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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey and Complaint Investigation on September 28, 2021 through September 30, 2021.	D 000		
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	D 188		

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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 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:
Based on interviews, and record reviews, the facility failed to ensure the required staffing hours for the assisted living unit (AL) with a census of 29 residents were met for 5 of 15 shifts sampled from 09/10/21 to 09/26/21.

The findings are:

Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 90 beds including a special care unit (SCU) with a capacity of 48 beds.

Review of the facility's resident census report dated 09/10/21 revealed there was an AL census of 25 residents, which required 16 staff hours on first and second shift and 8 staff hours on third shift.

Review of the employee timecards dated 09/10/21 revealed there was a total of 8 staff hours provided on second shift in the AL with a shortage of 8 hours.

Review of the facility's resident census report dated 09/18/21 revealed there was an AL census of 28 residents, which required 16 staff hours on first and second shift and 8 staff hours on third shift.

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D 188	Continued From page 2 Review of the employee timecards dated 09/18/21 revealed there was a total of 8 staff hours provided on first shift in the AL with a shortage of 8 hours. Review of the employee timecards dated 09/18/21 revealed there was a total of 9 staff hours provided on second shift in the AL with a shortage of 7 hours. Review of the facility's resident census report dated 09/19/21 revealed there was an AL census of 28 residents, which required 16 staff hours on first and second shift and 8 staff hours on third shift. Review of the employee timecards dated 09/18/21 revealed there was a total of 7.5 staff hours provided on first shift in the AL with a shortage of 8.5 hours. Review of the employee timecards dated 09/18/21 revealed there was a total of 8 staff hours provided on second shift in the AL with a shortage of 8 hours. Interview with a medication aide (MA) on 09/28/21 at 7:45pm revealed: -She was the only MA scheduled from 7:00pm to 7:00am for the entire facility every day she was scheduled. -Approximately half of the time there was only one personal care aide (PCA) for the special care unit (SCU) after 11:00pm. -She spent approximately 25% of her time on the SCU and 75% on the AL side. Interview with a second MA on 09/28/21 at 6:56pm revealed:	D 188		

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D 188	Continued From page 3 -There was only 1 MA and 2 PCA scheduled to work after 7:00pm for the facility. -There was 1 PCA for the AL side, 1 PCA for the SCU and 1 MA to administer medications to both sides. Confidential interview with a staff member on 09/29/21 at 6:20am revealed: -Staff members would stay over from the 7:00am-3:00pm shift for a few hours but then the AL side would be short until 11:00pm. -The facility would mainly be short from 5:00pm until 11:00pm on the weekends. Interview with the Administrator on 09/30/21 at 3:52pm revealed: -The staff schedule was previously made by a staff member that was no longer there. -The staff schedule was currently being completed by the lead MA/scheduler. -She came in on some shifts that they were short to help staff and she would clock in. -She was in the process of hiring two more MAs because she was aware that staffing was an issue. -It was not surprising to her that the facility was short staffed. -Staff was allotted a 30 minute on site break for every 8 hours worked and an hour total break time for a 12 hour shift. -Staff did not clock out for their break.	D 188		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to notify the primary care provider of changes in skin condition for 1 of 5 sampled residents (#2) who had discolorations to the skin of unknown origin.

The findings are:

Review of Resident #2's current FL-2 dated 05/18/21 revealed:
-Diagnoses included capsular dementia and reactive depression.
-She was incontinent of bladder.
-She was continent of bowel.
-She was intermittently disoriented.

Review of Resident #2's current care plan dated 07/01/21 revealed:
-She was totally dependent on staff for toileting, bathing dressing, grooming and transferring.
-She was totally dependent on staff for ambulation, using a wheelchair for an assistive device.

Observation of Resident #2 on 09/29/21 at 6:52am revealed:
-Two staff were performing incontinent care.
-There was purple bruising on the back of both of her hands that extended above the her wrists to her forearms and a palm sized, yellowish gray bruise on the inner aspect of her left thigh.
-The skin over the heel of her left foot was shiny and red.

Interview with a personal care aide (PCA) on 09/29/21 at 6:52am revealed:
-Resident #2's skin bruised easily and there were always new ones everyday.
-He did not know how Resident #2 obtained the

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bruising on her hands and arms.
-He did not know how long the bruise had been present on Resident #2's thigh.
-He saw the red area on her heel the previous weekend but did not report it to anyone.
-He should have reported the bruise and the area on Resident #2's heel to the medication aide (MA) when he first observed it.

Interview with the second PCA on 09/29/21 at 6:52am revealed that she had not seen the bruise on the inner thigh or red area on Resident #2's heel before and did not know how she got them.

Interview with a MA on 09/28/21 at 7:13pm revealed:
-She was notified by the PCA on duty that Resident #2 had redness on her skin but would not specify when she was made aware.
-She had not looked at the condition of Resident #2's skin because she did not bathe the residents at the facility.
-The process was for her to write a progress note and to notify the PCP for Resident #2 of changes in skin condition.
-She had not notified the PCP because she was busy with other tasks.

