on third shift leaving a shortage of 4.25 aide hours.

Review of the facility's DCR dated 03/05/22 revealed there was a census of 56 residents, which required 32 aide hours on first and second shift.

Review of staff timecards dated 03/05/22 revealed:
-There was a total of 23.25 aide hours provided on first shift leaving a shortage of 8.75 aide hours.
-There was a total of 17.5 aide hours provided on

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second shift leaving a shortage of 14.5 aide hours.

Review of the facility's DCR dated 03/06/22 revealed there was a census of 56 residents, which required 32 aide hours on second shift.

Review of staff timecards dated 03/06/22 revealed there was a total of 18.25 aide hours provided on second shift leaving a shortage of 13.75 aide hours.

Review of the facility's DCR dated 03/07/22 revealed there was a census of 56 residents, which required 32 aide hours on second shift.

Review of staff timecards dated 03/07/22 revealed there was a total of 25.25 aide hours provided on second shift leaving a shortage of 6.75 aide hours.

Review of the facility's DCR dated 03/08/22 revealed there was a census of 56 residents, which required 32 aide hours on first and second shift and 16 aide hours on third shift.

Review of staff timecards dated 03/08/22 revealed:
-There was a total of 25 aide hours provided on first shift leaving a shortage of 7 aide hours.
-There was a total of 28.5 aide hours provided on second shift leaving a shortage of 3.5 aide hours.
-There was a total of 12.75 aide hours provided on third shift leaving a shortage of 3.25 aide hours.

Review of the facility's DCR dated 03/09/22 revealed there was a census of 56 residents, which required 32 aide hours on first and second shift and 16 aide hours on third shift.

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D 188	Continued From page 11 Review of staff timecards dated 03/09/22 revealed: -There was a total of 24 aide hours provided on first shift leaving a shortage of 8 aide hours. -There was a total of 28 aide hours provided on second shift leaving a shortage of 4 aide hours. -There was a total of 12.5 aide hours provided on third shift leaving a shortage of 3.5 aide hours. Review of the facility's DCR dated 03/10/22 revealed there was a census of 55 residents, which required 32 aide hours on second shift. Review of staff timecards dated 03/10/22 revealed there was a total of 25.75 aide hours provided on second shift leaving a shortage of 6.25 aide hours. Review of the facility's DCR dated 03/11/22 revealed there was a census of 55 residents, which required 32 aide hours on second shift and 16 aide hours on third shift. Review of staff timecards dated 03/11/22 revealed: -There was a total of 29 aide hours provided on second shift leaving a shortage of 3 aide hours. -There was a total of 14.25 aide hours provided on third shift leaving a shortage of 1.75 aide hours. Review of the facility's DCR dated 03/12/22 revealed there was a census of 55 residents, which required 32 aide hours on first and second shift. Review of staff timecards dated 03/12/22 revealed: -There was a total of 24.75 aide hours provided	D 188		

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on first shift leaving a shortage of 7.25 aide hours.
-There was a total of 27.5 aide hours provided on second shift leaving a shortage of 4.5 aide hours.

Review of the facility's DCR dated 03/13/22 revealed there was a census of 55 residents, which required 32 aide hours on first and second shift.

Review of staff timecards dated 03/13/22 revealed:
-There was a total of 19.5 aide hours provided on first shift leaving a shortage of 12.5 aide hours.
-There was a total of 19.5 aide hours provided on second shift leaving a shortage of 12.5 aide hours.

Interview with the medication aide (MA) on 03/16/22 9:15am revealed:
-The Administrator was responsible for the schedule for all staff.
-She sometimes worked all 3 shifts in a row and would clock out and go to her car or an empty room to sleep a few hours and then clock back in to work.
-The Administrator filled in almost every day on all 3 shifts as well.
-Staff called the Administrator if they were calling out of work.
-If staff called out when the Administrator was not there, they would just tell the MA working as a Supervisor at the time.
-Staff were supposed to call 2 hours before their shift if they were not coming to work, but some called at the time they should be at work or just did not show up for work.
-She had never worked without another staff in the facility.

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D 188	Continued From page 13 Interview with a PCA on 03/16/22 9:20am revealed: -The Administrator was responsible for the schedule for all staff. -Shifts were usually covered with a MA and 3 PCAs for first shift, a MA and 3 PCAs (sometimes 2 PCAs) on second shift and a MA and 1 PCA (sometimes 2) on third shift. -Staff called and spoke to the Administrator or MA working to call off work. -She had never worked without another staff in the facility. Interview with a second MA on 03/16/25 at 3:10pm revealed: -The Administrator was responsible for the schedule for all staff. -Shifts should be covered with a MA and 3 PCAs for first shift, a MA and 3 PCAs on second shift and a MA and 1 PCA (sometimes 2) on third shift. -Staff called and spoke to the Administrator or MA working to call off work but most called off right before the shift was to start or just did not show up. -Some shifts may not have been covered when staff did not come in. -Staff had never worked without another staff on any shift in the facility. Telephone interview with a second PCA on 03/16/22 at 4:30pm revealed: -She mostly worked second shift. -There was usually a MA and 3 PCAs on second shift. -The Administrator was responsible for the staff schedule. -In the past 2 months, she had to leave before the next shift reported to work because other staff were usually late and she had family responsibilities.	D 188		

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D 188	Continued From page 14 Interview with the Administrator on 03/16/22 10:20am revealed: -She was aware that first and second shifts required 32 aide hours and third shift required 16 aide hours. -She was responsible for the daily staffing schedule and would place it in the business office for staff to review, but she had not completed the March 2022 schedule. -She rotated a biweekly schedule that had a Supervisor on duty for all shifts. -Staff would call out of work or not show up for a shift and she would cover as much as she could, but there would be some hours she could not cover. -Staff frequently called out or did not show up, so she found herself having to fill in on all 3 shifts 5 out of 7 days a week. -The facility did not use agency staff and there was just no staff to pull from when call outs or no shows happened. _____ [Refer to Tag 0366 10A NCAC 13F .1004(i) Medication Administration]. [Refer to Tag 0269 10A NCAC 13F .0901(a) Personal Care and Supervision]. _____ The facility failed to ensure there was the required aide hours for 23 of 42 shifts resulting in medication aides performing personal care aide tasks and not carrying out medication aide duties appropriately. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/22 for this violation.	D 188		

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D 188	Continued From page 15 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, APRIL 30, 2022.	D 188		
D 212	10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (a) On first and second shifts in facilities with a capacity or census of 31 or more residents and on third shift in facilities with a capacity or census of 91 or more residents, there shall be at least one supervisor of personal care aides, hereafter referred to as supervisor, on duty in the facility for less than 64 hours of aide duty per shift; two supervisors for 64 to less than 96 hours of aide duty per shift; and three supervisors for 96 to less than 128 hours of aide duty per shift. In facilities sprinklered for fire suppression with a capacity or census of 91 to 120 residents, the supervisor's time on third shift may be counted as required aide duty. (For staffing chart, see Rule .0606 of this Section.) This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Supervisor of personal care aides (PCAs) was on duty and available for 3 of 21 shifts sampled from 03/08/22 to 03/15/22 for third shift. The findings are:	D 212		

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D 212	Continued From page 16 Review of the facility's 2022 license revealed the facility had a capacity of 60 residents. Review of the daily census report (DCR) dated 03/08/22 revealed the facility census was 56 which required at least 8 Supervisor hours on first and second shifts and a Supervisor was in the facility or within 500 feet of the facility and immediately available on third shift. Review of the staff time card punch detail report dated 03/08/22 revealed: -There were 4.25 Supervisor hours worked on third shift, a shortage of 3.75 Supervisor hours. -There was not a Supervisor in the facility or within 500 feet of the facility on third shift. Review of the DCR dated 03/09/22 revealed the facility census was 56 which required at least 8 Supervisor hours on first and second shifts and a Supervisor was in the facility or within 500 feet of the facility and immediately available on third shift. Review of the staff time card punch detail reports dated 03/09/22 revealed: -There were 4.5 Supervisor hours worked on second shift, a shortage of 3.5 Supervisor hours. -There was not a Supervisor in the facility or within 500 feet of the facility on third shift. Review of the DCR dated 03/15/22 revealed the facility census was 55 which required at least 8 Supervisor hours on first and second shifts and a Supervisor was in the facility or within 500 feet of the facility and immediately available on third shift. Review of the staff time card punch detail reports dated 03/15/22 revealed:	D 212		

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-There were 4.25 Supervisor hours worked on third shift, a shortage of 3.75 Supervisor hours.
-The Administrator worked as 11:00pm-1:30am on 03/15/22 third shift.
-There was not a Supervisor in the facility or within 500 feet of the facility on third shift from 1:30am-5:22am .

Interview with the medication aide (MA)/Supervisor on 03/16/22 at 9:15am revealed:
-The Administrator was responsible for the schedule for all staff.
-She and another MA worked as Supervisors until 11:30pm on 03/15/22.
-She came back in on 03/15/22 third shift at 1:00am.
-She did not know why her time card punch was 5:22am for 03/15/22 third shift.

Interview with a PCA on 03/16/22 at 9:20am revealed:
-Two MAs worked as Supervisors until 11:30pm on 03/15/22 on third shift.
-She came in on 03/15/22 at 11:30pm.
-The Administrator worked part of third shift as the Supervisor on 03/15/22, but she could not remember what time she left.
-A MA came back into work during 03/15/22 third shift, but she could not remember what time.
-She was unsure of the amount of time when there was not a Supervisor working in the facility.

Interview with a second PCA on 03/16/22 at 3:25pm revealed:
-She was not sure of the times a Supervisor was in the facilioty on 03/15/22 on third shift.
-She worked from 11:00pm until 7:00am but must have forgotten to clock in on the time clock.
-There was one other PCA working with her on 3/15/22 on third shift.

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D 212	Continued From page 18 -No resident requested a medication during the night. Interview with the Administrator on 08/06/19 10:20am revealed: -She was aware that she had to have a Supervisor on duty on first and second shift and a Supervisor on duty in the facility or within 500 feet of the facility during third shift. -She was responsible for the daily staffing schedule and would place it in the business office for staff to review, but she had not completed the March 2022 schedule. -She rotated a biweekly schedule that had a Supervisor on duty for all shifts. -Supervisors would call out of work or not show up for a shift and she would cover as much as she could, but there would still be some hours she could not cover. -Staff would frequently call out or not show up, so she found herself having to fill in on all 3 shifts 5 out of 7 days a week.	D 212		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.	D 234		

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D 234	Continued From page 19 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) had completed two-step tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #4's current FL2 dated 10/21/21 revealed diagnoses included type 2 diabetes, seizures, asthma, neuropathy, pancreatitis, heartburn, posttraumatic stress disorder, schizoaffective disorder bipolar type, and agoraphobia. Review of Resident #4's Resident Register revealed an admission date of 10/18/21. Review of Resident #4's record revealed there was documentation of a second step TB skin test applied on 12/14/21 and read on 12/16/21, but there was no documentation of a first step TB skin test. Interview with Resident #4 on 03/16/22 at 4:38pm revealed she thought she had a TB skin test completed after she was admitted to the facility, but she did not remember when. Interview with the Administrator on 03/16/22 at 7:53pm revealed: -She was responsible for ensuring residents had their first and second step TB skin testing. -She found Resident #4's second step TB skin test, but she could not find her first step. -She usually had residents' first step TB skin tests completed upon admission to the facility, and she thought Resident #4 had her first step TB skin test.	D 234		

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D 234	Continued From page 20 -She did not know where documentation of the first step TB skin test was.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide personal care assistance according to the care plans for 1 of 5 sampled residents (#5) who required total care with incontinence care. The findings are: Review of Resident #5's current FL2 dated 11/17/21 revealed: -Diagnoses included cognitive dysfunction, severe thrombocytopenia, transient transaminitis (a complication of uncontrolled diabetes), gastrointestinal erosion, hypoglycemia, and hyperkalemia. -Resident #5 was constantly disoriented, non-ambulatory, and required total care. Review of Resident #5's care plan dated 11/18/21 revealed: -Resident #5 was non-ambulatory and required a wheelchair.	D 269		

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D 269	Continued From page 21 -Resident #5 had daily incontinence of bladder and bowel. -Resident #5 required total assistance with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring. Observations of Resident #5 at various times on 03/11/22 revealed: -At 1:15pm, the resident was alone in a parlor room, seated in her wheelchair in front of the television. -At 1:20pm, the Administrator walked by the room, looked at the resident, wiped her mouth with a paper towel where she had drooling; the Administrator turned and left Resident #5 alone in the room. -At 3:30pm, Resident #5 was seated in her wheelchair in front of the television with a staff member seated at a table in the room but not in the line of vision of Resident #5. -At 3:38pm, she was seated in her wheelchair in the same place in front of the television, Resident #5 made eye contact and made a grunting sound. -At 4:12pm, Resident #5 was seated in her wheelchair in front of the television with another resident sitting behind her knitting. -At 4:13pm, Resident #5 was seated in her wheelchair in front of the television when the Business Office Manager (BOM) walked by the door; Resident #5 made a loud noise and the BOM said "Hold on, I will be back," but never returned. -At 4:45pm, 4 residents were sitting in the parlor room behind Resident #5, watching television and conversing but Resident #5 was facing the television. -At 5:20pm, Resident #5 was seated in her wheelchair in front of the television.	D 269		

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D 269	Continued From page 22 Observation of Resident #5's room on 03/11/22 at 4:47pm revealed: -Resident #5 was not in the room. -Her bed was in a flat position. -The mattress on her bed appeared to be sagging in the middle, but it was not a concave mattress. Observations of the facility on 03/14/22 between 8:13am and 12:21pm revealed: -At 8:13am revealed Resident #5 was sitting in her wheelchair in her bedroom alone. -At 8:26am, Resident #5 was taken to the television room and left alone with the doors closed. -She started making sounds when she was left alone. -At 8:29am medication aide opened the doors to the television room and took Resident #5 to the dining hall. -At 10:24am, 11:37am, 11:54am, and 12:12pm Resident #5 was in the television room by herself with the door open. -At 4:14pm, Resident #5 was laying in her bed was awake. -At 6:52pm, Resident #5 was laying in her bed, and a MA was getting ready to feed her dinner in bed. -No staff were observed checking on Resident #5 or providing personal care. Review of personal care assignment sheets for Resident #5 revealed: -There was an assignment sheet dated 03/14/22 which revealed Resident #5 required total care and there was documentation she was toileted every 2 hours on 1st shift. -There were no other assignment sheets available for Resident #5 from 03/01/22 to 03/10/22.	D 269		

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D 269	Continued From page 23 Review of Resident #5's personal care logs revealed: -There was only a personal care log available for the month of March 2022. -On 03/11/22, staff documented a sponge bath was provided on third shift. -On 03/12/22, staff documented a sponge bath was provided on first and second shifts, hygiene was provided on first, second, and third shifts, assistance with dressing was provided on first, second and third shifts, assistance with eating was provided on first and second shifts, assistance with transfers was provided on first and second shifts, assistance with ambulation was provided on first and second shifts, and assistance with toileting was provided on first, second, and third shifts, but there was no documentation of how often Resident #5 was toileted. -On 03/13/22, staff documented a sponge bath was provided on first and second shifts, hygiene was provided on first and second shifts, assistance with dressing was provided on first, second and third shifts, assistance with eating was provided on first and second shifts, assistance with transfers was provided on first and second shifts, assistance with ambulation was provided on first and second shifts, and assistance with toileting was provided on first, second, and third shifts, but there was no documentation of how often Resident #5 was toileted. -There was no documentation of any personal care provided from 03/01/22 to 03/10/22. Interview with Resident #5's roommate on 03/11/22 at 8:00am revealed: -Resident #5 could not get in and of bed by herself. -Staff came around at night to check on the	D 269		

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residents but she could not remember how often.
-Resident #5 did not try to get out of bed.

Interview with a resident on 03/11/22 at 3:26pm revealed:
-Resident #5 was in the television room all day long in her reclined wheelchair.
-Resident #5 was fed breakfast, lunch, and dinner in the television room.
-He did not know how often or if staff provided incontinence care to Resident #5.

Interview with another resident on 03/11/22 at 3:40pm revealed Resident #5 was in the television room from the time she got up until she went to bed.

Interview with a third resident on 03/11/22 at 3:56pm revealed staff kept Resident #5 in the television room most of the day.

Interview with a medication aide (MA) on 03/11/22 at 4:25pm revealed:
-Staff got Resident #5 at up 7:00am and took her down to the television room.
-Staff usually took her to the television room because she liked to watch television and staff turned the television to the cartoon channel.
-Resident #5 sat in the television room until lunch and then whoever fed her the lunch meal took her to change her incontinence briefs.
-She did not know if Resident #5 had been provided incontinence care between 7:00am and lunch time on 03/11/22.
-She saw today that staff walked by Resident #5 and did not stop to check on her, but that was the first time she noticed.

Interview with a MA on 03/11/22 at 3:40pm revealed:

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-The PCAs were supposed to document care (toileting, moving from wheelchair or repositioning) on a daily care log.
-The supervisor was responsible to hand out the care log sheets to the personal care aides (PCAs) at the beginning of each shift; the sheets were kept in a cabinet on the wall on each hall.
-The PCAs were responsible for completing documentation of care by the end of each shift.
-There were no care log sheets available for review since January 2022.
-MAs were spending a lot of time completing PCA duties of personal care; the MAs had not been documenting personal care provided on the care logs.

Interview with a PCA on 03/11/22 at 3:45pm on revealed:
-She had not been shown to document personal care on the care logs.
-Resident #5 was a two person assist with transfers and incontinence care.
-She had not documented any care for Resident #5, but she had changed her once today (on 03/11/22 but no time provided).

Interview with another PCA on 03/15/22 at 7:15am revealed:
-Resident #5 was normally in the television room watching television.
-Staff checked on her about every 2 hours.
-Staff provided personal care to her when needed then took her back to the television room.

Interview with the Administrator on 03/11/22 at 5:00pm revealed:
-The Resident Care Director (RCD) was responsible to complete person care log assignment sheets for the PCAs to use as an guide for the residents assigned to the PCA and

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D 269	Continued From page 26 to document care provided to the residents. -The facility did not have a RCD at present, and the PCA assignment with the person care logs was to be completed by a medication aide (MA) supervisor. -There were designated care documentation stations located on each of the 3 halls where the personal care logs were stored and completed. -The Administrator assumed the personal care logs had been completed daily by the PCAs but she had not audited the logs in the last few months. -She was not able to locate any person care logs since January 2022 for Resident #5.	D 269		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (Resident #4) related to an order for fingerstick blood sugar (FSBS) checks. The findings are: Review of Resident #4's current FL2 dated 10/21/21 revealed: -Diagnoses included type 2 diabetes.	D 276		

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D 276	Continued From page 27 -There was an order for FSBS 4 times daily. Review of Resident #4's electronic medication administration record (eMAR) for January 2022 revealed: -There was an entry for FSBS 4 times daily before meals and at bedtime scheduled for 7:30am, 11:30am, 4:30am, and 8:00pm. -There was no documentation Resident #4's FSBS was checked 4 times daily for 9 of 31 days between 01/01/22 and 01/31/22. Review of Resident #4's glucometer history on 03/16/22 at 10:34am revealed: -Resident #4's glucometer history did not have FSBS readings 4 times daily for 16 of 31 days between 01/01/22 and 01/31/22. -The glucometer history coincided with the eMAR for the 9 days Resident #4's FSBS was not checked 4 times daily on the eMAR and there were 7 additional days in the glucometer history where FSBSs were not checked 4 times daily. Review of Resident #4's eMAR for February 2022 revealed: -There was an entry for FSBS 4 times daily before meals and at bedtime scheduled for 7:30am, 11:30am, 4:30am, and 8:00pm. -There was no documentation Resident #4's FSBS was checked 4 times daily for 7 of 28 days between 02/01/22 and 02/28/22. Review of Resident #4's glucometer history on 03/16/22 at 10:34am revealed: -Resident #4's glucometer history did not have FSBS readings 4 times daily for 19 of 28 days between 02/01/22 and 02/28/22. -The glucometer history coincided with the eMAR for the 7 days Resident #4's FSBS was not checked 4 times daily and there were 12	D 276		

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additional days in the glucometer history where FSBSs were not checked 4 times daily.

Review of Resident #4's eMAR for March 2022 revealed:
-There was an entry for FSBS 4 times daily before meals and at bedtime scheduled for 7:30am, 11:30am, 4:30am, and 8:00pm.
-There was no documentation Resident #4's FSBS was checked 4 times daily for 2 of 13 days between 03/01/22 and 03/13/22.

Review of Resident #4's glucometer history on 03/16/22 at 10:34am revealed:
-Resident #4's glucometer history did not have FSBS readings 4 times daily for 9 of 13 days between 03/01/22 and 03/13/22.
-The glucometer history coincided with the eMAR for the 2 days Resident #4's FSBS was not checked 4 times daily and there were 7 additional days in the glucometer history where FSBSs were not checked 4 times daily.

Interview with Resident #4 on 03/16/22 at 4:38pm revealed:
-She was supposed to get FSBS checks 4 times daily, but staff did not always check her FSBS 4 times daily.
-Sometimes she had to wait on staff to get her FSBS checked.
-Staff often did not check her FSBS at bedtime and she did not know why.

Interview with a medication aide (MA) on 03/16/22 at 12:24pm revealed:
-She did not know why Resident #4's FSBS was not checked 4 times daily as ordered.
-The batteries in Resident #4's glucometer may have died at times when her FSBS was not checked.

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-When the batteries died, the MAs were supposed to let the Administrator know.
-She did not know of any times when the batteries in Resident #4's glucometer died in January, February, or March 2022.

Interview with a second MA on 03/16/22 at 6:51pm revealed:
-She did not know why there were days when Resident #4's FSBS was not documented 4 times daily on the eMAR or why there were days when there were not 4 daily FSBS readings in Resident #4's glucometer.
-If the FSBS was not documented on the eMAR the MA probably just did not check it.
-Sometimes the batteries got low in the glucometer and someone would have to go out to get new batteries.
-FSBS should have been checked when the batteries were replaced in the glucometer so all of Resident #4's FSBS readings taken should have been in her glucometer.

Telephone interview with Resident #4's primary care provider (PCP) on 03/16/22 at 4:32pm revealed:
-He did not know Resident #4's FSBS were not being checked 4 times daily as ordered.
-He expected staff to check Resident #4's FSBSs daily and to contact him if they were unable to check Resident #4's FSBSs 4 times daily.

Interview with the Administrator on 03/16/22 at 7:53pm revealed:
-She did not know why Resident #4's FSBS were not documented 4 times daily for multiple days in January, February, and March 2022.
-She did not know why there was documentation of FSBS on the eMAR, but no documentation of FSBS readings in Resident #4's glucometer.

