Received via email on 12/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041052	A. BUILDING: _____ B. WING _____	R 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

(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 and Follow-up survey on 11/02/21 through 11/05/21.	D 000		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 2 chairs in the hallway of the Special Care Unit (SCU) and 1 chair in the SCU television room were clean. The findings are: Observation of the hallway area near Room #200 on 11/02/21 at 11:15am and 11:25am revealed: -There were two cloth chairs in the hallway with a light-colored fabric print. -The fabric on the arms of both chairs was layered with dirt build-up and unidentified stains. -There was a resident sitting in one of the chairs. Observation of the television room in the SCU on 11/03/21 at 8:20am revealed: -There was a cloth chair that matched the chair in the hallway area near Room #200. -There were unidentified dark colored stains on the fabric on both arms of the chair. Attempted interviews with 3 residents of the SCU on 11/02/21 between 12:22pm and 12:35pm was	D 076	1. Furniture was immediately cleaned/removed from area. 2. The Maintenance Director or designee to monitor the cleanliness and repair needed for furniture. 3. Furniture will be checked weekly to ensure that furniture is in good standing for 30 days. Furniture cleaning will be scheduled weekly. Maintenance Director or designee to schedule and ensure that weekly furniture checks and cleaning are being complete thereafter.	12-20-21

Reviewed and Acknowledged Keisha Banks 12/21/21

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D 076	Continued From page 1 unsuccessful. Interview with the Maintenance Director on 11/04/21 at 10:22am revealed: -The furniture in the SCU was cleaned once a month. -The chairs in the hallway and the television room were last cleaned about a month ago. -The chairs were purchased this past summer and were hard to keep clean. Interview with a housekeeper on 11/04/21 at 10:27am revealed: -He cleaned the furniture in the television room and in the hallway about 2 months ago. -He had not noticed the chairs had gotten stained again. -He wiped down the furniture as needed. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -The chairs in the SCU hallway and the matching one in the television room were purchased two summers ago. -She noticed the arms of the chairs in the hallway and television room were soiled and she brought it to the attention of the Maintenance Director and the Administrator. -If she did not clean the chairs in the SCU, they did not get cleaned. -She was working to try to get the cloth chairs switched to chairs with a wipeable covering. Interview with the Administrator on 11/05/21 at 9:09am revealed: -He did not know about the soiled and stained chairs in the SCU. -The maintenance and housekeeping staff were responsible for cleaning the furniture. -He expected the furniture in the SCU to be	D 076		

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D 076	Continued From page 2 cleaned once a week and as needed.	D 076		
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 2 of 6 sampled staff (Staff C and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1. Review of Staff C's, personnel care aide (PCA) personnel record revealed: -Staff C was hired on 08/24/21. -There was no documentation a HCPR check was completed upon hire. Telephone interview with Staff C on 11/05/21 at 5:05pm revealed: -She was hired in later August 2021 as a personal care aide (PCA). -She did not know if anyone at the facility completed a HCPR check on her when she was hired. Refer to interview with the Business Office Manager (BOM) on 11/04/21 at 5:35pm.	D 137	1. HCPR documentation filed for Staff requiring documentation. 2. New Hires to receive HCPR check and documentation to be filed in personnel charts. 3. BOM or designee to conduct weekly audits of personnel charts charts for 30 days. 4.BOM or designee to conduct monthly audits of personnel charts to ensure proper documentation has been filed in personnel charts.	12-20-21

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D 137	Continued From page 3 Refer to interview with the Administrator on 11/04/21 at 5:39pm. 2. Review of Staff E's, personal care aide (PCA) personnel record revealed: -Staff E was hired on 08/24/21. -There was no documentation a HCPR check was completed upon hire. Attempted telephone interview with Staff E on 11/05/21 at 5:07pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 11/04/21 at 5:35pm. Refer to interview with the Administrator on 11/04/21 at 5:39pm. Interview with the Business Office Manager (BOM) on 11-05-21 at 5:35pm revealed: -She could not find a HCPR check in staffs' personnel records. -She was responsible to complete HCPR checks on all new hires. -She had not audited 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 11-05-21 at 5:39pm revealed: -Documentation showing some staff had HCPR checks could not be found in their personnel records. -The BOM was responsible to complete HCPR checks. -He did not know why staff did not have HCPR checks when they were hired.	D 137		

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D 162	Continued From page 4	D 162		
D 162	10A NCAC 13F .0504(b) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (b) Competency validation shall be performed by the following licensed health professionals: (1) A registered nurse shall validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter. (2) In lieu of a registered nurse, a respiratory care practitioner licensed under G.S. 90, Article 38, may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (a)(11), (a)(16), (a)(18), (a)(19) and (a)(21) of Rule .0903 of this Subchapter. (3) In lieu of a registered nurse, a registered pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(8) of Rule .0903 of this Subchapter. (4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (27) of Rule .0903 of this Subchapter. This Rule is not met as evidenced by: Based on observations record reviews and interviews, the facility failed to ensure 4 of 6 sampled staff (Staff C, D, E and F) were competency validated by a Registered Nurse (RN) to perform Licensed Health Professional Support (LHPS) tasks including finger stick blood sugar checks, transferring and applying	D 162	1. Staff requiring proper training were provided training needed to perform job duties. 2. New Hires(PCAs/MAs) to receive check-off by licensed healthcare professional and documentation to be filed in personnel charts. 3. BOM or designee to conduct weekly audits of personnel charts charts for 30 days. 4.BOM or designee to conduct monthly audits of personnel charts to ensure proper documentation has been filed in personnel char	12-20-21

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D 162	Continued From page 5 compression stockings. The findings are: 1. Review of Staff C's, personal care aide (PCA) personnel record revealed: -She was hired on 08/24/21. -There was no documentation Staff C had completed the LHPS competency validation checklist. Observation of Staff C on 11/04/21 from 2:00pm to 3:00pm revealed she assisted residents with ambulating. Telephone interview with Staff C on 11/05/21 at 5:05pm revealed: -She started working at the facility in late August 2021. -She did not know what an LHPS checklist was. -She did not know who was responsible to complete LHPS checklists with staff. -She helped residents with bathing, toileting, transfer in and out of wheel chairs, bed and chairs and applied compression stockings to residents. -The MA or another PCA watched her perform some tasks but she did not remember a nurse training her for tasks such as applying compression stockings or helping residents transfer or ambulate. Refer to interview with Business Office Manager on 11/05/21 at 5:35pm. Refer to interview with Administrator on 11/05/21 at 5:39pm. 2. Review of Staff D's, medication aide (MA) personnel record revealed:	D 162		

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D 162	Continued From page 6 -She was hired on 07/06/21. -There was no documentation Staff D had completed the LHPS competency validation checklist. Review of residents' MARs revealed Staff D performed fingerstick blood sugar checks for 6 days in August 2021, 3 days in September 2021 and 6 days in October 2021. Review of residents' MARs revealed Staff D and applied/removed compression stockings for 3 days in August 2021 and 1 day in September 2021. Interview with Staff D on 11/02/21 at 10:54am revealed she assisted residents with applying and removing compression stockings. Refer to interview with Business Office Manager on 11/05/21 at 5:35pm. Refer to interview with Administrator on 11/05/21 at 5:39pm. 3. Review of Staff E's, personal care aide (PCA) personnel record on 11/04/21 revealed: -She was hired on 09/28/21. -There was no documentation Staff E had completed the LHPS competence validation checklist. Observation of Staff E in the Special Care Unit (SCU) on 11/03/21 at 7:55am revealed she assisted residents with transferring and ambulating from the dining room. Attempted telephone interview with Staff E on 11/05/21 at 5:07pm was unsuccessful.	D 162		

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D 162	Continued From page 7 Refer to interview with Business Office Manager on 11/05/21 at 5:35pm. Refer to interview with Administrator on 11/05/21 at 5:39pm. 4. Review of Staff F's, personal care aide (PCA) personnel record on 11/04/21 revealed: -She was hired on 05/04/21. -There was no documentation Staff F had completed the LHPS competency validation checklist. Telephone interview with Staff F on 11/05/21 at 5:05pm revealed: -She started working at the facility in May 2021. -She did not know what a LHPS checklist was. -She did not know who was responsible to complete LHPS competency validation checklists with staff. -She helped residents transfer in and out of wheel chairs, bed and chairs and had applied and removed compression stockings on residents. -She did not remember a nurse training her for tasks such as applying compression stockings or helping residents transfer or ambulate but was taught by MAs and other PCAs. Refer to interview with Business Office Manager on 11/05/21 at 5:35pm. Refer to interview with Administrator on 11/05/21 at 5:39pm. Interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm revealed: -She could not find documentation in personnel records showing Staff C, D, E and F had completed the LHPS competency validation checklist	D 162		

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D 162	Continued From page 8 -The nurse was responsible to complete the staffs' LHPS checklists. Interview with the Administrator on 11/05/21 at 5:39pm. revealed: -Documentation showing Staff C, D, E and F completed the LHPS competency validation checklist could not be found in their personnel records. -All MAs and PCAs should have LHPS competency validation. -There was a nurse employed until 10/10/21 who kept track of needed training and helped complete staff LHPS checklists.	D 162		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions;	D 164	1. Diabetic training provided for MAs requiring training. 2. MAs to receive Diabetic training from Qualified Healthcare professional. 3. BOM, RSD or designee to ensure MAs receive Diabetic training within 30days of hire. 4. LHCP will provide diabetic training for staff within 30 days of being hired and yearly thereafter. Documentation of training will be filed in staff profile charts. BOM or designee to audit personnel charts monthly to ensure training is complete.	12-20-21

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D 164	Continued From page 9 (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled medication aides (Staff A and D), who obtained fingerstick blood sugars (FSBS) for residents, completed training on the care of diabetic residents. The findings are: 1. Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A was hired on 07/07/20. -There was no documentation she had completed training on the care of diabetic residents. Review of a residents' October 2021 Medication Administration Record (MAR) revealed Staff A checked the residents' fingerstick blood sugar (FSBS) on 10 days that did not require insulin administration. Attempted telephone interview with Staff A on 11/05/21 at 5:19pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm. Refer interview with the Administrator on 11/05/21 at 5:39pm. 2. Review of Staff D's, medication aide (MA) personnel record revealed:	D 164		

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D 164	Continued From page 10 -Staff D was hired on 07/06/21. -There was no documentation she had completed training on the care of diabetic residents. Review of a residents' Medication Administration Record (MAR) revealed Staff D checked the resident's fingerstick blood sugar (FSBS) on 5 days in August 2021, on 4 days in September 2021 and on 5 days in October 2021. Attempted telephone interview with Staff D on 11/05/21 at 5:22pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm. Refer interview with the Administrator on 11/05/21 at 5:39pm. _____ Interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm revealed: -She could not find the documentation in personnel records showing Staff A and D had completed the diabetic care training. -The nurse was responsible for completing the staffs' diabetic care training. Interview with the Administrator on 11/05/21 at 5:39pm revealed: -Documentation showing Staff A and D had completed the diabetic care training could not be found in their personnel records. -All MAs should have completed training in diabetic care of residents. -There was a nurse employed until 10/10/21 who kept track of needed training and helped complete staff diabetic care training.	D 164		

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D 269	Continued From page 11	D 269		
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 ensure personal care was for 2 of 6 residents (#4 and #6) who needed assistance with toileting and bathing (Resident #6) and who needed assistance with toileting (Resident #4). The findings are: 1. Review of Resident #6's current FL2 dated 03/17/21 revealed: -Diagnoses include Alzheimer's disease, unspecified dementia without behavioral disturbance, essential primary hypertension, and cardiac murmur. -He was ambulatory, wandered, and was constantly disoriented. -He was incontinent of bladder and bowel. -He required assistance with bathing. Review of Resident #6's care plan dated 09/28/21 revealed he was totally dependent on staff for toileting, bathing, and personal hygiene. Review of Resident #6's Activities of Daily Living (ADL) log for August 2021 revealed:	D 269	1. LPN provided training to care staff on personal care and refusal of care. 2. Care staff to provide care for residents according to care plans. Care provided and refusal of care to be doucmented. 3. RSD or designee to monitor personal care/refusal of care daily for 30Days and then weekly there after. 4. Refusal of care provided by staff to be documented daily by each shift. RSD to ensure staff documenting care completed. Refusals shall be documented by staff. After 2 refusals, RSD to be notified of the refusals and a call should be made to resident's POA, notifying POA of the refusal. Periodic room checks should be performed weekly for residents who reside in special care units to ensure cleanliness of room. Residents to be cared for according to care plan. Residents rooms to be cleaned according to housekeeping schedule.	12-20-21

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D 269	Continued From page 12 -There was an entry to document assistance for ADLs on each shift for each day in August 2021. -There was documentation staff assisted Resident #6 with bathing on 7 shifts. -There was documentation staff assisted Resident #6 with toileting on 6 shifts. -There was documentation Resident #6 was totally dependent upon staff for bathing and toileting. -There was no documentation of refusals. Review of Resident #6's Weekly Skin Check Sheet revealed Resident #6's skin was checked/bath given on 08/03/21, 08/12/21, 08/17/21, 08/21/21, and 08/30/21 Review of Resident #6's ADL log for September 2021 revealed: -There was an entry to document assistance for ADLs on each shift for each day in September 2021. -There was no documentation staff assisted Resident #6 with bathing. -There was no documentation staff assisted Resident #6 with toileting. -There was no documentation of refusals. Review of Resident #6's Weekly Skin Check Sheet revealed: -Resident #6's skin was checked/bath given on 09/09/21, 09/14/21, 09/21/21, and 09/23/21. -There was documentation Resident #6 refused 3 a skin check/bath 3 times on 09/21/21. Review of Resident #6's ADL log for October 2021 revealed: -There was an entry to document assistance for ADLs on each shift for each day in August 2021. -There was documentation staff assisted Resident #6 with bathing on 1 shift.	D 269		

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D 269	Continued From page 13 -There was documentation staff assisted Resident #6 with toileting on 1 shift. -There was documentation Resident #6 was totally dependent upon staff for bathing and toileting. -There was no documentation of refusals. Review of Resident #6's Weekly Skin Check Sheet revealed: -Resident #6's skin was checked/bath was given on 10/12/21, 10/16/21, 10/21/21, 10/26/21, and 10/30/21 -There was no documentation of refusals. Observation of Resident #6's suite on 11/02/21 at 10:47am revealed: -He resided in the Special Care Unit (SCU). -Resident #6's suite consisted of a bedroom, a living area, and a bathroom. -There was dried feces on the light switch in his bathroom and dried feces on the light switch in his living area. Observation of Resident #6 on 11/02/21 at 10:51 revealed he had dried feces on top of and under the fingernails of his middle, ring, and pinky fingers of his left hand. Interview with a personal care aide (PCA) on 11/02/21 at 10:51am revealed: -Resident #6 was supposed to receive a bath on first shift, but he had not had one yet on 11/02/21. -Sometimes he received a bath on second shift. -It usually took 3 to 4 staff to assist with a bath and 3 staff to provide incontinence care. -She had not seen the feces on and under Resident #6's fingernails. Interview with a medication aide (MA)/PCA on 11/02/21 at 10:54am revealed:	D 269		

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D 269	Continued From page 14 -She noticed Resident #6 had feces on his fingers when she started her shift a 7:00am on 11/02/21. -She did not try to wash the feces off Resident #6's fingernails because she was helping with breakfast. -Resident #6 was very strong and tried to run from staff. -It usually took 3 people to bath him and assist with toileting. Observation of Resident #6 on 11/02/21 at 11:16am revealed: -PCAs were standing near Resident #6 after observing the feces on his fingernails and speaking with the surveyor. -The PCA's left the area where Resident #6 was standing and did not attempt to wash the feces from his fingernails. Interview with a MA on 11/04/21 at 9:35am revealed: -Resident #6 was scheduled to receive a bath 3 times weekly on first shift. -The Weekly Skin Care Sheets were completed each time a resident received a bath. -Resident #6 would pull feces from his incontinence brief so staff had to watch him and make sure to check him prior to meals. -PCAs were expected to provide baths and personal care on non-bath days if Resident #4 needed it. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -Resident #6 received total care except for feeding. -PCAs provided incontinence care and baths, but Resident #6 sometimes refused baths. -Sometimes it took up to 3 staff to assist with Resident #6's baths.	D 269		

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D 269	Continued From page 15 -It usually took 1 PCA to provide incontinence care. -Resident #6 played in his feces at times so staff had to watch him closely. -She did not know Resident #6 had feces on his fingernails on the morning of 11/02/21 and staff should have cleaned Resident #6's fingernails. Interview with the Administrator on 11/05/21 at 10:13am revealed he expected staff to provide personal care to resident #4 as needed. 2. Review of Resident #4's current FL2 dated 10/06/21 revealed: -Diagnoses included dementia, major depressive disorder, alcohol abuse, diabetes mellitus, and hypertension. -Resident #4 was intermittently disoriented. -Resident #4 was incontinent of bladder, but continent of bowel. Review of Resident #4's care plan dated 05/12/21 revealed: -Resident #4 ambulated using a rolling walker. -Resident #4 had occasional incontinence of the bladder, less than daily. -Resident #4 was sometimes disoriented. -Resident #4 was forgetful and needed reminders. -Resident #4 needed supervision for toileting. Review of Resident #4's Activities of Daily Living (ADL) log for August 2021 revealed: -There was an entry to document assistance for ADLs on each shift for each day in August 2021. -There was no documentation staff assisted Resident #4 with toileting. -Resident #4 was documented as independent with toileting. -There was no documentation of refusals.	D 269		