Telephone interview with a family member of Resident #2 on 09/30/21 at 10:05am revealed:
-The facility did not notify her of any bruises that were found on Resident #2.
-She saw bruises on Resident #2's arms and hands in various stages of healing on the facility's social media page.
-She expected the facility to notify her when bruising occurred.
-She was not aware any pressure ulcers or discoloration of the skin on any other part of Resident #2's body.

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D 273	Continued From page 6 Telephone interview with the primary care provider (PCP) for Resident #2 on 09/30/21 at 10:30am revealed: -She had not been notified of a red area over Resident #2's heel. -She expected to be notified of any discoloration on the skin of a resident because deep tissue injury could occur within hours that could extend to the bone. -She was aware of the bruising to Resident #2's arms and hands but was not aware of a bruise to her thigh. -She expected to be notified of the bruise found on Resident #2's thigh because the thigh was a suspicious place to have a bruise. Telephone interview with the hospice nurse for Resident #2 on 09/30/21 at 11:00am revealed: -She had noticed large bruises on the hands of Resident #2 that extended to her wrists on 09/14/21. -The facility did not report any bruises found anywhere on Resident #2's body. -She expected to be notified of bruising and other skin discoloration because tissue damage could happen quickly in residents receiving hospice services. -She was not notified of a red area on the heel of Resident #2. Interview with the Administrator on 09/30/21 at 4:15pm revealed: -If she had known about the bruise on Resident #2's inner thigh, she would have submitted a 24-hour report to the Health Care Personnel Registry and begun an investigation. -She expected staff to report bruises of unknown origin to her and the PCP. -She had not trained staff to report bruises of	D 273		

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D 273	Continued From page 7 unknown origin but had told staff that was what was expected. -She was not notified of a red area on the heel for Resident #2. -She expected staff to report changes in skin condition the PCP. Based on observations of Resident #2 it was determined she was not interviewable.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered for 4 of 5 residents (#4, #8, #9, #10) observed during the medication passes including errors with a medication for treatment of psychiatric behaviors and reflux disorder (#9), constipation (#8), allergies (#10), and an eye infection (#4). The findings are: The medication error rate was 17% as evidenced by the observation of 5 errors of 28 opportunities	D 358		

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during the morning medication pass on 09/29/21.

1. Review of Resident #9's current FL-2 dated 03/08/21 revealed:
-Diagnoses included dementia, bipolar disorder, and Alzheimer's disease.

a. There was an order for Risperidone 1mg, take one tablet once daily (Risperidone is used to treat psychiatric behaviors).

Observation of the 8:00am medication pass on 09/29/21 revealed Risperidone was not administered or offered to Resident #9 when she received her other morning medications at 8:43am.

Review of Resident #9's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Risperidone 1mg with instructions to take one tablet twice a day, scheduled for administration at 8:00am and 8:00pm.
-Risperidone 1mg was documented as administered on 09/29/21 at 8:00am.

Observation of Resident #9's medication on hand on 9/29/21 at 11:15am revealed there was no Risperidone medication available for administration.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/30/21 at 8:15am revealed:
-There were 60 tablets (1 month supply) of Risperidone 1mg dispensed on 08/20/21.
-The pharmacy received a refill request for Resident #9's Risperidone yesterday (09/29/21) afternoon.

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D 358	Continued From page 9 Interview with Resident #9 on 09/30/21 at 3:14pm revealed: -She could not recall if she received her Risperidone yesterday. -The medication aide (MA) handed her the medication cup and she assumed her Risperidone was there with the rest of her medication. Interview with the MA on 09/29/21 at 12:55pm revealed: -She was not aware that Resident #9 was out of her Risperidone. -Resident #9 was not exhibiting any psychiatric behaviors. -She was just clicking off medication on the eMAR and had not paid attention if the Risperidone was in the multidose pack. -When a medication packet was empty it was either the lead MA or the MA's responsibility to fill out a request to the pharmacy for a refill. -She was not aware if a pharmacy refill form was done for Resident #9's Risperidone. Interview with the Administrator on 09/29/21 at 2:10pm revealed: -She expected the MA to administer Resident #9's Risperidone as ordered. -She expected the MA to complete the refill process if the resident was out of her Risperidone. Telephone interview with Resident #9's primary care provider (PCP) on 09/30/21 at 9:50am revealed: -She expected Resident #9's Risperidone medication to be administered as ordered. -She was concerned that Resident #9 missing Risperidone doses could cause an increase in	D 358		

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psychiatric behaviors or withdraw symptoms including increased anxiety and agitation.
-She was not aware that Resident #9 had missed any Risperidone doses.

b. Review of Resident #9's current FL-2 dated 03/08/21 revealed there was an order for Pantoprazole 40mg daily (Pantoprazole is used to treat gastric reflux disorder).

Observation of the 8:00am medication pass on 09/29/21 revealed Pantoprazole was not administered or offered to Resident #9 when she received her other morning medications at 8:43am.