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D 276	Continued From page 30 -Staff may have made up some of the numbers on the eMAR and may not have actually checked the FSBS. -One of the MAs was supposed to review the eMARs once a month, but she did not know if that was being done. -There was a system in place where glucometers were checked weekly to ensure the FSBS reading matched the readings documented on the eMAR, but staff stopped checking the glucometers weekly due to staffing issues. -She expected Resident #4's FSBS to be checked 4 times daily as ordered.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure therapeutic diet orders were served as ordered for 1 of 5 sampled residents (#4) who had orders for a no concentrated sweets diet. The findings are: Review of Resident #4's current FL2 dated 10/21/21 revealed:	D 310		

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D 310	Continued From page 31 -Diagnoses included diabetes mellitus type 2. -There was an order for a diabetic diet. Review of Resident 4's diet order sheet dated 11/18/21 revealed an order for a no concentrated sweets (NCS) diet. Review of the undated therapeutic diet list posted in the kitchen revealed Resident #4 was to be served a NCS diet. Observation of the kitchen storage areas on 03/10/22 at 10:55am revealed: -There were no sugar free desserts, snacks, or beverages available. -There were canned mandarin oranges, tropical fruit salad, and applesauce and all had added sugars in the ingredients. Interview with the Dietary Manager (DM) on 03/10/22 at 10:57am revealed: -There were no low or no sugar desserts in the facility. -She was responsible for creating the order for the kitchen. -She ordered from the regular menu and did not order foods specific for therapeutic diets. -She tried to watch residents who were on a therapeutic diets to make sure they were not getting what they were not supposed to have. -Residents with an order for a NCS diet received the same dessert as all the other residents. -All residents would be served regular ice cream for dinner on 03/10/22. Review of the facility's NCS menu for 03/11/22 revealed baked herb fish, roasted red skin potatoes, California vegetable blend, wheat dinner roll or bread, no sugar added ice cream, and a diet beverage of choice was to be served.	D 310		

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D 310	Continued From page 32 Observation of Resident #4's lunch service on 03/11/22 between 11:45am and 12:45am revealed: -A dietary aide passed out sugar substitute packets to residents who were diabetic including Resident #4. -She was served tuna pasta with cheese, peas, cornbread, mandarin oranges, and fruit punch. Review of the fruit punch drink mix pouch on 03/11/22 at 12:02pm revealed there were 31 grams of added sugars accounting for 62% of the daily value of the fruit punch. Interview with a dietary aide on 03/11/22 at 12:02pm revealed: -He was responsible for making drinks for residents when he worked. -Fruit punch, lemonade, and unsweetened tea were available for residents on a NCS diet. -He added sugar to the fruit punch mix and lemonade mix prior to serving, but he did not add sugar to the residents who had orders for NCS. -He mixed the fruit punch mix with water and in a large stainless-steel tea dispenser and poured fruit punch into serving pitchers prior to adding sugar to the fruit punch mixture and gave the residents with NCS diets sugar substitute packets. -He used 2 to 3 packages of the fruit punch mix and filled the dispenser about halfway full; he did not know exactly how much water he added to the fruit punch mixture, but the residents always complained that it was not sweet enough if he did not add sugar. Interview with the DM on 03/11/22 at 12:09pm revealed: -She substituted food items for the lunch meal on	D 310		

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03/11/22.
-Regular and diet fruit punch were available for residents for the meal service on 03/11/22.
-There were no diet drinks available in the facility for residents on NCS diets.
-She routinely ordered a lemonade mix, a fruit punch mix, and tea, and she had never ordered any diet drinks.
-She thought the fruit punch could be served to diabetic residents if no sugar was added to the mixture.

Interview with Resident #4 on 03/11/22 at 11:56am revealed:
-Her fruit punch was sweet when it was served.
-She was supposed to be on a "diabetic" diet, but she drank and ate what the facility served her.
-She usually received the same meals as the other residents including the same desserts and snack as the other residents.

Interview with Resident #4's primary care provider (PCP) on 03/15/22 at 4:35pm revealed:
-Resident #4 had an order for and should have been served a NCS diet due to her diabetes.
-The fruit punch served to Resident #4 for lunch on 03/11/22 was not appropriate for a NCS diet.

Interview with the Administrator on 03/16/22 at 7:53pm revealed:
-The DM was responsible for ensuring therapeutic diets were served as ordered and for ordering food items.
-She knew residents were being served fruit punch and she had talked to the dietary staff about serving diet drinks to residents on a NCS diet.
-Residents on NCS diets should not be served regular drinks.

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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: TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to ensure residents were treated with respect and dignity related to a resident being isolated from other residents (#5) and a staff (Staff C) yelling at residents, taking items away from residents, and verbally demeaning a resident. The findings are: 1. Review of Resident #5's current FL2 dated 11/17/21 revealed: -Diagnoses included cognitive dysfunction, severe thrombocytopenia, transient transaminitis (complication of uncontrolled diabetes), gastrointestinal erosion, hypoglycemia, and hyperkalemia. -Resident #5 was constantly disoriented, non-ambulatory, and required total care. Review of Resident #5's care plan dated 11/17/21 revealed Resident #5 communicated by making noises and using gestures. Observation of the television room on 03/11/22 at 1:00pm revealed: -Resident #5 was being fed by a personal care aide (PCA) in the television room.	D 338		

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D 338	Continued From page 35 -There were no other residents present in the television room. Interview with the PCA on 03/11/22 at 1:00pm revealed: -Resident #5 was not fed in the dining hall because she screamed and hollered so much that she disturbed the other residents. -"They don't want to hear that while they're eating." Observations of Resident #5 at various times on 03/11/22 revealed: -At 1:15pm, the resident was alone in a parlor room, seated in her wheelchair in front of the television. -At 1:20pm, the Administrator walked by the room, looked at the resident, wiped her mouth with a paper towel where she had been drooling; the Administrator turned and left Resident #5 alone in the room. -At 3:30pm, Resident #5 was seated in her wheelchair in front of the television with a staff member seated at a table in the room but not in the line of vision of Resident #5. -At 3:38pm, she was seated in her wheelchair in the same place in front of the television, Resident #5 made eye contact and made a grunting sound. -At 4:12pm, Resident #5 was seated in her wheelchair in front of the television with another resident sitting behind her knitting. -At 4:13pm, Resident #5 was seated in her wheelchair in front of the television when the Business Office Manager (BOM) walked by the door; Resident #5 made a loud noise and the BOM said "Hold on, I will be back," but never returned. -At 4:45pm, 4 residents sitting in the parlor room behind Resident #5, watching television and conversing but Resident #5 was facing the	D 338		

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television.
-At 5:20pm, Resident #5 was seated in her wheelchair in front of the television.

Observation on 03/14/22 at 8:13am revealed:
-Resident #5 was sitting in her wheelchair in her bedroom alone.
-Resident #5 was patting her head and making sounds.

Observations on 03/14/22 between 8:26am and 12:21pm revealed:
-At 8:26am, a PCA took Resident #5 to the television room and left her alone with the doors closed.
-She started making sounds when she was left alone.
-At 8:29am, a medication aide (MA) opened the doors to the television room and took Resident #5 to the dining hall.
-At 10:24am, 11:37am, 11:54am, and 12:12pm Resident #5 was in the television room alone with the doors opened.
-At 4:14pm, Resident #5 was laying in her bed awake.
-At 6:52pm, Resident #5 was laying in her bed, and a MA was getting ready to feed her dinner in bed.

Observation of the dining hall on 03/16/22 between 9:30am and 10:13am revealed:
-All residents had been served their meals and exited the dining hall.
-Resident #5 was being fed by a MA at a table in the dining room and no other residents were present.

Interview with a resident on 03/11/22 at 3:26pm revealed:
-Resident #5 was in the television room all day

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long in her reclined wheelchair.
-Resident #5 was fed breakfast, lunch, and dinner in the television room and all the other residents ate their meals in the dining hall, but he did not know why.

Interview with another resident on 03/11/22 at 3:41pm revealed:
-Resident #5 was in the television room from the time she got up until she went to bed.
-There was usually no one in the room with her.
-The door was open most of the time, but when she started making noises, staff closed the doors to the room leaving her closed in the room alone.
-Resident #5 was fed all her meals in the television room; she did not know why because all the other residents ate in the dining hall.

Interview with a third resident on 03/11/22 at 3:56pm revealed:
-Staff kept Resident #5 in the television room most of the day.
-She did not like it that staff separated Resident #5 and she could not interact with the other residents in the facility.
-Residents sometimes went into the television room and sat with Resident #5.

Interview with a MA on 03/11/22 at 4:25pm revealed:
-Staff got Resident #5 up at 7:00am and took her down to the television room.
-Staff usually placed her in the television room because she liked to watch television and staff turned the television to the cartoon channel.
-She thought staff fed Resident #5 in the television room for all her meals because that was just what they had always done.
-Resident #5 sat in the television room until lunch and then whoever fed her the lunch meal took her

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to to provide incontinence care.
-She saw today that staff walked by Resident #5 and did not stop to check on her, but that was the first time she noticed staff not checking on her.

Interview with a PCA on 03/15/22 at 7:15am revealed:
-Resident #5 was normally in the television room watching television.
-Staff checked on her about every 2 hours.
-She did not know why Resident #5 was in the television room throughout the day or why she was not fed in the dining room.
-She had never seen Resident #5 eat her meals in the dining room as she was always fed in the television room, but she did not know why.

Telephone interview with Resident #5's guardian on 02/16/22 at 9:13am revealed:
-She last visited Resident #5 on 02/16/22 and prior to that in January 2022 and Resident #5 was in her bedroom both times.
-She did not know Resident #5 was being left in the television room all day and was being fed in the television room by herself instead of eating her meals with other residents.
-She thought the facility was socializing Resident #5 with other residents and now had concerns about her being isolated.

Interview with the Administrator on 03/11/22 at 4:53pm revealed:
-Resident #5 was unable to ambulate independently and required assistance to ambulate when she was up in her wheelchair.
-Resident #5 was placed in the television room during the day because she liked to watch television.
-She was supposed to eat lunch with the first seating in the dining room at each meal because

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residents who needed assistance with eating their meals ate during the first seating.
-She knew Resident #5 was fed her meals in the television room separately from other residents, but she did not know why.

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

2. Interview with a resident on 03/11/22 at 3:26pm revealed:
-It was the quietest it had been in a long time during lunch today, 03/11/22.
-Staff C, Medication Aide (MA), sometimes worked in the dining hall during meals.
-He once brought an extra cup with him into the dining hall and Staff C took the cup away from him and threw it away.
-A few nights ago, he was cold, so he went to the linen closet to get a blanket.
-Staff C jerked the blanket out of his hands and said to him, "You don't need that. Give me that."
-He was in the dining hall once and laid his toboggan the table.
-Staff C grabbed his toboggan and slammed it against his chest and said, "Keep your toboggan off the table."
-Staff C talked to him "like he was trash and he felt like trash under her feet."
-He talked to the Administrator about Staff C months ago and told her Staff C was hollering at residents too much.
-He heard Staff C hollering down the hallway for residents to come to the medication cart to get their medications.
-He thought Staff C was miserable at the facility and frustrated because she had too much responsibility.

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D 338	Continued From page 40 Interview with a second resident on 03/11/22 at 4:49 revealed Staff C yelled at her all the time and she did not like it. Interview with a third resident on 03/11/22 at 5:13pm revealed: -She carried cups in her rollator and liked to use them in the dining room during meals. -She did not remember when, but Staff C took her cups she had brought in the dining room and threw them in the trash can. -Staff C screamed at her to shut up and told her to sit down. -Staff C caused her to become mad when she screamed at her and gave her directives. -She talked to the Administrator about Staff C. Interview with Staff C, a Medication Aide (MA) on 03/11/22 at 4:25pm revealed: -Residents never complained to her that staff were mean to them or yelled at them. -Residents may have complained on other shifts, but not to her during her shift. -She did not know of any instances when residents had complained about her yelling at them or being mean to them. -She had not yelled at residents or been mean to them. -She tried not to do anything that would violate their rights. Interview with a MA on 03/16/22 at 7:44pm revealed residents had not told her Staff C had been mean to residents, but "I've had my bad days" with residents. Interview with the Administrator on 03/11/22 at 4:53pm revealed: -Residents have complained about Staff C yelling at them and being very hateful.	D 338		

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D 338	Continued From page 41 -She talked to Staff C and reeducated her on residents' rights. -She told Staff C she could not talk aggressively to residents because it was the residents' rights to be free from verbal, physical, and mental abuse. -She reported Staff C to the HCPR in 2018 for yelling at residents. -No residents had complained to her recently about Staff C yelling or being hateful. _____ The facility failed to ensure residents were treated with respect and dignity related to a resident who was non-ambulatory and nonverbal being isolated from other residents during meals and throughout the day (Resident #5) and a staff (Staff C) yelling at residents, taking items away from residents and throwing items away without the residents' permission, and made a resident feel like "trash." This failure was detrimental to the residents' well-being, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/11/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2022.	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 A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 residents (#1, #2 and #12) observed during the medication pass related to receiving medications scheduled for administration outside the one hour time frame including medications for calcium supplement, a blood thinner, a diabetic medication, an anti-anxiety medication and pain reliever (#1), an anti-psychotic and anti-anxiety medication (#12), and anti-anxiety medication, calcium supplement, a blood pressure medication, acid reflux medication and medication to treat constipation (#2) and an inhaler not available for administration (#2); for 5 of 6 residents sampled (#1, #2, #4, #5, and #9) for record review including errors with medications for anxiety (#1, #2,#4, #5); medication for pain (#1, #2, #9); an anti-psychotic and a blood pressure medication (#5); and insulins, an anti-depressant, a seizure medication, and a laxative were not available for administration (#4).

The findings are:

1. The medication error rate was 48% as evidenced by the observation of 13 errors out of 27 opportunities during the 8:00am medication pass on 03/10/22.

a. Review of Resident #1's current FL2 dated 11/17/21 revealed diagnoses included anxiety, osteoporosis, deep vein thrombosis, and type II

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diabetes.

Interview with Resident #1 during the initial tour on 03/10/22 at 10:00am revealed:
-Resident #1 was seated in the open area between the facility's halls.
-Resident #1 complained that she was in pain, her hips hurt bad.
-The medication aide (MA) was running late passing morning medications again.
-The MA had told her she would get to her medications as soon as she could.
-Resident #1's medications were not on the cart that the MA was currently working on.

Review of Resident #1's current FL2 dated 11/17/21 and signed physician's orders dated 11/17/21 revealed:
-There was an order for calcium with vitamin D 500mg/400mg (a vitamin supplement) one tablet twice a day.
-There was an order for Eliquis 5mg (a blood thinner) twice a day.
-There was an order for metformin 500mg (used to treat elevated blood sugar levels) one-half tablet (250mg) twice a day.
-There was an order for lorazepam 0.5mg (used to treat anxiety) one-half tablet (0.25mg) twice a day.
-There was an order for hydrocodone/acetaminophen 5/325 (used to treat moderate to severe pain) one tablet twice a day.

Observation of the 8:00am medication pass on 03/10/22 revealed:
-At 10:12am, the MA prepared 8 oral medications to administer to Resident #1.
-The medications included one calcium with vitamin D 500mg/400mg, one Eliquis 5mg tablet,

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one-half tablet of metformin 500mg, one-half tablet of lorazepam 0.5mg, and one hydrocodone/acetaminophen 5/325mg tablet.
-At 10:18am, Resident #1 took her medications standing at the medication cart.
-The MA documented administration of Resident #1's medications on the electronic medication administration record (eMAR).

Review of Resident #1's March 2022 eMAR on 03/10/22 at 11:00am revealed:
-There was an entry for calcium with vitamin D 500mg/400mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for Eliquis 5mg twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for metformin 500mg one-half tablet twice a day scheduled for administration at 8:00am and 5:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for lorazepam 0.5mg one-half tablet (0.25mg) twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for hydrocodone/acetaminophen 5/325 one tablet twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.

Interview with the MA on 03/10/22 at 10:15am revealed:
-There were supposed to be two MAs scheduled for the morning medication pass.

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D 358	Continued From page 45 -The second MA called out of work this morning leaving her with the medication pass for 52 residents. -She had to assist in the dining room with two different meal services at breakfast as well as the medication pass. -She was behind completing the medication pass for 8:00am medications. Telephone interview with the Resident #1's primary care provider (PCP) on 03/10/22 at 10:40am revealed: -He had seen Resident #1 a couple of times since the beginning of 2022. -He expected the resident's medications to be administered at the scheduled times. -Medications scheduled more often than one time per day should be evaluated for the length of time between doses. -The staff should notify the PCP when residents who received medications more than once a day did not receive the morning dose in time so the PCP could determine whether the next scheduled medication should be administered, held for later administration or not administered at all. Interview with the Administrator on 03/10/22 at 2:00pm revealed: -She did not know the morning medication pass was late. -The MAs were responsible for administering medications according to the time scheduled on the eMAR and within the one hour before and one hour after the scheduled time parameters. -She was a MA as well as the Administrator and could have assisted the MA with the morning medication pass. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.	D 358		

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D 358	Continued From page 46 Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. b. Review of Resident #12's current FL2 dated 11/17/21 revealed diagnoses included depression, and bipolar mood disorder. Review of Resident #12's current FL2 dated 11/17/21 and signed physician's orders dated 11/17/21 revealed: -There was an order for quetiapine 100mg (an anti-psychotic used to treat bi-polar disorder) one and one-half tablets (150mg) in the morning. -There was an order for quetiapine 50mg 2 tablets (100mg) at noon (12:00pm) and quetiapine 200mg take 2 and one-half (500mg) tablets every evening. -There was an order for clonazepam 0.5mg (used to treat anxiety) one-half tablet (0.25mg) 3 times a day. Observation of the 8:00am medication pass on 03/10/22 revealed: -At 10:22am, the medication aide (MA) prepared 4 oral medications to administer to Resident #12. -The medications included quetiapine 100mg one and one-half tablets (150mg), and clonazepam	D 358		

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0.5mg one-half tablet (0.25mg).
-At 10:28am, Resident #12 took his medications in his room.
-The MA documented administration of Resident #12's medications on the electronic medication administration record (eMAR).

Review of Resident #12's March 2022 eMAR on 03/10/22 at 11:00am revealed:
-There was an entry for quetiapine 100mg one and one-half tablets (150mg) in the morning scheduled for administration at 8:00am and documented as administered at 8:00am on 03/10/22.
-There was an entry for quetiapine 50mg 2 tablets (100mg) at noon (12:00pm) scheduled for administration at 12:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for clonazepam 0.5mg one-half tablet (0.25mg) 3 times a day scheduled for administration at 8:00am, 2:00pm, and 8:00pm and documented as administered at 8:00am on 03/10/22.

Interview with the MA on 03/10/22 at 10:15am revealed:
-There were supposed to be two MAs scheduled for the morning medication pass.
-The second MA called out of work this morning leaving her with the medication pass for 52 residents.
-She had to assist in the dining room with two different meal services at breakfast as well as the medication pass.
-She was behind completing the medication pass for 8:00am medications.

Telephone interview with Resident #12's primary care provider (PCP) on 03/10/22 at 10:40am revealed:

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-He had seen Resident #12 a few times since the beginning of 2022.
-He expected the resident's medications to be administered at the scheduled times.
-Medications scheduled more often than one time per day should be evaluated for the length of time between doses.
-The staff should notify the PCP when residents who received medications more than once a day did not receive the morning dose in time so the PCP could determine whether the next scheduled medication should be administered, held for later administration or not administered at all.

Interview with Resident #12 on 03/10/22 at 11:30am revealed:
-He received his medication late once in a while depending on which MA was working the medication cart.
-He had not noticed any difference in the way he felt if he received morning medications late and then his noon medications.
-He depended on staff to administer his medications the way they were ordered.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22 at 6:51pm.

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D 358	Continued From page 49 Refer to interview with the Administrator on 03/16/22 at 7:53pm. c. Review of Resident #2's current FL2 dated 12/03/21 revealed diagnoses included anxiety, vitamin D deficiency, coronary artery disease, schizophrenia, arthritis, and type II diabetes. Review of Resident #2's current FL2 dated 12/03/21 and signed physician's orders dated 01/27/22 revealed: -There was an order for lorazepam 0.5mg (used to treat anxiety) one tablet twice a day. -There was an order for calcium with vitamin D 600mg/400mg (a vitamin supplement) one tablet twice a day. -There was an order for metoprolol tartrate 50mg (used to treat high blood pressure) twice a day. -There was an order for omeprazole 40mg (used to treat acid reflux) one capsule twice a day. -There was an order for docusate sodium 100mg (used to treat constipation) 2 capsules twice a day. Observation of the 8:00am medication pass on 03/10/22 revealed: -At 10:45am, the medication aide (MA) prepared 12 oral medications to administer to Resident #2. -The medications included one calcium with vitamin D 500mg/400mg, one lorazepam 0.5mg tablet, one metoprolol tartrate 50mg tablet, 1 omeprazole 40mg capsule and 2 docusate sodium 100mg capsules. -At 10:50am, Resident #2 took her medications sitting on her rolling walker seat at the medication cart. -The MA documented administration of Resident #2's medications on the electronic medication administration record (eMAR).	D 358		

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Review of Resident #2's March 2022 eMAR on 03/10/22 at 11:00am revealed:
-There was an entry for lorazepam 0.5mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for calcium with vitamin D 600mg/400mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for metoprolol tartrate 50mg twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for omeprazole 40mg one capsule twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.
-There was an entry for docusate sodium 100mg 2 capsules twice a day scheduled for administration at 8:00am and 8:00pm, and documented as administered at 8:00am on 03/10/22.

Interview with the MA on 03/10/22 at 10:15am revealed:
-There were supposed to be 2 MAs scheduled for the morning medication pass.
-The second MA called out of work this morning leaving her with the medication pass for 52 residents.
-She had to assist in the dining room with two different meal services at breakfast as well as the medication pass.
-She was behind completing the medication pass for 8:00am medications.

Telephone interview with Resident #2's primary care provider (PCP) on 03/10/22 at 10:40am

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revealed:
-He had seen Resident #2 a few times since the beginning of 2022.
-He expected the resident's medications to be administered at the scheduled times.
-Medications scheduled more often than one time per day should be evaluated for the length of time between doses.
-The staff should notify the PCP when residents who received medications more than once a day did not receive the morning dose in time so the PCP could determine whether the next scheduled medication should be administered, held for later administration or not administered at all.

Review of Resident #2's current FL2 dated 12/03/21 and signed physician's orders dated 01/27/22 revealed there was an order for Flovent HFA inhaler 110mcg (used to treat breathing disorders) 2 puffs twice a day.

Observation of the 8:00am medication pass on 03/10/22 revealed:
-At 10:45am, the medication aide (MA) prepared 12 oral medications to administer to Resident #2.
-The MA looked in the resident's routine medications as well as the overstock for Resident #2.
-The Flovent inhaler was not available for administration.
-The MA told Resident #2 the Flovent inhaler was not available for administration and had to be ordered.

Review of Resident #2's March 2022 electronic medication administration record (eMAR) on 03/10/22 at 11:00am revealed:
-There was an entry for Flovent HFA inhaler 110mcg 2 puffs twice a day scheduled for administration at 8:00am and 8:00pm.

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-Flovent inhaler was documented at 8:00am and 8:00pm daily from 03/01/22 to 03/09/22.
-The MA's initials were circled on the eMAR for 8:00am on 03/10/22 with the reason for not administered indicated as not available.

Interview with the MA on 03/10/22 at 10:50am revealed:
-Resident #2 had medications dispensed on cycle fill.
-Flovent was not routinely dispensed by the contracted pharmacy and had to be ordered separately.
-She reordered Resident #2's Flovent inhaler from the contracted pharmacy through the eMAR system.

Interview with Resident #2 on 03/10/22 at 10:49am revealed:
-Resident #2 asked for her short acting inhaler when she was informed the long acting inhaler was not available.
-She waited for her medications until the morning medication aide (MA) got to her end of the hall.
-Sometimes her medications were late, same as today.

Interview with the Administrator on 03/10/22 at 1:05pm revealed Resident #2's Flovent 110mcg was reordered from the contracted pharmacy on 03/10/22 and should be delivered to the facility in the pharmacy order prior to the scheduled 8:00pm dose.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 2:30pm revealed:
-Resident #2 received medications on a cycle fill monthly.
-Resident #2's Flovent 110mcg had to be ordered

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separately from the cycle fill.
-Flovent 110 mcg was last filled by the contracted pharmacy on 12/08/21 for one inhaler (a 30 days supply).
-Flovent 100mcg was reordered on 03/10/22.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22 at 6:51pm.

Refer to interview with the Administrator on 03/16/22 at 7:53pm.

2. Review of Resident #2's current FL2 dated 12/03/21 revealed there was an order for lorazepam 0.5mg (used to treat anxiety) one tablet twice a day.

Review of Resident #2's medications brought to the facility upon admission revealed there was a controlled drug receipt form dated 12/07/21 sent upon admission from Resident #2's previous facility documenting 34 tablets available on 12/07/21.

Review of Resident #2's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg one

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tablet twice a day scheduled for administration at 8:00am and 8:00pm daily beginning on 12/08/21 at 8:00pm on the eMAR.
-On 12/12/21 at 8:00am, 12/18/21 at 8:00pm, 12/23/21 at 8:00am, there were 3 doses documented as "not available" and not administered as ordered on the eMAR.

Review of Resident #2's controlled drug receipt form dated 12/07/21 revealed on 12/12/21 at 8:00am, 12/18/21 at 8:00pm, 12/23/21 at 8:00am, there were 3 doses not signed out on the controlled drug receipt.

Review of Resident #2's signed physician's orders dated 01/27/22 revealed an order for lorazepam 0.5mg one tablet twice a day.

Telephone interview with a pharmacist at the contracted pharmacy on 03/10/22 at 3:00pm revealed:
-The pharmacy dispensed lorazepam 0.5mg quantity of 60 tablets for one time only on 01/25/22 for Resident #2.
-The pharmacy had not received a request for a refill of Resident #2's lorazepam 0.5mg tablets.