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D 269	Continued From page 16 Review of Resident #4's ADL log for September 2021 revealed: -There was an entry to document assistance for ADLs on each shift for each day September 2021. -There was no documentation staff assisted Resident #4 with toileting. -Resident #4 was documented as independent with toileting. -There was no documentation of refusals. Review of Resident #4's ADL log for October 2021 revealed: -There was an entry to document assistance for ADLs on each shift for each day in October 2021. -There was no documentation staff assisted Resident #4 with bathing. -Resident #4 was documented as independent with toileting. -There was no documentation of refusals. Observations upon entrance to the Special Care Unit (SCU) on 11/02/21 at 10:00am revealed: -There was a strong odor of urine immediately upon entrance. -Resident #4's room was located to the immediate left of the entrance to the SCU. -Resident #4's room door was closed and locked. Observation of Resident #4's room on 11/02/21 at 10:15am revealed: -There was a puddle of urine on the floor outside of Resident #4's bathroom. -There was a pair of urine-soaked underwear on the floor of Resident #4's bathroom. -There was a pair of underwear soiled with feces on Resident #4's bed. Observation of Resident #4's room on 11/03/21 at	D 269		

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D 269	Continued From page 17 8:04am revealed: -Resident #4's room door was closed, but it was unlocked, and Resident #4 was sitting on his rollator outside his room. -Resident #4 was clean and his clothes were dry. -There was an odor of urine coming from Resident #4's room. -On the floor outside his bathroom was a puddle of urine. Interview with Resident #4 on 11/03/21 at 7:52am revealed: -Staff did not assist him with bathing, dressing, or toileting. -He had urine on the floor outside of his bathroom this morning and that was why he was sitting outside his room. -He probably put the urine on the floor, but he did not know that for sure. -When he saw urine on the floor in his room, it was usually in the same spot. -He did not wear incontinence briefs and did not have accidents in his underwear. -He did not think he needed assistance with toileting. -Staff did not give him reminders to use the bathroom. Interview with a housekeeper in the SCU on 11/02/21 at 11:25am revealed: -There was usually a strong odor of urine near Resident #4's room door. -Resident #4 urinated on the floor a lot. -He tried to clean and mop Resident #4's floors twice daily and there was usually urine on Resident #4's floor when he went in to clean. -No other staff went in Resident #4's room to clean the urine off his floor. -He had seen Resident #4's underwear on the floor, but he had never seen any incontinence	D 269		

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D 269	Continued From page 18 briefs in his trash. Interview with a personal care aide (PCA) on 11/02/21 at 10:48am revealed: -She had noticed odors coming from Resident #4's room since she was hired a month ago. -Resident #4 urinated on the floor of his room. -She never assisted him with toileting because he would try to fight her. Interview with a second PCA on 11/02/021 at 10:54am revealed: -If Resident #4 wore incontinence briefs, he did not keep them on because his room smelled like urine. -Resident #4's room always smelled like urine. -She did not assist Resident #4 with toileting. -He would not let staff go in his room. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -She knew about the urine odor coming from Resident #4's room and Resident #4 urinating on the floor. -Resident #4 sat on his rollator and went to sleep, holding his urine until he had a hard time making it to his bathroom toilet. -Staff did not assist Resident #4 with toileting because he did not like females to assist him. -First shift staff has started prompting Resident #4 to use the bathroom over the last month, but she did not know what happened on second and third shifts. Interview with a PCA on 11/04/21 at 2:56pm revealed: -Resident #4 usually went to the bathroom by himself. -She had seen urine on Resident #4's floor a couple times, but she had not seen him soil or	D 269		

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D 269	Continued From page 19 urinate in his clothes. -She had never given Resident #4 any reminders or cues to use the bathroom. Interview with a another PCA on 11/04/21 at 3:18pm revealed: -Resident #4 toileted independently. -She did not provide reminders or cues for him to toilet. -He went to the bathroom by himself when he needed to go. -She had seen urine on the floor of Resident #4's room. -She did not know why Resident #4 urinated on his room floor. Interview with the Administrator on 11/05/21 at 10:13am revealed: -He had noticed an odor of urine coming from Resident #4's room. -Resident #4 urinated on the floor of his room at times. -He expected staff to assist Resident #4 with toileting as needed.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION	D 270	1. Resident's requiring more supervision reassessed. Residents provided supervision in accordance to residents needs. 2. Training on proper documentation for falls/fall Management as well as reporting changes in care, provided to Staff. 3. RSD or designee to check documentation of care weekly for 30days and monthly thereafter. 4.RSD and ED to review incident reports within 24hrs of receiving and implement plan of action as needed.	12-20-21

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D 270	Continued From page 20 Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 residents sampled (#4 and #5) related to a resident who had multiple falls resulting in injuries (#4), a male resident and a female resident (#4 and #5) found undressed and in bed together, the male resident (#4) inappropriately touching the female resident (#5), and the female resident (#5) visiting alone in the male resident's room (#4) without supervision. The findings are: 1. Review of the facility's Fall Management and Investigation Policy dated 09/01/18 revealed: -A service plan was updated post-fall to address potential risk factors and suggested interventions. -The Morse Fall Risk Evaluation Tool was completed post fall incident and if the score indicated risk, it may have prompted discussion of a referral for an outside rehabilitation consultation. -Post fall procedures included evaluating the resident, immediate first aide intervention, transfer to the hospital or urgent care if needed, notifying the family and attending physician, modifications to the resident's treatment and interventions accordingly if indicated, and fall interventions were reviewed for continued effectiveness. -Fall interventions were communicated to the staff, family, and the resident for safety awareness along with the risks and benefits of fall prevention. -There was no documentation regarding increasing supervision of residents after a fall. Review of Resident #4's current FL2 dated 10/06/21 revealed: -Diagnoses included unspecified dementia, major	D 270		

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D 270	Continued From page 21 depressive disorder, alcohol abuse, type 2 diabetes mellitus, and essential hypertension. -He was intermittently disoriented. -He was ambulatory and wandered. Review of Resident #4's care plan dated 05/12/21 revealed: -He required no assistance with ambulation or transfers. -He used a walker for ambulation. -He had sexually inappropriate behaviors at times and his family and physician were aware. Review of Resident #4's Wander Risk Evaluation dated 06/17/21 revealed: -Resident #4 was routinely disoriented and had a diagnosis of dementia. -Resident #4 was ambulatory with an assistive device. -Resident #4's goal was to have his safety maintained. -Interventions included: staff would observe Resident #4's location in the Special Care Unit (SCU). a. Review of Resident #4's Incident and Accident Report dated 03/10/21 at 12:40pm revealed: -Resident #4 had an unwitnessed fall and was found in the hallway. -Resident #4's primary care physician (PCP) and responsible party were notified. -There was no documentation regarding injuries. Review of Resident #4's progress note dated 03/10/21 revealed: -Resident #4 was found laying on his left side with his left arm under his head for support. -He was easy to assist from the floor with one person. -Resident #4 denied having any pain or	D 270		

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D 270	Continued From page 22 discomfort and stated he did not fall. -Resident #4's PCP, family member, and Administrator were notified. -Resident #4 was monitored after the fall and there were no concerns. Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the fall on 03/10/21. Review of Resident #4's Incident and Accident Report dated 04/06/21 at 10:26am revealed: -Resident #4 had an unwitnessed fall and was seen on the floor by staff. -Resident #4's PCP and responsible party were notified. -There was no documentation regarding injuries. Review of Resident #4's progress note dated 04/06/21 revealed: -Resident #4 had an unwitnessed fall. -He had an abrasion and a bump on the right side of his forehead. -Resident #4 got himself up from the floor while the medication aide (MA) was on the phone with Emergency Medical Services (EMS). -Resident #4 was sent out to the emergency department (ED) and returned to the facility on 04/06/21. Review of a fax document to Resident #4's PCP on 04/06/21 revealed: -Resident 4 was found on the floor in the hallway. -Resident #4 had a small abrasion and bump on the right side of his forehead. -Resident #4 was sent to the ED for evaluation. -Resident #4's PCP visited Resident #4 and signed the fax document on 04/07/21.	D 270		

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D 270	Continued From page 23 Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the fall on 04/06/21. Review of Resident #4's Incident and Accident Report dated 06/09/21 at 1:58pm revealed: -Resident #4 had an unwitnessed fall and was found on the floor. -Resident #4 complained of chest pain. -Resident #4's responsible party was notified. Review of Resident #4's progress notes revealed there was no progress note dated 06/09/21. Review of Resident #4's local hospital ED after visit summary dated 06/09/21 revealed: -Resident #4 was seen in the ED due to chest pain. -Diagnoses included atypical chest pain. -Resident #4 was evaluated for chest pain and no concerning findings were noted. Review of Resident #4's Fall Risk Evaluation dated 06/17/21 revealed: -Resident #4 had fallen within the past 6 months. -Resident #4's gait was impaired; he had difficulty rising from chairs, used chair arms to get up, and bounced to rise. -He kept his head down when walking and watched the ground. -He grasped furniture, person, or aid when ambulating. -Resident #4 could not walk unassisted. -Resident #4 was a fall risk and his goals were to have his fall risk minimized. -Interventions included: staff provided Resident #4 with a safe environment which was clutter free; support/assistive devices were available and in good repair, and personal items and call device	D 270		

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D 270	Continued From page 24 were within reach. Based on record reviews, there was no documentation of an increase in supervision implemented for Resident #4 after the fall on 06/09/21. Review of Resident #4's Incident Report Form dated 07/02/21 at 2:30pm revealed: -Resident #4 had an unwitnessed fall. -Resident #4's PCP was notified. -There was no documentation regarding injuries. Review of Resident #4's progress note dated 07/02/21 revealed: -Resident #4 had an unwitnessed fall on 07/02/21. -He did not complain of pain. -The MA did range of motion and checked for redness, bruising, and knots. -There were no injuries to report. -Resident #4's family member and the facility nurse were notified. Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the fall on 07/02/21. Review of Resident #4's Incident and Accident Report dated 07/11/21 at 10:22am revealed: -Resident #4 had an unwitnessed fall from a love seat. -Resident #4 injured the right side of his forehead. -Resident #4's primary care physician (PCP) and responsible party were notified. Review of Resident #4's progress note dated 07/11/21 revealed:	D 270		

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D 270	Continued From page 25 -Resident #4 was sitting on a loveseat asleep in the hallway when he fell face forward onto the floor. -His head was bleeding. -Resident #4 was sent out to the ED by EMS -The facility nurse and Resident #4's PCP were notified. -Resident #4 returned to the facility on 07/11/21 at 4:50pm with his head wrapped. -He did not have any stitches or staples. Review of Resident #4's local hospital ED after visit summary dated 07/11/21 revealed: -Resident #4 was seen in the ED due to a fall. -Resident #4's diagnoses included a fall, injury of the head, and abrasion of the scalp. Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the fall on 07/11/21. Review of Resident #4's Incident and Accident Reports revealed there was no Incident and Accident Report for 09/21/21. Review of Resident #4's progress notes revealed there was no progress note for 09/21/21. Review of Resident #4's local hospital ED after visit summary dated 09/21/21 revealed: -Resident #4 was seen in the ED due to a fall. -Resident #4's diagnoses included a fall and injury of the back. -There was no evidence of a significant injury or emergency on Resident #4's presentation to the ED on 09/21/21. -Resident #4 did not have significant back pain or bony tenderness to suggest a fracture of the spine.	D 270		

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D 270	Continued From page 26 Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the fall on 09/21/21. Observation of Resident #4 on 11/03/21 at 7:51am revealed he was sitting on the seat of his rollator walker outside of his room and the wheels were not locked. Interview with Resident #4 on 11/03/21 at 7:52am revealed he did not remember having any falls, injuries, or going to the ED. Interview with a personal care aide (PCA) on 11/04/21 at 2:56pm revealed: -She checked on residents every 2 hours including Resident #4. -She found Resident #4 on his back in the hallway in September 2021. -Resident #4 was sent to the local hospital ED, but he did not have any injuries. -She was not told to do anything differently for Resident #4 when he returned from the ED. -She was not told to increase supervision for Resident #4 after his falls. -She was not aware of any interventions put in place for Resident #4 after his fall. -Resident #4 could probably use a different pair of shoes. -He usually did not wear his shoes completely on his feet as he slid his feet in the shoes and stepped on the heels of the shoes. Interview with a MA on 11/04/12 at 9:35am revealed: -She remembered Resident #4 having two falls since March 2021, but she did not remember when.	D 270		

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	HAL041052	A. BUILDING: _____ B. WING _____	R 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 27 -The first time she remembered Resident #4 falling was when he was sitting in a chair in the hallway; he fell off the chair and hit his head; she did not witness the fall. -The second time she remembered Resident #4 falling was when he was sitting on his walker in hallway and fell backwards; she did not witness the fall. -When Resident #4 fell backwards, she had him sent out to the hospital for precaution because he fell on his back. -There were no interventions put in place for Resident #4 that she knew of after either fall. -The protocol was to check on all residents every 2 hours. -If a resident had a fall, she checked on the resident every hour or every 30 minutes, but there was no set length of time. -During her shift, she determined if the resident whether the resident was placed on 30 minute checks. -There was no documentation of any increased checks on residents after a fall. -Staff used to document increased safety checks, but staff had not completed the documentation in a while and she did not remember how long it had been. -Staff were just told to monitor residents. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -All residents were on a 1 to 2-hour safety checks in the SCU. -Resident #4 fell asleep in his rollator and most of his falls occurred while he was sleeping. -She did not think supervision was increased for Resident #4 after his falls, but he was in the common area most of the time. -Supervision of all residents was hard because of staffing.	D 270		

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D 270	Continued From page 28 -It was hard to have a visual on all residents, so staff tried to keep residents engaged in activities. -She did not think residents were being supervised in the SCU according to their needs. Interview with the SCUC on 11/05/21 at 11:45am revealed: -Anytime a resident had a fall, staff documented in the progress notes for 3 days. -During the 3 days after a fall, staff should have documented if there was any discomfort, bruises, or pain. -After a fall, the resident should have been monitored throughout the day. Interview with Resident #4's primary care provider (PCP) on 11/03/21 at 1:23pm revealed: -The facility notified her of Resident #4's falls. -After Resident #4's falls, she expected staff to notify her, call EMS if he hit his heat, and redirect him. -She would have to refer to the facility's policy regarding supervision of residents after a fall. Interview with the Administrator on 11/05/21 at 5:19pm revealed: -The facility had tried physical therapy, date unknown, with Resident #4, but he did not qualify. -Staff discussed Resident #4 falling asleep in his rollator and making his sure his rollator was locked when he sat on it. -There was no documentation of discussions of interventions for Resident #4. -Staff should have increased supervision for residents after falls including Resident #4. -Staff should have completed documentation for hourly checks on the resident for 72 hours after a fall. -Staff were not documenting hourly checks for residents after a fall.	D 270		

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D 270	Continued From page 29 -If a resident fell again, the staff were to notify the resident's physician, send out to the ED if necessary, and continue hourly checks. Attempted telephone interview with Resident #4's responsible party on 11/05/21 at 9:09am was unsuccessful. b. Review of Resident #4's Incident and Accident Report dated 05/04/21 at 6:30pm revealed: -Resident #4 exhibited sexual behavior and was found lying in his bed. -Resident #4's primary care physician (PCP), responsible party, the county Department of Social Services (DSS), and the Administrator were notified. -There was no additional information regarding the sexual behavior. Review of Resident #4's progress notes revealed there was no progress note for 05/04/21. Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the incident on 05/04/21. Review of Resident #4's Incident and Accident Reports revealed there was no Incident and Accident Reports dated 05/03/21 or 05/05/21. Review of Resident #4's progress note dated 05/05/21 revealed: -Resident #4 was in a female resident's room with the zipper of his pants down on 05/03/21. -Resident #4 was redirected away from the female resident and monitored. -"Resident #4 needed constant supervision due to not listening to staff."	D 270		

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D 270	Continued From page 30 Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the incident on 05/03/21. Review of Resident #4's Incident and Accident Reports revealed there was no Incident and Accident Report dated 05/10/21. Review of a Behavior/Intervention Monitoring Form for Resident #4 dated 05/10/21 at 1:55pm revealed: -Resident #4 exhibited sexually inappropriate behavior as he had another resident sitting in his lap. (There was no indication if the other resident was female or male.) -Resident #4 was redirected. Review of Resident #4's PCP's consultation notes dated 05/12/21 revealed: -Resident #4 had a sexual arousal disorder. -Staff reported to the PCP that two residents, Resident #4 and a female resident, were found in bed together. -Resident #4 and a female resident were unclothed from the waist down. -Resident #4 did not have any recollection of the incident occurring. -Staff contacted the county DSS and the female resident's family member, but they were not able to get in contact with Resident #4's family member. -The PCP assessed Resident #4 to be alert to self and roughly to place. -Resident #4 carried on a conversation with loose thoughts and said he did not remember the sexual incident. -The PCP recommended staff to continue to redirect, frequent monitoring, and administer bedtime aggression medication.	D 270		