Review of Resident #9's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Pantoprazole 40mg 1 tablet once a day, scheduled for administration at 8:00am.
-Pantoprazole 40 mg tablet was documented as administered on 09/29/21 at 8:00am.

Observation of Resident #9's medication on hand on 09/29/21 at 11:15am revealed there was a package of Pantoprazole 40mg tablets with 26 pills remaining.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/30/21 at 8:15am revealed there were 30 tablets (1 month supply) of Pantoprazole 40mg dispensed on 09/22/21.

Interview with Resident #9 on 09/30/21 at 3:14pm revealed:
-She had a history of reflux disorder, but it was well managed without symptoms.

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-She could not recall if she received her Pantoprazole yesterday.
-The medication aide (MA) handed her the medication cup and she assumed her Pantoprazole was there with the rest of her medication.

Interview with the medication aide (MA) on 09/29/21 at 12:55pm revealed:
-She was not aware that Resident #9 had not received her Pantoprazole during the morning medication pass (09/29/21).
-She was just clicking off medication on the eMAR and had not paid attention if the Pantoprazole was in the multidose pack.
-She should have checked the eMAR against the medication to ensure Resident #9 received her ordered medication including the Pantoprazole.

Interview with the Administrator on 09/29/21 at 2:10pm revealed she expected the MA to administer Resident #9's Pantoprazole as ordered.

Telephone interview with Resident #9's primary care provider (PCP) on 09/30/21 at 9:50am revealed:
-Resident #9 had an extensive history of gastric reflux disorder that was well controlled with Pantoprazole.
-She expected Resident #9 to receive her Pantoprazole as ordered.
-Resident #9 missing a dose of her Pantoprazole could have caused an increase in reflux including indigestion, nausea, and stomach discomfort.

2. Review of Resident #8's current FL-2 dated 09/03/21 revealed:
-Diagnoses included hypertension, gastroesophageal reflux disorder and heart

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failure.
-There was an order for Miralax 17gm daily (Miralax is used to treat occasional constipation).
-There was an order for Milk of Magnesia 30ml at bedtime as needed for constipation (Milk of Magnesia is used to treat constipation).

Observation of the morning medication pass on 09/29/21 revealed:
-Resident #8 requested Milk of Magnesia as he was leaving the dining room at 8:30am.
-The medication aide (MA) prepared Miralax 17gm for administration from the facility's house stock.
-Resident #8 drank the Miralax 17gm at 8:38am.

Review of Resident #8's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax 17gm daily, scheduled for administration at 9:00am.
-There was an entry for Milk of Magnesia 30ml to be given at bedtime as needed for constipation.
-Milk of Magnesia 30ml was documented as administered on 09/29/21 at 8:34am with a reason given as "resident asked for it".

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/30/21 at 8:15am revealed:
-The pharmacy dispensed Resident #8 Miralax on 09/26/21 for a one-month supply.
-The pharmacy received a request on 09/29/21 for a refill but informed the facility that it was too early to fill the request.

Interview with Resident #8 on 09/30/21 at 11:20am:
-He usually requested Miralax after breakfast because it helped keep his bowel movements

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regular.
-He couldn't remember whether he asked for Milk of Magnesia or Miralax yesterday morning because he got the two confused.
-He wanted the Miralax, which was what he received.

Interview with the MA on 09/29/21 at 12:55pm revealed:
-Resident #8 requested a laxative after most breakfast meals.
-She got the names of Milk of Magnesia and Miralax confused that was why she said Milk of Magnesia instead of Miralax this morning (09/29/21).
-She always administered Resident #8 Miralax, not Milk of Magnesia.

Interview with the Administrator on 09/29/21 at 2:10pm revealed:
-She expected the MA to administer Resident #8's medication as ordered.
-She was concerned that the MA mixed up the names of Miralax and Milk of Magnesia.

Telephone interview with Resident #8's primary care provider (PCP) on 09/30/21 at 9:50am revealed:
-She expected Resident #8 to receive his medication as ordered including Miralax and Milk of Magnesia.
-Resident #8 has tended to be obsessive about his bowel regimen and so she would have expected the MA to ensure that she was administering his medications appropriately.

3. Review of Resident #10's current FL-2 dates 08/27/21 revealed diagnoses included rheumatoid arthritis, hypertension and hyperlipidemia.