Review of Resident #2's January 2022 eMAR revealed:
-There was an entry for lorazepam 0.5mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm daily on the eMAR.
-On 01/01/22 at 8:00pm, 02/02/22 at 8:00pm, 01/03/22 at 8:00am,01/09/22 at 8:00am, and from 01/19/22 at 8:00am to 01/23/22 at 8:00am and 01/25/22 at 8:00pm, 14 doses of lorazepam 0.5mg were documented as "not available" on the eMAR and were not administered as ordered.
-On 01/13/22 at 8:00am and 01/14/22 at 8:00am, the eMAR was blank for administration of 2 doses

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of lorazepam 0.5mg and not administered as ordered
-There were 16 doses of lorazepam 0.5mg not administered as ordered to Resident #2 from 01/01/22 to 01/25/22 according to documentation on the January 2022 eMAR.

Review of Resident #2's eMARs, there were 19 doses of lorazepam 0.5mg not administered as ordered for Resident #2 from 12/07/21 to 01/31/22.

Observation of medication on hand for administration to Resident #2 on 03/11/22 at 11:00am revealed Resident # 2 had 19 of 30 tablets remaining on a bubble card of lorazepam 0.5mg dispensed on 02/20/22 with a different resident's name that was used for Resident #2, and 60 of 60 lorazepam 0.5mg dispensed on 03/10/22 on hand for administration.

Interview with Resident #2 on 03/15/22 at 11:17am revealed:
-She did not know all her medications.
-She took a medication to help with her nerves (lorazepam) but staff had to order it.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22

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D 358	Continued From page 56 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. 3. Review of Resident #9's current FL2 dated 12/01/21 revealed: -Diagnoses included diabetes type II with peripheral circulatory disorder, and rheumatoid arthritis. -There was an order for oxycodone (used to treat moderate to severe pain) 5mg twice a day as needed. Telephone interview on 03/14/22 at 11:48am with the pharmacist manager at the facility's contracted pharmacy revealed: -Resident #9 had written orders and was dispensed oxycodone/acetaminophen (a combination pain reliever used to treat moderate to severe pain) as follows: -On 01/06/22, oxycodone/acetaminophen 7.5/325 one tablet 4 times a day was dispensed for 56 tablets (14 days supply). -On 01/20/22, oxycodone/acetaminophen 7.5/325 one tablet 4 times a day was dispensed for 28 tablets (7 days supply). -On 01/27/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for 28 tablets (7 days supply). -On 02/10/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for 56 tablets (14 days supply). -On 02/25/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for 56 tablets (14 days supply). Review of Resident #9's January 2022 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 57 -There was an entry for oxycodone/acetaminophen 7.5/325 one tablet 4 times daily scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm daily. -On 01/10/22 at 11:00am and on 01/13/22 at 4:00pm, 2 doses were blank for documentation for administration on the eMAR. -From 01/14/22 at 7:00pm to 01/20/22 at 7:00pm, there were 14 of 24 opportunities with doses documented on the eMAR as "not available" for administration. Review of Resident #9's January 2022 eMAR revealed: -There was an entry for oxycodone/acetaminophen 10/325 one tablet 4 times daily scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm daily ending 01/27/22. -There were 4 doses documented on the eMAR as "not available" and not administered as ordered; on 01/26/22 at 4:00pm, and on 01/27/22 at 11:00am, at 4:00pm and at 7:00pm. -There was an entry for oxycodone/acetaminophen 10/325 one tablet 4 times scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm daily on the eMAR from 01/28/22 to 01/31/22. -From 01/30/22 at 8:00am to 01/31/22 at 8:00pm, there were 8 doses not administered as ordered with 2 blank spaces on the eMAR and 6 doses documented as "not available" for administration. Review of Resident #9's February 2022 eMAR revealed: -There was an entry for oxycodone/acetaminophen 10/325 one tablet 4 times scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm daily on the eMAR. -From 02/01/22 to 02/10/22, there were 40 doses	D 358		

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of oxycodone/acetaminophen 10/325 documented as "not available" on the eMAR and not administered as ordered.
-On 02/11/22 at 11:00am, one dose was documented as "not available".

Review of Resident #9's eMAR revealed were 20 doses of oxycodone/acetaminophen 7.5/325 not administered as ordered from 01/06/22 to 01/27/22 and 48 doses of oxycodone/acetaminophen 10/325 not administered as ordered from 01/28/22 to 03/11/22.

Observation of medication on hand for administration on 03/10/22 at 4:00pm revealed there were 20 oxycodone/acetaminophen 10/325 available for administration.

Interview with a medication aide (MA) on 03/14/22 at 9:00am revealed:
-She knew Resident #9 was out of his pain medication occasionally but not as often as the eMAR showed.
-The eMAR system did not make it easy to see missed doses unless you ran reports.

Interview with Resident #9 on 03/14/22 at 6:35pm revealed:
-He had bad arthritis in his hands, hips, and knees.
-He took pain medication so he could get up from his bed and be mobile with his walker.
-There had been a few times when he was out of his medication for several days.
-When he was out of pain medication, he had to lay in bed or use his wheelchair to get around.
-His physician told him he should not run out of medication because he had written orders to provide pain medication

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(oxycodone/acetaminophen).
-He had Tylenol (a mild pain reliever) ordered as needed that he asked for until he got his regular pain medication from the pharmacy.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22 at 6:51pm.

Refer to interview with the Administrator on 03/16/22 at 7:53pm.

4. Review of Resident #1's current FL2 dated 11/17/21 revealed diagnoses included anxiety, osteoporosis, deep vein thrombosis, and type II diabetes.

a. Review of Resident #1's current FL2 dated 11/17/21 and signed physician's orders dated 11/17/21 revealed there was an order for lorazepam 0.5mg (used to treat anxiety) one-half tablet (0.25mg) twice a day.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:15pm revealed.
-On 11/08/21, Resident #1 was dispensed lorazepam 0.5mg one-half tablet (0.25mg) twice a day for 60 doses.

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D 358	Continued From page 60 -On 12/20/21, Resident #1 was dispensed lorazepam 0.5mg one-half tablet (0.25mg) twice a day for 60 doses. -On 01/30/22, Resident #1 was dispensed lorazepam 0.5mg one-half tablet (0.25mg) twice a day for 60 doses. -On 03/06/22, Resident #1 was dispensed lorazepam 0.5mg one-half tablet (0.25mg) twice a day for 60 doses. Review of Resident #1's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 0.5mg one-half tablet (0.25mg) twice a day scheduled for administration at 8:00am and 8:00pm daily. -On 03/04/22 at 8:00am and 03/05/22 at 8:00am and 8:00pm, 3 doses were documented as "not available" for administration and not administered as ordered. Observation of Resident #1's medication on hand for administration on 03/10/22 at 10:30am revealed Resident #1 had a partial bubble card of 25 lorazepam 0.5mg one-half tablets to match 25 of 30 tablets remaining, and a bubble card with 30 of 30 one-half tablets in overstock. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm.	D 358		

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D 358	Continued From page 61 Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. b. Review of Resident #1's current FL2 dated 11/17/21 and signed physician's orders dated 11/17/21 revealed there was an order for hydrocodone /acetaminophen 5/325 (used to treat moderate to severe pain) twice a day. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:15pm for controlled substances dispensed for Resident #1 revealed: -On 11/03/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 doses. -On 12/27/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 doses. -On 01/24/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 doses. -On 02/21/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 doses. Review of Resident #1's January 2022 eMAR revealed: -There was an entry for hydrocodone /acetaminophen 5/325 twice a day scheduled for administration at 8:00am and 8:00pm daily. -On 01/09/22 at 8:00am, one dose of hydrocodone /acetaminophen 5/325 was blank for administration. -From 01/11/22 at 8:00am to 01/23/22 at 8:00pm, there were 17 of 48 opportunities documented as "not available" and the medication was not	D 358		

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D 358	Continued From page 62 administered as ordered. Review of Resident #1's eMARs revealed from 01/11/22 at 8:00am to 01/23/22 at 8:00pm, there were 17 of 48 opportunities documented as "not available" and the resident did not receive hydrocodone /acetaminophen 5/325 as ordered. Observation of medication on hand for administration for Resident #1 on 03/11/22 at 10:45am revealed there were 30 doses of hydrocodone /acetaminophen 5/325 remaining of the 60 doses dispensed on 02/21/22. Interview with Resident #1 on 03/11/22 at 10:00am revealed: -She was out of pain medication for several weeks in January. -The medication aides (MA) told her they had none to administer. -She was told she needed a new order from the provider and they were trying to get one. -She was not able to ambulate with her walker due to the pain, and mostly stayed in her room. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm.	D 358		

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D 358	Continued From page 63 Refer to interview with the Administrator on 03/16/22 at 7:53pm. 5. Review of Resident #4's current FL2 dated 10/21/21 revealed diagnoses included type 2 diabetes, seizures, asthma, neuropathy, pancreas, heartburn, post traumatic stress disorder, schizoaffective disorder bipolar type, and agoraphobia. a. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for clonazepam 0.5mg 1 tablet twice daily (used to treat anxiety). Review of Resident #4's electronic medication administration record (eMAR) for November 2021 revealed: -There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was no documentation clonazepam was administered at 8:00am and 8:00pm on 11/06/21, 11/08/21, and 11/18/21 due to not available. Review of Resident #4's eMAR for December 2021 revealed: -There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was no documentation clonazepam was administered at 8:00am and 8:00pm on 12/17/21 due to out of facility, at 8:00am on 12/18/21 due to not available, at 8:00pm on 12/19/21 due to not available, at 8:00pm on 12/25/21 due to out of the facility, at 8:00pm on 12/27/21 due to not available, and at 8:00pm 12/31/21 due to out of facility. Review of Resident #4's eMAR for January 2022 revealed:	D 358		

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-There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was no documentation clonazepam was administered at 8:00am on 01/01/22 due to out of facility with family, at 8:00pm on 01/04/22 due to not available, at 8:00pm on 01/06/22 due to not available, at 8:00am and 8:00pm on 01/19/22 due to out of facility and not available.

Review of Resident #4's eMAR for March 2022 revealed:
-There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was no documentation clonazepam was administered at 8:00pm 03/05/22 due to not available, and at 8:00am and 8:00pm on 03/06/22 due to not available.

Observation of medications available for Resident #4 on 03/15/22 at 9:01am revealed:
-A medication bubble card (1 of 2) of clonazepam 0.5mg 1 tablet twice daily was available on the medication cart with quantity of 30 tablets.
-Sixty tablets of clonazepam 0.5mg were dispensed to the facility on 03/07/22 with 30 tablets in 2 bubble cards.
-There was a quantity of 14 tablets remaining on the medication cart.
-The second bubble card (2 of 2) of 30 tablets of clonazepam was available in a locked box in the Administrator's office.

Interview with a pharmacist at the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed:
-There was an order for clonazepam 0.5mg 1 tablet twice daily.
-Clonazepam was dispensed to the facility on

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10/27/21 with a quantity of 34 tablets, on 11/22/21 with a quantity of 60 tablets, on 12/19/21 with a quantity of 60 tablets, on 01/19/22 with a quantity of 60 tablets, and on 03/07/22 with a quantity of 60 tablets.

Interview with Resident #4 on 03/15/22 at 10:21am revealed:
-She was administered clonazepam for anxiety.
-The facility was out of clonazepam about a month ago, but she did not remember for how long.
-She was experiencing anxiety during the time she was out of clonazepam and asked to go to the hospital, but she was not sent out.

Interview with a medication aide (MA) on 03/11/22 at 10:03am revealed:
-She did not know Resident #4 had been out of clonazepam.
-MAs were responsible for reordering medications from the pharmacy through the eMAR system.
-Controlled substances could not be reordered through the eMAR system.
-When a resident was out of a controlled substance, the MA had to contact the resident's primary care provider (PCP) to let them know the resident needed a new prescription and the PCP faxed the new order for the controlled substance to the pharmacy.
-Medications should have been reordered when there was about a week left.

Telephone interview with a second MA on 03/16/22 at 4:26pm revealed:
-MAs were responsible for reordering medication when there was about 7 days of medication remaining.
-She knew Resident #4 had been out of

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clonazepam, but she did not remember when.
-She did not remember if she contacted the pharmacy to reorder clonazepam when it was not available in the facility.

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know clonazepam had notbeen available in the facility for administration and that there were days when clonazepam had not been administered.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22 at 6:51pm.

Refer to interview with the Administrator on 03/16/22 at 7:53pm.

b. Review of Resident #4's current FL2 dated 10/21/21 revealed an order novolog (a fast acting insulin used to lower blood sugar levels) 100units/ML inject 6 units 3 times daily.

Review of Resident #4's electronic medication administration record (eMAR) for December 2021 revealed:
-There was an entry for novolog 100/mL inject 6 unites 3 times daily with meals scheduled for administration at 8:00am, 12:00pm, and 5:00pm.

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-There was no documentation novolog was administered for 7 of 93 opportunities between 12/01/21 and 12/31/21.
-There were blank spaces with no documentation on 12/01/21 at 12:00pm, on 12/07/21 at 12:00pm, on 12/13/21 at 12:00pm and on 12/24/21 at 5:00pm.
-There was documentation novolog was not administered on 12/25/21 at 5:00pm due to out of facility, and on 12/31/21 at 12:00pm and 5:00pm due to out of facility.
-Fingerstick blood sugars (FSBSs) ranged from 129 to 472 from 12/01/22 to 12/31/22.

Review of Resident #4's eMAR for January 2022 revealed:
-There was an entry for novolog 100/mL inject 6 unites 3 times daily with meals scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was no documentation novolog was for 13 of 93 opportunities between 01/01/22 and 01/31/22.
-There were blank spaces with no documentation on 01/01/22 at 5:00pm, on 01/02/22 at 5:00pm, on 01/11/22 at 12:00pm, on 01/13/22 at 8:00am, on 01/21/22 at 12:00pm, on 01/22/22 at 5:00pm, and on 01/30/22 at 5:00pm.
-There was documentation novolog was not administered on 01/10/22 at 5:00pm due to resident refused, on 01/13/22 at 5:00pm due to resident refused, on 01/15/22 at 12:00pm due to resident refused, and on 01/16/22 at 5:00pm due to out of facility.
-FSBSs ranged from 71 to 368 from 01/01/22 to 01/31/22.

Review of Resident #4's eMAR for February 2022 revealed:
-There was an entry for novolog 100/mL inject 6 unites 3 times daily with meals scheduled for

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administration at 8:00am, 12:00pm, and 5:00pm.
-There was no documentation novolog was administered for 5 of 84 opportunities between 02/01/22 and 02/28/22.
-There was a blank space with no documentation on 02/04/22 at 12:00.
-There was documentation novolog was not administered on 02/19/22 at 8:00am and 5:00pm due to resident refused, on 02/23/22 due to not available, and on 02/24/22 due to resident refused.
-FSBSs ranged from 73 to 350 from 02/01/22 to 02/28/22.

Observation of medications available for administration to Resident #4 on 03/16/22 at 4:39pm revealed:
-There was 1 novolog insulin pen in Resident 4's insulin kit box.
-There was no documentation of when the novolog insulin pen was dispensed or opened.
-The Administrator brought 1 novolog pen from the medication room; the pen was dialed to 0 and there was no resident name on the pen.

Interview with Resident #4 on 03/16/22 at 4:38pm revealed:
-She was administered insulin due to having a diagnosis of diabetes.
-She was supposed to get FSBS and insulin 4 times daily, but staff did not always check her FSBS or administer insulin 4 times daily (She received lantus insulin at bed time in addition to novolog 3 times daily).
-She got upset at times because she sometimes had to wait to be administered her insulin.
-She had not refused to have her FSBS checked or receive her insulin.

Telephone interview with a pharmacist from the

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facility's contracted pharmacy on 03/15/22 at 3:43pm revealed:
-Resident #4 had an order for novolog 100/ML inject 6 units 3 times daily.
-One vial of novolog was dispensed to the facility on 12/23/21 and 02/09/22.
-One vial of novolog could last up to 55 days, but it expired 28 days after opening.

Interview with a MA on 06/16/22 at 4:26pm revealed:
-Resident #4 was admitted to the facilty with novolog pens, but she did not know how many.
-She did not realize there were times when Resident #4's novolog was not administered.
-She did not know why there were blank spaces for entries for FSBSs.
-If there were blank spaces on the eMAR for insulin administration, it probably meant the MA just did not administer the medication.

Interview with Resident #4's primary care provider (PCP) on 03/16/22 at 4:32pm revealed:
-Resident #4 had an order for FSBS and insulin 4 times daily (She received lantus insulin at bed time in addition to novolog 3 times daily).
-He did not know there were multiple days when Resident #4's novolog was not administered.
-He expected the facility to contact him if insulin was not being administered.

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did know there were days when novolog had not been administered to Resident #4.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on

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D 358	Continued From page 70 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. c. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for lantus (a long-acting insulin used to lower blood sugar 100unit/mL inject 30 units at bedtime. Interview with a representative from the facility's contracted pharmacy on 03/16/22 at 4:28pm revealed: -Resident #4 had an order dated 10/15/21 for lantus 100u/mL inject 30 units at bedtime. -Lantus had not been requested by the facility and was never dispensed. Review of Resident #4's electronic medication administration record (eMAR) for February 2021 revealed: -There was an entry for lantus 100/mL inject 30 units at bedtime scheduled for 8:00pm. -There was no documentation lantus was administered for 3 of 28 opportunities between 02/01/21 and 02/28/21. -There was a blank space with no documentation on 02/07/22. -There was documentation lantus was not administered on 02/08/22 and 02/09/22 due to not available.	D 358		

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D 358	Continued From page 71 -Fingerstick blood sugars (FSBSs) ranged from 73 to 350 from 02/01/22 to 02/28/22. Observation of medications available for administration to Resident #4 on 03/16/22 at 4:39pm revealed: -There was a pen of lantus insulin in Resident 4's insulin kit box. -There was no documentation of when the lantus pen was dispensed. -The lantus pen had a white sticker on it to document the date the pen was opened, but there was no opened date documented on the sticker. -There was documentation on the sticker to discard the pen of lantus 28 days after it was opened. -There were 300 units of insulin in the pen and 140 units were remaining. -The Administrator brought 2 lantus pens from the medication room; one pen was dialed to 2 units and there was no resident name or open date; the other pen was dialed to 0 and there was no resident name on the pen. Interview with Resident #4 on 03/16/22 at 4:38pm revealed: -She was administered insulin due to having a diagnosis of diabetes. -She was supposed to get FSBS and insulin 4 times daily, but staff did not always check her FSBS or administer insulin 4 times daily. -Sometimes she had to wait to be administered her insulin. -She often did not receive her insulin at bedtime. -She did not know if her FSBS readings ran high or low. Interview with a medication aide (MA) on 03/16/22 at 4:49pm revealed: -Resident #4 was admitted to the facility (October	D 358		

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2021) with a lantus insulin pen, but she did not know how many.
-She noticed there was no open date on the lantus insulin pen and she was told the pen was opened the day before she administered the insulin to Resident #4.
-She tried to write the date the pen was opened with an ink pen, but the ink would not transfer onto the sticker.
-She did not know how long the current lantus insulin pen had been on the medication cart.
-She had not reordered the lantus insulin pen for Resident #4.

Interview with a second MA on 03/16/22 at 6:51pm revealed:
-She tried to audit the medication carts once a week and looked for expired medications, spills, and that the right medication was on the cart for the right resident.
-She last audited the medication cart last week and she did not notice there was not an open date on Resident #4's lantus pen.
-Resident #4 was admitted to the facilty with a lantus pen, but she did not know how many.
-She did not know if lantus pens were reordered since Resident #4 was admitted to the facility in October 2021.
-When lantus insulin pens were ordered from the pharmacy, there were 4 dispensed in a box and the pens usually lasted about a month.

Interview with Resident #4's primary care provider (PCP) on 03/16/22 at 4:32pm revealed:
-Resident #4 had an order for FSBS and insulin 4 times daily.
-He did not know there were days when Resident #4's lantus was not administered due to the medication not being available.
-He expected the facility to contact him if insulin

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D 358	Continued From page 73 was not being administered. Interview with the Administrator on 03/16/22 at 4:40pm revealed: -She did not know lantus had not been ordered from the pharmacy since Resident #4 was admitted to the facility in October 2021. -Resident #4 may have brought insulin with her when she was admitted to the facility, but she did not know how much. -Staff should have completed an inventory sheet of medications brought to the facility with Resident #4. -She did not know there was no documentation of when Resident #4's lantus insulin pen was opened and that there were days when lantus was not administered due to not being available in the facility. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. d. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for fluoxetine 40mg 1 capsule daily (used to treat depression).	D 358		

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D 358	Continued From page 74 Review of Resident #4's electronic medication administration record (eMAR) for November 2021 revealed: -There was an entry for fluoxetine 40mg 1 capsule daily scheduled for 8:00am. -There was no documentation fluoxetine was administered for 24 of 28 opportunities from 11/01/21 through 11/30/21. -Fluoxetine was documented as not administered on 11/01/21 through on 11/03/21, on 11/05/21, on 11/06/21, on 11/08/21 through 11/12/21 due to not available; on 11/13/21 due to out of facility; on 11/15/21 through 11/18/21, on 11/20/21 through 11/24/21 due to not available; on 11/27/21 and 11/28/21 due to out of facility; and on 11/29/21 and 11/30/21 due to not available. Review of Resident #4's eMAR for December 2021 revealed: -There was an entry for fluoxetine 40mg 1 capsule daily scheduled for 8:00am. -There was no documentation fluoxetine was administered for 9 of 31 opportunities from 12/01/21 through 12/31/21. -Fluoxetine was documented as not administered from 12/01/21 through 12/09/21 due to not available. Review of Resident #4's eMAR for January 2022 revealed: -There was an entry for fluoxetine 40mg 1 capsule daily scheduled for 8:00am. -There was no documentation fluoxetine was administered for 3 of 31 opportunities from 01/01/22 through 01/31/22. -There was documentation fluoxetine was not administered on 01/01/22 due to out of facility; on 01/08/22 and on 01/09/22 due to not available.	D 358		

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D 358	Continued From page 75 Observation of Resident #4's medications available for administration on 03/15/22 at 8:32am revealed: -Fluoxetine 40mg 1 tablet daily was available for administration. -Thirty tablets of fluoxetine were dispensed to the facility on 03/10/22 and 25 tablets were remaining. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed: -Resident #4 had an order for fluoxetine 40mg 1 capsule daily. -Fluoxetine 40mg was dispensed to the facility on 12/07/21, 01/06/22, 02/02/22, and on 03/30/22 with a quantity of 30 capsules on each date. Interview with Resident #4 on 03/15/22 at 10:21am revealed: -She was administered fluoxetine for depression. -She had been out of fluoxetine for a few days, but she did not remember when or for how long. -She experienced episodes of depression 3 to 4 times a week. Interview with a medication aide (MA) on 03/16/22 at 6:51pm revealed: -If a medication was documented on the eMAR as not available, it meant the medication was not in the facility. -She did not remember when fluoxetine was not available on the medication cart for Resident #4. -She had not followed up with the Administrator or the pharmacy about the fluoxetine not being available. -MA's were responsible for reordering medications that were not available in the facility from the pharmacy through the eMAR system.	D 358		

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D 358	Continued From page 76 Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know Resident #4 had been out of fluoxetine. Attempted telephone interview with Resident #4's mental health provider on 02/16/22 at 12:17pm was unsuccessful. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. e. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for gabapentin 600mg 1 tablet 4 times daily (used to prevent and control seizures and/or pain). Review of Resident #4's electronic medication administration record (eMAR) for December 2021 revealed: -There was an entry for gabapentin 600mg 1 tablet 4 times daily scheduled at 8:00am, 12:00pm. 5:00pm, and 8:00pm. -There was no documentation gabapentin was administered for 21 of 124 opportunities from 12/01/21 through 12/31/21.	D 358		

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ST GALES ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

(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 358	Continued From page 77 -There were blank spaces with no documentation on 12/01/21 at 12:00pm, on 12/07/21 at 12:00pm, on 12/13/21 at 12:00pm and on 12/24/21 at 5:00pm. -Gabapentin was documented as not administered on 12/02/21 and 12/03/21 at 5:00pm and 8:00pm due to not available; on 12/17/21 at 12:00pm due to out of facility; on 12/19/21 at 8:00am and 5:00pm due to not available; on 12/25/21 at 5:00pm and 8:00pm due to out of facility; on 12/26/21 at 5:00pm and 8:00pm due to not available; on 12/28/21 at 12:00pm due to not available; on 12/30/21 at 5:00pm and 8:00pm due to not available; and on 12/31/21 at 12:00pm, 5:00pm, and 8:00pm due to out of facility. Review of Resident #4's eMAR for January 2022 revealed: -There was an entry for gabapentin 600mg 1 tablet 4 times daily scheduled at 8:00am, 12:00pm. 5:00pm, and 8:00pm. -There was no documentation gabapentin was administered for 9 of 124 opportunities from 01/01/22 through 01/31/21. -There were blank spaces with no documentation on 01/01/22 and 01/02/22 at 5:00pm, on 01/11/22 at 12:00pm, on 01/22/22 at 5:00pm, and on 01/30/21 at 5:00pm. -There was documentation gabapentin was not administered on 01/01/22 at 8:00am and 12:00pm due to out of facility; on 01/15/21 at 12:00pm due to resident refused; on 01/16/21 at 5:00pm due to out of facility. Review of Resident #4's eMAR for February 2022 revealed: -There was an entry for gabapentin 600mg 1 tablet 4 times daily scheduled at 8:00am, 12:00pm. 5:00pm, and 8:00pm.	D 358		

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D 358	Continued From page 78 -There was no documentation gabapentin was administered for 2 of 112 opportunities from 02/01/22 through 02/28/21. -There were blank spaces with no documentation on 01/04/22 at 12:00pm and on 02/07/22 at 8:00pm. Observation of Resident #4's medications available for administration on 03/15/22 at 8:32am revealed gabapentin 600mg 1 tablet 4 times daily was available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed: -Resident #4 had an order for gabapentin 600mg 1 tablet four times daily. -Gabapentin was dispensed to the facility with a quantity of 40 tablets on 12/06/21 and a quantity of 120 tablets on 12/07/21, 12/30/21, 01/06/22, 02/02/22, and on 03/03/22. Interview with Resident #4 on 03/15/22 at 10:21am revealed: -She had a history of seizures, but she had not had any lately. -She did not think the facility had been out of gabapentin. Interview with a medication aide (MA) on 03/16/22 at 6:51pm revealed: -She remembered Resident #4 being out of gabapentin once, but she did not remember when. -She contacted the pharmacy when she realized Resident #4 was out of gabapentin, but she had not followed up with the pharmacy regarding gabapentin not being available at any other times. -She had not followed up with the Administrator or the pharmacy about the gabapentin not being	D 358		

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available.