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D 270	Continued From page 31 Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the incident on 05/10/21. Review of Resident #4's Incident and Accident Report dated 05/16/21 at 5:50pm revealed: -Resident #4 had a female resident in his room. (female resident was not identified) -Resident #4's PCP and responsible party were notified. -No injuries were identified. Review of Resident #4's progress note dated 05/16/21 revealed: -Resident had a female resident in his room. (female resident was not identified) -Staff redirected them apart. -Staff left Resident #4 in his room and let him "cool off." -Resident #4's family member, the facility nurse, Administrator, and PCP were notified. Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the incident on 05/16/21. Review of Resident #4's Incident and Accident Reports revealed there was no Incident and Accident Report dated 09/20/21. Review of Resident #4's progress note dated 09/20/21 revealed: -Resident #4 was "caught" touching on a female resident. -A Personal Care Aide (PCA) told him to stop and moved him to a different area. -The incident was reported to the facility nurse.	D 270		

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D 270	Continued From page 32 Based on record reviews, there was no documentation of interventions or increase in supervision implemented for Resident #4 after the incident on 09/20/21. Observation in the Special Care Unit (SCU) on 11/04/21 at 3:05pm revealed: -Resident #4 was seated on the seat his rollator walker in the common area and a female resident was standing beside him. -Resident #4 put his arm around the female resident's waist. -There was no staff intervention. Observation of the SCU on 11/04/21 between 3:44pm and 4:15pm revealed: -Resident #4's room was located on the same hall as the female resident's room. -At 3:44pm, the female resident was observed coming out of Resident #4's room. -At 3:56pm, the female resident entered Resident #4's room. -At 4:11pm, Resident #4 and the female resident came out of Resident #4's room. -At 4:13pm, the female resident was pushing Resident #4 down the hallway seated in his rollator walker. -At 4:14pm, a personal care aide (PCA) walked down the hallway where Resident #4's room was located. -No staff came to observe the whereabouts of Resident #4 and the female resident between the time the female resident entered Resident #4's room at 3:56pm and the time they exited Resident #4's room at 4:13pm. Interview with Resident #4 on 11/03/21 at 7:52am revealed: -He did not have a girlfriend in the SCU.	D 270		

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D 270	Continued From page 33 -Staff told him he could not be around a certain female, but he could not remember which one. Interview with a PCA on 11/02/21 at 10:54am revealed: -Resident #4 displayed inappropriate behaviors with the female resident. -He tried to feel on the female resident's breasts and tried to kiss her. -The female resident's family member asked staff to keep Resident #4 away from her. -If she saw Resident #4 displaying inappropriate behaviors, she tried to get female resident to walk with her. Interview with a medication aide (MA) on 11/02/21 at 4:37pm revealed: -Resident #4 was infatuated with the female resident, but female resident thought he was her family member. -Resident #4 and the female resident were usually together. -Resident #4 was usually out of his room in the hallway or in the open dining area. Interview with another MA on 11/04/21 at 9:35am revealed: -It was hard to keep Resident #4 and the female resident apart. -The female resident thought Resident #4 was her family member. -Resident #4 and the female resident were caught in bed together by staff, but she did not remember when. -Resident #4 inappropriately touched the female resident and the female resident sat in his lap. -She did not know if there was any increased supervision of Resident #4 and the female resident after they were caught in bed together or after any other sexual behaviors.	D 270		

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D 270	Continued From page 34 -Staff locked Resident #4's room when he was out of his room. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -Resident #4 was very friendly with the female resident. -The female resident thought Resident #4 was her family member. -It was difficult to contact Resident #4's family, but the family was aware of his behaviors. -The female resident's family member was okay with her being around Resident #4, but he did not want them being alone or Resident #4 touching the female resident. -Staff tried to keep an eye on both Resident #4 and the female resident. -Supervision of all residents was hard because of staffing. -It was hard to have a visual on all residents, so staff tried to keep residents engaged in activities. -She did not think residents were being supervised in the SCU according to their needs. Interview with a personal care aide (PCA) on 11/04/21 at 2:56pm revealed: -The female resident thought Resident #4 was her family member. -Resident #4 played along with the female resident. -The female resident's family member did not want Resident #4 around the female resident at all. -It was difficult to keep Resident #4 separated from the female resident. Interview with the SCUC on 11/05/21 at 11:45am revealed: -Staff checked on Resident #4 every 1 to 2 hours. -Staff always had a visual on Resident #4 and the	D 270		

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D 270	Continued From page 35 female resident. -She did not know the female resident was in Resident #4's room unsupervised for 15 minutes. Interview with Resident #4's PCP on 11/03/21 at 1:23pm revealed: -She was aware of Resident #4's inappropriate sexual behaviors with the female resident. -She could not remember the details of incidents staff reported to her without looking at her documentation. -The female Resident approached Resident #4 more so than Resident #4 approached the female resident from what she had seen. -She expected staff to redirect Resident #4 if there were incidents of inappropriate sexual behaviors. Interview with the Administrator on 11/05/21 at 5:19pm revealed: -He knew about the sexual behaviors exhibited between Resident #4 and the female resident. -Resident #4's and the female resident's family did not mind them being together, but they did not want them in either of their rooms. -He expected staff to redirect Resident #4 and the female resident when inappropriate behaviors were observed. -He expected staff to provide increased checks on Resident #4 and the female resident ongoing and for staff to keep an eye on the two residents as much as humanly possible. Attempted telephone interview with Resident #4's Responsible party on 11/05/21 at 9:09am was unsuccessful. 2. Review of Resident #5's current FL2 dated 03/17/21 revealed diagnoses included dementia with behavioral disturbance.	D 270		

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D 270	Continued From page 36 Review of Resident #5's resident profile dated 08/26/21 revealed: -Her behaviors included sadness and wandering. -Her degree of cognitive impairment included lack of orientation to time and place. -She was independent with dressing, transfers, and ambulation. Review of Resident #5's personal care aide (PCA) activities of daily living (ADL) log for August 2021 revealed: -There was an entry for staff to check on her every 2 hours. -There was documentation that staff completed 2-hour checks on Resident #5 two days in the month, on 08/10/21 and 08/16/21 on the 11:00pm to 7:00am shift. Review of Resident #5's PCA ADL log for September 2021 revealed: -There was an entry for staff to check on her but there was a blank space where it would specify how often. -There was no documentation staff completed any checks on Resident #5. Review of Resident #5's PCA ADL log for October 2021 revealed: -There was an entry for staff to check on her but there was a blank space where it would specify how often. -There was documentation that staff completed checks on Resident #5 for one day, on 10/09/21 on the 3:00pm to 11:00pm shift and the 11:00pm to 7:00am shift. Review of Resident #5's Incident and Accident Report dated 05/04/21 revealed: -During rounds after dinner it was reported that	D 270		

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D 270	Continued From page 37 Resident #5 was seen laying in the bed in a male resident's room with no clothing on, under the blankets. Staff assisted Resident #5 out of the room. Resident #5 did not want to leave the male resident, thinking that he was her spouse. The male resident was lying on his side towards Resident #5 with his pants down. -The incident occurred on 05/04/21 at 6:30pm. -It was noted there was no apparent injury to Resident #5 at the time the incident was discovered. -The corporate Director of Clinical Services was notified on 05/06/21 at 4:45pm. -The responsible person of Resident #5 was notified on 05/06/21 at 5:00pm. -The County Department of Social Services was notified on 05/07/21 at 8:00am. -The primary care provider (PCP) was notified on 05/07/21 at 9:20am. -Resident #5 was redirected from the male resident. Full assessment was completed upon notification (05/06/21) that Resident #5 had no pain, redness, bruising, or swelling. No cognition changes, emotional changes noted. Review of Resident #5's progress note dated 05/05/21 revealed: -Resident #5 was found with her clothes off in her room with a male resident. Resident #5 was redirected to dress in her clothes and told male resident was not her spouse. -The action taken was that staff redirected Resident #5 from the male resident and monitored frequently. -The result listed documented that Resident #5 needed constant supervision from staff due to not understanding "the need to leave male resident alone." Review of Resident #5's progress note dated	D 270		

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D 270	Continued From page 38 05/06/21 revealed: -Resident #5 was monitored for behaviors and needed to be redirected. The resident was admitted to hospice services. -Staff were monitoring and redirecting as needed. Review of Resident #5's progress note dated 05/16/21 revealed: -Resident #5 was in another resident's room. She was safely redirected away. No clothing had been removed. -Staff notified Resident #5's power of attorney (POA), the Executive Director (ED), the nurse on staff, and PCP. -There was documentation to keep redirecting the resident to go other places or to sit down. Interview with a PCA on 11/05/21 at 11:35am revealed: -Resident #5 liked to stay in her room. -Staff did checks on her every 2 hours if she was not already visible in the common areas. -Usually she was easy to redirect but sometimes if she was in another resident's room she did not like to leave. -She was not working the night Resident #5 was found undressed in the male resident's room, but she knew that Resident #5 did like to sit and stand close to him in the common areas. Interview with a medication aide (MA) on 11/05/21 at 11:40am revealed: -It was difficult to redirect Resident #5 from the male resident's room as she thought he was either her family member, or her spouse at various times. -She needed to redirect Resident #5 away from the male resident's room every day. -Resident #5 wandered in the halls and she would frequently go to the male resident's room and	D 270		

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D 270	Continued From page 39 knock or shake his door handle when the room was locked. Staff would redirect her when they saw her at the male resident's door. -If staff did not see Resident #5 in the common areas, they would check other resident rooms until staff found her. Interview with Resident #5's Responsible Party on 11/05/21 at 12:32pm revealed: -The facility would call him immediately whenever there was an incident with Resident #5. -Every resident in the Special Care Unit (SCU) wandered into other residents' rooms. -He visited Resident #5 every day from around 9:00am to noon. -He was notified by the facility of the incident with Resident #5 and the male resident being undressed in bed together. -He did not want Resident #5 and the male resident alone in a room together after he had learned about the incident of them being together in a bed, but was "okay" if the two of them were together in the common areas. Interview with another PCA on 11/05/21 at 3:50pm revealed: -Resident #5 spent most of her time in her room or in the hallways. -The staff were supposed to do checks on all the residents every two hours, but they watched all the residents "all the time" due to the residents having dementia and wandering behavior. -Resident #5 liked to walk the halls with the male resident but she had never seen them together in one of the resident rooms. -She was unaware of the incident that occurred between Resident #5 and the male resident where they were undressed together in May 2021.	D 270		

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	HAL041052	A. BUILDING: _____ B. WING _____	R 11/05/2021

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D 270	Continued From page 40 Interview with the Administrator on 11/05/21 at 5:20pm revealed: -He expected the PCAs to complete documentation every shift that they performed two hours checks on Resident #5. -Resident #5's family and the male resident's family were both "okay" with the residents being together in common areas but not alone together in a room. -He expected staff would supervise and intervene as needed if Resident #5 went into another resident's room. The facility failed to provide supervision of residents including a resident who was intermittently disoriented and had a diagnosis of dementia which resulted in the resident having multiple falls, 4 emergency department visits, and injuries including abrasion and bump on the right side of the forehead, head injury and abrasion of the scalp, and an injury to the back (#4); and two residents in the Special Care Unit (#4 and #5) who both had a diagnosis of dementia who were found unsupervised in bed together undressed and alone in one of their rooms, and Resident #4 inappropriately touching Resident #5. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/05/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care	D 273	1.Audit of residents medication completed 11/4/21 to ensure medications ordered, are on the medication carts.	12-20-21

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D 273	Continued From page 41 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews, observations and interviews the facility failed to ensure referral and follow-up with health care providers, for 1 of 5 sampled residents (Resident #2) regarding an ordered cholesterol medication and a urinalysis not obtained. The findings are: 1. Review of Resident #2's current FL2 dated 08/29/21 revealed diagnoses included ischemic stroke, hyperlipidemia, urinary tract infection (UTI), and history of sepsis (a blood infection) due to urinary tract infection. a. Review of Resident #2's hospital discharge summary and medication orders dated 08/29/21 revealed: -Resident #2's primary diagnosis for the hospital stay was ischemic stroke. -There was a physician's order for atorvastatin (a medication used to treat high cholesterol and reduce the risk of heart attack or stroke) 20mg daily to start on 08/30/21. Review of a fax sent from the facility to the primary care provider (PCP) on 09/02/21 revealed: -There was a request for an order for atorvastatin 20mg daily, as Resident #2 had returned from the hospital with the order but the hospital had not sent a prescription to the pharmacy. -The area on the fax labeled "Physician's Response" was blank.	D 273	2. Education provided to MAs by RSD on 12/13/21 about receiving orders and following up to ensure medications/order are received and followed through within a timely manner. Also training to be provided on the follow-up on orders such as UTIs and XRays. 3. RSD or Designee to provide follow-up on all orders of medications as well as other orders such as UTIs and XRays. Follow-up to be provided daily. 4.RSD or designee to complete daily monitoring of Medication administration and order follow-up for 30 days and then weekly thereafter to ensure all medications are in the community and on the medication cart.	

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D 273	Continued From page 42 Review of Resident #2's September and October 2021 medication administration record (MAR) revealed there were no entries for atorvastatin 20mg daily. Interview with the Director of Clinical Services on 11/03/21 at 12:00pm revealed: -The process the facility used to clarify or request new orders from a provider included using an "order tracking form." -The medication aide (MA) or nurse who faxed the order request to the PCP would start the form, then either the MA or Wellness Coordinator (WC) would await a response from the PCP and complete the form once the request had been addressed and completed. -If a shift was ending and no response had been received from the PCP yet, the form was to be placed in the WC's mailbox for follow up so orders would not be missed. Interview with a representative from the facility's contracted pharmacy on 11/03/21 at 12:10 revealed the only order for atorvastatin they had on file for Resident #2 was from December of 2019. Interview with Resident #2's PCP on 11/03/21 at 1:30pm revealed: -She did not receive an order request for atorvastatin from the facility. -She did not feel there was any potential harm to Resident #2 for not having started the atorvastatin as ordered. -It would have been her expectation that the facility would try contacting her again for the order if they had not received a response the first time. Interview with the WC on 11/03/21 at 4:45pm	D 273		

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D 273	Continued From page 43 revealed: -When a resident was discharged from the hospital the MA should review the paperwork and fax any new orders to the pharmacy. -If there were new orders that required clarification, the MA should send a fax to the PCP. -Her role was to review the hospital discharge paperwork for new orders and to make sure the MA transcribed everything correctly. -If an order request was faxed to the PCP and no response was received from the PCP during that shift, the MA should notify the oncoming MA to watch for a faxed response back from the PCP. Interview with the Administrator on 11/04/21 at 3:00pm revealed: -The WC was responsible for following up on new orders received from the PCP or hospital. -If a new medication was ordered and not received, he would expect the WC to notify the nurse or Director of Clinical Services so that the facility could obtain the medication for the resident. Interview with an MA on 11/05/21 at 4:20pm revealed: -The MA staff used the order tracking form whenever a fax was sent to the PCP for a new order or clarification. -If a response was not received by the PCP during their shift, the order tracking form was left on the desk in the office for the oncoming shift to see. b. Review of Resident #2's physician orders on 11/02/21 revealed: -There were two lab order request sheets from the PCP dated 09/22/21 and 09/29/21 requesting staff to collect a urine sample for testing to rule	D 273		

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D 273	Continued From page 44 out a urinary tract infection (UTI). -There were no lab results for the urinalysis (UA) and urine culture (UC) orders dated 09/22/21 and 09/29/21. Interview with the Director of Clinical Services on 11/03/21 at 12:00pm revealed: -The Wellness Coordinator (WC) was responsible for following up on new orders received from the PCP. -She did not know why there were no UA/UC lab results in Resident #2's record. Interview with Resident #2 on 11/03/21 at 12:41 revealed: -She got frequent UTIs. -She remembered giving a urine specimen in September 2021 where she urinated into a collection device in her toilet, but it sat at room temperature for too long and could not be used for the lab test. -She remembered giving a second urine specimen in September 2021, but it was on a weekend and she never received the result. -She had asked what the result of her UA was but had been told by staff that they had not heard back from the lab. Interview with Resident #2's PCP on 11/03/21 at 1:30pm revealed: -She was not aware that the UA and UC labs from September 2021 had not been collected. -There was no harm Resident #2 for not having completed the ordered lab tests. Interview with the WC on 11/03/21 at 4:45pm revealed: -When a new order was written by the PCP, either a MA or herself would be responsible for following up on the order.	D 273		

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D 273	Continued From page 45 -She did not know why the UA/UC orders did not have results, or if the specimens had ever been collected. Interview with a representative from the facility contracted laboratory on 11/04/21 at 8:45am revealed: -The lab had a request from the facility to pick up a urine specimen on 10/01/21. -They had gone to the facility to pick up the specimen that day and there was no specimen ready or available to bring to the lab. -They were told that a MA would call the lab once staff obtained the specimen and it was available to be picked up, but they never received a call to return to the facility. -They had received another request for a specimen pick-up on 10/07/21, but when they arrived at the facility to pick it up, again there was no specimen ready for them. -The lab did not run a UA or UC lab for Resident #2 in September or October 2021. Interview with the Administrator on 11/04/21 at 3:00pm revealed: -When a lab specimen was collected at the facility it is the responsibility of the MA or a supervisor to call the lab to pick up the specimen for testing once it is ready. -He did not know why the lab orders had been missed or why lab was called to pick up a specimen before it had been collected.	D 273		
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	D 276	1.Audit of residents medication completed by Director of Clinical to ensure medications ordered, are on the medication carts. 2. MAs provided with education on ordering process by RSD on 12/13/21	12-20-21

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D 276	Continued From page 46 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 observation, record reviews, and interviews, the facility failed to ensure physician's orders were implemented for 1 of 5 sampled residents (#1) with an order for inhaled nebulizer solution every 6 hours. The findings are: 1. Review of Resident #1's current FL2 dated 10/08/21 revealed: -Diagnoses included muscle weakness, urinary tract infections and unsteadiness of feet. -There was an order for ipratropium bromide albuterol 0.5-2.5mg/3ml solution inhale 3ml via nebulizer every 6 hours for emphysema. Review of Resident #1's Resident Register revealed she was admitted to the facility on 10/18/21. Review of Resident #1's November 2021 medication administration record (MAR) revealed: -There was a handwritten entry for ipratropium bromide albuterol 0.5-2.5mg/3ml solution inhale 3ml via nebulizer every 6 hours for emphysema with "prn" written beside the entry. -There was no documentation ipratropium bromide albuterol 0.5-2.5mg/3ml solution inhale 3ml via nebulizer every 6 hours for emphysema was administered. -There was no documentation on back of the MAR as to why medication was not administered. Review of Resident #1's medication on hand on	D 276	3. RSD or Designee to monitor MAs MAs are following the policies of getting medication ordered and ensure in the building. 4.RSD or designee to complete daily monitoring of Medication administration for 30 days and then weekly thereafter to ensure all medications are in the community and on the medication cart.	