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D 358	Continued From page 14 Review of Resident #10's physician's orders dated 09/07/21 revealed an order for Azelastine 137mcg inhale 2 sprays into each nostril twice a day (Azelastine is used to treat allergy symptoms). Observation of the 8:00am medication pass on 09/29/21 revealed the medication aide (MA) administered one spray of Azelastine 137mcg nasal spray in each nostril to Resident #10 at 8:50am. Review of Resident #10's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Azelastine 137mcg nasal spray, inhale 2 sprays into each nostril twice daily, scheduled for administration at 8:00am and 8:00pm. -Azelastine 137mcg nasal spray, inhale 2 sprays into each nostril twice daily was documented as administered on 09/29/21 at 8:00am. Interview with the MA on 09/29/21 at 12:55pm revealed: -She was not sure how many sprays of Azelastine Resident #10 received in each nostril that morning (09/29/21) during the morning medication pass. -It was easy to confuse residents with nasal sprays because multiple residents received nasal sprays during the morning medication pass. -She was aware that she should be checking the eMAR prior to administration of Resident #10's nasal spray but she was in a hurry this morning and missed it. Interview with the Administrator on 09/29/21 at 2:10pm revealed:	D 358		

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-She expected Resident #10 to receive the correct dosage of Azelastine 137mcg of two sprays into each nostril.
-She expected the MA to review Resident #10's eMAR for Azelastine nasal spray prior to administration.

Attempted telephone interview with Resident #10's primary care provider (PCP) on 09/30/21 at 9:12am was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #10 was not interviewable.

4. Review of Resident #4's current FL-2 dated 03/15/21 revealed diagnoses included prostate cancer and benign prostatic hyperplasia.

Review of Resident #4's physician order dated 09/18/21 revealed there was an order for Polymyxin B Sulfate-Trimethoprim eye drops, administer 2 drops into the effected eye twice a day for 14 days (Polymyxin B Sulfate-Trimethoprim is used to treat bacterial eye infections).

Review of Resident #4's physician order dated 09/22/21 revealed there was an order for Erythromycin eye ointment twice a day to the right eye for 30 days (Erythromycin is used to treat eye infections).

Observation of the morning medication pass on 09/28/21 revealed:
-The medication aide (MA) administered Erythromycin ointment to Resident #4's right eye at 8:58am.
- Polymyxin B Sulfate-Trimethoprim eye drops were not offered or administered to Resident #4

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during the morning medication pass.

Review of Resident #4's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Polymyxin B Sulfate-Trimethoprim eye drops, administer 2 drops into the effected eye twice a day for 14 days, scheduled for administration at 8:00am and 8:00pm.
-Polymyxin B Sulfate-Trimethoprim eye drops, administer 2 drops into the effected eye twice a day for 14 days was documented as administered on 09/29/21 at 8:00am.
-There was an entry for Erythromycin eye ointment twice a day to the right eye for 30 days, scheduled for administration at 8:00am and 8:00pm.
- Erythromycin eye ointment was documented as administered on 09/29/21 at 8:00am.

Observation of Resident #4's medication on hand on 9/29/21 at 11:17am revealed there was Polymyxin B Sulfate-Trimethoprim eye drops available for administration.

Interview with Resident #4 on 09/28/21 at 7:45pm revealed:
-He had the right eye infection for about two weeks.
-The eye doctor recently changed the drops that he was receiving for the eye infection.
-He did not have any pain, but he did have blurry vision that still has not improved even with the change in medications.

Interview with the MA on 09/29/21 at 12:55pm revealed:
-She was told by another MA that Resident #4's eye drops had been discontinued.

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D 358	Continued From page 17 -She did not realize that they were still scheduled for administration on the resident's eMAR. -She should have double checked the eMAR for Resident #4 prior to administering his medications. Interview with the Administrator on 09/29/21 at 2:10pm revealed she expected Resident #4 to receive his medications as ordered. Telephone interview with Resident #4's primary care provider (PCP) on 09/30/21 at 9:50am revealed: -She received a call the afternoon of 09/29/21 to clarify if Resident #4 was to receive the Polymyxin B Sulfate-Trimethoprim eye drops along with the Erythromycin ointment. -She discontinued the Polymyxin B Sulfate-Trimethoprim eye drops on 09/29/21 but she expected to receive a call earlier to clarify if Resident #4 was to receive both treatments. The facility failed to ensure medications were administered as ordered for 4 residents observed during the medication pass. Resident #9 did not receive her psychiatric medication which put her at increased risks for psychiatric behaviors including increased agitation and anxiety, as well as not receiving her medication for reflux which could have caused an increase in indigestion or stomach discomfort. Resident #4 did not receive his antibiotic eye drops for his eye infection which resulted in continued blurred vision. The facility's failure to ensure medications were administered as ordered was detrimental to the health, welfare and safety of the residents and constitutes a Type B Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 09/29/21 for	D 358		

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D 358	Continued From page 18 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2021.	D 358		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in	D 363		

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D 363	Continued From page 19 a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that medications that were prepared for administration in advance were kept in a sealed and labeled package for 5 of 5 residents (#2, #11, #12, #13, and #14). The findings are: 1. Observation of the medication aide on duty on 09/29/21 from 6:38am to 6:40am revealed: -She removed a small clear medication cup with applesauce and a pill from the locked medication cart. -There was a letter on the medication cup. -She entered Resident #11's room and had the resident swallow the applesauce and pills. Review of Resident #11's current FL-2 dated 03/08/21 revealed: -Diagnoses included hypothyroidism and gastroesophageal reflux disorder. -There was an order for Levothyroxine 88mcg, take one tablet daily (Levothyroxine is used to treat thyroid disorder). -There was an order for Pantoprazole 40mg, take one tablet every morning (Pantoprazole is used to treat gastric reflux disorder). Review of Resident #11's September 2021 electronic medication administration record (eMAR) revealed:	D 363		

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-There was an entry for Levothyroxine 88mcg, take one tablet daily, scheduled for administration at 7:00am.
-Levothyroxine 88mcg was documented as administered on 09/29/21 at 7:00am.
-There was an entry for Pantoprazole 40mg, take one tablet every morning, scheduled for administration at 7:00am.
-Pantoprazole 40mg was documented as administered on 09/29/21 at 7:00am.