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did know the facility had been out of gabapentin for administration to Resident #4.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22 at 6:51pm.

Refer to interview with the Administrator on 03/16/22 at 7:53pm.

f. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for linzess 72 mcg 1 capsule daily before breakfast (used to treat constipation).

Review of Resident #4's electronic medication administration record (eMAR) for October 2021 revealed:
-There was an entry for linzess 72 mcg capsules 1 capsule daily before breakfast scheduled for 8:00am.
-There was no documentation linzess was administered for 15 of 16 opportunities between 10/16/21 and 10/31/21.
-There were blank spaces with no documentation

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on 10/20/21.
-There was documentation linzess was not administered on 10/16/21, on 10/17/21 and 12/19/21 due to not available; on 10/21/21 due to withheld per doctor's orders; and from 10/22/21 through 10/31/21 due to not available.

Review of Resident #4's eMAR for November 2021 revealed:
-There was an entry for linzess 72 mcg capsules 1 capsule daily before breakfast scheduled for 8:00am.
-There was no documentation linzess was administered for 19 of 30 opportunities between 11/01/21 and 11/30/21.
-There was documentation linzess was not administered on 11/01/21, 11/02/21, 11/03/21, 11/12/21, 11/13/821, 11/15/21, 11/16/21, 11/14/21, 11/18/21, 11/20/21, 11/21/21, 11/23/21, 11/24/21, 11/25/21, 11/27/21, 11/29/21, and on 11/30/21 due to not available; and on 11/22/21, 11/27/21, 11/28/21 due to out of facility.

Review of Resident #4's eMAR for December 2021 revealed:
-There was an entry for linzess 72 mcg capsules 1 capsule daily before breakfast scheduled for 8:00am.
-There was no documentation linzess was administered for 26 of 31 opportunities between 12/01/21 and 12/03/21.
-There was documentation linzess was not administered from 12/01/21 through 12/10/21, from 12/12/21 through 12/16/21, and from 12/18/21 through 12/27/21 due to not available; and on 12/17/21 due to out of facility.

Review of Resident #4's eMAR for February 2022 revealed:
-There was an entry for linzess 72 mcg capsules

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1 capsule daily before breakfast scheduled for 8:00am.
-There was no documentation linzess was administered for 19 of 28 opportunities between 02/01/21 and 02/28/21.
-There was documentation linzess was not administered from 02/09/21 through 02/13/21, from 02/15/21 through 02/23/21, and from 02/25/21 through 02/28/21 due to not available; and on 02/24/21 due to out of facility.

Review of Resident #4's eMAR for March 2022 revealed:
-There was an entry for linzess 72 mcg capsules 1 capsule daily before breakfast scheduled for 8:00am.
-There was no documentation linzess was administered for 2 of 14 opportunities between 03/01/21 through 03/14/21 on 03/13/21 and on 03/14/21 due to not available.

Observation of Resident #4's medications available for administration on 03/15/22 at 8:32am revealed linzess was not available on the medication cart.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed:
-There was an order on file for linzess dated 11/17/21, but linzess was never dispensed to the facility.
-There were no notes regarding linzess so she could not tell if there was an insurance issue.

Interview with Resident #4 on 03/15/22 at 10:21am revealed:
-Staff did not offer linzess to her.
-She told the staff not to give her linzess because it made her go to the bathroom too much.

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D 358	Continued From page 82 -She had not talked to her primary care provider (PCP) about not taking linzess. Interview with a medication aide (MA) on 03/16/22 at 6:51pm revealed: -Linzess was not available on the medication cart for Resident #4. -She had not followed up with the pharmacy, Administrator or the PCP about the medication not being available. Interview with Resident #4's PCP on 03/15/22 at 4:35pm revealed: -He started providing services for Resident #4 on 02/10/21. -Linzess was used to treat constipation. -He did not know Resident #4 was not being administered linzess and staff documented that linzess was not available. -He did not know if there was an issue with insurance paying for linzess, but he or the previous PCP should have been contacted regarding linzess not being administered. Interview with the Administrator on 03/15/22 at 3:28pm revealed: -She remembered Resident #4 talking to her about the facility food making her go to the bathroom frequently and she did not want to take linzess anymore. -She told Resident #4 she could refuse to take linzess and staff would follow up with her PCP to get it discontinued. -She did not contact Resident #4's PCP and did not know if any other MA contacted Resident #4's PCP about discontinuing linzess. -She did not know linzess was not on the medication cart and was documented as unavailable.	D 358		

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D 358	Continued From page 83 Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. 6. Review of Resident #5's current FL2 dated 11/17/21 revealed diagnoses included hypoglycemia, hyperkalemia, sepsis, cognitive dysfunction, dysphagia, sever thrombocytopenia, transient transaminitis (complication of uncontrolled diabetes), and gastrointestinal erosion. a. Review of Resident #5's current FL2 dated 11/17/21 revealed there was an order for quetiapine 50mg 1 tablet 3 times daily (used to treat mood disorders). Review of Resident #5's electronic medication administration record (eMAR) for January 2022 revealed: -There was an entry for quetiapine 50mg 1 tablet 3 times daily scheduled for 8:00am, 2:00pm, and 8:00pm. -There was no documentation quetiapine was administered for 9 of 93 opportunities from 01/01/22 through 01/31/22.	D 358		

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D 358	Continued From page 84 -There were blank spaces with no documentation on 01/03/22 at 2:00pm, on 01/05/22 at 8:00am, 2:00pm and 8:00pm, on 01/08/22 at 8:00pm, on 01/17/22 at 2:00pm, on 01/29/22 at 8:00pm, and on 01/31/22 at 8:00pm. -There was documentation quetiapine was not administered on 01/16/22 due to out of facility. Review of Resident #5's eMAR for February 2022 revealed: -There was an entry for quetiapine 50mg 1 tablet 3 times daily scheduled for 8:00am, 2:00pm, and 8:00pm. -There was no documentation quetiapine was administered for 11 of 84 opportunities from 02/01/22 through 02/28/22. -There was documentation quetiapine was not administered on 02/08/22 at 8:00pm, on 02/09/22 at 8:00am and 8:00pm, on 02/10/22, 02/11/22, and on 02/13/22 at 8:00am and 12:00pm, and on 02/14/22 at 8:00am and 8:00pm due to not available. Observation of Resident #5's medications available for administration on 03/15/22 at 9:50am revealed: -Quetiapine 50mg 1 tablet 3 times daily was available for administration. -Ninety tablets of quetiapine were dispensed to the facility on 03/10/22 in 3 bubble cards of 30 tablets each. -There were 26 tablets remaining in the first bubble card, 28 tablets remaining in the second bubble card, and 28 tablets remaining in the third bubble card Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed: -Resident #5 had an order for quetiapine 50mg 1	D 358		

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tablet three times daily.
-Quetiapine was dispensed to the facility on 01/06/22, on 02/14/22, and on 03/08/22 with a quantity of 90 tablets each date.

Interview with a medication aide (MA) on 03/16/22 at 6:51pm revealed:
-She had administered quetiapine to Resident #5.
-She did not remember if Resident #5's quetiapine had not been available in the facility.
-If Resident #5 had been out of quetiapine, she would have contacted the pharmacy to see why it was not in the facility.

Interview with Resident #5's primary care provider (PCP) on 03/15/22 at 4:35pm revealed:
-He started providing services for Resident #5 on 02/10/21.
-Resident #5 saw a mental health provider from his office who managed her psychotropic medications.

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know Resident #5 had been out of quetiapine.

Attempted telephone interview with Resident #5's mental health provider on 02/16/22 at 12:17pm was unsuccessful.

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

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care

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provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22 at 6:51pm.

Refer to interview with the Administrator on 03/16/22 at 7:53pm.

b. Review of Resident #5's current FL2 dated 11/17/21 revealed there was an order for midodrine (used to treat low blood pressure) 10mg 1 tablet twice daily.

Review of Resident #5's electronic medication administration record (eMAR) for January 2022 revealed:
-There was an entry for midodrine 10mg 1 tablet 3 times daily scheduled for 8:00am, 12:00pm, and 5:00pm.
-There was no documentation midodrine was administered for 8 of 93 opportunities from 01/01/22 through 01/31/22.
-There were blank spaces and with no documentation on 01/01/22 at 5:00pm, on 01/03/22 at 12:00pm and 5:00pm, on 01/05/22 at 8:00am and 12:00pm, on 01/24/22 at 5:00pm, and on 01/30/22 at 5:00pm.
-Midodrine was documented as not administered on 01/16/22 at 12:00pm due to out of facility.

Review of Resident #5's eMAR for February 2022 revealed:
-There was an entry for midodrine 10mg 1 tablet 3 times daily scheduled for 8:00am, 12:00pm, and 5:00pm.
-There was no documentation midodrine was administered for 6 of 84 opportunities from

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02/01/22 through 02/28/22.
-Midodrine was documented as not administered on 02/09/22 and 02/10/22 at 8:00am, on 02/11/22 at 8:00am and 8:00pm, on 02/13/22 at 12:00pm, and on 02/14/22 at 8:00am due to not available.

Observation of Resident #5's medications available for administration on 03/15/22 at 9:50am revealed:
-Midodrine 10mg 1 tablet 3 times daily was available for administration.
-Ninety tablets of midodrine were dispensed to the facility on 03/10/22 in 3 bubble cards of 30 tablets each.
-There were 27 tablets remaining in the first bubble card, 28 tablets remaining in the second bubble card, and 25 tablets remaining in the third bubble card.

Telephone interview with a pharmacist from the facility contracted pharmacy on 03/15/22 at 3:43pm revealed:
-Resident #5 had an order for midodrine 10mg 1 tablet 3 times daily.
-Midodrine was dispensed to the facility on 01/06/22, on 02/14/22, and on 03/08/22 with a quantity of 90 tablets each date.

Interview with a medication aide (MA) on 03/16/22 at 6:51pm revealed:
-She did not remember if Resident #5's midodrine had not been available in the facility.
-If Resident #5 had been out of midodrine, she would have contacted the pharmacy to see why it was not in the facility.

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know midodrine had not been administered to Resident #5 as ordered.

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D 358	Continued From page 88 Interview with Resident #5's primary care provider (PCP) on 03/15/22 at 4:35pm revealed he started providing services for Resident #5 on 02/10/21 and he was not aware of her missing doses of any medications. Based on observations and record reviews, it was determined Resident #5 was not interviewable. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. c. Review of Resident #5's current FL2 dated 11/17/21 revealed there was an order for Ativan (a medication used to treat anxiety) 0.5mg 1 tablet twice daily. Review of Resident #5's electronic medication administration record (eMAR) for January 2022 revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for 8:00am and 8:00pm. -There were blank spaces with no documentation of administration on 01/05/22 at 8:00am and 8:00pm, on 01/08/22 at 8:00pm, on 01/29/22 at	D 358		

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8:00pm, and on 01/31/22 at 8:00pm.
-There was documentation Ativan was not administered on 01/22/22 at 8:00am due to not available.

Review of Resident #5's eMAR for February 2022 revealed:
-There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for 8:00am and 8:00pm.
-There was no documentation Ativan was not administered for 20 of 56 opportunities from 02/01/22 through 02/28/22.
-Ativan was documented as not administered due to not available on 02/08/22 at 8:00pm, on 02/09/22 at 8:00am and 8:00pm, on 02/10/22 at 8:00am, on 02/11/22 at 8:00am, on 02/13/22 at 8:00pm, on 02/14/22 at 8:00am and 8:00pm, on 02/15/22 at 8:00am, on 02/17/22 at 8:00am and 8:00pm, on 02/18/22 at 8:00am, and on 02/19/22, 02/20/22, and 02/21/22 at 8:00am and 8:00pm, and on 02/16/22 due to out of facility.

Observation of Resident #5's medications available for administration on 03/15/22 at 9:50am revealed:
-Ativan 0.5mg 1 tablet twice daily was available for administration.
-Thirty tablets of Ativan were dispensed by the pharmacy on 02/22/22 and 1 of 2 bubble cards was available on the medication cart with a quantity of 3 tablets remaining.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed:
-Resident #5 had a previous order for Ativan 0.5mg 1 tablet twice daily as needed and was dispensed to the facility on 11/22/21 with a quantity of 60 tablets.
-The as needed order for Ativan was discontinued

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on 12/20/21 and none of these tablets were returned to the pharmacy.
-Resident #5 had a current order for Ativan 0.5mg 1 tablet twice daily dated 12/20/22.
-Ativan 0.5mg 1 tablet twice daily was dispensed to the facility on 12/20/22 and 02/20/22 with a quantity of 60 tablets each date.

Interview with a MA on 03/16/22 at 12:24pm revealed:
-Resident #5 was out of Ativan a couple of days, but she did not remember when.
-She thought there may have been an issue with the pharmacy regarding dispensing Ativan.
-She did not remember contacting the pharmacy or Resident #5's primary care provider (PCP) regarding Ativan not being available for administration.

Interview with Resident #5's PCP on 03/15/22 at 4:35pm revealed
-He started providing services for Resident #5 on 02/10/21.
-Resident #5 saw a mental health provider from his office who managed her psychotropic medications.

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know Resident #5 had been out of Ativan and that Ativan was not administered as documented on the eMAR.

Attempted telephone interview with Resident #5's mental health provider on 02/16/22 at 12:17pm was unsuccessful.

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

Refer to interview with a medication aide (MA) on

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D 358	Continued From page 91 03/14/22 at 9:00am. Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. _____ Interview with a medication aide (MA) on 03/14/22 at 9:00am revealed: -When a resident was admitted, the MA on duty would be responsible to ensure orders were received, orders and/or FL2 were faxed to the pharmacy, and medications were reviewed for accuracy. -The facility did not have a Resident Care Director (RCD) who would be responsible to double check new admissions's orders and medications. -She assumed some of the RCD duties. -All MAs were responsible to administer medications according to the orders. -When a resident came to the facility with medications, the MA should administer from the eMAR and not the medication labels. -There was no system currently in place to monitor medications compared to the eMAR to ensure medications were administered as ordered. -There were a lot of new staff filling in due to staff turnover and current MA staff was working	D 358		

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multiple shifts to cover the facility's medication administration needs.

Interview with the Administrator on 03/14/22 at 9:40am revealed there was no system in place to routinely audit medication administration, including adjusting medication administration times, auditing control substances, reviewing eMAR accuracy compared to medication administration.

Interview with the facility's PCP on 03/15/22 at 4:35pm revealed:
-He came to the facility once a week.
-He was not aware of any issues with residents' medications.
-The facility handled ordering medications and pharmacy could contact him for refills.
-If the facility had any issues with medications the facility should have contacted the PCP by fax or paging.

Interview with a second MA on 03/16/22 at 12:24pm revealed:
-If a medication was not on the medication cart, she documented the medication was not available.
-If she came across medications that were not available, she made a list of the medications and gave it to another MA to see what was going on with the medications.
-Sometimes medications were in the facility in the medication room and not on the medication cart and sometimes nobody took the time to go look for the medications in the medication room to put on the cart.

Second interview with a MA on 03/16/22 at 6:51pm revealed:
-Sometimes medications were not on the

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medication cart because they were in the medication room in the overstock supply.
-Some MAs did not look in the overstock supply for medications that were not on the medication cart.
-If a medication was not on the medication cart, MAs should have notified the Administrator after 3 days that the medication was not available.
-She did not know of any medications that were not available in the facility for residents.

Interview with the Administrator on 03/16/22 at 7:53pm revealed:
-MAs were responsible for reviewing new orders and sending the orders to the pharmacy.
-If the medication was not dispensed to the facility, the MA should have followed up with the pharmacy.
-All MAs were to audit the medication carts weekly looking for expired medication and that the eMAR matched the medication on the medication cart.
-Residents should never run out of medication.
-MAs should have contacted the pharmacy or the resident's PCP and requested a prescription within a week of running out of medication.
-She expected medication to be administered as ordered.

_____

The facility failed to administer medications as ordered for 3 of 3 residents (#1, #2 and #12) observed during the medication pass related to receiving medications scheduled for administration outside the one hour time frame including medications of a pain reliever causing the resident unnecessary pain from not having her pain medication (#1); a blood pressure medication placing the resident at risk for elevated blood pressure (#2); and for 5 of 6 residents sampled (#1, #2, #4, #5, and #9) for

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D 358	Continued From page 94 record review including errors with medications for anxiety and pain which could result in increased anxiety and pain (#2); medication for pain causing the resident unnecessary pain and limited mobility (#9); medications for anxiety and pain which could result in increased anxiety and pain (#1); and an anxiety and antidepressant medications resulting in the resident experiencing increased anxiety and depression (#4). This failure placed residents at substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/10/22 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 15, 2022.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide observed a resident taking their medication	D 366		

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D 366	Continued From page 95 for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 11/18/21 revealed: -Diagnoses included edema, constipation, arthralgia, anemia, and muscle spasms, acute renal failure, hypertension, leg ulcer, cellulitis, and unsteady gait. -There was an order for Tylenol (used to treat pain) 325mg 2 tablets 3 times daily. -There was an order for gabapentin (used to treat pain) 300mg 1 capsule 3 times daily. Review of Resident #3's electronic medication administration record (eMAR) for March 2022 revealed: -There was an entry for Tylenol 325mg 2 tablets 3 times daily scheduled for administration at 6:00am, 1:00pm, and 6:00pm. -There was an entry for gabapentin 300mg 1 capsule 3 times daily scheduled for administration at 7:00am, 1:00pm, and 7:00pm. -Tylenol and gabapentin were documented as administered at 1:00pm on 03/11/22. Observation of Resident #3's room on 03/11/22 at 1:04pm revealed: -Resident #3's she was up in her wheelchair and had a medication cup in one hand and was reaching for her cup of water. -Resident #3 took the medication from the medication cup. -There was no staff present when Resident #3 took the medication. Interview with Resident #3 on 03/11/22 at 1:05pm revealed: -She just took her midday medication which were	D 366		

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D 366	Continued From page 96 2 Tylenol tablets and 1 gabapentin capsule. -The medication aide (MA) working today usually brought her medication to her and left it in the room with her because the MA knew she would take it. -"She trusts me." -Many of the MAs left medication with her in her room if it was not time for her to take the medication. -She usually took the medication "pretty soon" after the MAs brought it to her. Interview with the MA on 03/14/22 at 7:51am revealed: -When she entered Resident #3's room to administer her medication, Resident #3 was in her bathroom with a personal care aide (PCA). -She usually watched Resident #3 take her medications before she left the room. -She did not watch Resident #3 take her medications on 03/11/22 because there was a call light going off in another resident's room and she had to go check on the other resident. -She left Resident #3's medication in a medication cup for her to take when she came out of the bathroom. Interview with the Administrator on 03/16/22 at 7:53pm revealed: -There had been an ongoing issue with MAs leaving medication in Resident #3's room without observing her take them. -Resident #3 asked MAs to leave her medication if she was not ready at the time and she would take the medication later. -She told the MAs they had to watch Resident #3 take her medication and could not leave it in her room for her to take later.	D 366		

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D 372	Continued From page 97	D 372		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were borrowed only in an emergency and replaced promptly and documented for 1 of 2 residents sampled (#6) related to staff borrowing a controlled substance to treat anxiety from Resident #6 and administering it to another resident. The findings are: Review of Resident #6's current FL2 dated 12/03/21 revealed: -Diagnoses included hypertension, schizophrenia, chronic bronchitis, and arthritis. -There was an order for lorazepam 0.5mg (used to treat anxiety) at bedtime. Telephone interview with a pharmacist at the contracted pharmacy on 03/10/22 at 3:00pm revealed: -On 02/20/22, the pharmacy dispensed 30 lorazepam 0.5mg one tablet at bedtime for Resident #6 labeled for the date dispensed and quantity dispensed. -The lorazepam 0.5mg dispensed for Resident #6 had a identifying control number specific to the	D 372		

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resident and medication as well as.
-The identifying number on the bubble card matched lorazepam 0.5mg dispensed on 02/20/22 for Resident #6.

Observation of medication administration on 03/10/22 at 10:35am revealed:
-The MA punched one lorazepam 0.5mg tablet from a bubble card of lorazepam 0.5mg dated 02/20/22 with instructions to take one tablet every night for a quantity of 30 tablets with Resident #6's name pre-printed on the label marked out and another resident' name handwritten on the label.
-The MA signed out the lorazepam on the controlled substance count sheet (CSCS) log dated 02/20/22 for a quantity of 30 tablets with Resident #6's name pre-printed on the CSCS and marked out and documented administration on the other resident's electronic medication administration record (eMAR).

Review of the CSCS dated 02/20/22 for a quantity of 30 with Resident #6's pre-printed name on the label marked out and the other resident's name handwritten on the label revealed:
-There were 11 doses of lorazepam 0.5mg tablets signed out on the CSCS as administered from 03/04/22 at 8:00pm to 03/10/22 at 10:00am corresponding to days documented as administered on the other resident's March 2022 eMAR .
-There was no documentation on the CSCS regarding the lorazepam was borrowed from Resident #6 or replacement of the borrowed lorazepam.