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D 276	Continued From page 47 11/02/21 at 4:00pm revealed Resident #1 did not have ipratropium bromide albuterol 0.5-2.5mg/3ml solution available. Interview with a MA on 11/02/21 at 4:05pm revealed: -MA's were responsible for ordering medication from the facility pharmacy. -She did not know if Resident #1 had a nebulizer machine. -If residents needed equipment the Wellness Coordinator (WC) would get an order and home health companies delivered it. -Resident #1's family member brought in all of her medications himself. -She had not requested Resident #1's missing Ipratropium bromide albuterol solution 0.5mg(2.5mg)3ml every 6 hours from the facility pharmacy because her family member said he would bring in her missing medications. -She had reminded him multiple times since her admission that he needed to bring in the Ipratropium bromide albuterol solution 0.5mg(2.5mg)3ml, but she could not remember the dates. -She last spoke to him in person 11/01/2021 and he said he would bring the rest of her missing medications to the facility, but she never asked him to bring in a nebulizer machine. -He had not yet delivered the Ipratropium bromide albuterol solution 0.5mg(2.5mg)3ml to the facility. -MAs were responsible to inform the WC when medications were not in the facility or that residents had missed taking medications. -She notified the WC that Resident #1 did not have Ipratropium bromide albuterol solution 0.5mg(2.5mg)3ml every 6 hours, but she could not remember the dates she informed her of the missing medications. -She did not know who her provider was and had	D 276		

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D 276	Continued From page 48 not notified the PCP that she had missed doses of ipratropium bromide albuterol solution or requested an order for a nebulizer machine. -She did not know if Resident #1's PCP was notified that she did not have ipratropium bromide albuterol solution and a nebulizer machine to administer the solution. Observation room #104 where Resident #1 resided on 11/02/21 at 4:10pm revealed there was no nebulizer machine available. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -She could not name her medications but did not remember one for breathing. -She did not remember using a machine to inhale breathing medication. -She had not had any trouble breathing and had not had a cough since she was admitted. Interview with Resident #1's family on 11/02/21 at 4:19pm revealed: -He had supplied the facility with Resident #1's medication from their family pharmacy. -He did not know she had an order for nebulizer solutions and did not have a prescription for any. -She did not have a machine for breathing medicine that he could remember. -He was not asked if he had a nebulizer machine or to bring one in. -She did not have breathing problems that needed medication. -He depended on staff at the facility to tell him when she needed medications filled. -He spoke to the WC on 10/29/21 and 11/01/21 but he was not told he needed to bring anything to the facility. Interview with the WC on 11/02/2021 at 4:45pm	D 276		

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D 276	Continued From page 49 revealed: -MAs were responsible to report to her the residents missed medications and notify the PCP. -MAs or herself order resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy can only fill a 3-day supply for a resident. -She knew Resident #1 was missing ipratropium bromide albuterol 0.5-2.5mg/3ml solution since her admission 10/18/2021. -She had not requested ipratropium bromide albuterol 0.5-2.5mg/3ml solution the missing medications from emergency pharmacy because the family member said he would bring them in. -She spoke to Resident #1's family member the week of 10/25/2021-10/29/2021 and gave him a list of needed medications for her including ipratropium bromide albuterol 0.5-2.5mg/3ml solution . -She did not know if she had a nebulizer machine and had not requested a machine from the provider or the family member. -She had not followed up with him to see if he brought in ipratropium bromide albuterol 0.5-2.5mg/3ml solution. Telephone interview with a pharmacist from the facility pharmacy on 11/03/2021 at 12:05pm revealed: -There was a profile on file for Resident #1, but they provide emergency pharmacy services for her. -The FL2 on file dated 10/08/2021 had an order for ipratropium bromide albuterol 0.5-2.5mg/3ml solution every 6 hours. -There was no request to fill ipratropium bromide albuterol 0.5-2.5mg/3ml solution every 6 hours for Resident #1 before 11/3/2021.	D 276		

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D 276	Continued From page 50 Interview with a representative at Resident #1's primary care provider (PCP) on 11/04/21 at 8:35am revealed: -The PCP followed Resident #1's care at her previous assisted living and continued following her care to this facility. -He expected all medications to be administered as ordered. -She did not see an order for a nebulizer machine but it would stand to reason that one would be needed to administer for ipratropium bromide albuterol 0.5-2.5mg/3ml solution. -There was no communication from the facility to request an order for a nebulizer machine. -There was no communication from the facility to notify the provider of missed doses of ipratropium bromide albuterol solution. -She could not speak to the results of not administering ipratropium bromide albuterol solution every 6 hours. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The Resident Care Coordinator (RCC) or WC process orders on admission, including faxing orders to pharmacy and writing medication orders on the MAR. -He expected MAs to administer medications as ordered by the PCP. -He did not know if Resident #1 had a nebulizer machine. -MAs were to fax the pharmacy to refill needed medications. -MAs were to report to him, the WC or RCC if medications or equipment were not in the facility to give to residents. -If a family member did not bring in needed equipment or medication, the facility would get an order from the PCP and obtain the equipment or	D 276		

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D 276	Continued From page 51 medication and work out payment later. -Resident #1's family member chose to use their own pharmacy and only use the facility's pharmacy for emergency pharmacy needs. -He did not know Resident #1's family member did not bring in her ipratropium bromide albuterol solution and a nebulizer machine.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to have a therapeutic diet menu for 1 of 5 sampled residents with a diet order for a no added salt (NAS)/consistent carbohydrate diet (CCHO)/heart healthy (HH) diet (#1). The findings are: Review of the Resident #1's current FL2 10/08/21 revealed there was an order for a NAS/CCHO/HH diet with a regular texture. Review of Resident #1's Diet Order Form dated 10/22/21 revealed an order for a NAS/CCHO/HH diet with a regular texture. Review of the Therapeutic Diet List dated 10/31/21 revealed Resident #1 was to be served	D 296	1. RSD met with Dining Service Director (DSR) on 12/14/21 to ensure diets on file for residents matched diets that were on file in Dining Services. 2. Dining services servers to receive training by DSR on ensuring residents receive diet ordered/on file 3.RSD, Dining Service Director or designee, shall ensure the facility has a matching therapeutic diet menu for all physician-ordered therapeutic diets. 4. RSD or Designee or Dining Service Director or Designee to ensure all listed therapeutic diets are being offered daily for 30days and then weekly thereafter. Water will be provided for all residents during each meal setting with no exceptions. DSR to ensure that water is being offered to each resident.	12-20-21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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D 296	Continued From page 52 a CCHO diet. Review of the facility's therapeutic menus revealed there was no therapeutic menu for a NAS/CCHO/HH diet. Review of the regular menu for the lunch meal on 11/03/21 revealed residents had a choice of lasagna or fried chicken, parsley, leeks and zucchini squash, corn on the cob, and/or southern green beans, Texas toast, and berry yogurt pie. Observation of Resident #1's lunch meal service on 11/03/21 at 12:23pm revealed: -Resident #1 ate her meal in her room. -Resident #1 was served two pieces of fried chicken, corn on the cob, mixed vegetables, chocolate cake, and tea. -It could not be determined what Resident #1 should have been served due to no combination diet menu available for staff guidance. Interview with Resident #1 on 11/03/21 at 12:27pm revealed: -She usually ate her meals in her room. -She was served whatever she requested for her meals. -She thought she was on a special diet, but she did not know which one. Interview with the Dietary Manager (DM) on 11/04/21 at 8:59am revealed: -She knew Resident #1 had an order for a NAS/CCHO/HH diet with a regular texture, but there was no menu for a NAS/CCHO/HH diet. -She had individual menus for NAS, CCHO, and HH, but she did not have a menu for a combination of all three diets. -She did not know what to serve Resident #1, so	D 296		

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D 296	Continued From page 53 she served her a NAS diet with a regular consistency. -She told the Wellness Coordinator (WC) Resident #1 could not have 3 diets during the facility's morning meetings, but she had not received any updated diet orders for Resident #1. Interview with a cook on 11/03/21 at 9:12am revealed: -Resident #1 was new and he was not familiar with her diet order. -He did not know what Resident #1 was supposed to be served. -He had never seen a menu for NAS/CCHO/HH diet. Interview with the WC on 11/04/21 at 11:20am revealed: -She completed the diet order sheet for Resident #1. -She thought Resident #1 could have more than 1 diet type. -She did not remember if the DM talked to her about not being able to serve Resident #1 more than 1 diet. -She did not know there had to be a matching menu for Resident #1's diet order of NAS/CCHO/HH diet. -She did not know if the facility had a matching menu for a NAS/CCHO/HH diet. -She had not followed up with Resident #1's primary care provider (PCP) to clarify the diet order. Interview with the Administrator on 11/04/21 at 11:34am revealed: -He did not know Resident #1 had an order for a NAS/CCHO/HH diet. -The facility did not have a menu for a NAS/CCHO/HH diet.	D 296		

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D 296	Continued From page 54 -He did not know this was an issue prior to 11/03/21.	D 296		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure water was served, in addition to other beverages to each resident in the Special Care Unit (SCU). The findings are: Review of the facility's menus for regular diets revealed water was not listed on the menu. Observation of the breakfast meal service in the SCU on 11/03/21 between 12:00pm and 12:30pm revealed: -There were 11 residents present in the dining room and 7 residents in the open dining area for the breakfast meal service. -There were 4 residents in the dining room who had been served water. -No residents in the open dining area had been served water. Interview with a SCU resident on 11/04/21 at	D 306	1. RSD met with Dining Service Director (DSR) on 12/14/21 to ensure diets on file for residents matched diets that were on file in Dining Services. 2. Dining services servers to receive training by DSR on ensuring residents receive diet ordered/on file within 30 days. 3.RSD, Dining Service Director or designee, shall ensure the facility has a matching therapeutic diet menu for all physician-ordered therapeutic diets. 4. RSD or Designee or Dining Service Director or Designee to ensure all listed therapeutic diets are being offered daily for 30days and then weekly thereafter. Water will be provided for all residents during each meal setting with no exceptions. DSR to ensure that water is being offered to each resident.	12-20-21

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D 306	Continued From page 55 3:41pm revealed: -Staff gave residents water if they asked for it. -Staff did not automatically offer or place water on the tables for residents. -Staff gave her water at lunch today. -All residents had 3 glasses at the lunch meal for milk, tea, and water. Interview with the Dietary Manager (DM) on 11/04/21 at 8:47am revealed: -All residents in the SCU should be served water in addition to other beverages at each meal. -She did not know all residents were not served water in the SCU during the breakfast meal on 11/03/21. Interview with a MA on 11/04/21 at 9:35am revealed: -She assisted with serving residents in the SCU at times during meals. -All residents should have 3 glasses at each meal. -For the breakfast meal, residents had three glasses for water, juice, and milk. Interview with the Special Care Unit Supervisor (SCUC) on 11/04/21 at 12:47pm revealed: -She assisted during the breakfast meal in the SCU on 11/03/21. -Water, milk, and residents' choice of beverage should have been served to all residents in the SCU during the breakfast meal. -She did not realize and did not know why water was not served to all residents during the breakfast meal on 11/03/21. Interview with the Administrator on 11/04/21 at 11:34am revealed: -He did not know all residents were not served water in the SCU on 11/02/21.	D 306		

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D 306	Continued From page 56 -He expected for all residents to be served water at each meal.	D 306		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure clarification of medication orders for 1 of 5 residents sampled (#1) who had orders for a pain medication and a bronchodilator. The findings are: 1. Review of Resident #1's current FL2 dated 10/08/21 revealed there was an order for tramadol 50mg every 8 hours for heel pain. Review of Resident #1's November 2021 medication administration record (MAR) revealed: -There was an entry for tramadol 50mg take 1 tablet every 8 hours for heel pain with "prn"	D 344	1.Audit of residents medication completed 11/4/21 by Director of clinical services to ensure medications ordered, are on the medication carts. 2. Education provided to MAs by RSD on 12/13/21 about receiving orders and following up to ensure medications/order are received and followed through within a timely manner. 3. RSD or Designee to monitor MAs MAs are following the policies of getting medication ordered and ensure in the building. 4.RSD or designee to complete daily monitoring of Medication administration for 30 days and then weekly thereafter to ensure all medications are in the community and on the medication cart.	12-20-21

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D 344	Continued From page 57 written beside the entry. -There was no documentation that tramadol 50mg had been administered every 8 hours. Interview with a medication aide (MA) on 11/02/21 at 4:05pm revealed: -She knew Resident #1 had an order for tramadol 50mg but thought it was as needed for pain. -Her family member supplied her medications and had not brought in tramadol and so she had not administered it to the resident. -The WC or the nurse were responsible to add orders to the MARs. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facility. -She did not know if her family member brought in tramadol 50mg for her or how often she was to take it. -She did not remember taking tramadol 50mg but needed something occasionally for a headache but not for heel pain. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -He filled her medications at their family pharmacy. -He did not bring in the tramadol 50mg and did not know she had an order and he did not have a prescription for it. -He did not know how often she was supposed to take tramadol 50mg. Interview with the Wellness Coordinator (WC) on 11/02/2021 at 4:45pm revealed: -She was responsible to add orders to the resident MARs. -She added Resident #1's tramadol 50mg every 8	D 344		

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D 344	Continued From page 58 hours as needed to the MAR. -She did not verify with the provider if the tramadol was scheduled or as needed. Telephone interview with a pharmacist from the facility pharmacy on 11/03/2021 at 12:05pm revealed: -There was a profile on file for Resident #1, but they provide emergency pharmacy services only for her. -The FL2 on file dated 10/08/2021 had an order for tramadol 50mg every 8 hours. Telephone interview with a representative from Resident #1's prmary care provider's (PCP) office 11/04/2021 at 8:35am revealed: -There was an order for tramadol 50mg every 8 hours. -He expected all medications to be administered as ordered. -She could not speak to the result of missing scheduled tramadol 50mg every 8 hours. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The Resident Care Coordinator RCC) or WC processed orders on admission, including faxing orders to pharmacy and writing medication orders on the MAR. -He expected orders be entered on the MAR and given as ordered by the PCP. 2. Review of Resident #1's current FL2 dated 10/08/21 revealed there was an order for ipratropium bromide albuterol 0.5-2.5mg/3ml solution inhale via nebulizer every 6 hours for emphysema. Review of Resident #1's November 2021 medication administration record(MAR) revealed:	D 344		

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D 344	Continued From page 59 -There was an entry for ipratropium bromide albuterol 0.5-2.5mg/3ml solution inhale via nebulizer every 6 hours for emphysema with "prn" written beside the entry. -There was no documentation that ipratropium bromide albuterol 0.5-2.5mg/3ml solution had been administered every 6 hours. Interview with a medication aide (MA) on 11/02/21 at 4:05pm revealed: -She knew Resident #1 had an order for nebulizers but she could not remember the name and thought it was as needed for shortness of breath and coughing. -Her family member supplied her medications and had not brought in her nebulizer solution and so she had not administered it to the resident. -The WC or the nurse were responsible to add orders to the MARs. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facility. -She did not know if her family member brought in nebulizer solution her or how often she was to take it. -She did not remember taking a nebulizer but did not having breathing problems. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -He filled her medications at their family pharmacy. -He did not bring in the nebulizer solution and did not know she had an order and he did not have a prescription for it. -He did not know how often she was supposed to take ipratropium bromide albuterol solution.	D 344		