Refer to interview with the medication aide (MA) on 09/29/21 at 7:38am.

Refer to interview with the Administrator on 09/29/21 at 2:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 09/30/21 at 9:50am.

2. Observation of the medication aide (MA) on duty on 09/29/21 from 6:42am to 6:46am revealed:
-She removed a small clear medication cup with applesauce and pills from the locked medication cart.
-There was a letter on the medication cup.
-She entered Resident #13's room and had the resident swallow the applesauce and pills.

Review of Resident #13's current FL-2 dated 03/15/21 revealed diagnoses included chronic obstructive pulmonary disease and chronic kidney disease.

Review of Resident #13's physician's orders dated 08/30/21 revealed:
-There was an order for Pantoprazole 40mg, take one tablet before breakfast every morning

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(Pantoprazole is used to treat gastric reflux disorder).
-There was an order for Sucralfate 1gm, take one tablet four times a day, one hour before each meal and at bedtime (Sucralfate is used to treat stomach inflammation).

Review of Resident #13's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Pantoprazole 40mg, take one tablet every morning, scheduled for administration at 7:00am.
-Pantoprazole 40mg was documented as administered on 09/29/21 at 7:00am.
-There was an entry for Sucralfate 1gm, take one tablet four times a day, one hour before each meal and at bedtime scheduled for administration at 7:00am, 11:00am, 4:00pm, and 8:00pm.
-Sucralfate 1gm was documented as administered on 09/29/21 at 7:00am

Refer to interview with the medication aide (MA) on 09/29/21 at 7:38am.

Refer to interview with the Administrator on 09/29/21 at 2:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 09/30/21 at 9:50am.

3. Observation of the medication aide on duty on 09/29/21 from 6:49am to 6:52am revealed:
-She removed a small clear medication cup with applesauce and a pill from the locked medication cart.
-There was a letter on the medication cup.
-She entered Resident #12's room and had the resident swallow the applesauce and pill.

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Review of Resident #12's current FL-2 dated 05/18/21 revealed:
-Diagnoses included hypothyroidism.
-There was an order for Levothyroxine 50mcg, take one tablet daily (Levothyroxine is used to treat thyroid disorder).

Review of Resident #12's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 50mcg, take one tablet daily, scheduled for administration at 7:00am.
-Levothyroxine 50mcg was documented as administered on 09/29/21 at 7:00am.

4. Observation of the medication aide on duty on 09/29/21 from 6:54am to 6:56am revealed:
-She removed a small clear medication cup with applesauce and a pill from the locked medication cart.
-There was a letter on the medication cup.
-She entered Resident #14's room and had the resident swallow the applesauce and pill.

Review of Resident #14's current FL-2 dated 12/07/20 revealed:
-Diagnoses included dementia.
-There was an order for Levothyroxine 100mcg, take one tablet daily (Levothyroxine is used to treat thyroid disorder).

Review of Resident #14's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 100mcg, take one tablet daily, scheduled for administration at 7:00am.
-Levothyroxine 100mcg was documented as

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administered on 09/29/21 at 7:00am.

5. Observation of the medication aide on duty on 09/29/21 from 7:01am to 7:04am revealed:
-She removed a small clear medication cup with applesauce and a pill from the locked medication cart.
-There was a letter on the medication cup.
-She entered Resident #2's room and had the resident swallow the applesauce and pill.

Review of Resident #2's current FL-2 dated 05/18/21 revealed:
-Diagnoses included hypothyroidism.
-There was an order for Levothyroxine 100mcg, take one tablet daily (Levothyroxine is used to treat thyroid disorder). .

Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 100mcg, take one tablet daily, scheduled for administration at 7:00am.
-Levothyroxine 100mcg was documented as administered on 09/29/21 at 7:00am.

Refer to interview with the medication aide (MA) on 09/29/21 at 7:38am.

Refer to interview with the Administrator on 09/29/21 at 2:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 09/30/21 at 9:50am.

_____

Interview with the medication aide (MA) on 09/29/21 at 7:38am revealed:
-She prepared the morning medications on the

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assisted living (AL) side of the facility and then went to the Special Care Unit (SCU) side of the facility to prepare their morning medications, while the AL medications 'soften' in the applesauce.
-Residents complained about being woken up to have to swallow pills, so she placed them in the applesauce so that it was easier for the residents to swallow.
-The cups were marked with the resident's first initial and locked in the medication cart.
-She was the only person with access to the medication cart and it stayed locked if she was not at it.
-She did not sign off the medications on the electronic medication administration record (eMAR) until the medications were given.
-She prepared residents medications ahead of time because she was the only MA administering morning medications and in order to not get behind it was easier to prepare the medications ahead.