Interview with a medication aide/Supervisor (MA/S) on 03/10/22 at 2:00pm revealed Resident #6 was discharged from the facility more than one

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D 372	Continued From page 99 month ago. Interview with a medication aide/Supervisor (MA/S) on 03/10/22 at 2:00pm revealed: -She did not know how or why Resident #6's name was marked out and the other resident's name was handwritten on the lorazepam 0.5mg bubble card for Resident #6. -She administered lorazepam from the bubble card hand written for another resident but labeled for Resident #6 during medication administration earlier today (03/10/22). Interview with the Administrator on 03/10/22 at 4:00pm revealed: -She did not know why MAs would have used Resident #6's lorazepam for a different resident. -Resident #6 was no longer at the facility, so maybe staff wanted to use up overstock medications instead of ordering residents' medications. -Overstock controlled medications were moved to her office in a locked box around 03/09/22 to help track the overstock controls and limit access to controlled medications to only the Administrator. -She did not know staff were using other residents' controlled medications to administer medications. -MAs were not supposed to borrow medications from other residents, especially controlled substances.	D 372		
D 380	10a NCAC 13F .1006 (d) Medication Storage 10a NCAC 13F .1006 Medication Storage (d) Accessibility to locked storage areas for medications shall only be by staff responsible for medication administration and administrator or	D 380		

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D 380	Continued From page 100 person in charge. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure accessibility to the locked storage area for medications and 3 medication carts was by staff responsible for medication administration and Administrator related to no medication aide on duty during a night shift and the keys to the medication room and medication carts being hidden by a personal care aide for the oncoming medication aide on first shift. The findings are: Review of the facility's medication storage policy revealed: -Medication storage areas, rooms, and medication carts were to be locked. -Only authorized personnel were allowed access to medication storage areas. Observation of the area behind the nurse's desk area between Hall A and Hall E revealed there was a tan cabinet box affixed to the right side of the back wall of the nurse's desk that had a lockable door. Review of the facility's staff timecards dated 03/15/22 for the 3:00pm to 11:00pm shift revealed there were 2 staff identified as medication aides (MA) that punched out at 11:44pm. Review of the staff timecards dated 03/15/22 for the 11:00pm to 7:00am shift revealed: -There was one personal care aide (PCA) that punched in at 11:32pm and was still at the facility on 03/15/22 at 9:30am.	D 380		

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-There was was no additional staff who worked from 11:00pm on 03/15/22 to 7:00am on 03/16/22.

Interview with the PCA on 03/16/22 at 9:00am revealed:
-She worked from 11:00pm on 03/15/22 to 7:00am on 03/16/22 with another PCA.
-There was no MA in the facility after 11:30pm until this morning (03/16/22) at around 6:30am.

Interview with a MA on 03/16/22 at 8:45am revealed:
-She worked 03/15/22 from 7:00am to 11:30pm.
-When she left the facility (03/15/22 at 11:30pm) there was another MA and the Administrator in the facility.
-She arrived at the facilty on 03/16/22 at 6:00am and had to assist changing a resident.
-The second MA for 03/16/22 gave her the keys to the A Hall medication cart around 7:00am.

Interview with a second MA on 03/16/22 at 9:00am revealed:
-The facility was currently very short staffed.
-She left the facilty on 03/15/22 at 11:40pm.
-She arrived back at the facility at around 6:45am on 03/16/22.
-She received the keys to the medication cart from the MA already in the facility.

Interview with the Administrator on 03/16/22 at 9:20am revealed:
-There was no MA on the 11:00pm to 7:00am shift on 03/15/22 to 03/16/22 due to a no show for the scheduled MA.
-She stayed at the facility until after midnight (12:00am on 03/16/22) and left.
-The MA keys for the medication carts and storage were left with a PCA who was to place

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the keys in a hidden spot for the next arriving MA.
-She did not leave the facility without a MA on duty routinely, however she thought the scheduled MA was running late and would show up in a while.

Second interview with the second MA on 03/16/22 at 2:00pm revealed:
-She gave the medication cart and storage keys to the Administrator when she left at 11:40pm on 03/15/22.
-She got the keys from a hiding spot behind the nurse's desk when she arrived on 03/16/22 at 6:20am because the PCA had hidden the keys when the scheduled MA for 11:00pm to 7:00am on 03/15/22 was a no show.
-She had gotten the keys from that spot on a few occasions in the past couple of years.

Interview with a second PCA on 03/16/22 at 3:25pm revealed:
-She worked last night (03/15/22) as the second PCA.
-She arrived around 1:30am and left at 6:30am to 6:45am this morning (03/16/22) when a MA arrived.
-She was not a MA.
-There was no resident that requested a medication during the night (03/15/22).
-The Administrator or the leaving MA (not sure which person) gave her the keys for the medication cart/storage for the next morning MA.
-She hid the keys in a cabinet box behind the nurse's desk area between Hall A and Hall E.
-She had hidden the keys another time or two when the MA for the 3:00pm to 11:00pm shift had left before the MA arrived for the 11:00pm to 7:00am shift.

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D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 7 of 7 sampled residents (#1, #2, #4, #5, #6, #7, #9) with physician orders for narcotic pain medications and anti-anxiety medications. The findings are: Review of the facility's policy for medication policy revealed documentation of controlled substances will be maintained by the facility and available for review. Interview with a medication aide (MA) on 03/10/22 at 11:00am revealed: -All controlled substances should be counted prior to a MA receiving keys to the medication cart. -MAs should review the controlled substance count sheet and the medication on hand for verifying accuracy of the number on the punch	D 392		

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card and the count sheet.

1. Review of Resident #9's current FL2 dated 12/01/21 revealed diagnoses included diabetes type II with peripheral circulatory disorder, and rheumatoid arthritis.

Telephone interview on 03/14/22 at 11:48am with the pharmacist manager at the facility's contracted pharmacy revealed:
-Resident #9 had orders for oxycodone/acetaminophen (a Schedule II narcotic pain reliever used to treat moderate to severe pain) sent to the pharmacy and dispensed as follows:
-On 01/06/22, oxycodone/acetaminophen 7.5/325 one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).
-On 01/20/22, oxycodone/acetaminophen 7.5/325 one tablet 4 times a day was dispensed for a quantity of 28 tablets (7 days supply).
-On 01/27/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 28 tablets (7 days supply).
-On 02/10/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).
-On 02/25/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).

Review of the controlled substance count sheets (CSCS) provided for Resident #9 revealed:
-There were 2 of 4 CSCS dated 01/07/22 for oxycodone/acetaminophen 7.5/325 one tablet 4 times a day dispensed on 01/06/22 for 14 tablets on each CSCS accounting for a total of 28 tablets.
-There were no additional CSCS for 28 tablets without an accurate accounting for the

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administration or disposition resulting in 28 tablets unaccounted for.

Review of Resident #9's January 2022 eMAR revealed:
-There was an entry for oxycodone/acetaminophen 7.5/325 one tablet 4 times daily scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm.
-There were 37 tablets documented as administered on the eMAR from 01/06/22 to 01/20/22.
-There were 24 tablets documented as administered on the eMAR from 01/21/22 to 01/27/22 and 4 tablets documented as not available for administration.
-There were 21 of 28 opportunities for oxycodone/acetaminophen 7.5/325 documented as administered on the eMAR from 01/20/22 at 9:00pm to 01/27/22 at 7:00pm.
-On 01/26/22 and 01/27/22, there were 4 tablets documented on the eMAR as not available for administration.
-On 01/28/22 and 01/29/22, there were 8 tablets documented as administered on the eMAR.
-From 01/30/22 at 8:00am to 01/31/22 at 8:00pm, there were 8 tablets not administered with 2 blank spaces on the eMAR and 6 tablets documented as "not available" for administration.

Review of Resident #9's CSCS for 56 tablets of oxycodone/acetaminophen 7.5/325 dispensed on 01/06/22 revealed:
-There were 28 of 37 tablets documented on the January eMAR corresponding to tablets signed out on the CSCS.
-The CSCSs for 28 tablets were missing for medication that should have been administered from 01/06/22 to 01/20/22.
-There were 14 tablets documented as

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administered on the eMAR from 01/07/22 to 01/20/22 with no accompanying CSCS documentation.
-There were 14 tablets not accounted for on the CSCS or eMAR and missing.

Review of Resident #9's CSCSs for oxycodone/acetaminophen 7.5/325 quantity of 28 tablets dispensed on 01/20/22 revealed:
-There were 3 of 4 CSCS, with 7 tablets, each available for review with oxycodone/acetaminophen 7.5/325.
-There was 1 CSCS for 7 tablets not available for review.
-From 01/20/22 at 9:00pm to 01/27/22 at 7:00pm, there were 21 of 28 opportunities for oxycodone/acetaminophen 7.5/325 signed out on the CSCS.
-On 01/21/22 at 11:00am, on 01/24/22 at 11:00am, and 01/25/22 at 4:00pm, there were 3 tablets not signed out on a CSCS.
-There were 4 tablets not accounted for on the CSCS or eMAR and not available for administration from 28 tablets of oxycodone/acetaminophen 7.5/325 dispensed on 01/20/22.

Review of Resident #9's CSCSs for oxycodone/acetaminophen 10/325 quantity of 28 tablets dispensed on 01/27/22 (4 bubble packed cards with 7 tablets each) revealed:
-On 01/28/22 and 01/29/22, there were 6 tablets accounted for on a CSCS, but 8 tablets were documented as administered on the eMAR..
-From 02/01/22 to 02/03/22, there were 12 tablets of oxycodone/acetaminophen 10/325 documented as "not available" on the eMAR and no CSCS available for review.
-There were 21 tablets of oxycodone/acetaminophen 10/325 not accounted

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for on the eMAR or CSCS and not available for administration, and missing from 28 tablets dispensed on 01/27/22.

Review of Resident #9's February 2022 eMAR revealed:
-There was an entry for oxycodone/acetaminophen 10/325 one tablet 4 times daily scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm.
-There were 12 tablets of oxycodone/acetaminophen 10/325 documented as "not available" from 02/01/22 to 02/03/22.
-There were 17 tablets of oxycodone/acetaminophen 10/325 documented as administered from 02/11/22 to 02/15/22 .
-Oxycodone/acetaminophen 10/325 was documented as administered on 02/25/22 at 7:00pm
-Oxycodone/acetaminophen 10/325 were documented as administered on 02/26/22 at 11:00am and 7:00pm.
-Oxycodone/acetaminophen 10/325 was documented as administered on 02/27/22 at 11:00am, 2:00pm, and 7:00pm.

Review of Resident #9's CSCSs for oxycodone/acetaminophen 10/325 quantity of 56 tablets (4 bubble packed cards with 14 tablets each) dispensed on 02/10/22 that should have lasted until 02/25/22 revealed:
-There were 12 tablets of oxycodone/acetaminophen 10/325 documented as "not available" on the eMAR from 02/01/22 to 02/03/22 and no CSCS available for review.
-From 02/11/22 to 02/15/22, there were 17 tablets of oxycodone/acetaminophen 10/325 with no corresponding CSCS.
-On 02/25/22 at 7:00pm, one tablet of oxycodone/acetaminophen 10/325 was not

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signed out on the CSCS.
-On 02/26/22 at 11:00am and 7:00pm, 2 tablets of oxycodone/acetaminophen 10/325 were not signed out on the CSCS.
-On 02/27/22 at 11:00am, 2:00pm, and 7:00pm, 3 tablets of oxycodone/acetaminophen 10/325 were not signed out on a CSCS.
-There was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 missing for an accurate accounting for the administration or disposition from 02/11/22 to 02/15/22 and 11 tablets documented as administered on the eMAR and not signed out on a CSCS from 02/10/22 to 02/28/22 to equal 25 tablets of oxycodone/acetaminophen 10/325 not accounted from 02/10/22 to 02/28/22.

Review of Resident #9's March 2022 eMAR revealed:
-There was an entry for oxycodone/acetaminophen 10/325 one tablet 4 times daily scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm.
-Oxycodone/acetaminophen 10/325 was documented as administered on 03/01/22 at 11:00am.
-Oxycodone/acetaminophen 10/325 was documented as administered on 03/03/22 at 4:00pm.
-Oxycodone/acetaminophen 10/325 was documented as administered on 03/05/22 at 11:00am.
-Oxycodone/acetaminophen 10/325 was documented as administered on 03/06/22 at 4:00am.

Review of Resident #9's CSCSs dated 2/24/22 for oxycodone/acetaminophen 10/325 one tablet 4 times a day dispensed for 56 tablets (4 bubble packed cards with 14 tablets each) that should

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D 392	Continued From page 109 last until 03/10/22 revealed: -On 03/01/22 at 11:00am, oxycodone/acetaminophen 10/325 was not signed out on the CSCS. -On 03/03/22 at 4:00pm, oxycodone/acetaminophen 10/325 was not signed out on the CSCS. -On 03/05/22 at 11:00am, oxycodone/acetaminophen 10/325 was not signed out on the CSCS. -On 03/06/22 at 4:00am, oxycodone/acetaminophen 10/325 was not signed out on the CSCS. -There were 4 of 36 tablets of oxycodone/acetaminophen 10/325 not accurately documented as administered from 02/28/22 to 03/10/22. Review of Resident #9's eMAR and CSCS revealed there were 34 tablets of oxycodone/acetaminophen 7.5/325 without an accurate accounting for the administration or disposition from 01/06/22 to 01/27/22, and 35 tablets of oxycodone/acetaminophen 10/325 without an accurate accounting for the administration or disposition from 01/28/22 to 03/11/22 as follows: -On 01/06/22, oxycodone/acetaminophen 7.5/325 was dispensed for 56 tablets that should have been administered from 01/06/22 to 01/20/22; the CSCSs for 28 tablets were missing for medication; with 14 tablets documented as administered on the eMAR from 01/07/22 to 01/20/22 with no accompanying CSCS documentation; and 14 tablets were not accounted for on the CSCS or eMAR and missing. -On 01/20/22, oxycodone/acetaminophen 7.5/325 was dispensed for 28 tablets; there were 21 tablets documented on the CSCS corresponding	D 392		

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D 392	Continued From page 110 to the January 2022 eMAR and the CSCS for 7 tablets was missing with 7 tablets without an accurate accounting. -On 01/27/22, oxycodone/acetaminophen 10/325 was dispensed for 28 tablets; 7 tablets were accounted for on a CSCS and on the January 2022 eMAR and there were 21 tablets documented as not available on the eMARs from 01/30/22 to 02/05/22 that the corresponding CSCS was missing and 21 tablets were not on hand for administration and missing. -On 02/10/22, oxycodone/acetaminophen 10/325 was dispensed for 56 tablets that should have lasted until 02/25/22 revealed; there was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 missing for an accurate accounting for the administration or disposition from 02/11/22 to 02/15/22 and 11 doses documented as administered on the eMAR and not signed out on a CSCS from 02/10/22 to 02/28/22 to equal 25 tablets of oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 to 02/28/22. -On 2/24/22 for oxycodone/acetaminophen 10/325 was dispensed for 56 tablets that should last until 03/10/22; there were 4 of 36 tablets of oxycodone/acetaminophen 10/325 not accurately documented as administered from 02/28/22 to 03/10/22. -There were CSCS missing for 28 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22 and CSCS missing for 35 tablets of oxycodone/acetaminophen 10/325 for 140 tablets dispensed from 01/27/22 to 02/24/22 for Resident #9. -There were 21 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22 and 21 tablets of oxycodone/acetaminophen 10/325	D 392		

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missing for a total of 140 tablets dispensed from 01/27/22 to 02/24/22 for Resident #9.

Observation of Resident #9's medication on hand for administration on 03/10/22 at 4:00pm revealed there were 20 tablets of oxycodone/acetaminophen 10/325 available for administration matching the CSCS dated 02/24/22.

Interview with a medication aide (MA) on 03/14/22 at 9:00am revealed she knew Resident #9 was out of his pain medication occasionally but not as often as the eMAR showed.

Interview with Resident #9 on 03/14/22 at 6:35pm revealed:
-He had bad arthritis in his hands, hips, and knees.
-He took pain medication so he could get up from his bed and be mobile with his walker.
-There had been a few times when he was out of his medication for several days.
-When he was out of pain medication, he had to lay in bed or use his wheelchair to get around.
-His physician told him he should not run out of medication because he had written orders to provide pain medication (oxycodone/acetaminophen).
-He had Tylenol (a mild pain reliever) ordered as needed that he asked for until he got his regular pain medication from the pharmacy.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care

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provider (PCP) on 03/15/22 at 4:35pm.

2. Review of Resident #1's current FL2 dated 11/17/21 revealed:
-Diagnoses included anxiety, osteoporosis, deep vein thrombosis, and type II diabetes.
-There was an order for lorazepam 0.5mg (Schedule IV narcotic used to treat anxiety) one-half tablet (0.25mg) twice a day.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:15pm revealed:
-The pharmacy sent controlled substance count sheets (CSCS) with controlled substances that were dispensed from the pharmacy to be used for accounting for controlled substances.
-On 12/20/21, Resident #1 was dispensed lorazepam 0.5mg one-half tablet (0.25mg) twice a day for 60 tablets.
-On 01/31/22, Resident #1 was dispensed lorazepam 0.5mg one-half tablet (0.25mg) twice a day for 60 tablets.
-On 03/06/22, Resident #1 was dispensed lorazepam 0.5mg one-half tablet (0.25mg) twice a day for 60 tablets.

Review of Resident #1's December 2021 and January 2022 eMARs revealed:
-There was an entry for lorazepam 0.5mg one-half tablet (0.25mg) twice a day scheduled for administration at 8:00am and 8:00pm.
-There were 30 lorazepam 0.5mg one-half tablets documented administered on the eMARs from 12/25/21 at 8:00pm to 01/14/22 at 8:00am.

Review of Resident #1's CSCS for lorazepam 0.5mg one-half tablet (0.25mg) for 60 doses dispensed on 12/20/21 revealed there was no CSCS for 30 tablets documented as administered

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D 392	Continued From page 113 on the eMARs from 12/25/21 at 8:00pm to 01/14/22 at 8:00am. Review of Resident #1's March 2022 eMAR revealed: -There was an entry for lorazepam 0.5mg one-half tablet (0.25mg) twice a day scheduled for administration at 8:00am and 8:00pm daily. -There were 6 doses documented as administered on the eMAR from 03/03/22 at 8:00pm to 03/08/22 at 7:00am. Review of Resident #1's CSCS for lorazepam 0.5mg one-half tablet (0.25mg) for 60 tablets dispensed on 01/31/22 and on 03/06/22 revealed there was no CSCS available for review for 6 doses documented as administered from 03/03/22 at 8:00pm to 03/08/22 at 7:00am. Review of Resident #1's eMARs and CSCS for lorazepam 0.5mg revealed there were 36 of 180 tablets of lorazepam 0.5mg (1/2) tablet twice a day dispensed from 12/20/21 to 03/06/22 with no CSCS for sign out and accurate accounting. Observation of Resident #1's medication on hand for administration on 03/10/22 at 10:30am revealed there was a partial bubble card of 25 lorazepam 0.5mg one-half tablets to match 25 of 30 tablets remaining and a bubble card with 30 of 30 tablets in overstock. Interview with Resident #1 on 03/11/22 at 10:00am revealed: -She was out of medication for her nerves occasionally. -The medication aides (MA) told her they had none to administer. -She was told she needed a new order from the provider and they were trying to get one.	D 392		

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D 392	Continued From page 114 Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. b. Review of Resident #1's current FL2 dated 11/17/21 and signed physician's orders dated 11/17/21 revealed there was an order for hydrocodone /acetaminophen 5/325 (a Schedule II narcotic used to treat moderate to severe pain) twice a day. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:15pm for controlled substances dispensed for Resident #1 revealed: -The pharmacy sent controlled substance count sheets (CSCS) with controlled substances that were dispensed from the pharmacy to be used for accounting for controlled substances. -On 11/03/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 tablets. -On 12/27/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 tablets. -On 01/24/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 tablets. -On 02/21/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 tablets. Review of Resident #1's December 2021 and January 2022 electronic medication	D 392		

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administration record (eMAR) revealed:
-There was an entry for hydrocodone /acetaminophen 5/325 twice a day scheduled for administration at 8:00am and 8:00pm.
-Hydrocodone /acetaminophen 5/325 twice a day was documented as administered from 12/05/21 at 8:00pm to 12/27/21 at 8:00am at 8:00am and 8:00pm.
-There were 38 of 57 opportunities hydrocodone /acetaminophen 5/325 was documented as administered from 12/27/21 at 8:00pm to 01/24/22 at 8:00pm.
-There was documentation hydrocodone/acetaminophen 5/325 as "not available" for 19 of 57 opportunities; and blank for administration for 1 of 57 opportunities on the eMAR.

Review of Resident #1's CSCS for hydrocodone /acetaminophen 5/325 twice a day dispensed revealed there was no dispensing date and no corresponding CSCS available for review for hydrocodone /acetaminophen 5/325 documented as administered on the eMAR from 12/05/21 at 8:00pm to 12/27/21 at 8:00am at 8:00am and 8:00pm.

Review of Resident #1's CSCS for hydrocodone /acetaminophen 5/325 twice a day 60 tablets dispensed on 12/27/21 that should have lasted to 01/26/22 compared to Resident #1's January 2022 eMAR revealed:
-The CSCS for 60 tablets was not available for review.
-There were 20 tablets of hydrocodone/acetaminophen 5/325 missing from the dispensing of 60 tablets on 12/27/21.

Review of Resident #1's February 2022 and March 2022 eMARs revealed:

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D 392	Continued From page 116 -There was an entry for hydrocodone/acetaminophen 5/325 twice a day scheduled for administration at 8:00am and 8:00pm daily on the eMARS. -Hydrocodone/acetaminophen 5/325 were documented as administered from 02/23/22 at 8:00pm to 02/25/22 at 8:00pm. -Hydrocodone/acetaminophen 5/325 twice a day was documented as administered from 02/25/22 at 8:00pm to 03/11/22 at 8:00am and 8:00pm. -On 03/01/22 at 8:00pm and 03/04/22 at 7:00am, 2 tablets were documented as dropped and improperly documented for wasted according to the facility's policy for wasting a controlled substance. (Review of the policy revealed when a controlled substance could not be used for any reason by the resident the dose is disposed of and witnessed by 2 facility staff members). Review of Resident #1's CSCS for hydrocodone /acetaminophen 5/325 twice a day for 60 tablets dispensed on 02/21/22 revealed: -From 02/23/22 at 8:00pm to 02/25/22 at 8:00pm, 4 hydrocodone /acetaminophen 5/325 tablets were not signed out on a CSCS. -From 02/25/22 at 8:00pm to 03/11/22 at 8:00am, hydrocodone/acetaminophen 5/325 tablets for a total of 28 tablets were not signed out on the CSCS. -On 03/01/22 at 8:00pm and 03/04/22 at 7:00am, 2 tablets were documented as dropped and improperly documented for wasted according to the facility's policy for wasting a controlled substance. (Review of the policy revealed when a controlled substance could not be used for any reason by the resident the dose is disposed of and witnessed by 2 facility staff members). Review of Resident #1's eMARs and CSCS, Resident #1 did not have an accurate accounting	D 392		

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for 87 of 240 tablets of hydrocodone /acetaminophen 5/325 dispensed from 11/02/21 to 02/21/22 as follows:
-On 12/27/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 for 60 tablets, with missing CSCS for 60 tablets and 20 tablets missing and not accounted for on the eMARs or CSCS.
-On 02/21/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 for 60 tablets, with 7 tablets not signed out on the CSCS and not properly accounted for.

Interview with Resident #1 on 03/11/22 at 10:00am revealed:
-She was out of pain medication for several weeks in January.
-The medication aides (MA) told her they had none to administer.
-She was told she needed a new order from the provider and they were trying to get one.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

3. Review of Resident #2's current FL2 dated 12/03/21 revealed diagnoses included anxiety, vitamin D deficiency, coronary artery disease, schizophrenia, arthritis, and type II diabetes.

a. Review of Resident #2's medications brought to the facility upon admission revealed there was a controlled drug receipt form (CDRF) dated 12/07/21 sent upon admission from Resident #2's

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previous facility documenting 18 oxycodone/acetaminophen 5/325 tablets (a Schedule II narcotic used to treat moderate to severe pain) with directions to administer one tablet every 6 hours as needed up to 5 days.

Review of Resident #2's current FL2 dated 12/03/21 and signed physician's orders dated 01/27/21 revealed there was no order for oxycodone/acetaminophen 5/325 tablets one tablet every 6 hours as needed up to 5 days.

Telephone interview with Resident #2's previous pharmacy on 03/15/22 at 2:00pm revealed the pharmacy dispensed 20 tablets of oxycodone/acetaminophen 5/325 for Resident #2 on 11/24/21.

Review of the controlled drug receipt form dated 12/07/21 sent upon admission from Resident #2's previous facility documenting 18 oxycodone/acetaminophen 5/325 tablets revealed the tablets were signed out from 12/08/21 at 4:00pm to 12/27/21 at 8:00am by various medication aides (MA).