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D 344	Continued From page 60 Interview with the WC on 11/02/2021 at 4:45pm revealed: -She was responsible to add orders to the resident MARs. -She added Resident #1's ipratropium bromide albuterol solution 6 hours as needed to the MAR. -She did not verify with the provider if the nebulizer solution was scheduled or as needed. Telephone interview with a pharmacist from the facility pharmacy on 11/03/2021 at 12:05pm revealed: -There was a profile on file for Resident #1, but they provided emergency pharmacy services only for her. -The FL2 on file dated 10/08/2021 had an order for ipratropium bromide albuterol solution every 6 hours for emphysema. Telephone interview with a representative from Resident #1's primary care provider's (PCP) office 11/04/2021 at 8:35am revealed: -There was an order for ipratropium bromide albuterol solution every 6 hours. -He expected all medications to be administered as ordered. -She could not speak to the result of missing scheduled ipratropium bromide albuterol solution every 6 hours. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The Resident Care Coordinator(RCC) or WC processed orders on admission, including faxing orders to pharmacy and writing medication orders on the MAR. -He expected orders be entered on the MAR and given as ordered by the PCP.	D 344		

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D 358	Continued From page 61	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 5 residents sampled (Residents #1, #2, #4, and #5) related to a topical pain medication, an antibiotic, an irrigation solution and 2 eye drops (#2); a blood thinner (#5); a mild pain reliever, an expectorant, a bronchodilator, a moderate pain reliever, a protein supplement and a multivitamin (#1); and a topical pain medication, a pain medication, a muscle relaxer, a cholesterol lowering medication, and a behavior medication (#4). The findings are: 1. Review of Resident #5's current FL2 dated 03/17/21 revealed diagnoses included paroxysmal atrial fibrillation and dementia with behavioral disturbance. Review of Resident #5's physician's orders dated 07/02/21 revealed: -There was an order to discontinue warfarin (a blood thinning medication used to prevent blood	D 358	1.Audit of residents medication completed 11/4/21 by Director of clinical services to ensure medications ordered, are on the medication carts. 2. Education provided to MAs by RSD on 12/13/21 about receiving orders and following up to ensure medications/order are received and followed through within a timely manner. 3. RSD or Designee to monitor MAs to ensure MAs are following guidelines of medication administration and order follow-up. 4.RSD or designee to complete daily monitoring of Medication administration and order follow-up for 30 days and then weekly thereafter to ensure all medications are in the community and on the medication cart.	12-20-21

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D 358	Continued From page 62 clots) 3mg daily. -There was an order to start warfarin 3mg once daily on Monday, Tuesday, Wednesday, Thursday and Friday. -There was an order to start warfarin 3mg, take one and a half tablets (total 4.5mg) on Saturday and Sunday. Review of Resident #5's August 2021 medication administration record (MAR) revealed: -There was an entry for warfarin 3mg tablets, take 1 and a half tablets (4.5mg total) every Saturday and Sunday at 5:00pm with an order date of 06/17/21. -There was no documentation warfarin 4.5mg was administered on 08/14/21 but no documented reason why. -There was no documentation warfarin 4.5mg was administered on 08/15/21 with the reason the medication was not available and on order at the pharmacy. -There was an entry for warfarin 3mg tablets, take 1 tablet every Monday, Tuesday, Wednesday, Thursday and Friday at 5:00pm with an order date of 06/17/21. -There was no documentation warfarin 3mg was administered on the following dates: 08/03/21, 08/06/21, 08/09/21, 08/11/21, and 08/20/21 with no documented reason why it was not administered. -There was no documentation warfarin 3mg was administered on 08/16/21 with the reason the medication was not available and awaiting pharmacy. Review of Resident #5's physician order dated 09/08/21 revealed: -There was an order to discontinue warfarin 4.5mg Saturday and Sunday. -There was an order to start warfarin 5mg, take	D 358		

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MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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D 358	Continued From page 63 one tablet every Saturday and Sunday and continue warfarin 3mg every Monday, Tuesday, Wednesday, Thursday and Friday. Review of Resident #5's September 2021 MAR revealed: -There was an entry for warfarin 3mg tablets, take 1 and a half tablets (4.5mg total) every Saturday and Sunday at 5:00pm, with a discontinue date of 09/08/21. -There was an entry for warfarin 3mg tablets, take 1 tablet every Monday, Tuesday, Wednesday, Thursday, and Friday at 5:00pm. -There was no documentation warfarin 3mg was administered on 09/10/21, 09/14/21, 09/20/21, or 09/27/21 and no documented reason why it was not administered. -There was no documentation warfarin 3mg was administered on 09/28/21, 09/29/21 and 09/30/21, with the reason documented on 09/28/21 and 09/30/21 as medication was on order from the pharmacy. -There was an entry for warfarin 5mg tablets, take 1 tablet every Saturday and Sunday at 5:00pm, with a start date of 09/08/21. -There was no documentation warfarin 5mg was administered on 09/19/21 with no documented reason why it was not administered. Review of Resident #5's signed physician's orders dated 10/06/21 revealed: -There was an order for warfarin 5mg tablets, take 1 tablet every Saturday and Sunday at 5:00pm. -There was an order for warfarin 3mg tablets, take 1 tablet every Monday, Tuesday, Wednesday, Thursday and Friday at 5:00pm. Review of Resident #5's October 2021 MAR revealed:	D 358		

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	HAL041052	A. BUILDING: _____ B. WING _____	R 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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D 358	Continued From page 64 -There was an entry for warfarin 3mg tablets, take 1 tablet every Monday, Tuesday, Wednesday, Thursday, and Friday at 5:00pm. -There was no documentation warfarin 3mg was administered on 10/15/21 and no documented reason why it was not administered. -There was an entry for warfarin 5mg tablets, take 1 tablet every Saturday and Sunday at 5:00pm. -There was no documentation that warfarin 5mg was administered on 10/10/21 with no documented reason why it was not administered. -There was no documentation warfarin 5mg was administered on 10/09/21 with the reason medication was on order from the pharmacy. -There was documentation warfarin 3mg tablet and warfarin 5mg tablet were both administered on 10/16/21 and 10/17/21. Observation of Resident #5's medications on hand on 11/05/21 at 10:00am revealed: -There were warfarin 3mg tablets with a dispensed date of 10/26/21, 21 tablets of 22 total tablets dispensed were remaining. -There were warfarin 5mg tablets with a dispensed date of 10/10/21, 4 tablets of 8 total tablets dispensed were remaining. Interview with a medication aide (MA) on 11/05/21 at 11:40am revealed: -She did not recall a time when Resident #5 did not have warfarin available in the medication cart. -She always ordered medications when the medication supply was down to 7-days' worth so that medication did not run out. -When a medication was ordered from the pharmacy it arrived within a day; the pharmacy made deliveries to the facility every day except for Sunday. -She never left blank spaces on the MAR; if	D 358		

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D 358	Continued From page 65 Resident #5 refused a medication she initialed the MAR with a circle around her initials, then documented the explanation on the back of the MAR. -Resident #5 sometimes did refuse medications but she could not remember specific dates of medication refusals. Interview with a pharmacist from the facility's contracted pharmacy on 11/05/21 at 12:20pm revealed: -They did not automatically refill medications; the facility either needed to fax them a refill request or a new order. -They dispensed warfarin 3mg (take 1 tablet daily Monday through Friday) on 10/26/21 for a quantity of 22 tablets. -They dispensed warfarin 3mg (take 1 tablet daily Monday through Friday) on 09/30/21 for a quantity of 25 tablets. -They dispensed warfarin 3mg (take 1 tablet daily Monday through Friday and 1 and a half tablets daily on Saturday and Sunday) on 08/16/21 for a quantity of 35 tablets. -They dispensed warfarin 3mg (take 1 tablet daily Monday through Friday and 1 and a half tablets daily on Saturday and Sunday) on 06/17/21 for a quantity of 35 tablets. -They dispensed warfarin 5mg (take 1 tablet daily on Saturday and Sunday) on 10/10/21 for a quantity of 8 tablets. -They dispensed warfarin 5mg (take 1 tablet daily on Saturday and Sunday) on 09/08/21 for a quantity of 8 tablets. Interview with Resident #5's primary care provider (PCP) on 11/05/21 at 3:30pm revealed: -Resident #5's goal international normalized ratio (INR) (laboratory bloodwork used to check the effectiveness of a blood thinner) used to be	D 358		

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D 358	Continued From page 66 2.0-3.0 (the normal range for a person taking a blood thinner due to atrial fibrillation) but since she was admitted to hospice the INR was expected to be subtherapeutic. -Resident #5 had her INR lab drawn once a month and she would adjust the warfarin dose based on the INR result. -It was her expectation that staff requested refills from the pharmacy one week prior to the medication running out. -She expected MAs to document if Resident #5 refused her warfarin and then notify her. -She had not been notified that Resident #5 had missed doses of her warfarin in the last three months. -The potential harm to Resident #5 from missing warfarin doses was that her INR could decrease and cause a blood clot in her leg or chest. Interview with the Special Care Unit Coordinator (SCUC) on 11/05/21 at 4:05pm revealed: -She expected staff to reorder medications when they were down to 7 doses or by the "refill by" date on the sticker from the pharmacy. -If there was no initial on the MAR it would indicate that the medication had not been administered. -It was their process to notify the PCP if a resident went without/refused a medication for a week or more, and to notify the nurse if there were more than two missed doses. Interview with the Wellness Coordinator (WC) on 11/05/21 at 4:40pm revealed: -She had never known Resident #5 to not have her warfarin available on the medication cart. -She felt the blank spaces on the MAR were from the MAs forgetting to document their initials. Interview with the Administrator on 11/05/21 at	D 358		

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D 358	Continued From page 67 5:20pm revealed: -He was not aware of Resident #5 not receiving her warfarin as ordered. -It was his expectation that MAs would administer medications as ordered and would document administrations or refusals on the MAR. -If a space on the MAR was left blank it would indicate that the medication was not administered. Based on observation, record review and attempted interview, it was determined Resident #5 was not interviewable. 2. Review of Resident #2's current FL2 dated 08/29/21 revealed diagnoses included chronic pain, back pain, urinary tract infection, and history of sepsis due to urinary tract infection (UTI). a. Review of Resident #2's signed physician's orders dated 10/06/21 revealed there was an order for Diclofenac sodium 1% topical gel (a pain-relief medication applied to the skin). Review of Resident #2's August 2021 treatment administration record (TAR) revealed: -There was an entry for Diclofenac sodium 1% gel, apply 2 grams to low back four times a day transdermal at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Diclofenac was applied 48 out of 124 opportunities. -There was no documented reason why Diclofenac was not applied the remaining 76 opportunities. Review of Resident #2's September 2021 TAR revealed: -There was an entry for Diclofenac sodium 1% gel, apply 2 grams to low back four times a day	D 358		

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D 358	Continued From page 68 transdermal at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was no documentation that Diclofenac was applied from 09/01/21 to 09.30/21. Review of Resident #2's October 2021 TAR revealed: -There was an entry for Diclofenac sodium 1% gel, apply 2 grams to low back four times a day transdermal at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation that Diclofenac was applied 1 out of 124 opportunities. -There was no documented reason why Diclofenac was not applied the remaining 123 opportunities. Observation of medications on hand for Resident #2 revealed there was 1 tube of Diclofenac gel labeled for Resident #2 with half of a tube remaining. Interview with Resident #2 on 11/04/21 at 10:40am revealed: -She was able to ask for a medication or treatment when she needed to. -She did not know what medications she had that were scheduled to be administered or applied at scheduled times versus as needed. -The staff did apply a cream to her back sometimes but she did not know how often. -Sometimes she needed to ask to have the cream applied but if she asked, the MA would apply it for her. Interview with Resident #2's primary care provider (PCP) on 11/05/21 at 3:30pm revealed: -The Diclofenac gel was ordered to help alleviate joint pain for Resident #2. -She had not been notified that Resident #2 had	D 358		

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D 358	Continued From page 69 not been receiving the Diclofenac gel four times daily as ordered. -It was her expectation that staff would document the Diclofenac gel as either administered, or not administered along with the reason why. Interview with a medication aide (MA) on 11/05/21 at 4:20pm revealed: -She could not remember whether she ever applied Diclofenac gel to Resident #2. -She reviewed the TAR and the blank spaces indicated a medication or treatment was not administered. Interview with the Wellness Coordinator (WC) on 11/05/21 at 4:40pm revealed: -The Diclofenac gel should be administered four times daily as scheduled because it was ordered that way. -The MAs were probably administering it as ordered but had forgotten to sign their initials on the TAR afterward. Interview with the Administrator on 11/05/21 at 5:20pm revealed: -The facility had been working to improve their documentation. -If the MA staff did not document each administration, they could not prove the MAs applied the medication as ordered. -It was his expectation that staff document every medication/treatment administered or that the medication was offered and was refused. b. Review of Resident #2's hospital discharge paperwork dated 08/29/21 revealed there was an order for Fosfomycin tromethamine (an antibiotic medication used to treat bladder infections) 3 gram (gm) packet, take 3gm every three days starting 08/31/21.	D 358		

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D 358	Continued From page 70 Review of Resident #2's signed physician's orders dated 10/06/21 revealed there was an order for Fosfomycin tromethamine 3gm packet, take 1 packet every 3 days. Review of Resident #2's August 2021 medication administration record (MAR) revealed: -There was a hand-written entry for Fosfomycin 3gm pack, take 3gm every three days at 8:00am to start 08/31/21. Review of Resident #2's September 2021 MAR revealed there was no entry for Fosfomycin 3gm packet. Review of Resident #2's physician order dated 10/13/21 revealed there was an order for a one-time administration of Fosfomycin 3gm packet. Review of Resident #2's October 2021 MAR revealed: -There was a hand-written entry dated 10/14/21 for Fosfomycin 3gm packet, mix 3 gm in 8 ounces (oz) water, one time dose. -Fosfomycin was documented as administered once on 10/14/21, time unspecified. -There was no entry for Fosfomycin 3gm pack, take 3gm every three days at 8:00am Observation of Resident #2's medications on hand on 11/03/21 at 11:20am revealed there was no Fosfomycin available for administration. Review of Resident #2's physician's order sheet dated 10/20/21 revealed Resident #2's PCP had discontinued the order for Fosfomycin, dose to be discontinued was unspecified.	D 358		

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D 358	Continued From page 71 Interview with the pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:10pm revealed: -Fosfomycin had been ordered on 08/29/21 from a hospital physician, to dispense 1 pack. -The pharmacy received another one time dose order of Fosfomycin on 10/13/21 and it was dispensed. Interview with Resident #2 on 11/03/21 at 12:41pm revealed she did not remember taking a medication mixed in liquid or water every three days. Interview with Resident #2's PCP on 11/03/21 at 1:30pm revealed: -Fosfomycin was not an ongoing medication, it was usually prescribed for one dose. -It was not typical to take Fosfomycin every three days as it was not a prophylactic (preventative) medication. Interview with the Wellness Coordinator (WC) on 11/03/21 at 4:45pm revealed: -When a resident was discharged from the hospital the MA should review the paperwork and fax any new orders to the pharmacy. -If there were new orders that required clarification, the MA should send a fax to the PCP. -It was her responsibility to review the hospital discharge paperwork for new orders and to make sure the MA transcribed everything correctly. Interview with the Administrator on 11/04/21 at 3:00pm revealed: -The WC was responsible for following up on new orders received from the PCP or hospital. -If a new medication was ordered and not received, he would expect the WC to notify the	D 358		

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D 358	Continued From page 72 nurse or Director of Clinical Services so that the facility could obtain the medication for the resident. c. Review of Resident #2's signed physician's orders dated 10/06/21 revealed there was an order for acetic acid irrigation 0.25% solution (used to help prevent bacteria growth or infection from the urethra to the bladder), use 200mL to wash perineum area thoroughly once weekly with a start date of 05/10/21. Review of Resident #2's August 2021 MAR revealed: -There was an entry for acetic acid irrigation 0.25% irrigation solution, use 200mL to wash perineum area thoroughly once weekly. -There were no documented applications from 08/01/21 to 08/31/21. Review of Resident #2's September 2021 MAR revealed: -There was an entry for acetic acid irrigation 0.25% irrigation solution, use 200mL to wash perineum area thoroughly once weekly. -There were no documented applications from 09/01/21 to 09/30/21. Review of Resident #2's October 2021 MAR revealed: -There was an entry for acetic acid 0.25% irrigation solution, use 200mL to wash perineum area thoroughly once weekly. -There were no documented applications from 10/01/21 to 10/31/21. Observation of Resident #2's medication on hand on 11/03/21 at 11:20am revealed there was one full container of acetic acid irrigation solution labeled with Resident #2's name with a dispensed	D 358		

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D 358	Continued From page 73 date of 05/10/21. Interview with a pharmacist from the facility's contracted pharmacy on 11/04/21 at 10:06am revealed: -The last time they dispensed acetic acid irrigation solution for Resident #2 was 05/10/21 for an order to use once weekly. -To obtain refills, staff would need to either fax a refill request for the medication or fax a new order. Interview with Resident #2 on 11/04/21 at 10:40am revealed she did not remember staff ever offering the acetic acid solution, but since she experienced frequent urinary tract infections (UTI), she would be interested in trying it. Interview with Resident #2's PCP on 11/05/21 at 3:30pm revealed: -The acetic acid irrigation solution was prescribed as a prophylactic for UTIs. -She would expect staff to document either applications or refusals of this medication. -There would be no potential harm to Resident #2 for not having received the weekly treatments with the acetic acid solution since Resident #2 was able to report symptoms if she were to have any. Interview with a MA on 11/05/21 at 4:20pm revealed: -If there was missing documentation on the MAR it would indicate that the medication was not administered. -She did not know if Resident #2 had received the acetic acid perineal irrigation as she usually worked the afternoon shift and it was ordered for once a week, but at no specified time.	D 358		