Interview with the Administrator on 09/29/21 at 2:10pm revealed:
-She was not aware that the MA prepared her medications prior to administration.
-She had recently fired another MA for pre-pouring medications and was not aware that other staff were also pre-pouring.
-MA were expected to prepare one resident's medications at a time and administer them immediately.
-She was concerned that residents' medications would get mixed up causing serious health issues.

Telephone interview with the facility's contracted primary care provider (PCP) on 09/30/21 at 9:50am revealed:

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D 363	Continued From page 25 -She expected staff to prepare and immediately administer medications to the residents. -She was concerned that medications that were sitting in a substance to soften may lose properties that make them extended release, therefore effecting the away the medication works. -She was concerned that residents may not receive the proper medication.	D 363		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medication	D 367		

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administration records were accurate for 5 of 9 residents sampled including medications for psychiatric behavior management and reflux disorder (#4), constipation (#8), allergy relief (#10), and an eye infection (#4).

The findings are:

1. Review of Resident #9's current FL-2 dated 03/08/21 revealed:
-Diagnoses included dementia, bipolar disorder, and Alzheimer's disease.
-There was an order for Risperidone 1mg, take one tablet once daily (Risperidone is used to treat psychiatric behaviors).

Observation of the 8:00am medication pass on 09/29/21 revealed Risperidone was not administered or offered to Resident #9 when she received her other morning medications at 8:43am from the medication aide (MA).

Interview with the MA that completed Resident #9's morning medication pass on 09/29/21 at 12:55pm revealed she had not administered Risperdone to Resident #9.

Review of Resident #9's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Risperidone 1mg with instructions to take one tablet twice a day, scheduled for administration at 8:00am and 8:00pm.
-Risperidone 1mg was documented as administered on 09/29/21 at 8:00am.

Refer to the interview with the MA on 09/29/21 at 12:55pm.

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Refer to the interview with the Administrator on 09/29/21 at 2:10pm.

Refer to the telephone interview with the facility's primary care provider (PCP) on 09/30/21 at 9:50am.

3. Review of Resident #9's current FL-2 dated 03/08/21 revealed there was an order for Pantoprazole 40mg daily (Pantoprazole is used to treat gastric reflux disorder).

Observation of the 8:00am medication pass on 09/29/21 revealed Pantoprazole was not administered or offered to Resident #9 when she received her other morning medications at 8:43am from the medication aide (MA).

Review of Resident #9's September 2021 eMAR on 09/29/21 at 10:22 am revealed:
-There was an entry for Pantoprazole 40mg 1 tablet once a day, scheduled for administration at 8:00am.
-Pantoprazole 40 mg tablet was documented as administered on 09/29/21 at 8:00am.

Refer to the interview with the MA on 09/29/21 at 12:55pm.

Refer to the interview with the Administrator on 09/29/21 at 2:10pm.

Refer to the telephone interview with the facility's primary care provider (PCP) on 09/30/21 at 9:50am.

4. Review of Resident #8's current FL-2 dated 09/03/21 revealed:
-There was an order for Miralax 17gm daily (Miralax is used to treat occasional constipation).

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-There was an order for Milk of Magnesia 30ml at bedtime as needed for constipation (Milk of Magnesia is used to treat constipation).

Observation of the morning medication pass on 09/29/21 revealed:
-Resident #8 requested Milk of Magnesia as he was leaving the dining room at 8:30am.
-The medication aide (MA) prepared Miralax 17gm for administration from the facility's house stock.
-Resident #8 drank the Miralax 17gm at 8:38am.

Review of Resident #8's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax 17gm daily, scheduled for administration at 9:00am.
-There was an entry for Milk of Magnesia 30ml to be given at bedtime as needed for constipation.
-Milk of Magnesia 30ml was documented as administered on 09/29/21 at 8:34am with a reason given as "resident asked for it".

Refer to the interview with the MA on 09/29/21 at 12:55pm.

Refer to the interview with the Administrator on 09/29/21 at 2:10pm.

Refer to the telephone interview with the facility's primary care provider (PCP) on 09/30/21 at 9:50am.

5. Review of Resident #10's current FL-2 dates 08/27/21 revealed diagnoses included rheumatoid arthritis, hypertension and hyperlipidemia.

Review of Resident #10's physician's orders

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dated 09/07/21 revealed an order for Azelastine 137mcg inhale 2 sprays into each nostril twice a day (Azelastine is used to treat allergy symptoms).

Observation of the 8:00am medication pass on 09/29/21 revealed the medication aide (MA) Resident #10 administered one spray of Azelastine 137mcg nasal spray in each nostril at 8:50am.