Review of Resident #2's December 2021 electronic medication administration record (eMAR) revealed:
-There was no entry for oxycodone/acetaminophen 5/325 tablet one tablet every 6 hours as needed up to 5 days on the eMAR.
-There was no documentation oxycodone/acetaminophen 5/325 was administered from 12/01/21 to 12/31/21.

Telephone interview with a medication technician at the facility's contracted pharmacy on 03/10/22 at 3:00pm revealed:

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-The pharmacy entered orders on the eMAR from the FL2, signed physician's orders, hospital discharge orders or any physician's orders received for a resident.
-The facility was responsible to send all orders to the pharmacy for entering on the resident's eMAR.
-The pharmacy had nothing to indicate Resident #2 was ordered oxycodone/acetaminophen 5/325.

Interview with Resident #2 on 03/15/22 at 11:17am revealed:
-She had dental surgery removing several teeth just before coming to the facility.
-She thought she had a medication for the dental pain.
-She could not remember if she took the pain medication or not.

Review of the controlled drug receipt form for Resident #2 revealed there were 18 oxycodone/acetaminophen 5/325 tablets dispensed on 11/24/21 without an accurate accounting for the administration and disposition for Resident #2.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

b. Review of Resident #2's current FL2 dated 12/03/21 revealed there was an order for lorazepam 0.5mg (a Schedule IV narcotic used to treat anxiety) one tablet twice a day.

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D 392	Continued From page 120 Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 12/07/21. Review of Resident #2's medications brought to the facility upon admission revealed there was a controlled drug receipt form dated 12/07/21 sent upon admission from Resident #2's previous facility documenting 34 tablets available on 12/07/21. Review of Resident #2's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 0.5mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm daily beginning on 12/08/21 at 8:00pm. -There were 34 doses of lorazepam 0.5mg documented as administered on the eMAR. -Lorazepam 0.5mg was documented as administered on 12/12/21 at 8:00am. -Lorazepam 0.5mg was documented as administered on 12/18/21 at 8:00pm. -Lorazepam 0.5mg was documented as administered on 12/23/21 at 8:00am. Review of Resident #2's controlled drug receipt form dated 12/07/21 revealed: -Lorazepam 0.5mg was signed out on the controlled drug receipt form for 34 doses starting from 12/08/21 at 4:00pm to 12/27/21 at 8:00am. -On 12/12/21 at 8:00am, lorazepam 0.5mg was not signed out on the controlled drug receipt form. -On 12/18/21 at 8:00pm, lorazepam 0.5mg was not signed out on the controlled drug receipt form. -On 12/23/21 at 8:00am, lorazepam 0.5mg was not signed out on the controlled drug receipt form. -There were 3 doses without an accurate	D 392		

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accounting for the administration and disposition for December 2021 eMAR compared to the controlled drug receipt form.

Review of Resident #2's signed physician's orders dated 01/27/22 revealed an order for lorazepam 0.5mg one tablet twice a day.

Review of the controlled substance count sheet (CSCS) provided for Resident #2 on 03/10/22 revealed:
-There was a CSCS dated 08/27/21 with instructions to take one tablet every 8 hours as needed for anxiety or agitation for a quantity of 30 tablets with another resident's name pre-printed on the label marked out and Resident #2's name handwritten on the label.
-The directions had twice a day handwritten over the pre-printed label's instructions.

Review of Resident #2's January 2022 eMAR revealed:
-There was an entry for lorazepam 0.5mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm daily.
-Lorazepam 0.5mg was not documented as administered on 01/02/22 at 8:00pm.
-Lorazepam 0.5mg was not documented as administered on 01/03/22 at 8:00am.
-Lorazepam 0.5mg was documented as administered on 01/04/22 at 8:00pm.
-Lorazepam 0.5mg was documented as administered on 01/07/22 at 8:00am.
-Lorazepam was documented as administered on 01/15/22 at 8:00am and 8:00pm.
-On 01/11/22 at 8:00am, one lorazepam 0.5mg tablet was documented as dropped and incorrectly documented for wasted according to the facility's policy for wasting a controlled substance.

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D 392	Continued From page 122 Review of Resident #2's January 2022 CSCS (with Resident #7's name handwritten on it) dated 08/27/21 revealed: -There were 30 lorazepam 0.5mg tablets signed out on the CSCS as administered from 01/02/22 at 6:00am to 01/18/22 at 8:00pm. -There were 8 of 30 opportunities that did not match doses signed out on the CSCS with examples as follows: -On 01/02/22 at 8:00pm, lorazepam 0.5mg was signed out on the CSCS, and not documented as administered on the eMAR. -On 01/03/22 at 8:00am, lorazepam 0.5mg was signed out on the CSCS, and not documented as administered on the eMAR. -On 01/04/22 at 8:00pm, lorazepam 0.5mg was not signed out on the CSCS. -On 01/07/22 at 8:00am, lorazepam 0.5mg was not signed out on the CSCS. -On 01/15/22 at 8:00am and 8:00pm, lorazepam was not signed out on the CSCS. -On 01/11/22 at 8:00am, one lorazepam 0.5mg was documented as dropped and incorrectly documented for wasted according to the facility's policy for wasting a controlled substance. -Lorazepam 0.5mg was not documented as administered on 01/28/22 at 8:00pm. -There were 30 doses of lorazepam 0.5mg tablets administered that belonged to another resident and 1 dropped dose without an accurate accounting for the administration and disposition for January 2022. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:00pm revealed: -One time only on 01/25/22, the pharmacy dispensed lorazepam 0.5mg quantity of 60 tablets for Resident #2.	D 392		

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D 392	Continued From page 123 -The pharmacy sent a controlled substance count sheet (CSCS) with each bubble card of controlled medications dispensed. -The pharmacy had not received a request for a refill of Resident #2's lorazepam 0.5mg tablets. Review of Resident #2's February 2022 eMARs revealed: -There was an entry for lorazepam 0.5mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm daily. -Lorazepam 0.5mg was documented as administered on 02/02/22 at 8:00pm. -There were 7 tablets documented as administered from 02/25/22 at 8:00pm to 02/28/22 at 8:00pm. -On 02/03/22 at 8:00am, 02/07/22 at 8:00pm and again on 02/07/22 at 8:00pm, there was a total of 3 lorazepam 0.5mg were documented as dropped and incorrectly documented for wasted according to the facility's policy for wasting a controlled substance. Review of Resident #2's CSCS dated 01/25/22 for 60 tablets revealed: -There were 60 doses documented as signed out on the CSCS from 01/26/22 at 8:00am to 02/25/22 at 7:00am. -On 01/28/22 at 8:00pm, lorazepam 0.5mg was signed out on the CSCS and not documented as administered on the eMAR. -On 02/02/22 at 8:00pm, lorazepam 0.5mg was not signed out on the CSCS. -From 02/25/22 at 8:00pm to 02/28/22 at 8:00pm, there were 7 tablets not signed out on a CSCS. -On 02/03/22 at 8:00am, 02/07/22 at 8:00pm and again on 02/07/22 at 8:00pm, there was a total of 3 lorazepam 0.5mg tablets documented as dropped and incorrectly documented for wasted according to the facility's policy for wasting a	D 392		

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controlled substance.
-There were 12 tablets of lorazepam 0.5mg without an accurate accounting for the administration and disposition for January 2022 and February 2022.

Review of Resident #2's March 2022 eMARs compared to the CSCS dated 02/20/22 for a quantity of 30 with the resident's pre-printed name on the label marked out and Resident #2's name handwritten on the label revealed:
-From 03/01/22 at 8:00am to 03/04/22 at 8:00am, there were 7 doses documented as administered on the eMAR with no corresponding CSCS available to review.
-On 03/08/22 at 8:00am, lorazepam 0.5mg was not signed out on the CSCS, and was documented as administered on the eMAR.
-There were 8 doses of lorazepam 0.5mg without an accurate accounting for the administration and disposition for March 2022.

Review of an additional CSCS provided for Resident #2 revealed:
-There was a CSCS dated 02/20/22 with instructions to take one tablet every night for a quantity of 30 with a third resident's name pre-printed on the label marked out and Resident #2's name handwritten on the label.
-The directions had not been changed.
-There were 11 tablets signed out on the CSCS from 03/04/22 at 8:00pm to 03/09/22 at 8:00pm leaving 19 tablets which matched the quantity on hand for administration.

Review of Resident #2's CSCS and eMARs revealed there were 64 doses of lorazepam 0.5mg without an accurate accounting for the administration and disposition for Resident #2 from 12/07/21 to 03/10/22.

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D 392	Continued From page 125 Interview with Resident #2 on 03/15/22 at 11:17am revealed: -She did not know all her medications. -She took a medication to help with her nerves (lorazepam) but staff ordered it. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. 4. Review of Resident #7's current FL2 dated 11/17/21 revealed diagnoses included type II Diabetes Mellitus, schizoaffective disorder, bipolar disorder and dementia. Review of Resident #7 signed physician's orders dated 11/17/21 revealed an order for lorazepam 0.5mg (a Schedule IV narcotic used to treat anxiety) one tablet every 8 hours as needed for anxiety or agitation. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:00pm revealed: -The pharmacy sent a controlled substance count sheet (CSCS) with each bubble card of controlled medication dispensed. -On 08/27/21, the pharmacy dispensed 90 lorazepam 0.5mg one tablet every 8 hours as needed for Resident #7 labeled for the date dispensed and quantity dispensed (3 bubble cards with 30 tablets in each card). Review of Resident #7's CSCS on 03/10/22 at	D 392		

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D 392	Continued From page 126 3:00pm revealed: -There was one CSCS labeled as dispensed on 08/27/21 for 30 of 30 card labeled as card 1 of 3 available for administration on the medication cart with 19 tablets signed out from 08/24/21 at 8:00pm to 02/13/22 at 8:00am. -There was one CSCS dated 08/27/21 for 30 tablets (labeled 2 of 3) available for review with the name of another resident handwritten on the label and a change of directions handwritten on the label with 30 tablets signed out on the CSCS from 01/02/22 at 6:00am to 01/18/22 at 8:00pm and documented on the January electronic medication administration record (eMAR) for the other resident. -There was no CSCS for 08/27/21 labeled 3 of 3 for a quantity of 30 tablets or the remaining 30 tablets of lorazepam 0.5mg missing in the overstock medications. -There was one CSCS available for review for Resident #7. Observation of Resident #7's medication on hand for administration on 03/10/22 at 3:00pm revealed there were 11 tablets remaining on the CSCS which matched 11 lorazepam 0.5mg available for administration. Review of Resident #7 eMARs and CSCS revealed Resident #7 had 60 lorazepam 0.5mg tablets dispensed on 08/27/21 with no accurate accounting for administration, or disposition and 30 tablets missing. Interview with Resident #7 on 03/15/22 at 11:17am revealed: -She knew she had a medication she could ask for used to treat her anxiety. -She hardly ever needed the medication. -She did not remember the last time she had	D 392		

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asked for the anxiety medication because it had been so long.
-She did not think she had used more than 30 in the last 6 month. Maybe 1 or 2 tablets per month.

Interview with a medication aide/Supervisor (MA/S) on 03/10/22 at 2:00pm revealed she did not know how or why the other resident's name was marked out and Resident #2's name was handwritten on the lorazepam 0.5mg bubble card.

Interview with the Administrator on 03/10/22 at 4:00pm revealed:
-She did not know why MAs would have used lorazepam for a different resident.
-Overstock controlled medications were moved to her office in a locked box around 03/09/22 to help track the overstock controls and limit access to her.
-She did not know staff were using other resident's controlled medications to administer medications.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

5. Review of Resident #6's current FL2 dated 12/03/21 revealed:
-Diagnoses included hypertension, schizophrenia, chronic bronchitis, and arthritis.
-There was an order for lorazepam 0.5mg (a Schedule IV narcotic used to treat anxiety) at bedtime.

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D 392	Continued From page 128 Observation of medication administration on 03/10/22 at 10:35am revealed the medication aide (MA) punched one lorazepam 0.5mg tablet from a controlled substance count sheet (CSCS) dated 02/20/22 with instructions to take one tablet every night for a quantity of 30 tablets with another resident's name pre-printed on the label marked out and Resident #6's on the label and signed out the lorazepam administered to another resident on the CSCS. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:00pm revealed on 02/20/22, the pharmacy dispensed 30 lorazepam 0.5mg one tablet at bedtime for Resident #6 labeled for the date dispensed and quantity dispensed. Review of Resident #6's CSCS revealed there was no CSCS dated 02/20/22 available for review other than the one with the identifying control number with the name of another resident handwritten on the label. Review of the March 2022 electronic medication administration record (eMAR) for the resident's name handwritten on the CSCS for lorazepam dispensed on 02/20/22 revealed documentation for administration on the eMAR corresponded to lorazepam signed out on the CSCS for 11 of 11 opportunities from 03/03/22 at 8:00pm to 03/10/22 at 10:30am. Review of the eMARs and CSCS revealed Resident #6 had 30 lorazepam 0.5mg dispensed on 02/20/22 with no accurate accounting for administration or disposition. Interview with a medication aide/Supervisor (MA/S) on 03/10/22 at 2:00pm revealed:	D 392		

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-Resident #6 was discharged from the facility more than one month ago.
-She did not know how or why Resident #6's name was marked out and another resident's name was handwritten on the lorazepam 0.5mg bubble card dated 02/20/22 dispensed for 30 lorazepam 0.5mg
-She administered lorazepam from the bubble card hand written for another resident during medication administration earlier today (03/10/22).
-She did not tell the Administrator lorazepam 0.5mg was borrowed from Resident #6.

Interview with the Administrator on 03/10/22 at 4:00pm revealed:
-She did not know why MAs would have used Resident #6's lorazepam for a different resident.
-Resident #6 was no longer at the facility, so maybe staff wanted to use up overstock medications instead of ordering residents' medications.
-MAs should not be borrowing any medications from another resident, especially controlled substances.
-Overstock controlled medications were moved to her office in a locked box around 03/09/22 to help track the overstock controls and limit access to her.
-She did not know staff were using other resident's controlled medications to administer medications.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care

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provider (PCP) on 03/15/22 at 4:35pm.

6. Review of Resident #4's current FL2 dated 10/21/21 revealed:
-Diagnoses included schizoaffective disorder bipolar type, agoraphobia, and traumatic stress disorder, and seizures.
-There was an order for clonazepam 0.5mg twice daily (a Schedule IV controlled substance used to treat anxiety related disorders and seizure disorders).

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed:
-Resident #4 had an order for clonazepam 0.5mg 1 tablet twice daily was dispensed to the facility on 10/27/21 with a quantity of 34 tablets (17-day supply).
-Clonazepam 0.5mg 1 tablet twice daily was dispensed to the facility on 11/22/21, 12/19/21, 01/19/21, and 03/07/21 with a quantity of 60 tablets (30-day supply) each time.

Review of Resident #4's December 2021 electronic medication administration record revealed (eMAR) revealed:
-There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-On 12/01/21 at 8:00pm, clonazepam was documented as administered.
-On 12/02/21, there was documentation clonazepam was administered at 8:00am.
-On 12/18/21 at 8:00pm, clonazepam was documented as administered.

Review of Resident #4's compared to the undated CSCSs revealed:
-On 12/01/21 at 8:00pm, clonazepam was not

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signed out on the CSCS.
-On 12/02/21, 1 tablet of clonazepam was signed out at 6:00am and 1 tablet was signed out at 7:00am.
-On 12/18/21 at 8:00pm, clonazepam was not signed out on the CSCS.
-There were 3 tablets not accurately accounted for on the CSCS compared to the eMAR.

Review of Resident #4's December 2021 eMAR revealed:
-There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-On 12/19/21 at 8:00am, clonazepam was documented as administered.
-On 12/23/21, there was documentation clonazepam was administered at 8:00am and 8:00pm.
-On 12/31/21 at 8:00am, clonazepam was documented as administered.

Review of Resident #4's CSCS dated 12/19/21 revealed:
-On 12/19/21 at 8:00am, clonazepam was not signed out on the CSCS.
-On 12/23/21, clonazepam was signed out at 8:00am, 12:00pm, 5:00pm, and 10:00pm.
-On 12/31/21 at 8:00am, clonazepam was not signed out on the CSCS.
-On 12/31/21 at 2:00pm, there was documentation that clonazepam was sent home with Resident #4, but there was no documented number of tablets sent; the balance on 12/30/21 at 8:00pm was 8 tablets and the next documented balance on 01/01/22 was 4. (Review of Resident #4's Medication Release Form dated 12/31/21 revealed 7 tablets of clonazepam were sent home with her.)
-There were 12 tablets not accurately accounted

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D 392	Continued From page 132 for on the CSCS compared to the eMAR. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 01/04/22 at 8:00pm, clonazepam was documented as not administered. -On 01/06/22 at 8:00pm, clonazepam was documented as not administered. Review of Resident #4's CSCS dated 01/03/22 revealed: -On 01/04/22 at 8:00pm, clonazepam was signed out on the CSCS. -On 01/06/22 at 8:00pm, clonazepam was signed out on the CSCS. -There was undated entry where 1 tablet was deducted from the balance, but there was no date, time, dosage, or signature of who administered the tablet. -There were 3 tablets not accurately accounted for on the CSCS compared to the eMAR. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 01/19/22 at 8:00pm, clonazepam was documented as not administered, but clonazepam was signed out on the CSCS. Review of Resident #4's CSCSs dated 01/19/21 revealed: -On 01/19/22 at 8:00pm, clonazepam was signed out on the CSCS. -There was 1 tablet not accurately accounted for on the CSCS compared to the eMAR.	D 392		

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D 392	Continued From page 133 Review of Resident #4's February 2022 eMAR revealed: -There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 02/07/22 at 8:00pm, there was no documentation clonazepam was administered (blank space), but clonazepam was signed out on the CSCS. -On 02/17/22, there were 2 tablets signed out at 8:00am on the CSCS. Review of Resident #4's CSCS dated 02/03/22 revealed: -On 02/07/22 at 8:00pm, clonazepam was signed out on the CSCS. -On 02/17/22, there were 2 tablets signed out at 8:00am on the CSCS. -There were 2 tablets not accurately accounted for on the CSCS compared to the eMAR. Review of Resident #4's February 2022 eMAR revealed: -There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 02/18/22 at 8:00am, clonazepam was documented as administered, but clonazepam was not signed out on the CSCS. Review of Resident #4's CSCS dated 02/18/22 revealed: -On 02/18/22 at 8:00am, clonazepam was documented as administered, but clonazepam was not signed out on the CSCS. -There was 1 tablet not accurately accounted for on the CSCS compared to the eMAR. Review of Resident #4's eMARS and CSCSs	D 392		

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revealed there were 22 clonazepam 0.5mg tablets without an accurate accounting for administration and disposition.

Observation of medications available for Resident #4 on 03/15/22 at 9:01am revealed:
-A medication bubble card (1 of 2) of clonazepam 0.5mg 1 tablet twice daily was available on the medication cart with quantity of 30 tablets.
-Sixty tablets of clonazepam 0.5mg were dispensed to the facility on 03/07/22 with 30 tablets in 2 bubble cards.
-There was a quantity of 14 tablets remaining on the medication cart.
-The second bubble card (2 of 2) of 30 tablets of clonazepam was available in a locked box in the Administrator's office.

Interview with Resident #4 on 03/15/22 at 10:21am revealed:
-She was administered clonazepam for anxiety.
-The facility was out of clonazepam about a month ago, but she did not remember for how long.
-She was experiencing anxiety during the time she was out of clonazepam and asked to go to the hospital, but she was not sent out.

Interview with a medication aide (MA) on 03/11/22 at 10:03am revealed:
-She did not know Resident #4 had been out of clonazepam.
-MAs were responsible for reordering medications from the pharmacy through the eMAR system.
-Controlled substances could not be reordered through the eMAR system.
-When a resident was out of a controlled substance, the MA had to contact the resident's primary care provider (PCP) to let them know the

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resident needed a new prescription and the PCP faxed the new order for the controlled substance to the pharmacy.
-Medications should have been reordered when there was about a week left.

Telephone interview with a second MA on 03/16/22 at 4:26pm revealed:
-MAs were responsible for reordering medication when there was about 7 days of medication remaining.
-She knew Resident #4 had been out clonazepam, but she did not remember when.
-She did not remember if she contacted the pharmacy to reorder clonazepam when it was not available in the facility.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

7. Review of Resident #5's current FL2 dated 11/17/21 revealed:
-Diagnoses included cognitive dysfunction, severe thrombocytopenia, transient transaminitis (complication of uncontrolled diabetes), gastrointestinal erosion, hypoglycemia, and hyperkalemia.
-There was an order for Ativan 0.5mg tablet twice daily (a medication used to treat anxiety).

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed:
-Resident #5 had a previous order for Ativan

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0.5mg 1 tablet twice daily as needed and was dispensed to the facility on 11/22/21 with a quantity of 60 tablets.
-The as needed order for Ativan was discontinued on 12/20/21 and none of these tablets were returned to the pharmacy.
-Resident #5 had an order dated 12/20/21 for Ativan 0.5mg 1 tablet twice daily dispensed to the facility on 12/20/21 and 02/20/22 with a quantity of 60 tablets (30-day supply) each time.

Review of Resident #5's January 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-On 01/05/22 at 8:00am, there was no documentation of administration (blank space).
-On 01/06/22 at 8:00am, Ativan was documented as administered.
-On 01/07/22 at 8:00pm, Ativan was documented as administered.
-On 01/10/22 at 8:00am, Ativan was documented as administered.
-On 01/13/22 at 8:00am and 8:00pm, Ativan was documented as administered.
-On 01/15/22 at 8:00am and 8:00pm, Ativan was documented as administered.
-On 01/16/22 at 8:00am and 8:00pm, Ativan was documented as administered.
-On 01/17/22 at 8:00am, Ativan was documented as administered.
-On 01/18/22 at 8:00pm, Ativan was documented as administered.

Review of Resident #5's CSCS dated 01/03/22 revealed:
-On 01/05/22 at 8:00am, Ativan was signed out.
-On 01/06/22 at 8:00am, Ativan was not signed

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D 392	Continued From page 137 out. -On 01/07/22 at 8:00pm, Ativan was not signed out. -On 01/10/22 at 8:00am, Ativan was not signed out. -On 01/13/22 at 8:00am and 8:00pm, Ativan was not signed out. -On 01/15/22 at 8:00am and 8:00pm, Ativan was not signed out. -On 01/16/22 at 8:00am and 8:00pm, Ativan was not signed out. -On 01/17/22, Ativan was signed out twice at 7:00am. -On 01/18/22 at 8:00pm, Ativan was signed out twice. -There were 12 tablets not accurately accounted for on the CSCS compared to the eMAR. Review of Resident #5's January 2022 eMAR revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 01/24/22 at 8:00pm, Ativan was documented as administered, but Ativan was not signed out on the CSCS. Review of Resident #5's handwritten CSCS dated 01/22/22 revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 01/24/22 at 8:00pm, Ativan was not signed out. -There was an undated entry where 1 tablet was deducted from the balance, but there was no date, time, dosage, or signature of who administered the tablet. -There were 2 tablets not accurately accounted for on the CSCS compared to the eMAR.	D 392		

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D 392	Continued From page 138 Review of Resident #5's February 2022 eMAR revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 02/01/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 02/02/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 02/06/22 at 8:00pm, Ativan was documented as administered. Review of Resident #5's CSCS dated 01/22/22 revealed: -On 02/01/22, 1 tablet of Ativan was signed out at 8:00am leaving a balance of 11 and 1 tablet of Ativan was signed out at 8:00pm leaving a balance of 10. -On 02/02/22, 1 tablet of Ativan was signed out at 8:00am leaving a balance of 11 and 1 tablet of Ativan was signed out at 8:00pm leaving a balance of 10. (The balance was the same as the balance on 02/01/22 at 8:00am and 8:00pm.) -On 02/06/22 at 8:00pm, Ativan was not signed out on the CSCS. -There were 3 tablets not accurately accounted for on the CSCS compared to the eMAR. Review of Resident #5's February 2022 eMAR between 02/07/22 and 02/21/22 revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -Ativan was documented as administered at 8:00am and 8:00pm on 02/07/22, 8:00am on 02/08/22, 8:00pm on 02/10/22 and 02/11/22, 8:00am and 8:00pm on 02/12/22, 8:00am on 02/13/22, 8:00pm on 02/18/22. -Ativan was documented as not administered at	D 392		

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D 392	Continued From page 139 8:00pm on 02/08/22, 8:00am and 8:00pm on 02/09/22, 8:00am on 02/10/22 and 02/11/22, 8:00pm on 02/13/22, 8:00am and 8:00pm on 02/14/22, 8:00am on 02/15/22, 8:00am and 8:00pm on 02/16/22 and 02/17/22, 8:00am on 02/18/22, 8:00am and 8:00pm on 02/19/22, 02/20/22, and 02/21/22 due to not available. Review of the CSCSs provided for Resident #5 revealed: -There was no CSCS documentation of any Ativan signed out for Resident #5 between 02/07/22 and 02/21/22 (15 days for 30 tablets). -There were 30 tablets not accurately accounted for on the CSCS compared to the eMAR. Review of Resident #5's March 2022 eMAR revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 03/02/22 at 8:00am, Ativan was documented as administered. -On 03/03/22 at 8:00pm, Ativan was documented as administered. -On 03/08/22 at 8:00am, Ativan was documented as administered. -On 03/09/22 at 8:00am, Ativan was documented as administered. -On 03/10/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 03/11/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 03/12/22 at 8:00pm, Ativan was documented as administered. -On 03/13/22 at 8:00am, Ativan was documented as administered. -On 03/11/22 at 8:00am and 8:00pm, Ativan was documented as administered.	D 392		

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Review of Resident #5's CSCS dated 02/21/22 revealed:
-On 03/02/22 at 8:00am, Ativan was not signed out..
-On 03/03/22 at 8:00pm, Ativan was not signed out.
-On 03/08/22 at 8:00am, Ativan was not signed out.
-On 03/09/22 at 8:00am, Ativan was not signed out.
-On 03/10/22 at 8:00am and 8:00pm, Ativan was not signed out.
-On 03/11/22 at 8:00am and 8:00pm, Ativan was not signed out.
-On 03/12/22 at 8:00pm, Ativan was not signed out.
-On 03/13/22 at 8:00am, Ativan was not signed out.
-On 03/11/22 at 8:00am and 8:00pm, Ativan was not signed out.
-There were 12 tablets not accurately accounted for on the CSCS compared to the eMAR.