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D 358	Continued From page 74 Interview with the Administrator on 11/05/21 at 5:20pm revealed: -The facility had been working to improve their documentation. -He was not aware of Resident #2 not receiving the ordered acetic acid solution. -It was his expectation that MAs would administer medications and treatments as ordered. -It was his expectation that MAs would document administrations or refusals on the MAR. -If the MA did not document each administration, they could not prove the MAs administered the medication as ordered. d. Review of Resident #2's current FL2 dated 08/29/21 revealed: -There was an order for Dorzolamide-timolol 2%-0.5% eye drops, instill 1 drop into both eyes twice daily (used to lower high pressure in the eye to prevent blindness). -There was an order for Lumigan 0.01% eye drops, instill 1 drop into both eyes at bedtime (used to lower high pressure in the eye to prevent blindness). Review of Resident #2's signed physician's orders dated 10/06/21 revealed: -There was an order for Dorzolamide-timolol 2%-0.5% eye drops, instill 1 drop into both eyes twice daily, with an order start date of 07/01/20. -There was an order for Lumigan 0.01% eye drops, instill 1 drop into both eyes at bedtime, with an order start date of 08/05/20. Review of Resident #2's August 2021 MAR revealed: -There was an entry for Dorzolamide-timolol 2%-0.5% eye drops, instill 1 drop into both eyes twice daily at 8:00am and 8:00pm. -There was documentation of administration 61	D 358		

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D 358	Continued From page 75 out of 62 opportunities. -There was no documented reason why Dorzolamide-timolol eye drops were not administered on 08/23/21. -There was an entry for Lumigan 0.01% eye drops, instill 1 drop into both eyes at bedtime. -There was documentation of administration 30 out of 31 opportunities for the month. -There was no documented reason why Lumigan eye drops were not administered on 08/24/21. Review of Resident #2's September 2021 MAR revealed: -There was an entry for Dorzolamide-timolol 2%-0.5% eye drops, instill 1 drop into both eyes twice daily at 8:00am and 8:00pm. -There was documentation of administration 56 out of 60 opportunities. -There was no documented reason why Dorzolamide-timolol eye drops were not administered on 09/02/21, 09/05/21, 09/06/21, or 09/21/21. -There was an entry for Lumigan 0.01% eye drops, instill 1 drop into both eyes at bedtime. -There was documentation of administration 25 out of 30 opportunities. -There was no documented reason why the Lumigan eye drops were not administered on 09/02/21, 09/05/21, 09/06/21, 09/21/21, or 09/26/21. Review of Resident #2's October 2021 MAR revealed: -There was an entry for Dorzolamide-timolol 2%-0.5% eye drops, instill 1 drop into both eyes twice daily at 8:00am and 8:00pm. -There was documentation of administration 59 out of 62 opportunities. -There was no documented reason why Dorzolamide-timolol eye drops were not	D 358		

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D 358	Continued From page 76 administered on 10/08/21, 10/16/21 or 10/26/21. -There was an entry for Lumigan 0.01% eye drops, instill 1 drop into both eyes at bedtime. -There was documentation of administration 30 out of 31 opportunities. -There was no documented reason why the Lumigan eye drops were not administered on 10/08/21. Observation of Resident #2's medications on hand on 11/03/21 at 11:20am revealed: -There was one bottle of Dorzolamide-timolol 2%-0.5% eye drops labeled with Resident #2's name and a dispensed date of 10/06/21, with less than half of the bottle remaining. -There was one full bottle of Lumigan 0.01% eye drops labeled with Resident #2's name and a dispensed date of 11/01/21. Interview with Resident #2 on 11/02/21 at 10:05am revealed: -There had been times when the staff waited until she was completely out of her eye drops before reordering more, causing her to miss doses, but she did not know specific dates. -She was concerned about missing doses because her eye doctor told her there was no reason why she should ever miss a dose. Interview with a MA on 11/04/21 at 9:15am revealed: -She could not remember Resident #2 ever missing a dose of her eye drops more than "maybe one time." -She always ordered medications 7 days ahead of time so that the medications did not run out. Interview with a MA on 11/05/21 at 4:20pm revealed: -She could only think of one time when Resident	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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D 358	Continued From page 77 #2 did not have eye drops available in the medication cart. -She ordered medications once they were down to a 7-day supply so that they would not run out. -If a medication was not available, she faxed the pharmacy for a refill and then call to follow up if the medications were not received within a day. -If a space on the MAR was left blank, it indicated that the medication was not administered. Interview with a representative with the facility contracted pharmacy on 11/04/21 at 10:06am revealed: -Dorzolamide-timolol eye drops were dispensed on 10/06/21, and 08/14/21, and one bottle was expected to last around 50 days. -Lumigan eye drops were dispensed on 11/01/21 and 09/27/21, and one bottle was expected to last around 25 days. -They did not automatically refill medications; the facility needed to send either a refill request or a new order to the pharmacy to get refills. -If a medication was not in stock, the pharmacy would let the facility know and the pharmacy would try to get it from another local pharmacy. -If a medication refill was requested prior to noon, it would arrive with that evening's medication delivery, but if it was requested after noon, it would be delivered the following day. Interview with a medical technician at Resident #2's ophthalmologist office on 11/05/21 at 1:32pm revealed: -Resident #2 was prescribed the Dorzolamide-timolol and Lumigan eye drops to treat her open angle glaucoma. -It was the ophthalmologist's expectation that she received her eye drops exactly as ordered. -Missing dosages of her eye drops could cause an increase in the pressure in her eyes and	D 358		

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D 358	Continued From page 78 cause vision loss; she already had very limited vision in her left eye, so the goal was to preserve the vision she had left. -Missing dosages of her eye drops could cause eye pain from the increased pressure. Interview with the Administrator on 11/05/21 at 5:20pm revealed: -The facility had been working to improve their documentation. -He was not aware of Resident #2 not receiving her two eye drops daily as ordered. -It was his expectation that MAs would administer medications as ordered and would document administrations or refusals on the MAR. -If the MA did not document each administration, they could not prove the MAs administered the medication as ordered. 3. Review of Resident #4's current FL2 dated 10/06/21 revealed diagnoses included dementia, major depressive disorder, alcohol abuse, diabetes mellitus, and hypertension. a. Review of Resident #4's FL2 dated 10/06/21 revealed there was an order for baclofen 5mg 1 tablet twice daily (used to treat muscle spasms). Review of Resident #4's physician's orders dated 08/11/21 revealed an order for baclofen 5mg twice daily. Review of Resident #4's medication administration record (MAR) for August 2021 revealed: -There was an entry for baclofen 5mg 1 tablet twice daily scheduled for administration at 9:00am and 9:00pm. -There was no documentation baclofen 5mg was administered for 3 out of 31 opportunities at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 79 9:00pm on 08/13/21, 08/16/21, and 08/20/21. -There was no documentation on the back of the MAR why baclofen was not administered. Review of Resident #4's MAR for September 2021 revealed: -There was an entry for baclofen 5mg 1 tablet twice daily scheduled for administration at 9:00am and 9:00pm. -There was no documentation baclofen 5mg was administered for 4 out of 30 opportunities at 9:00am on 09/13/21, 09/14/21, 09/15/21, and 09/29/21 and 7 out of 30 opportunities at 9:00pm on 09/13/21, 09/14/21, 09/15/21, 09/19/21, 09/21/21, 09/23/21, and 09/26/21. -There was no documentation on the back of the MAR why baclofen was not administered. Review of Resident #4's MAR for October 2021 revealed: -There was an entry for baclofen 5mg 1 tablet twice daily scheduled for administration at 9:00am and 9:00pm. -There was no documentation baclofen 5mg was administered for 2 out of 31 opportunities at 9:00pm on 10/08/21 and 10/13/21. -There was no documentation on the back of the MAR why baclofen was not administered. Review of Resident #4's MAR for November 2021 revealed: -There was an entry for baclofen 5mg 1 tablet twice daily scheduled for administration at 9:00am and 9:00pm. -There was no documentation baclofen 5mg was administered for 2 out of 4 opportunities at 9:00am on 11/03/21 and 11/04/21 and 2 of 3 opportunities at 9:00pm on 11/02/21 and 11/03/21. -There was documentation on the back of the	D 358		

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D 358	Continued From page 80 MAR baclofen had been ordered. Observation of Resident #4's medications on hand on 11/04/21 at 9:20am revealed baclofen was not available for administration. Interview with a representative from Resident #4's pharmacy on 11/05/21 at 8:48am revealed: -Resident #4 had an order for baclofen 5mg 1 tablet daily. -Baclofen was dispensed by the pharmacy on 08/09/21 with a quantity of 14 tablets, on 10/25/21 with a quantity of 14 tablets, and on 11/03/21 with a quantity of 14 tablets. -Baclofen should have lasted 14 days if administered daily as ordered. -There were no requests to refill baclofen in September 2021. -Medications were only refilled upon request. Interview with Resident #4 on 11/03/21 at 7:52am revealed: -He did not know anything about his medications. -He did not know if the facility ever ran out of any of his medications. -He was not having any current pain, but he had pain in his back occasionally. Interview with a medication aide (MA) on 11/04/21 at 9:21am revealed: -She usually reordered medication within 7 days of the medication running out. -If a medication was ordered from the pharmacy before 12:00pm, the medication would be delivered to the facility on third shift. -If a medication was ordered from the pharmacy after 12:00pm, the medication would not be delivered to the facility until the next day. -She did not know why there were blank spaces for administration on Resident #4's MAR.	D 358		

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D 358	Continued From page 81 Interview with a second MA on 11/04/21 at 9:35am revealed: -She reordered medications when the medication count on the bubble pack was down to 7 tablets. -Sometimes Resident #4 refused medications, but there should have been documentation the medication was refused. -If there was a blank space on the MAR, it meant that the medication was not administered. -She did not specifically remember Resident #4 being out of baclofen, but sometimes when she arrived at work, Resident #4 was out of medication and she called the pharmacy for refills. -Sometimes there were issues with billing for Resident #4's medications and she would let the former facility nurse know. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -MAs were expected to reorder medication 7 days in advance of the medication running out. -There should not have been a lapse in Resident #4 being administered his medication. Interview with Resident #4's primary care physician (PCP) on 11/03/21 at 1:23pm revealed: -Resident #4 had an order for baclofen for muscle spasms. -She did not know staff had not administered baclofen to Resident #4 as ordered twice daily. -If Resident #4 missed doses of baclofen his muscle spasms could have increased. -Sometimes Resident #4 had issues with his insurance covering his medication, but the facility sometimes covered the cost. -She expected Resident #4's medications to be administered as ordered.	D 358		

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D 358	Continued From page 82 Interview with the Administrator on 11/04/21 at 11:34am revealed: -He did not know Resident #4 missed doses of baclofen. -He expected staff to reorder medication prior to the medication running out. -Resident #4 should not have gone without any doses of his medication. Attempted interviews with Resident #4's family member on 11/05/21 at 9:09am and at 3:38pm were unsuccessful. b. Review of Resident #4's FL2 dated 10/06/21 revealed there was an order for gabapentin 300mg 1 capsule three times daily (used to treat nerve pain). Review of Resident #4's physician's orders dated 08/11/21 revealed an order for gabapentin 300mg 1 capsule 3 times daily. Review of Resident #4's medication administration record (MAR) for August 2021 revealed: -There was an entry for gabapentin 300mg 1 capsule 3 times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was no documentation gabapentin was administered for 4 out of 31 opportunities at 8:00am on 08/17/21, 08/19/21, 08/20/21, and 08/21/21, 6 out of 31 opportunities at 2:00pm 08/14/21, 08/17/21, 08/18/21, 08/19/21, 08/20/21, and 08/21/21, and 4 out of 31 opportunities at 8:00pm on 08/13/21, 08/16/21, 08/18/21, and 08/19/21. -There was documentation on the back of the MAR medication not available. Review of Resident #4's MAR for September	D 358		

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D 358	Continued From page 83 2021 revealed: -There was an entry for gabapentin 300mg 1 capsule 3 times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was no documentation gabapentin was administered for 2 out of 30 opportunities at 2:00pm on 09/06/21 and 09/20/21 and 5 out of 30 opportunities at 8:00pm on 09/19/21, 09/21/21, 09/23/21, 09/26/21, and 09/29/21. -There was no documentation on the back of the MAR why gabapentin was not administered. Review of Resident #4's MAR for October 2021 revealed: -There was an entry for gabapentin 300mg 1 capsule 3 times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was no documentation gabapentin was administered for 2 out of 31 opportunities at 2:00pm on 10/04/21 and 10/14/21 and 3 out of 31 opportunities at 8:00pm on 10/04/21, 10/08/21, and 10/13/21. -There was no documentation on the back of the MAR why gabapentin was not administered. Observation of Resident #4's medications on hand on 11/04/21 at 9:20am revealed: -There was a bubble pack of gabapentin 300mg 1 capsule three times daily available for administration. -Gabapentin 300mg was dispensed by the pharmacy on 10/22/21 with a quantity of 90 tablets (3 bubble packs of 30 tablets) and there was a quantity of 3 tablets remaining in the first bubble pack. Interview with a representative from Resident #4's pharmacy on 11/05/21 at 8:48am revealed: -Resident #4 had an order for gabapentin 300mg 1 capsule 3 times daily.	D 358		

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D 358	Continued From page 84 -Gabapentin was dispensed by the pharmacy on 08/20/21 with a quantity of 90 capsules and on 10/22/21 with a quantity of 90 tablets. -Gabapentin should have lasted 30 days if administered 3 times daily as ordered. -There were no requests to refill gabapentin in September 2021. -Medications were onlyrefilled upon request. Interview with Resident #4 on 11/03/21 at 7:52am revealed: -He did not know anything about his medications. -He did not know if the facility ever ran out of any of his medications. -He was not having any current pain, but he had pain in his back on occasion. Interview with a MA on 11/04/21 at 9:21am revealed: -She usually reordered medication within 7 days of the medication running out. -If a medication was ordered from the pharmacy before 12:00pm, the medication would be delivered to the facility on third shift. -If a medication was ordered from the pharmacy after 12:00pm, the medication would not be delivered to the facility until the next day. -She did not know why there were blank spaces for administration on Resident #4's MAR. -If there was no documentation of initials on the MAR, then the medication was not administered. Interview with a second MA on 11/04/21 at 9:35am revealed: -She reordered medications when the medication count on the bubble pack was down to 7 tablets. -Sometimes Resident #4 refused medications, but there should have been documentation the medication was refused. -If there was a blank space on the MAR, it meant	D 358		

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D 358	Continued From page 85 that the medication was not administered. -She did not specifically remember Resident #4 being out of gabapentin, but sometimes when she arrived at work, Resident #4 was out of medication and she called the pharmacy for refills. -Sometimes there were issues with billing for Resident #4's medications and she would let the former facility nurse know. Interview with the SCUC on 11/04/21 at 12:47pm revealed: -MAs were expected to reorder medication 7 days in advance of the medication running out. -There should not have been a lapse in Resident #4 being administered his medication. Interview with Resident #4's PCP on 11/03/21 at 1:23pm revealed: -Resident #4 had an order for gabapentin for nerve pain. -She did not know staff had not administered gabapentin to Resident #4 as ordered three times daily. -If Resident #4 missed doses of gabapentin his nerve pain could have increased. -She expected Resident #4's medications to be administered as ordered. Interview with the Administrator on 11/04/21 at 11:34am revealed: -He did not know Resident #4 missed doses of gabapentin. -He expected staff to reorder medication prior to the medication running out. -Resident #4 should not have gone without any doses of his medication. Attempted interviews with Resident #4's family member on 11/05/21 at 9:09am and at 3:38pm	D 358		

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D 358	Continued From page 86 were unsuccessful. c. Review of Resident #4's FL2 dated 10/06/21 revealed there was an order for biofreeze 4% gel apply four times daily (used on the skin to treat pain). Review of Resident #4's physician's orders dated 08/11/21 revealed an order for biofreeze 4% gel apply 4 times daily. Review of Resident #4's MAR for August 2021 revealed: -There was an entry for biofreeze 4% gel apply four times daily scheduled for administration at 8:00am, 1:00pm, 6:00pm, and 10:00pm. -There was no documentation biofreeze was administered for 1 out of 31 opportunities at 8:00am on 08/18/21, 2 out of 31 opportunities at 1:00pm on 08/14/21 and 08/17/21, 10 out of 31 opportunities at 6:00pm on 08/11/21, 08/12/21, 08/14/21, 08/16/21, 08/18/21, 08/19/21, 08/20/21, 08/21/21, 08/22/21, and 08/25/21, and 3 out of 31 opportunities at 10:00pm on 08/13/21, 08/20/21, and 08/23/21. -There was no documentation on the back of the MAR why biofreeze was not administered. Review of Resident #4's MAR for September 2021 revealed: -There was an entry for biofreeze 4% gel apply four times daily scheduled for administration at 8:00am, 1:00pm, 6:00pm, and 10:00pm. -There was no documentation biofreeze was administered for 3 out of 30 opportunities at 1:00pm on 09/06/21, 09/20/21, and 09/29/21, 3 out of 30 opportunities at 6:00pm on 09/06/21, 09/12/21, and 09/19/21, and 2 out of 30 opportunities at 10:00pm on 09/19/21, and 09/21/21.	D 358		