Review of Resident #10's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Azelastine 137mcg nasal spray, inhale 2 sprays into each nostril twice daily, scheduled for administration at 8:00am and 8:00pm.
-Azelastine 137mcg nasal spray, inhale 2 sprays into each nostril twice daily was documented as administered on 09/29/21 at 8:00am.

Refer to the interview with the MA on 09/29/21 at 12:55pm.

Refer to the interview with the Administrator on 09/29/21 at 2:10pm.

Refer to the telephone interview with the facility's primary care provider (PCP) on 09/30/21 at 9:50am.

6. Review of Resident #4's current FL-2 dated 03/15/21 revealed diagnoses included prostate cancer and benign prostatic hyperplasia.

Review of Resident #4's physician order dated 09/18/21 revealed there was an order for Polymyxin B Sulfate-Trimethoprim eye drops, administer 2 drops into the effected eye twice a

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day for 14 days (Polymyxin B Sulfate-Trimethoprim is used to treat bacterial eye infections).

Observation of the morning medication pass on 09/28/21 revealed Polymyxin B Sulfate-Trimethoprim eye drops were not offered or administered to Resident #4 during the morning medication pass by the medication aide (MA).

Review of Resident #4's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Polymyxin B Sulfate-Trimethoprim eye drops, administer 2 drops into the effected eye twice a day for 14 days, scheduled for administration at 8:00am and 8:00pm.
-Polymyxin B Sulfate-Trimethoprim eye drops, administer 2 drops into the effected eye twice a day for 14 days was documented as administered on 09/29/21 at 8:00am.

Refer to the interview with the MA on 09/29/21 at 12:55pm.

Refer to the interview with the Administrator on 09/29/21 at 2:10pm.

Refer to the telephone interview with the facility's primary care provider (PCP) on 09/30/21 at 9:50am.

_____

Interview with the medication aide (MA) on 09/29/21 at 12:55pm revealed:
-She was not careful to check the electronic medication administration record (eMAR) before clicking off on medication which indicated that the resident took the medication.

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D 367	Continued From page 31 -She was responsible for ensuring that the eMAR matched the medications she administered. -She understood the importance of an accurate eMAR and the harm that it could cause the residents including missed doses or unnecessary changes in their health regimen. Interview with the Administrator on 09/29/21 at 2:10pm revealed: -She expected the eMAR to be complete and accurate. -It was the MA's responsibility to ensure that the eMAR was accurate and complete. -There was no audit process currently in place to ensure that eMAR are accurate and complete. Telephone interview with the facility's primary care provider (PCP) on 09/30/21 at 9:50am revealed: -She expected the eMAR to be complete and accurate. -She was concerned that medical decisions were being made based on the idea that residents were receiving what medications were recorded. -She adjusted some medications based on the understanding that the eMAR was complete and accurate. -It was vitally important that the eMAR accurately reflects what medications the residents are receiving.	D 367		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and	D 465		

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second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the required staffing hours for the special care unit (SCU) with a census of 11 residents were met for 5 of 15 shifts sampled from 09/10/21 to 09/26/21.

The findings are:

Review of the facility's current license effective January 1, 2021 revealed the facility was licensed for a capacity of 90 beds including a special care unit (SCU) with a capacity of 48 beds.

Review of the facility's resident census report dated 09/18/21 revealed there was a SCU census of 14 residents, which required 14 staff hours on first and second shift and 11.2 staff hours on third shift.

Review of the employee timecards dated 09/18/21 revealed there was a total of 9.5 staff hours provided on second shift in the SCU with a shortage of 4.5 hours.

Review of the employee timecards dated 09/18/21 revealed there was a total of 9.5 staff hours provided on third shift in the SCU with a shortage of 1.7 hours.

Review of the facility's resident census report dated 09/25/21 revealed there was a SCU census of 14 residents, which required 14 staff hours on first and second shift and 11.2 staff hours on third shift.

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Review of the employee timecards dated 09/25/21 revealed there was a total of 9.5 staff hours provided on third shift in the SCU with a shortage of 1.7 hours.

Review of the facility's resident census reports dated 09/26/21 revealed there was a SCU census of 13 residents, which required 13 staff hours on first and second shift and 10.4 staff hours on third shift.

Review of the employee timecards dated 09/26/21 revealed there was a total of 9.5 staff hours provided on third shift in the SCU with a shortage of 0.9 hours.

Interview with a Personal Care Aide (PCA) on 09/29/21 at 6:31am revealed:
-She worked the 11:00pm to 7:00am shift Monday through Friday and every other weekend on the Special Care Unit (SCU).
-She had worked alone on weekends.
-She last worked alone about 3 to 4 weeks ago.
-The shift had always been short staffed (did not give dates).
-Working alone presented challenges because there were some residents with acting out behaviors in the mornings and some residents walked a lot during the night.

Interview with a second PCA on 09/29/21 at 6:42am revealed:
-He worked the 11:00am to 7:00am shift on various days and on the weekends on SCU.
-He worked alone on 11:00am to 7:00am shift when he worked on the weekends.
-He last worked alone on 09/24/21 and 09/25/21.