Review of Resident #5's eMARs and CSCSs revealed there were 49 Ativan 0.5mg tablets without an accurate accounting for administration and disposition.

Observation of Resident #5's medications available for administration revealed:
-Ativan 0.5mg 1 tablet twice daily was available on the medication cart.
-Ativan was dispensed by the pharmacy on 02/20/22 with a quantity of 30 tablets and 3 tablets were remaining. (There were 2 tablets remaining on the CSCS dispensed by the pharmacy 02/20/22.)

Interview with a MA on 03/15/22 at 9:51am revealed:

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D 392	Continued From page 141 -She did not realize she documented she administered Ativan to Resident #5 but had not signed Ativan out on the CSCS on 03/15/22 at 8:00am. -She thought she forgot to give Ativan to Resident #5. Interview with a second MA on 03/16/22 at 12:24pm revealed: -Resident #5 was out of Ativan a couple of days, but she did not remember when. -She thought there may have been an issue with the pharmacy regarding dispensing Ativan. -She did not remember contacting the pharmacy or Resident #5's primary care provider regarding Ativan not being available for administration. Based on observations and record reviews it was determined Resident #5 was not interviewable. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. _____ Interview with a medication aide (MA) on 03/14/22 at 9:00am revealed: -When a resident was admitted, the MA on duty would be responsible to ensure medications were received, orders and/or FL2 were faxed to the pharmacy, and medications were reviewed for accuracy. -The facility did not have a Resident Care Director (RCD) who would be responsible to double check new admissions's orders and medications, and to do audits.	D 392		

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D 392	Continued From page 142 -She assumed some of the RCD duties. -She did not have time to complete audits of the CSCS compared to the residents' eMARs or receipt of the controlled substances. -All MAs were responsible to administer medications according to the orders, including documenting medication administration appropriately. -She was responsible to ensure the CSCS were filed in the residents' records or in the filing room. -There was no system currently in place to monitor medications compared to the eMAR to ensure accuracy, or audit the eMARs or CSCS. -There were a lot of new staff filling in due to staff turnover and current MA staff was working multiple shifts to cover the facility's medication administration needs. Interview with the Administrator on 03/14/22 at 9:40am revealed: -There was no system in place to routinely audit medication administration, including adjusting medication administration times, auditing control substances, reviewing eMAR accuracy compared to medication administration. -MAs were supposed to place the completed CSCS in the resident's records or in a tray located in the nurse's desk area. Interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm revealed: -He came to the facility once a week. -He was not aware of any issues with controlled substance for any resident. -The facility was responsible for ordering medications and pharmacy could contact him for refills. -If the facility had any issues with medications (including controlled substances) the facility should have contacted the PCP by fax or paging.	D 392		

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D 392	Continued From page 143 [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. [Refer to Tag D0399, 10A NCAC 13F .1008(h) Controlled Substances (Type B Violation)]. [Refer to Tag D0935, G.S. 131D-4.5B(b) Adult Care Home Medication Aide; Training and Competency (Standard Deficiency)]. _____ The facility failed to ensure a readily retrievable record of controlled substances for 7 of 7 residents related to 21 tablets of oxycodone/acetaminophen 7.5/325 missing from 84 tablets and 21 tablets of oxycodone/acetaminophen 10/325 missing from 140 tablets dispensed resulting in the resident experiencing increased pain (#9); 20 of 240 tablets of hydrocodone /acetaminophen 5/325 missing and 36 of 180 tablets of lorazepam 0.5mg with missing CSCS (#1); 18 tablets of oxycodone/acetaminophen 5/325 without an accurate accounting for the administration and 64 tablets of lorazepam 0.5mg without an accurate accounting for the administration and disposition (#2); a CSCS dated 08/27/21 and 30 tablets of lorazepam 0.5mg missing (#7); 30 lorazepam 0.5mg tablets missing (#6); and 30 missing Ativan 0.5mg tablets (#5) resulted in resident experiencing increased pain (#9, #1) and increased anxiety (#4). This failure placed residents at serious risk of physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/10/22 for this violation. THE CORRECTION DATE FOR THIS TYPE A2	D 392		

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D 392	Continued From page 144 VIOLATION SHALL NOT EXCEED APRIL 15, 2022.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to report suspected drug diversions for controlled substances of unknown origin to the pharmacy for 3 of 3 sampled residents (#1, #7, #9) with physician orders for narcotic pain medications and anti-anxiety medications. The findings are: 1. Review of Resident #9's current FL2 dated 12/01/21 revealed diagnoses included diabetes type II with peripheral circulatory disorder, and rheumatoid arthritis. Telephone interview on 03/14/22 at 11:48am with the pharmacist manager at the facility's	D 399		

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contracted pharmacy revealed Resident #9 had orders for oxycodone/acetaminophen (a Schedule II narcotic pain reliever used to treat moderate to severe pain) sent to the pharmacy and dispensed as follows:
-On 01/06/22, oxycodone/acetaminophen 7.5/325 one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).
-On 01/20/22, oxycodone/acetaminophen 7.5/325 one tablet 4 times a day was dispensed for a quantity of 28 tablets (7 days supply).
-On 01/27/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 28 tablets (7 days supply).
-On 02/10/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).
-On 02/25/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).

Review of Resident #9's electronic medication administration record (eMAR) and controlled substance count sheets (CSCS) revealed:
-There were with 21 oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22.
-There were 21 oxycodone/acetaminophen 10/325 missing for 140 tablets dispensed from 01/27/22 to 02/24/22.

Refer to telephone interview with the Coordinator of the facility's contracted pharmacy on 03/10/22 at 3:30pm.

Refer to interview with the Administrator on 03/15/22 at 4:00am.

2. Review of Resident #1's current FL2 dated 11/17/21 revealed diagnoses included anxiety,

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osteoporosis, deep vein thrombosis, and type II diabetes.

Review of Resident #1's signed physician's orders dated 11/17/21 revealed there was an order for hydrocodone /acetaminophen 5/325 (a Schedule II narcotic used to treat moderate to severe pain) twice a day.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:15pm for controlled substances dispensed for Resident #1 revealed:
-The pharmacy sent controlled substance count sheets (CSCS) with controlled substances that were dispensed from the pharmacy to be used for accounting for controlled substances.
-On 11/03/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 tablets.
-On 12/27/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 tablets.
-On 01/24/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 tablets.
-On 02/21/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day for 60 tablets.

Review of Resident #1's CSCS for hydrocodone /acetaminophen 5/325 twice a day dispensed on 11/03/21 compared to the November 2021 and December 2021 eMAR revealed:
-From 11/03/21 to 12/05/21 at 7:00am hydrocodone /acetaminophen 5/325 was dispensed on 11/03/21 for 60 tablets and signed out on the CSCS and documented on the eMAR to complete the CSCS.
-From 12/05/21 at 8:00pm to 12/27 at 8:00am,

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hydrocodone /acetaminophen 5/325 twice a day was documented as administered at 8:00am and 8:00pm daily on the eMAR for 43 of 43 tablets and there was no dispensing date and no corresponding CSCS available for review.

Review of Resident #1's CSCS for hydrocodone /acetaminophen 5/325 twice a day dispensed on 12/27/21 that should have lasted to 01/26/22 compared to Resident #1's January 2022 eMAR revealed:
-From 12/27/21 at 8:00pm to 01/24/22 at 8:00pm, there were 57 opportunities for administering hydrocodone /acetaminophen 5/325 twice a day at 8:00am and 8:00pm daily with and documented administered on the eMAR for 38 of 57 opportunities.
-There was documentation hydrocodone/acetaminophen 5/325 as "not available" for 19 of 57 opportunities on the eMAR; and blank for administration for 1 of 57 opportunities on the eMAR.
-The CSCS for 60 tablets was not available for review.
-There were 20 tablets of hydrocodone/acetaminophen 5/325 missing from the dispensing of 60 tablets on 12/27/21.

Refer to telephone interview with the Coordinator of the facility's contracted pharmacy on 03/10/22 at 3:30pm.

Refer to interview with the Administrator on 03/15/22 at 4:00am.

3. Review of Resident #7's current FL2 dated 11/17/21 revealed diagnoses included type II Diabetes Mellitus, schizoaffective disorder, bipolar disorder and dementia.

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Review of Resident #7 physician's order with no date and faxed on 08/27/21 documented on the order and signed physician's orders dated 11/17/21 revealed an order for lorazepam 0.5mg (a Schedule IV narcotic used to treat anxiety) one tablet every 8 hours as needed for anxiety or agitation.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:00pm revealed:
-The pharmacy sent a controlled substance count sheet (CSCS) with each bubble card of controlled medication dispensed.
-On 08/27/21, the pharmacy dispensed 90 tablets of lorazepam 0.5mg one tablet every 8 hours as needed for Resident #7 labeled for the date dispensed and quantity dispensed (3 bubble cards with 30 tablets in each card).

Review of Resident #7's CSCS compared to medication on hand for administration on 03/10/22 at 3:00pm revealed:
-There was one CSCS labeled as dispensed on 08/27/21 for 30 of 30 tablets labeled as card 1 of 3 available for administration on the medication cart with 19 tablets signed out from 08/24/21 at 8:00pm to 02/13/22 at 8:00am.
-There were 11 tablets remaining on the CSCS which matched 11 lorazepam 0.5mg tablets available for administration.
-There were no other lorazepam 0.5mg tablets or CSCS available for review for Resident #7.
-There was one CSCS dated 08/27/21 for 30 tablets (labeled 2 of 3) available for review with the name of another resident handwritten on the label and a change of directions handwritten on the label with 30 tablets signed out on the CSCS from 01/02/22 at 6:00am to 01/18/22 at 8:00pm and documented on the January 2022 electronic

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medication administration record (eMAR) the other resident.
-There was no CSCS for 08/27/21 labeled 3 of 3 for a quantity of 30 tablets and the remaining 30 tablets of lorazepam 0.5mg were missing.

Refer to telephone interview with the Coordinator of the facility's contracted pharmacy on 03/10/22 at 3:30pm.

Refer to interview with the Administrator on 03/15/22 at 4:00am.

[Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation)].

_____

Telephone interview with the Coordinator of the facility's contracted pharmacy on 03/10/22 at 3:30pm revealed:
-The Coordinator was the contact person at the pharmacy for reporting suspected or know controlled substances discrepancies.
-There had been no discrepancies for controlled substances rweported by the facility.

Interview with the Administrator on 03/15/22 at 4:00pm revealed she had not reported the missing controlled substances to the pharmacy.

_____

The facility failed to report instances of suspected drug diversion for 3 of 3 residents identified on 03/11/22 to the pharmacy resulting in an increased risk of continued drug diversions and residents not receiving pain medication (#1, and #9) and as needed anti-anxiety medication (#7). This failure 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

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D 399	Continued From page 150 accordance with G.S. 131D-34 on 03/16/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2022.	D 399		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure follow up on recommendations on the Quarterly Pharmacy Medication review for 3 of 5 sampled residents (#2, #4, and #5). The findings are: 1. Review of Resident #2's current FL2 dated 12/03/21 revealed: -Diagnoses included anxiety, vitamin D deficiency, coronary artery disease, schizophrenia, arthritis, and type II diabetes. -There was an order for omeprazole (used to treat acid reflux and heartburn) 40mg twice a day. Review Resident #2's Consultant Pharmacist progress notes for Quarterly Pharmacy Medication Review dated 01/31/22 for revealed	D 406		

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there was a recommendation to reduce omperazole.

Review of Resident #2's physician orders revealed:
-There was a signed physician's order dated 01/27/22 for omperazole 40mg twice a day.
-There was no subsequent order for omeprazole 40mg.

Review of Resident #2's current electronic medication administration records (eMAR) for January 2022, February 2022, and March 2022 revealed:
-The was an entry for omeprazole 40mg twice a day scheduled at 8:00am and 8:00pm daily.
-Omeprazole 40mg was documented as administered twice a day from 01/01/22 to 03/10/22.

Refer to telephone interview with the Consultant Pharmacist on 03/15/22 at 2:52pm.

Refer to interview with the Administrator on 03/16/22 at 3:00pm.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:14pm.

Refer to interview with a medication aide (MA) on 03/15/22 at 6:20pm.

2. Review of Resident #4's current FL2 dated 10/21/21 revealed:
-Diagnoses included type 2 diabetes, seizures, asthma, neuropathy, pancreatitis, heartburn, posttraumatic stress disorder, schizoaffective disorder bipolar type, and agoraphobia.
-There was an order for Novolog (a rapid acting insulin used to lower blood sugar levels) 100/mL

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inject 6 units 3 times daily with meals.

Review of Resident #4's Consultant Pharmacist progress notes for Quarterly Pharmacy Medication Review dated 01/31/22 revealed there was a recommendation to add parameters to the Novolog order.

Review of Resident #4's electronic medication administration record (eMAR) for January, February, and March 2022 revealed:
-There was an entry for Novolog 100/ML inject 6 units 3 times a day with meals.
-There were no parameters included with the entry.

Refer to telephone interview with the Consultant Pharmacist on 03/15/22 at 2:52pm.

Refer to interview with the Administrator on 03/16/22 at 3:00pm.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:14pm.

Refer to interview with a medication aide (MA) on 03/15/22 at 6:20pm.

3. Review of Resident #5's current FL2 dated 11/17/21 revealed diagnoses included hypoglycemia, hyperkalemia, sepsis, cognitive dysfunction, dysphagia, sever thrombocytopenia, transient transaminitis (a complication of uncontrolled diabetes), and gastrointestinal erosion.

Review Resident #5's Consultant Pharmacist progress notes for Quarterly Pharmacy Medication Review dated 01/31/22 revealed there was a recommendation to monitor weights.

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D 406	Continued From page 153 Review of Resident #5's electronic medication administration records (eMARs) for January, February, and March 2022 revealed there was not an entry to document Resident #5's weights. Review of the facility's weight logs revealed there were no weights documented for Resident #5 for January, February, and March 2022. Refer to telephone interview with the Consultant Pharmacist on 03/15/22 at 2:52pm. Refer to interview with the Administrator on 03/16/22 at 3:00pm. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:14pm. Refer to interview with a medication aide (MA) on 03/15/22 at 6:20pm. _____ Telephone interview with the Consultant Pharmacist on 03/15/22 at 2:52pm revealed: -She visited the facility in late January 2022. -She left a copy of the recommendations in the residents' records. -She emailed a copy of the recommendations to the Administrator and included the sheets for the PCP to review. -She did not fax the PCP directly with the recommendations. -She did not do a medication cart audit or controlled substance cart audit due to the facility disclosing active COVID -19 in January 2022 when she came. Interview with the Administrator on 03/16/22 at 3:00pm revealed: -The Pharmacy Consultant came to the facility for	D 406		

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2 days once quarterly.
-The pharmacy review report was then emailed to her at a later date.
-The Administrator was responsible to process the Quarterly Pharmacy Reviews which included reviewing the pharmacy recommendations and requests and then delegating the recommendations or request to the facility staff to follow-up on.
-She was supposed to print out the PCP request or recommendations that were prepared by the Pharmacy Consultant and place them in the PCP folder for the PCP to review at the next facility visit.
-She had not processed the recommendations from the last Quarterly Review on 01/31/22 because she was short staffed and had been conducting staffing duty.

Interview with the facility's primary care provider (PCP) on 03/15/22 at 4:14pm revealed:
-He had been coming to the facility since January 2022.
-He did not recall seeing any pharmacy recommendations needing his response.
-He would prefer the pharmacy send the request or recommendations directly to him instead of the facility.
-He would be able to respond in a more timely manner and reduce the chance of the pharmacy recommendations not provided to him in a timely manner.

Interview with a medication aide (MA) on 03/15/22 at 6:20pm revealed:
-The Quarterly Pharmacy Medication reviews were emailed to the Administrator.
-The Administrator looked over the quarterly reviews for recommendations she could work on herself and placed the remaining

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D 406	Continued From page 155 recommendations in the box designated for the PCP for him to review with his next visit. -She had seen the PCP's copy of pharmacy reviews in the PCP's box a long time ago. -She had not seen any Quarterly Medication Review recommendations from the Consultant Pharmacist review in January 2022.	D 406		
D 424	10A NCAC 13F .1104 (f) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (f) The resident's personal needs allowance shall be credited to the resident' s account within 24 hours of the check being deposited following endorsement This Rule is not met as evidenced by: Based on interviews and review of the resident's; personal funds, the facility failed to ensure 3 of 6 sampled residents (#1, #11 and #12) that received a personal needs allowance were credited to the residents accounts within 24 hours of the funds being deposited. The findings are: 1. Review of Resident #1's FL2 dated 11/17/21 revealed diagnoses included anxiety and intellectual disability. Review of Resident #1's Resident Register revealed she was admitted on 09/17/12. Interview with Resident #1 on 03/15/22 at	D 424		

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D 424	Continued From page 156 10:55am revealed: -She received Special assistance deposit in the amount of $66.00 on the 10th of each month. -She had previously signed an agreement to deduct $10.00 to be paid to pharmacy for her copay. -She did not receive her monthly amount out of her resident funds until days after the 10th, sometimes as late as the 15th like today. Review of Resident #1's bank account revealed the facility's corporate office received deposits for special assistance for Resident #1 for in the amount of $1,248.00 on the 3rd of each month for January-March 2022. Review of Resident #1's Resident Fund Account Ledger revealed she received $56.00 on 01/12/22 $56 on 02/14/22 and $56.00 on 03/15/22 with her signature and the signature of the Business Office Manager. Refer to interview with the Business Office Manager on 03/16/22 at 8:10am. Refer to interview with the Administrator on 03/16/22 at 8:37am. 2. Review of Resident #11's FL2 dated 11/17/21 revealed diagnoses included panic disorder, depression and hypertension. Review of Resident #11's Resident Register revealed she was admitted on 04/19/10. Interview with Resident #11 on 03/15/22 at 10:50am revealed: -She received Special Assistance deposit in the amount of $66.00 on the 10th of each month. -She did not receive her monthly amount out of	D 424		

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her resident funds until the 13th- 15th of each month for over a year now.
-She did receive $56.00 for January and February 2022 but was still waiting to withdraw her money for March 2022 and was supposed to have a refund of previous months pharmacy charges that were mistakenly deducted from her account.
-The Business Office Manager and Administrator told her she did not know when she would have money to give them their resident funds.

Resident #11's bank account statement was not available for review.

Review of Resident #11's Resident Funds Account Ledger revealed:
-She received $56.00 on 02/14/22 that included $10.00 withheld for pharmacy payment with her signature and the signature of the Business Office Manager.
-She received $96.00 on 03/15/22 that included $30.00 refund for January-March 2022 pharmacy payment with her signature and the signature of the Business Office Manager..
-There was no entry for funds withdrawn in January 2022.

Refer to interview with the Business Office Manager on 03/16/22 at 8:10am.

Refer to interview with the Administrator on 03/16/22 at 8:37am.

3. Review of Resident #12's FL2 dated 11/17/21 revealed diagnoses included bipolar mood disorder and hypertension.

Review of Resident #12's Resident Register revealed he was admitted on 02/14/19.

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Interview with Resident #12 on 03/15/22 at 4:43pm revealed:
-He received Special Assistance deposit in the amount of $66.00 on the 10th of each month.
-He got his money from the Business Office Manager (BOM) in the front office.
-He usually did not receive the money from the business office until the 13th or 15th of every month since he had been admitted.
-Each time he would ask when his money would be available, the BOM or Administrator would say they didn't know.

Review of Resident #12's bank account statement revealed the facility's corporate office received deposits for Resident #1 from his local Department of Social Services in the amount of $1,152.00 on the 1st of each month for January-March 2022.

Review of Resident #12's Resident Funds Account Ledger revealed:
-He received $36.00 on 01/12/22 and $66.00 on 03/15/22 with his signature and the signature of the Business Office Manager.
-There was no entry for funds withdrawn in February 2022.

Refer to interview with the Business Office Manager on 03/16/22 at 8:10am.

Refer to interview with the Administrator on 03/16/22 at 8:37am.

_____

Interview with the Business Office Manager on 03/16/22 at 8:10am revealed:
-She was responsible to give residents their money from their resident funds accounts.
-On the 12th or 13th the Administrator brings checks written out to residents from the facility's

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D 424	Continued From page 159 corporate account for those residents who received Special Assistance funds to have residents endorse the checks. -The Administrator then cashed all the resident's checks and brings her back the cash. -She separates the cash according to each resident's Special Assistance allowance amount. -All residents are given their full balance at once each month. -Residents usually get their money from their resident funds account on the 13th of the month or after. Interview with the Administrator on 03/16/22 at 8:37am revealed: -The BOM gave residents cash from their resident funds accounts. -The corporate office gave her company checks for each resident who received Special Assistance funds, usually on the 11th or 12th of each month. -She or the BOM would have the residents sign the company checks. -She would then cash all the residents' checks and the BOM would separate the money according to the allowance of each resident. -The process of receiving printed company checks from the facility's corporate office, having residents sign the checks and then her cashing the checks took a few days. -Residents funds were not usually available until the 12th of each month or after.	D 424		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and	D 438		

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D 438	Continued From page 160 supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge followed by a 5 day investigation report related to a staff (Staff C) yelling at residents, and missing and/or controlled substances unaccounted for. The finding are: Interview with the Administrator on 03/10/22 at 4:45pm revealed she was responsible to complete reports to the HCPR starting with the initial allegation report followed by the 5 day investigation report. 1. Review of Staff C's, medication aide (MA), personnel record revealed Staff C was hired as a on 10/18/17. Interview with a resident on 03/11/22 at 3:26pm revealed: -Staff C sometimes worked in the dining hall during meals. -He once brought an extra cup with him into the dining hall and Staff C took the cup away from him and threw it away. -A few nights ago, he was cold, so he went to the linen closet to get a blanket. -Staff C jerked the blanket out of his hands and said to him, "You don't need that. Give me that." -There was an incident when he had his toboggan laying on the table in the dining hall;	D 438		

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Staff C grabbed his toboggan and slammed it against his chest and said, "Keep your toboggan off the table."
-Staff C talked to him like he was trash and he felt like trash under her feet.
-He talked to the Administrator about Staff C months ago and told her Staff C was hollering at residents too much.
-He heard Staff C hollering down the hallway for residents to come to the medication cart to get their medications.
-He thought Staff C was miserable at the facility and frustrated because she had too much responsibility.