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D 358	Continued From page 87 -There was no documentation on the back of the MAR why biofreeze was not administered. Review of Resident #4's MAR for October 2021 revealed: -There was an entry for biofreeze 4% gel apply four times daily scheduled for administration at 8:00am, 1:00pm, 6:00pm, and 10:00pm. -There was no documentation biofreeze was administered for 4 out of 31 opportunities at 1:00pm on 10/04/21, 10/14/21, 10/18/21, and 10/28/21, 4 out of 31 opportunities at 6:00pm 10/04/21, 10/10/21, 10/14/21, and 10/27/21, and 3 out of 31 opportunities at 10:00pm on 10/08/21 and 10/15/21. -There was no documentation on the back of the MAR why biofreeze was not administered. Observation of Resident #4's medications on hand on 11/04/21 at 9:20am revealed a tube of biofreeze was available for administration. Interview with a representative from Resident #4's pharmacy on 11/05/21 at 8:48am revealed: -Resident #4 had an order for biofreeze 4% gel apply 4 times daily. -Biofreeze was dispensed by the pharmacy on 04/28/21 with a quantity of 89mL and there had been no other dispensed dates. -The biofreeze dispensed on 04/28/21 should have lasted approximately 15 days depending on the amount used when applied daily. -Biofreeze was an over the counter medication and was not covered by Resident #4's insurance. -Medications were only refilled upon request. Interview with Resident #4 on 11/03/21 at 7:52am revealed: -He did not know anything about his medications. -He did not know if the facility ever ran out of any	D 358		

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MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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D 358	Continued From page 88 of his medications. -He was not having any current pain, but he had pain in his back occasionally. Interview with a MA on 11/04/21 at 9:21am revealed: -She usually reordered medication within 7 days of the medication running out. -If a medication was ordered from the pharmacy before 12:00pm, the medication would be delivered to the facility on third shift. -If a medication was ordered from the pharmacy after 12:00pm, the medication would not be delivered to the facility until the next day. -She did not know why there were blank spaces for administration on Resident #4's MAR. -If there was no documentation of initials on the MAR, then the medication was not administered. Interview with a second MA on 11/04/21 at 9:35am revealed: -She reordered medications when the medication count on the bubble pack was down to 7 tablets. -Sometime Resident #4 refused medications, but there should have been documentation the medication was refused. -If there was a blank space on the MAR, it meant that the medication was not administered. -She did not specifically remember Resident #4 being out of biofreeze, but sometimes when she arrived at work, Resident #4 was out of medication and she called the pharmacy for refills. -Sometimes there were issues with billing for Resident #4's medications and she let the former facility nurse know. Interview with the SCUC on 11/04/21 at 12:47pm revealed: -MAs were expected to reorder medication 7 days	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041052	A. BUILDING: _____ B. WING _____	R 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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D 358	Continued From page 89 in advance of the medication running out. -There should not have been a lapse in Resident #4 being administered his medication. Interview with Resident #4's PCP on 11/03/21 at 1:23pm revealed: -Resident #4 had an order for biofreeze for pain. -She did not know staff had not administered biofreeze to Resident #4 as ordered four times daily. -If Resident #4 missed doses of biofreeze, he could have increased muscle or joint pain. -She expected Resident #4's medications to be administered as ordered. Interview with the Administrator on 11/04/21 at 11:34am revealed: -He did not know Resident #4 missed doses of biofreeze. -He expected staff to reorder medication prior to the medication running out. -Resident #4 should not have gone without any doses of his medication. Attempted interviews with Resident #4's family member on 11/05/21 at 9:09am and at 3:38pm were unsuccessful. d. Review of Resident #4's FL2 dated 10/06/21 revealed there was an order for Lipitor 40mg 1 tablet at bedtime (used to treat high cholesterol levels). Review of Resident #4's physician's orders dated 08/11/21 revealed an order for Lipitor 40mg 1 tablet at bedtime. Review of Resident #4's MAR for August 2021 revealed: -There was an entry for Lipitor 40mg 1 tablet at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 90 bedtime scheduled for administration at 8:00pm. -There was no documentation Lipitor was administered for 5 out of 30 opportunities on 08/11/21, 08/12/21, 08/13/21, 08/20/21, and 08/21/21. -There was no documentation on the back of the MAR why Lipitor was not administered. Review of Resident #4's MAR for September 2021 revealed: -There was an entry for Lipitor 40mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was no documentation Lipitor was administered for 1 out of 30 opportunities on 09/19/21. -There was no documentation on the back of the MAR why Lipitor was not administered. Review of Resident #4's MAR for October 2021 revealed: -There was an entry for Lipitor 40mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was no documentation Lipitor was administered for 2 out of 30 opportunities on 10/04/21 and 10/08/21. -There was no documentation on the back of the MAR why Lipitor was not administered. Observation of Resident #4's medications on hand on 11/04/21 at 9:20am revealed: -Lipitor 40mg 1 tablet at bedtime was available for administration. -Lipitor was dispensed by the pharmacy on 10/09/21 with a quantity of 30 tablets and 29 tablets were remaining. Interview with a representative from Resident #4's pharmacy on 11/05/21 at 8:48am revealed: -Resident #4 had an order for Lipitor 40mg 1 tablet at bedtime.	D 358		

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D 358	Continued From page 91 -Lipitor was dispensed by the pharmacy on 08/07/21 with a quantity of 30 tablets, on 09/15/21 with a quantity of 30 tablets, and on 10/09/21 with a quantity of 30 tablets. -Lipitor 40mg should have lasted for 30 days if administered daily as ordered. -Medications were only refilled upon request. Interview with Resident #4 on 11/03/21 at 7:52am revealed: -He did not know anything about his medications. -He did not know if the facility ever ran out of any of his medications. Interview with a MA on 11/04/21 at 9:21am revealed: -She usually reordered medication within 7 days of the medication running out. -If a medication was ordered from the pharmacy before 12:00pm, the medication would be delivered to the facility on third shift. -If a medication was ordered from the pharmacy after 12:00pm, the medication would not be delivered to the facility until the next day. -She did not know why there were blank spaces for administration on Resident #4's MAR. -If there was no documentation of initials on the MAR, then the medication was not administered. Interview with a second MA on 11/04/21 at 9:35am revealed: -She reordered medications when the medication count on the bubble pack was down to 7 tablets. -Sometime Resident #4 refused medications, but there should have been documentation the medication was refused. -If there was a blank space on the MAR, it meant that the medication was not administered. -She did not specifically remember Resident #4 being out of Lipitor, but sometimes when she	D 358		

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D 358	Continued From page 92 arrived at work, Resident #4 was out of medication and she called the pharmacy for refills. Interview with the SCUC on 11/04/21 at 12:47pm revealed: -MAs were expected to reorder medication 7 days in advance of the medication running out. -There should not have been a lapse in Resident #4 being administered his medication. Interview with Resident #4's PCP on 11/03/21 at 1:23pm revealed: -Resident #4 had an order for Lipitor for cholesterol. -She did not know staff had not administered Lipitor to Resident #4 as ordered daily. -If Resident #4 missed doses of Lipitor he could have increased cholesterol levels. -She did not have any current concerns with Resident #4's cholesterol levels. -She expected Resident #4's medications to be administered as ordered. Interview with the Administrator on 11/04/21 at 11:34am revealed: -He did not know Resident #4 missed doses of Lipitor. -He expected staff to reorder medication prior to the medication running out. -Resident #4 should not have gone without any doses of his medication. Attempted interviews with Resident #4's family member on 11/05/21 at 9:09am and at 3:38pm were unsuccessful. e. Review of Resident #4's FL2 dated 10/06/21 revealed there was an order for Seroquel 25mg 1 tablet at bedtime with 100mg dose for a total	D 358		

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D 358	Continued From page 93 dose of 125mg (used to treat agitation). Review of Resident #4's physician's orders dated 08/11/21 revealed an order for Seroquel 25mg 1 tablet at bedtime with 100mg for a total dose of 125mg. Review of Resident #4's MAR for August 2021 revealed: -There was an entry for Seroquel 25mg 1 tablet at bedtime with 100mg tablet for a total dose of 125mg scheduled for administration at 8:00pm. -There was no documentation Seroquel was administered for 1 out of 31 opportunities on 08/20/21. -There was no documentation on the back of the MAR why Seroquel was not administered. Review of Resident #4's MAR for September 2021 revealed: -There was an entry for Seroquel 25mg 1 tablet at bedtime with 100mg tablet for a total dose of 125mg scheduled for administration at 8:00pm. -There was no documentation Seroquel was administered for 6 out of 30 opportunities on 09/04/21, 09/05/21, 09/17/21, 09/18/21, 09/19/21, 09/20/21, and 09/25/21 -There was documentation on the back of the MAR medication was not available and on order. Review of Resident #4's MAR for October 2021 revealed: -There was an entry for Seroquel 25mg 1 tablet at bedtime with 100mg tablet for a total dose of 125mg scheduled for administration at 8:00pm. -There was no documentation Seroquel was administered for 1 out of 30 opportunities on 10/08/21. -There was no documentation on the back of the MAR why Seroquel was not administered.	D 358		

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D 358	Continued From page 94 Observation of Resident #4's medications on hand on 11/04/21 at 9:20am revealed: -Seroquel 25mg 1 tablet at bedtime with 100mg for a total dose of 125mg was available for administration. -Seroquel was dispensed by the pharmacy on 10/31/21 with a quantity of 30 tablets and 23 tablets were remaining. Interview with a representative from Resident #4's pharmacy on 11/05/21 at 8:48am revealed: -Resident #4 had an order for Seroquel 25mg 1 tablet at bedtime with 100mg dose for a total dose of 125mg. -Seroquel was dispensed by the pharmacy on 07/26/21 with a quantity of 30 tablets and on 10/31/21 with a quantity of 30 tablets. -Seroquel 25mg tablets should have lasted for 30 days if administered daily as ordered. -There had been no requests to refill Seroquel 25mg tablets in August or September 2021. -Medications were only refilled upon request. -There had not been an order to discontinue Seroquel 25mg. Interview with Resident #4 on 11/03/21 at 7:52am revealed: -He did not know anything about his medications. -He did not know if the facility ever ran out of any of his medications. Interview with a MA on 11/04/21 at 9:21am revealed: -She usually reordered medication within 7 days of the medication running out. -If a medication was ordered from the pharmacy before 12:00pm, the medication would be delivered to the facility on third shift. -If a medication was ordered from the pharmacy	D 358		

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D 358	Continued From page 95 after 12:00pm, the medication would not be delivered to the facility until the next day. -She did not know why there were blank spaces for administration on Resident #4's MAR. -If there was no documentation of initials on the MAR, then the medication was not administered. Interview with a second MA on 11/04/21 at 9:35am revealed: -She reordered medications when the medication count on the bubble pack was down to 7 tablets. -Sometime Resident #4 refused medications, but there should have been documentation the medication was refused. -If there was a blank space on the MAR, it meant that the medication was not administered. -She did not specifically remember Resident #4 being out of Seroquel, but sometimes when she arrived at work, Resident #4 was out of medication and she called the pharmacy for refills. -Sometimes there were issues with billing for Resident #4's medications and she let the former facility nurse know. Interview with the SCUC on 11/04/21 at 12:47pm revealed: -MA were expected to reorder medication 7 days in advance of the medication running out. -There should not have been a lapse in Resident #4 being administered his medication. Interview with Resident #4's PCP on 11/03/21 at 1:23pm revealed: -Resident #4 had an order for Seroquel for agitation. -She did not know staff had not administered Seroquel to Resident #4 as ordered daily at bedtime with his 100mg dose of Seroquel. -If Resident #4 missed doses of Seroquel he	D 358		

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D 358	Continued From page 96 could have an increase in aggressive behaviors. -She expected Resident #4's medications to be administered as ordered. Interview with the Administrator on 11/04/21 at 11:34am revealed: -He did not know Resident #4 missed doses of Seroquel. -He expected staff to reorder medication prior to the medication running out. -Resident #4's family has not paid for his medications at times. -Resident #4 should not have gone without any doses of his medication. Attempted interviews with Resident #4's family member on 11/05/21 at 9:09am and at 3:38pm were unsuccessful. 4. Review of Resident #1's current FL2 dated 10/08/21 revealed diagnoses included generalized weakness, history of falling, unsteadiness of feet and urinary tract infection due to Klebsiella pneumoniae. a. Review of Resident #1's current FL2 dated 10/08/21 revealed there was an order for acetaminophen 500mg 1 tablet every 6 hours (used to treat mild pain). Review of Resident #1's Resident Register revealed Resident #1 was admitted on 10/18/21. Review of Resident #1's medication administration record (MAR) for October 2021 revealed: -There was an entry for acetaminophen 500mg 1 tablet every 6 hours scheduled for administration at 8:00am, 2:00pm and 8:00pm. -There were 50 out of 53 doses of	D 358		

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D 358	Continued From page 97 acetaminophen 500mg documented as not administered (initials circled) and 2 spaces on 10/18/21 and 10/19/21 for 8:00am which were left blank. -There were no reasons documented on the back of the MAR as to why the acetaminophen 500mg was not administered. Observation of Resident #1's medication on hand on 11/02/21 at 4:00 pm revealed there were no acetaminophen 500mg tablets available for administration. Interview with a medication aide (MA) on 11/02/21 at 4:05pm revealed: -MAs were responsible for ordering medication from the pharmacy. -Resident #1's family member brought in all of her medications himself . -She had not requested Resident #1's acetaminophen 500mg from the pharmacy because her family member told the MA he would bring in her medications.. -She had reminded him multiple times since her admission that he needed to bring in the acetaminophen 500mg, but she could not remember the dates. -She last spoke to him in person on 11/01/21 and he said he would bring the rest of her medications to the facility. -He had not yet delivered the acetaminophen 500mg to the facility. -MAs were responsible to inform the Wellness Coordinator (WC) when medications were not in the facility or that residents had missed taking medications. -She notified the WC that Resident #1 did not have acetaminophen 500mg, but she could not remember the dates she informed the WC of the missing medication.	D 358		

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D 358	Continued From page 98 -She did not know who Resident #1's primary care provider (PCP) was and had not notified the PCP that she had missed doses of acetaminophen 500mg. -She did not know if Resident #1's PCP was notified that she did not have acetaminophen 500mg available for administration. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facility. -She was unable to name all her medications and did not know if her family member brought in acetaminophen 500mg for her. -She did not remember taking acetaminophen 500mg, but needed something occasionally for a headache. -She had never refused any medication at the facility. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -Resident #1's provider from the previous facility followed her and ordered her medications. -He filled her medications at their family pharmacy. -He asked the MAs or WC to give him the medication prescription numbers when they needed to be filled. -He last spoke to a MA and the WC on 10/29/21 and 11/01/21 but was not asked to bring in any medications. -He did not bring in acetaminophen 500mg because she had aspirin (used to treat fever and mild pain) to take for headaches. Interview with the WC on 11/02/21 at 4:45pm revealed: -MAs were responsible to report concerns to her	D 358		

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D 358	Continued From page 99 the residents missed medications and notify the PCP. -MAs or herself ordered resident medications from the pharmacy, but Resident #1's family member had chosen to use the contracted pharmacy as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew Resident #1 was not administered acetaminophen 500mg since her admission 10/18/2021. -She had not requested acetaminophen 500mg from the emergency pharmacy because the family member said he would bring them in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications for her including acetaminophen 500mg tablets. -She had not followed up with the family member to see if he brought in acetaminophen 500mg. Telephone interview with a pharmacist from the facility's pharmacy on 11/03/21 at 12:05pm revealed: -There was a profile on file for Resident #1, and the pharmacy only provided emergency pharmacy services for her. -The FL2 on file dated 10/08/21 had an order for acetaminophen 500mg every 6 hours. -There was no request to fill acetaminophen 500mg every 6 hours for Resident #1 before 11/03/21. Telephone interview with a representative from Resident #1's PCP's office on 11/04/21 at 8:35am revealed: -He followed her care and wrote medication orders at the previous facility where Resident #1 resided and since her admission to the current facility.	D 358		

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D 358	Continued From page 100 -The PCP expected all medications to be available and administered as ordered. -He had not had a face to face visit since her admission on 10/18/21. -There was no record of communication from the facility of missed doses of acetaminophen 500mg. -He did not know she had not been administered acetaminophen 500mg since she was admitted. -The representative could not speak to the result of not taking acetaminophen 500mg every 6 hours. Telephone interview with Resident #1's family pharmacy on 11/04/21 at 9:05am revealed: -The was no FL2 for Resident #1 or medication orders on file for acetaminophen 500mg. -If the resident had not taken acetaminophen for mild pain, she could have increased or prolonged pain. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The Resident Care Coordinator (RCC) or WC processed orders on admission, including faxing orders to the pharmacy and entering medication orders on the MAR. -He expected MAs to administer medications as ordered by the PCP. -MAs were to fax the pharmacy to refill needed medications. -MAs were to report to him, the WC or RCC if medications were not in the facility to administer to residents. -If a family member did not bring in needed medications, the facility would order and pay for medications from the facility's pharmacy or the back-up pharmacy. -Resident #1's family member chose to use their own pharmacy and only used the facility's	D 358		