Interview with a medication aide (MA) on

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D 465	Continued From page 34 09/28/21 at 6:53pm revealed: -There was only one MA scheduled to work when she got off at 7:00pm. -The on-coming MA would work on both the special care unit (SCU) and the assisted living (AL) side of the facility. -There was frequently only 1 MA for the facility but she could not say how often. Interview with a second MA on 09/28/21 at 6:56pm revealed: -There was only 1 MA and 2 personal care aides (PCA) scheduled to work after 7:00pm for the facility. -There was 1 PCA for the AL side, 1 PCA for the SCU and 1 MA to administer medications to both sides. Interview with a third MA on 09/28/21 at 7:45pm revealed: -She was the only MA scheduled from 7:00pm to 7:00am for the entire facility every shift that she was scheduled. -Approximately half of the time there was only one PCA for the SCU after 11:00pm. -She spent approximately 25% of her time on the SCU and 75% on the AL side. Interview with the Administrator on 09/28/21 at 8:20pm revealed staffing was a concern for her and she was hoping to hire more staff. Second interview with the Administrator on 09/30/21 at 3:52pm revealed: -The staff schedule was previously made by an employee that was no longer there. -The staff schedule was now being completed by the lead MA/scheduler. -She was in the process of hiring two more MA because she knew staffing was an issue.	D 465		

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D 465	Continued From page 35 -It was not surprising to her that the facility was short staffed. -Staff was allotted a 30 minute on site break for every 8 hours worked and an hour total break time for a 12 hour shift.	D 465		
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 observation, 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 and Medication Aide Training and Competency Validation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered for 4 of 5 residents (#4, #8, #9, #10) observed during the medication passes including errors with a medication for treatment of psychiatric behaviors and reflux disorder (#9), constipation (#8), allergies (#10), and an eye infection (#4). [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		

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D912	Continued From page 36 2. Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff C) who was administering medications had completed the 5-hour online medication aide training and completed the medication skills validation checklist prior to administering medications. [Refer to Tag D935 G.S. 131-D 4.5B(b) Medication Aide Training and Competency Validation (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following:	D935		

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D935	Continued From page 37 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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff C) who was administering medications had completed the 5-hour online medication aide training and completed the medication skills validation checklist prior to administering medications. The findings are: Review of Staff C's, medication aide (MA) personnel record revealed: -She had a hire date of 09/01/21. -She completed the Medication Administration 5 Hour Training Course for Adult Care Homes on 09/21/21. -She was signed off on the Medication Clinical Skills Checklist on 09/22/21. Interview with Staff C on 09/30/21 at 12:25pm revealed: -She started working at the facility as a MA on	D935		

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D935	Continued From page 38 09/01/21. -She had three days of training on the medication cart before she started passing medications independently. -She passed medications independently starting on 09/07/21. -She completed the 5 hour training course on 09/21/21 and was signed off on the Medication Clinical Skills Checklist by the facility's training nurse on 09/22/21. -She was not aware that she was not able to pass medications independently prior to completing the Medication Clinical Skills Checklist and Medication Administration 5 Hour Training Course for Adult Care Homes. Review of September 2021 electronic medication administration records revealed Staff C administered medications independently 6 days prior to completing the Medication Clinical Skills Checklist and Medication Administration 5 Hour Training Course for Adult Care Homes from 09/07/21 to 09/15/21. Observation of the 8:00am medication pass on 09/29/21 revealed: -Staff C made 5 medications errors on 4 residents. -Staff C did not administer medications as ordered for psychiatric behaviors, reflux disease, and an eye infection. -Staff C administered an incorrect dosage on a nasal spray ordered for allergies. Interview with a resident on 09/30/21 at 5:00pm revealed: -She took medication every morning before breakfast. -On the morning of 09/29/21, she was administered her medication by the MA that	D935		

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worked the night shift.
-Staff C brought her a second dose of medication for administration after her breakfast on the same day.

Interview with the facility's training nurse on 09/30/21 at 2:25pm revealed:
-She was not aware that Staff C was required to take the 5-hour training course and complete the medication skills checklist prior to passing medications.
-She completed the Medication Clinical Skills Checklist with Staff C on 09/22/21 after she began passing medications independently.
-It was her responsibility that newly hired MA's completed the prior training prior to passing medications independently.

Interview with the Administrator on 09/30/21 at 3:52pm revealed:
-She was not aware that Staff C had not completed the appropriate training prior to passing medications independently.
-It was the facility's training nurse's responsibility to ensure that all staff completed training prior to passing medications independently.

Observation of the medication pass on 09/29/21 revealed a medication error rate of 17%.

Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).

_____

The facility failed to ensure Staff C, a medication aide, completed the Medication Skills Checklist and Medication Administration 5 Hour Training Course for Adult Care Homes. The facility's failure to ensure Staff C was properly trained prior to administering medications independently resulted in a 17% error rate during the medication

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D935	Continued From page 40 pass on 09/29/21 and was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 09/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2021.	D935		