Interview with a second resident on 03/11/22 at 4:49 revealed Staff C yelled at her all the time and she did not like it.

Interview with a third resident on 03/11/22 at 5:13pm revealed:
-She carried cups in her rollator and liked to use them in the dining room during meals.
-She did not remember when, but Staff C took her cups she had brought in the dining room and threw them in the trash can.
-Staff C screamed at her to shut up and told her to sit down.

Interview with Staff C, a medication aide (MA) on 03/11/22 at 4:25pm revealed:
-She did not know of any instances when residents had complained about her yelling at them or being mean to them.
-She had not yelled at residents or been mean to them.
-She tried not to do anything that would violate their rights.

Interview with the Administrator on 03/11/22 at

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D 438	Continued From page 162 4:53pm revealed: -Residents had complained about Staff C yelling at them and being very hateful. -She talked to Staff C and re-educated her on residents' rights. -She told Staff C she could not talk aggressively to residents because it was the residents' rights to be free from verbal, physical, and mental abuse. -Staff C had a reported allegation to the HCPR in 2018 (no details were presented). -No residents had complained to her recently about Staff C yelling or being hateful. Refer to the interview with the Administrator on 03/15/22 at 4:00pm. 2. The facility had not reported missing controlled substances and discrepancies related to the records that accurately reconciled the receipt, administration, and disposition of controlled substances after being aware on 03/10/22 for 4 sampled residents (#1, #2, #7, #9) with physician orders for narcotic pain medications and anti-anxiety medications. Review of Resident #9's current FL2 dated 12/01/21 revealed diagnoses included diabetes type II with peripheral circulatory disorder, and rheumatoid arthritis. Review of Resident #9's eMAR and CSCS revealed there were 34 tablets of oxycodone/acetaminophen 7.5/325 without an accurate accounting for the administration or disposition from 01/06/22 to 01/27/22, and 35 tablets of oxycodone/acetaminophen 10/325 without an accurate accounting for the administration or disposition from 01/28/22 to 03/11/22 as follows:	D 438		

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D 438	Continued From page 163 -On 01/06/22, oxycodone/acetaminophen 7.5/325 was dispensed for 56 tablets that should have been administered from 01/06/22 to 01/20/22; the CSCSs for 28 tablets were missing for medication; with 14 tablets documented as administered on the eMAR from 01/07/22 to 01/20/22 with no accompanying CSCS documentation; and 14 tablets were not accounted for on the CSCS or eMAR and missing. -On 01/20/22, oxycodone/acetaminophen 7.5/325 was dispensed for 28 tablets; there were 21 tablets documented on the CSCS corresponding to the January 2022 eMAR and the CSCS for 7 tablets was missing with 7 tablets without an accurate accounting. -On 01/27/22, oxycodone/acetaminophen 10/325 was dispensed for 28 tablets; 7 tablets were accounted for on a CSCS and on the January 2022 eMAR and there were 21 tablets documented as not available on the eMARs from 01/30/22 to 02/05/22 that the corresponding CSCS was missing and 21 tablets were not on hand for administration and missing. -On 02/10/22, oxycodone/acetaminophen 10/325 was dispensed for 56 tablets that should have lasted until 02/25/22 revealed; there was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 missing for an accurate accounting for the administration or disposition from 02/11/22 to 02/15/22 and 11 doses documented as administered on the eMAR and not signed out on a CSCS from 02/10/22 to 02/28/22 to equal 25 tablets of oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 to 02/28/22. -On 2/24/22 for oxycodone/acetaminophen 10/325 was dispensed for 56 tablets that should last until 03/10/22; there were 4 of 36 tablets of oxycodone/acetaminophen 10/325 not accurately	D 438		

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documented as administered from 02/28/22 to 03/10/22.
-There were CSCS missing for 28 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22 and CSCS missing for 35 tablets of oxycodone/acetaminophen 10/325 for 140 tablets dispensed from 01/27/22 to 02/24/22 for Resident #9.
-There were 21 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22 and 21 tablets of oxycodone/acetaminophen 10/325 missing for a total of 140 tablets dispensed from 01/27/22 to 02/24/22 for Resident #9.

Review of Resident #9's facility's notes revealed there was no documentation the facility had reported discrepancies with the accounting for Resident #9's oxycodone/acetaminophen 7.5/325 and oxycodone/acetaminophen 10/325 to the Health Care Personnel Registry (HCPR) .

Refer to the interview with the Administrator on 03/15/22 at 4:00pm.

3. Review of Resident #1's current FL2 dated 11/17/21 revealed diagnoses included anxiety, osteoporosis, deep vein thrombosis, and type II diabetes.

Review of Resident #1's signed physician's orders dated 11/17/21 revealed there was an order for hydrocodone /acetaminophen 5/325 (a Schedule II narcotic used to treat moderate to severe pain) twice a day.

Review of Resident #1's December 2021 and January 2022 eMARs revealed:
-There was an entry for lorazepam 0.5mg

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one-half tablet (0.25mg) twice a day scheduled for administration at 8:00am and 8:00pm.
-There were 30 lorazepam 0.5mg one-half tablets documented administered on the eMARs from 12/25/21 at 8:00pm to 01/14/22 at 8:00am.

Review of Resident #1's CSCS for lorazepam 0.5mg one-half tablet (0.25mg) for 60 doses dispensed on 12/20/21 revealed there was no CSCS for 30 tablets documented as administered on the eMARs from 12/25/21 at 8:00pm to 01/14/22 at 8:00am.

Review of Resident #1's eMARs and CSCS for lorazepam 0.5mg revealed there were 36 of 180 tablets of lorazepam 0.5mg (1/2) tablet twice a day dispensed from 12/20/21 to 03/06/22 with no CSCS for sign out and accurate accounting.

Review of Resident #1's facility's notes revealed there was no documentation the facility had reported discrepancies with the accounting for Resident #1's hydrocodone/acetaminophen to the Health Care Personnel Registry (HCPR) .

Refer to the interview with the Administrator on 03/15/22 at 4:00pm.

4. Review of Resident #7's current FL2 dated 11/17/21 revealed diagnoses included type II Diabetes Mellitus, schizoaffective disorder, bipolar disorder and dementia.

Review of Resident #7 physician's order with no date and faxed on 08/27/21 documented on the order and signed physician's orders dated 11/17/21 revealed an order for lorazepam 0.5mg (used to treat anxiety) one tablet every 8 hours as needed for anxiety or agitation.

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D 438	Continued From page 166 Based on observation, and review of Resident #7 eMARs and CSCS, Resident #7 had 30 lorazepam 0.5mg dispensed on 08/27/21 missing with no accurate accounting for administration, or disposition and 19 lorazepam 0.5mg administered to another resident for a total of 49 lorazepam 0.5mg tablets unaccounted for accurately. Review of Resident #7's facility's notes revealed there was no documentation the facility had reported discrepancies with the accounting for Resident #7's lorazepam to the Health Care Personnel Registry (HCPR). Refer to the interview with the Administrator on 03/15/22 at 4:00pm. [Refer to Tag D0312, 10A NCAC 13F .0909 Residents Rights (Type B Violation)]. [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation)]. [Refer to Tag D0399, 10A NCAC 13F .1008(h) Controlled Substances (Type B Violation)]. _____ Interview with the Administrator on 03/15/22 at 4:00pm revealed: -She had not started the initial or 5 days reports to the Health Care Personnel Registry. -The facility was experiencing critical staffing shortages and she was working both as a personal care aide and medication aide to cover facility shift staff shortages. _____ The facility failed to report to the HCPR within 24 hours and complete the 5 day investigation report	D 438		

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D 438	Continued From page 167 for Staff C regarding an allegation of staff abuse related to Staff C yelling at residents; and did not complete the initial 24 hour report for missing and inaccurate accounting for controlled substances. Staff C continuing to work without an investigation of the allegation of abuse. This failure 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 March 15, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2022.	D 438		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by:	D 612		

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D 612	Continued From page 168 Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) and routine screening for signs and symptoms of COVID-19 by staff and visitors. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed: -Source control measures were to be implemented for HCP. -Source control referred to the use of a well-fitting facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughing. -Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCP. -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/19/21 revealed: -Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose. -Cloth masks were not considered PPE and should not be worn by staff.	D 612		

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D 612	Continued From page 169 Review of the facility's undated Standard Operating Procedures/Guidelines related to COVID-19 revealed: -In-service training should be provided to assure all staff understand the CDC guidance including: proper use of PPE including face masks. -Cloth face coverings were not PPE. Observation of the facility upon entrance and during the tour on 03/10/22 between 8:50am and 10:22am revealed: -There was a CDC generated flyer posted on the entrance door which stated to "Please wear a mask and maintain a distance of 6 feet whenever possible. -The Activity Director (AD) greeted surveyors at the entrance and was not wearing a mask. -At 8:52am, there were 3 personal care aides (PCAs) assisting in the dining hall: 1 staff had her mask below her nose and 1 staff did not have a mask on. -At 9:00am, a medication aide (MA) was administering medication and did not have a mask on. -At 9:02am, a housekeeper was in the hallway and was not wearing a mask. -At 9:07am, the Administrator was in the hallway and was not wearing a mask. -At 9:13am, the MA was wearing a mask, but the mask was below her nose. -At 9:49am, the MA was wearing her mask below her nose and mouth and was administering medication. -At 10:07am, a PCA walked from the linen closet to a resident's room with her mask hanging from her right ear. -At 10:16am, the housekeeper was wearing a mask, but it was below his nose. -At 10:22am, the AD was delivering snacks to	D 612		

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residents' rooms and was not wearing a mask.

Interview with 4 residents on 03/10/22 between 9:32am and 10:23am revealed:
-Some staff did not wear a mask when they administered medication and served food in the dining hall.
-Staff normally wore their masks below their noses and mouths and sometimes below their chin.
-Sometimes staff did not wear a mask.
-The AD normally did not wear a mask in the facility.

Interview with a MA on 03/10/22 at 11:37am revealed:
-Masks should be worn upon entering the facility and should cover the nose and mouth.
-She did not wear her mask to cover her nose and mouth because sometimes she could not breath.
-She also pulled her mask down at times so residents could hear her.

Interview with a PCA on 03/10/22 at 10:49am revealed:
-She had her mask hanging from her ear because it was hard for her to breathe through it.
-She could not keep her mask up all day long.
-Masks were supposed to be worn in the facility and should cover the nose and mouth.

Interview with the AD on 03/10/22 at 11:49am revealed:
-He usually wore a mask "although it had been proven that masks did not work."
-He was not wearing a mask today because he could not breath due to a medical condition.

Interview with a second PCA on 03/10/22 at

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D 612	Continued From page 171 2:36pm revealed: -She wore her mask below her nose because it was too big and kept falling down. -She brought her masks from home to wear in the facility and she had not tried to tighten the loops of the mask for a better fit. Observation of the facility on 03/11/22 between 9:51am and 10:45am revealed: -At 9:51am, the housekeeper was not wearing a mask and was in the hallway. -At 10:22am, the housekeeper was not wearing a mask and was going into a resident's room. -At 10:35, the housekeeper pulled a cloth mask out of his pocket and put it on to cover his nose and mouth. -At 10:44, the Administrator was wearing a cloth mask. Interview with the housekeeper on 03/11/22 at 10:34am revealed: -He had his mask in his pocket and forgot to put it on today. -No one told him cloth masks were not appropriate for work in a health care setting. -He had not had any COVID-19 training. -He was just told to wear a mask and he had worn a cloth mask to work in the facility since he started a month and a half ago. Interview with the Administrator on 03/10/22 at 1:17pm revealed: -If a staff was in the facility around residents, they should wear a facemask to cover their nose and mouth. -Staff should have known to wear their masks in the facility. -She knew she should have had her mask on earlier today and there was no reason why she did not have it on.	D 612		

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D 612	Continued From page 172 Interview with the Administrator on 03/11/22 at 10:45am revealed: -She provided COVID-19 training to staff upon hire, but she probably needed to do a refresher for the housekeeper. -Staff should be wearing a surgical mask while working. -She had surgical masks available for staff to wear if needed. 2. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status, who has a positive test for COVID-19, symptoms of COVID-19, or close contact/higher risk exposure to COVID-19. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/19/21 revealed all staff should be screened for symptoms prior to every shift. Review of the facility's undated Standard Operating Procedures/Guidelines related to COVID-19 revealed: -All health care providers were to be screened before starting each shift for fever and respiratory symptoms that included: monitoring temperature and questioning regarding cough, shortness of breath, sore throat and any other symptoms relevant to COVID-19. -All visitors should be screened for fever and symptoms of COVID-19 including monitoring temperature and questioning regarding cough,	D 612		

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shortness of breath, sore throat, and any other symptoms relevant to COVID-19.

Observation upon entrance to the facility on 03/10/22 at 8:50am revealed:
-There was no information regarding COVID-19 or screening for COVID-19
-There was no screening station for COVID-19.
-There was a table to the right in the lobby with hand sanitizer and a sign-in sheets for visitors, but there was not a separate sign-in sheet for staff.
-There was no information on the table
-There were no screening questionnaires or a thermometer available for visitors to take temperatures.
-Staff did not take the surveyors' temperature or ask screening questions.

Review of the visitor sign-in sheet for March 2022 (03/01/22 through 03/07/22) revealed:
-There was documentation at the top of the sheet: We ask that all visitors to our facility wear masks and have their temperature checked.
-There was a space to enter the date, time, temperature, name, and time out.
-On 03/01/22, there were 6 names on the sign-in sheet and no temperatures were documented.
-On 03/02/22, there were 7 names on the sign-in sheet and no temperatures were documented.
-On 03/03/22, there were 6 names on the sign-in sheet and 1 temperature was documented.
-On 03/04/22, there were 11 names on the sign-in sheet and 1 temperature was documented.
-On 03/05/22, there were 3 names on the sign-in sheet and no temperatures were documented.
-On 03/06/22, there were 4 names on the sign-in sheet and no temperatures were documented.
-On 03/07/22, there were 9 names on the sign-in sheet and 1 temperature was documented.

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D 612	Continued From page 174 Interview with a personal care aide (PCA) on 03/10/22 at 10:49am revealed she did not have her temperature checked at the front entrance or complete any type of screening questionnaire for COVID-19 because staff tested for COVID-19 every other week and wore masks. Interview with a medication aide (MA) on 03/10/22 at 11:37am revealed: -Staff were to sign in in the front lobby and have their temperature taken. -There was a thermometer in the front office and the Business Office Manager (BOM) usually checked staff and visitors' temperatures. -There was not a thermometer available at the entrance of the facility for staff and visitors to check their own temperatures when the BOM was not present. -Staff were supposed to document their temperatures on the visitor's sign-in sheet. -She took her temperature this morning using the thermometer on the medication cart. Interview with the Activity Director (AD) on 03/10/22 at 11:49am revealed: -He got his temperature checked on days when he entered the facility with the Administrator. -If the Administrator was not in the facility when he arrived, he went into the facility and began to work. -He had never completed a screening questionnaire for COVID-19, and no one asked him any screening questions. Interview with the BOM on 03/10/22 at 12:11pm revealed: -She checked staff and visitors' temperatures with a handheld thermometer that was kept in her office.	D 612		

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D 612	Continued From page 175 -She also asked staff and visitors if they had tested positive for COVID-19, had a COVID-19 test, or have been around anyone positive for COVID-19. -She thought there was a thermometer on the medication carts and thought the MAs used the thermometers on the cart to check their own temperatures. -Staff and visitor temperatures were supposed to be documented on the visitor sign-in sheet. -There was not a separate sign-in sheet for staff; she signed the visitor sign in sheet and recorded her temperature on the sheet daily. -She did not think any other staff took staff or visitors' temperatures or asked screening questions when she was not in the facility or not present in her office. Interview with the housekeeper on 03/11/22 at 10:34am revealed: -He usually did not sign in when he entered the facility. -He did not take his temperature and no other staff had taken his temperature since he started working at the facility about a month and a half ago. -No one asked him COVID-19 screening questions and he had not completed any screening questionnaires. Interview with the Administrator on 03/10/22 at 1:17pm revealed: -Staff and visitors were to stop at the BOM's office upon entrance to the facility to screen for COVID-19. -Staff and visitors were asked if they had been out of town, around people with a confirmed positive case of COVID-19, and if they had any signs or symptoms of COVID-19. -The BOM took staff and visitors' temperatures	D 612		

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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 612	Continued From page 176 and staff and visitors were to sign in and record their temperatures on the visitor's sign-in sheet. -If the BOM was not in the facility, staff and visitors entered the facility and were to be screened by a MA using a thermometer on the medication cart. Interview with the Administrator on 03/16/22 at 3:14pm revealed: -The facility used to use a screening questionnaire for visitors and staff to screen for symptoms and temperatures. -She did not know why the facility stopped using the questionnaire, but it stopped last year.	D 612		
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, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration, controlled substances, training on cardio-pulmonary resuscitation, personal care and other staffing and examinations and screening. The findings are: 1. Based on observations, interviews, and record	D912		

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D912	Continued From page 177	D912		

reviews, the facility failed to administer medications as ordered for 3 of 3 residents (#1, #2 and #12) observed during the medication pass related to receiving medications scheduled for administration outside the one hour grace period including medications for calcium supplement, a blood thinner, a diabetic medication, an anti-anxiety medication and pain reliever (#1), an anti-psychotic and anti-anxiety medication (#12), and anti-anxiety medication, calcium supplement, a blood pressure medication, acid reflux medication and medication to treat constipation (#2) and an inhaler not available for administration (#2); for 5 of 6 residents sampled (#1, #2, #4, and #5, and #9) for record review including errors with medications for anxiety (#1, #2,#4, #5); medication for pain (#1, #2, #9); an anti-psychotic and a blood pressure medication (#5); and insulins, an anti-depressant, a seizure medication, and a laxative were not available for administration (#4). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 7 of 7 sampled residents (#1, #2, #4, #5, #6, #7, #9) with physician orders for narcotic pain medications and anti-anxiety medications. [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation)].

3. Based on record reviews and interviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management

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D912	Continued From page 178 within the last 24 months for 6 of 10 sampled staff (Staff A, B, D, F, G and H) for 12 of 42 sampled shifts from 02/28/22 to 03/13/22. [Refer to Tag D0167, 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 4. Based on observations, record reviews and interviews, the facility failed to ensure the required aide hours for 23 of 42 shifts sampled from 02/28/22 to 03/13/22. [Refer to Tag D0188, 10A NCAC 13F .0604(e) Personal care and Other Staffing (Type B Violation)]. 5. Based on interviews and record reviews, the facility failed to report suspected drug diversions for controlled substances of unknown origin to the pharmacy for 3 of 3 sampled residents (#1, #7, #9) with physician orders for narcotic pain medications and anti-anxiety medications. [Refer to Tag D0399, 10A NCAC 13F .1008(h) Controlled Substances (Type B Violation)]. 6. Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 3 of 5 sampled staff (A, B and E) prior to hire. [Refer to Tag D0992, G.S. 131D-45(a) Examination and Screening (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 179 This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure residents were free from neglect as related to Resident Rights and reporting to the Health Care Personnel Registry. The findings are: 1. Based on observations, record reviews and interviews the facility failed to ensure residents were treated with respect and dignity related to a resident being isolated from other residents (#5) and a staff (Staff C) yelling at residents, taking items away from residents, and verbally demeaning a resident. [Refer to Tag #D0338, 10A NCAC 13F .0909 Residents Rights (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge followed by a 5 day investigation report related to a staff (Staff C) yelling at residents, and missing and/or controlled substances unaccounted for. [Refer to Tag D0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].	D914		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory,	D934		

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D934	Continued From page 180 annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the mandatory annual state approved infection control training was completed for 1 of 4 sampled medication aides (Staff D). The findings are: Review of Staff D's, medication aide (MA) personnel record revealed: -Staff D was hired on 07/24/18. -There was no documentation Staff D had completed the mandatory annual state approved infection control training. Interview with Staff D on 03/16/22 at 11:20am revealed: -She was rehired in December 2020 as a medication aide (MA). -She completed the mandatory annual state approved infection control training since she was hired but she could not remember the date. Interview with the Administrator on 03/16/22 at 8:35am revealed: -She knew all MAs were to have annual state	D934		

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D934	Continued From page 181 approved infection control training. -She was responsible to schedule staff to complete the infection control training on the facility's contracted pharmacy's website. -She remembered Staff D completed the infection control training but she could not find it in her personnel records. -She did not have an audit system for personnel records to ensure the annual infection control training was completed.	D934		
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	D935		

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D935	Continued From page 182	D935		

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.
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 record reviews and interviews, the facility failed to ensure 1 of 4 sampled staff (Staff B) who administered medications had passed a written medication aide exam within 60 days of completing the Medication Clinical Skills Competency Validation checklist.

The findings are:

Review of Staff B's, medication aide (MA), personnel record revealed:
-She was hired on 06/10/21.
-She completed the Medication Clinical Skills Competency Validation checklist on 02/16/22.
-There was documentation Staff B completed the 5,10, or 15-hour Medication Administration Training Course on 02/16/22.
-There was no documentation Staff B passed the written medication aide examination.

Review of Controlled Substance Count Sheet (CSCS) revealed Staff B had signed out narcotics on 37 days from November 2021-March 2022

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D935	Continued From page 183	D935		

revealed.

Review of electronic medication administration records (eMAR) revealed Staff B had not documented any medication administration from November 2021-March 2022.

Interview with the Administrator on 03/15/22 at 3:30pm revealed:
-Staff B was hired as a personal care aide (PCA) in June 2021 and began MA training in February 2022.
-Since November 2021, she allowed Staff B to administer residents' medications when staffing was short.
-Staff B's credentials had not been entered into the eMAR system and she could not sign-in to document administration of medications on the eMAR.
-She left herself signed-in on the eMAR system multiple times since November 2021 for Staff B to document administration of medications to residents and to document medication administration when staffing was short.
-Staff B was signing the controlled substances count sheets with her signature (or initials) but the eMAR did not correctly reflect that she was administering medications.
-Any time Staff B had signed out a medication on the CSCS, she had worked that shift administering medications to the residents on those dates (without proper eMAR documentation).

Attempted telephone interview with Staff B on 03/15/22 at 3:36pm was unsuccessful.

Attempted telephone interview with the contracted pharmacy's training nurse on 03/15/22 at 09:10am was unsuccessful.

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D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: TYPE B VIOLATION	D992		

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D992	Continued From page 185 Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 3 of 5 sampled staff (A, B and E) prior to hire. The findings are: 1. Review of Staff A's, personal care aide (PCA), personnel record revealed: -Staff A was hired on 04/20/18. -There was no documentation Staff A completed a drug screening. Telephone interview with Staff A on 03/15/22 at 12:15pm revealed: -She was hired as a PCA in April 2018. -She submitted to a drug test when she was hired that was negative. -She could not remember who performed the test but thought it was a nurse or one of the facility providers. Refer to interview with the Administrator on 03/16/22 at 4:45pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff A was hired on 06/10/21. -There was no documentation Staff B completed a drug screening. Attempted telephone interview with Staff B on 03/15/22 at 3:36pm was unsuccessful. Refer to interview with the Administrator on 03/16/22 at 4:45pm. 3. Review of Staff E's, Administrator, personnel record revealed:	D992		

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D992	Continued From page 186 -Staff E was hired on 2019. -There was no documentation Staff E completed a drug screening. Attempted telephone interview with Staff E on 03/16/22 at 3:53pm was unsuccessful. Refer to interview with the Administrator on 03/16/22 at 4:45pm. _____ Interview with the Administrator on 03/16/22 at 4:45pm revealed: -She was aware of the state regulations related to drug testing new employees. -She was responsible to perform drug testing on new employees. -She conducted drug tests on new employees before they were hired. -Each test kit she used had a form to document results from the tests, but she could not find the documentation. _____ [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation)]. [Refer to Tag D0399, 10A NCAC 13F .1008(h) Controlled Substance (Type B Violation)]. _____ The facility failed to ensure an examination and screening for the presence of controlled substances was completed for 3 of 5 sampled staff (A(PCA), B and E(MAs)) prior to hire resulting in discrepancies on the Controlled Substance Count Sheet (CSCS) logs, missing CSCS logs, and missing controlled substances. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____	D992		

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D992	Continued From page 187 The facility provided a plan of correction in accordance with G.S. 131D-34 on 03/16/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, APRIL 30, 2022.	D992		