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D 358	Continued From page 101 pharmacy for emergency pharmacy needs. -He did not know Resident #1's family member did not bring in her acetaminophen to administer in the facility. b. Review of Resident #1's current FL2 dated 10/08/21 revealed there was an order for Mucinex ER 600mg 1 tablet 2 times a day for cough (used to treat cough and congestion). Review of Resident #1's Resident Register revealed Resident #1 was admitted on 10/18/21 Review of Resident #1's MAR for October 2021 revealed: -There was an entry for Mucinex ER 50mg 1 tablet 2 times a day scheduled for administration at 8am and 8:00pm. -There were 25 out of 27 doses of Mucinex ER 50mg documented as not administered (initials circled) and 2 spaces on 10/19/21 and 10/21/21 at 8:00am which were left blank. -There were no reasons documented on the back of the MAR as to why the Mucinex ER 50mg was not administered. Observation of Resident #1's medication on hand on 11/02/21 at 4:00 pm revealed there were no Mucinex ER 50mg tablets available for administration. Telephone interview with Resident #1's family pharmacy on 11/04/21 at 9:05am revealed: -There was no FL2 or medication orders on file for Mucinex ER 50mg for Resident #1. -If the resident had not taken Mucinex ER 50mg for cough, she could experience cough and shortness of breath. Interview with a MA on 11/02/21 at 4:05pm	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041052	A. BUILDING: _____ B. WING _____	R 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

(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 102 revealed: -MAs were responsible for ordering medication from the pharmacy. -Resident #1's family member brought in all of her medications himself. -She had not requested Resident #1's Mucinex ER 50mg from the facility pharmacy because her family member said he would bring in her missing medications. -She had reminded him multiple times since her admission that he needed to bring in the Mucinex ER 50mg, but she could not remember the dates. -She last spoke to him in person on 11/01/21 and he said he would bring the rest of her missing medications to the facility. -He had not yet delivered the Mucinex ER 50mg to the facility. -MAs were responsible to inform the WC when medications were not in the facility or that residents had missed taking medications. -She notified the WC that Resident #1 did not have Mucinex ER 50mg 2 times a day, but she could not remember the dates she informed her of the missing medications. -She did not know who her PCP was and had not notified the PCP that she had missed doses of Mucinex ER 50mg. -She did not know if Resident #1's PCP was notified that she did not have Mucinex ER 50mg 2 to administer. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facility. -She was unable to name all her medications and did not know if her family member brought in Mucinex ER 50mg for her. -She did not remember taking Mucinex but did not have any congestion or cough.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 103 -She had never refused any medication at the facility. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -Her provider from the previous facility followed her and ordered her medications. -He filled her medications at their family pharmacy. -He asked the MAs or WC to give him the medication prescription numbers when they needed to be filled. -He last spoke to a MA and the WC on 10/29/2021 and 11/01/21 but was not asked to bring in any medications. -He had Mucinex at home but did not bring it because she did not have a cough. Interview with the WC on 11/02/21 at 4:45pm revealed: -MAs were responsible to report to her concerning residents' missed medications and notify the PCP. -MAs or herself ordered resident medications from the facility pharmacy but Resident #1's family member had chosen to use the facility's contracted pharmacy as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew Resident #1 was missing Mucinex ER 50mg 2 times a day since her admission 10/18/21. -She had not requested Mucinex ER 50mg 2 times a day from the emergency pharmacy because the family member said he would bring them in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications for her including Mucinex	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 104 ER. -She had not followed up with the family member to see if he brought in Mucinex ER 50mg. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed: -There was a profile on file for Resident #1, but the pharmacy only provided emergency pharmacy services for her. -The FL2 on file dated 10/08/21 included an order for acetaminophen 500mg every 6 hours. -There was no request to fill Mucinex 50mg 2 times a day for Resident #1 before 11/03/21. Telephone interview with a representative from Resident #1's PCP's office 11/04/21 at 8:35am revealed: -He followed her care and wrote medication orders at the previous facility where Resident #1 resided and since her admission to this facility. -The PCP expected all medications to be available and administered as ordered. -He had not had a face to face visit since her admission on 10/18/21. -There was no record of communication from the facility of missed doses of Mucinex ER 50mg 2 times a day. -He did not know Resident #1 had not been administered Mucinex since she was admitted. -The representative could not speak to the result of not taking any of the missing doses of Mucinex ER 50mg 2 times a day. Telephone interview with Resident #1's family pharmacy on 11/04/21 at 9:05am revealed: -The was no FL2 for Resident #1 or medication orders on file for Mucinex 50mg. -If the resident had not taken Mucinex ER 50mg, she could have cough and congestion.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 105 Interview with the Administrator on 11/04/21 at 10:15am revealed: -The Resident Care Coordinator (RCC) or WC process orders on admission, including faxing orders to pharmacy and writing medication orders on the MAR. -He expected MAs to administer medications as ordered by the provider. -MAs were to fax the pharmacy to refill needed medications. -MAs were to report to him, the WC or RCC if medications were not in the facility to administer to residents. -If a family member did not bring in needed medications, the facility would order and pay for medications from the facility's pharmacy or the back-up pharmacy. -Resident #1's family member chose to use their own pharmacy and only use the facility's pharmacy for emergency pharmacy needs. -He did not know Resident #1's family member did not bring in her Mucinex tablets to administer in the facility. c. Review of Resident #1's current FL2 dated 10/08/21 revealed there was an order for Ipratroplum bromide albuterol solution 0.5mg(2.5mg)3ml inhale 1 vial via nebulizer every 6 hours for emphysema (used to treat shortness of breath). Review of Resident #1's Resident Register revealed Resident #1 was admitted on 10/18/21. Review of Resident #1's MAR for October 2021 revealed: -There was an entry for Ipratropium bromide albuterol solution 0.5mg (2.5mg) 3ml via nebulizer every 6 hours for emphysema with as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 106 needed (prn) hand written beside the order. -There was no documentation Ipratropium bromide albuterol solution 0.5mg(2.5mg)3ml via nebulizer was administered for 54 times out of 54 opportunities from 10/18/21 through 10/31/21. -There were no reasons documented on the back of the MAR as to why the Ipratropium bromide albuterol solution 0.5mg(2.5mg)3ml was not administered. Observation of Resident #1's medication on hand on 11/02/21 at 4:00 pm revealed there were no Ipratropium bromide albuterol solution 0.5mg (2.5mg) 3ml vials available for administration. Interview with a MA on 11/02/21 at 4:05pm revealed: -MAs were responsible for ordering medication from the pharmacy. -Resident #1's family member brought in all of her medications himself. -She had not requested Resident #1's Ipratropium bromide albuterol solution 0.5mg (2.5mg) 3ml from the pharmacy because her family member said he would bring in her missing medications. -She had reminded him multiple times since her admission that he needed to bring in the Ipratropium bromide albuterol solution 0.5mg (2.5mg) 3ml, but she could not remember the dates. -She last spoke to him in person on 11/01/21 and he said he would bring the rest of her missing medications to the facility. -He had not yet delivered the Ipratropium bromide albuterol solution 0.5mg (2.5mg) 3ml to the facility. -MAs were responsible to inform the WC when medications were not in the facility or that residents had missed taking medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 107 -She notified the WC that Resident #1 did not have Ipratropium bromide albuterol solution 0.5mg (2.5mg) 3ml, but she could not remember the dates she informed her of the missing medications. -She did not know who her PCP was and had not notified the PCP that she had missed doses of ipratropium bromide albuterol solution 0.5mg (2.5mg) 3ml. -She did not know if Resident #1's PCP was notified that she did not have ipratropium bromide albuterol solution 0.5-2.5mg/3ml to administer. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facility. -She was unable to name all her medications and did not know if her family member brought in ipratropium bromide albuterol solution for her. -She did not remember taking ipratropium bromide albuterol solution but did not have shortness of breath or breathing problems. -She had never refused any medication at the facility. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -Her provider from the previous facility followed her and ordered her medications. -He filled her medications at their family pharmacy. -He asked the MAs or WC to give him the medication prescription numbers when they needed to be filled. -He last spoke to a MA and the WC on 10/29/21 and 11/01/21 but was not asked to bring in any medications. -He did not fill ipratropium bromide albuterol nebulizer solutions because he did not have a	D 358		

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D 358	Continued From page 108 prescription for them and did not know she had an order for them. Interview with the WC on 11/02/21 at 4:45pm revealed: -MAs were responsible to report to her concerning residents' missed medications and notify the PCP. -MAs or herself order resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew Resident #1 was missing ipratropium bromide albuterol 0.5-2.5mg/3ml solution since her admission 10/18/21. -She had not requested ipratropium bromide albuterol 0.5-2.5mg/3ml solution the missing medications from the emergency pharmacy because the family member said he would bring them in. -She spoke to Resident #1's family member the week of 10/25/2021-10/29/2021 and gave him a list of needed medications for her including ipratropium bromide albuterol 0.5-2.5mg/3ml solution . -She had not followed up with the family member to see if he brought in ipratropium bromide albuterol 0.5-2.5mg/3ml solution. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/2021 at 12:05pm revealed: -There was a profile on file for Resident #1, but they only provided emergency pharmacy services for her. -The FL2 on file dated 10/08/2021 had an order for ipratropium bromide albuterol 0.5-2.5mg/3ml solution every 6 hours.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 109 -There was no request to fill ipratropium bromide albuterol 0.5-2.5mg/3ml solution every 6 hours for Resident #1 before 11/03/21. Telephone interview with a representative from Resident #1's PCP's office 11/04/21 at 8:35am revealed: -He followed her care since her admission to this facility. -The PCP expected all medications to be available and administered as ordered. -He had not had a face to face visit since her admission on 10/18/21. -There was no record of communication from the facility of missed doses of ipratropium bromide albuterol 0.5-2.5mg/3ml solution every 6 hours. -He did not know she had not been administered ipratropium bromide albuterol 0.5-2.5mg/3ml solution every 6 hours since she was admitted. -The representative could not speak to the result of not taking ipratropium bromide albuterol 0.5-2.5mg/3ml solution. Telephone interview with Resident #1's family pharmacy on 11/04/21 at 9:05am revealed: -The was no FL2 or medication orders on file for Ipratropium bromide albuterol solution 0.5mg(2.5mg)3ml vials for Resident #1. -If the resident had not taken Ipratropium bromide albuterol solution 0.5mg(2.5mg)3ml vials she could have cough and shortness of breath. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The Resident Care Coordinator(RCC) or WC processed orders on admission, including faxing orders to pharmacy and writing medication orders on the MAR. -He expected MAs to administer medications as ordered by the PCP.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 110 -MAs were to fax the pharmacy to refill needed medications. -MAs were to report to him, the WC or RCC if medications were not in the facility to administer to residents. -If a family member did not bring in needed medications, the facility would order and pay for medications from the facility's pharmacy or the back-up pharmacy. -Resident #1's family member chose to use their own pharmacy and only use the facility's pharmacy for emergency pharmacy needs. -He did not know Resident #1's family member did not bring in her ipratropium bromide albuterol solution to administer in the facility. d. Review of Resident #1's current FL2 dated 10/08/21 revealed there was an order for tramadol HCL 50mg 1 tablet every 8 hours for heel pain (used to treat pain). Review of Resident #1's Resident Register revealed Resident #1 was admitted on 10/18/21. Review of Resident #1's MAR for October 2021 revealed: -There was an entry for tramadol HCL 50mg 1 tablet every 8 hours for (L) heel pain (used to treat pain) with "prn" hand written beside the order. -There was no documentation tramadol HCL 50mg was administered for 40 of 40 opportunities from 10/18/21 to 10/31/21. -There were no reasons documented on the back of the MAR as to why the tramadol 50mg was not administered. Observation of Resident #1's medication on hand on 11/02/21 at 4:00 pm revealed there were no tramadol HCL 50mg tablets available for	D 358		

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D 358	Continued From page 111 administration. Interview with a MA on 11/02/21 at 4:05pm revealed: -MAs were responsible for ordering medication from the pharmacy. -Resident #1's family member brought in all of her medications himself. -She had not requested Resident #1's tramadol HCL 50mg from the facility pharmacy because her family member said he would bring in Resident #1's missing medications. -She had reminded him multiple times since her admission that he needed to bring in the tramadol HCL 50mg, but she could not remember the dates. -She last spoke to him in person 11/01/21 and he said he would bring the rest of her missing medications to the facility. -He had not yet delivered the tramadol HCL 50mg to the facility. -MAs were responsible to inform the WC when medications were not in the facility or that residents had missed taking medications. -She notified the WC that Resident #1 did not have tramadol HCL 50mg , but she could not remember the dates she informed her of the missing medications. -She did not know who her PCP was and had not notified the PCP that she had missed doses of tramadol HCL 50mg. -She did not know if Resident #1's PCP was notified that she did not have tramadol HCL 50mg available for administration. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facility. -She was unable to name all her medications and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 112 did not know if her family member brought in tramadol for her. -She did not remember taking tramadol 50mg for heel pain but did not need medication for heel pain. -She had never refused any medication at the facility. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -Her PCP from the previous facility followed her and ordered her medications. -He filled her medications at their family pharmacy. -He asked the MAs or WC to give him the medication prescription numbers when they needed to be filled. -He last spoke to a MA and the WC on 10/29/21 and 11/01/21 but was not asked to bring in any medications. -He did not bring in tramadol 50mg because he did not know she had an order for it. Interview with the WC on 11/02/21 at 4:45pm revealed: -MAs were responsible to report to her concerning residents' missed medications and notify the PCP. -MAs or herself order resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew she was missing tramadol 50mg since her admission on 10/18/21. -She had not requested tramadol 50mg from the emergency pharmacy because the family member said he would bring them in. -She spoke to Resident #1's family member the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 113 week of 10/25/21-10/29/21 and gave him a list of needed medications for her including tramadol 50mg. -She had not followed up with the family member to see if he brought in her tramadol 50mg. Telephone interview with a pharmacist from the facility pharmacy on 11/03/21 at 12:05pm revealed: -There was a profile on file for Resident #1, but the pharmacy only provided emergency pharmacy services for her. -The FL2 on file dated 10/08/21 had an order tramadol 50mg take 1 every 8 hours. -There was no request to fill tramadol 50mg take 1 every 8 hours for Resident #1 before 11/03/21. Telephone interview with a representative from Resident #1's PCP's office 11/04/21 at 8:35am revealed: -He followed her care and wrote medication orders at the previous facility where Resident #1 resided and since her admission to this facility. -He expected all medications to be available and administered as ordered. -He had not had a face to face visit since her admission on 10/18/2021. -There was no record of communication from the facility of missed doses of tramadol 50mg. -He did not know that she had not been administered tramadol 50mg since she was admitted. -The representative could not speak to the result of not taking tramadol 50mg. Telephone interview with Resident #1's family pharmacy on 11/04/21 at 9:05am revealed: -There was no FL2 or medication orders on file for tramadol HCL 50mg for Resident #1. -If the resident had not taken tramadol HCL	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

(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 114 50mg she could have increased or prolonged pain. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The Resident Care Coordinator (RCC) or WC processed orders on admission, including faxing orders to pharmacy and writing medication orders on the MAR. -He expected MAs to administer medications as ordered by the PCP. -MAs were to fax the pharmacy to refill needed medications. -MAs were to report to him, the WC or RCC if medications were not in the facility to administer to residents. -If a family member did not bring in needed medications, the facility would order and pay for medications from the facility's pharmacy or the back-up pharmacy. -Resident #1's family member chose to used their own pharmacy and only use the facility's pharmacy for emergency pharmacy needs. -He did not know Resident #1's family member did not bring in her tramadol to administer in the facility. e. Review of Resident #1's current FL2 dated 10/08/21 revealed there was an order for Prostat 30ml 2 times a day to aid in wound healing (used to help with wound healing). Review of Resident #1's Resident Register revealed Resident #1 was admitted on 10/18/21. Review of Resident #1's MAR for October 2021 revealed: -There was an entry for Prostat 30ml 2 times a day to aid in wound healing. -There were 25 of 27 doses of Prostat 30ml	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 115 documented as not administered (initials circled) 2 spaces on 10/19/21 and 10/20/21 at 8:00am which were left blank. -There were no reasons documented on the back of the MAR as to why the Prostat 30ml was not administered. Observation of Resident #1's medication on hand on 11/02/21 at 4:00 pm revealed there was no Prostat 30ml available for administration. Interview with a MA on 11/02/21 at 4:05pm revealed: -MAs were responsible for ordering medication from the pharmacy. -Resident #1's family member brought in all of her medications himself. -She had not requested Resident #1's Prostat 30ml 2 times a day from the facility pharmacy because her family member said he would bring in her missing medications. -She had reminded him multiple times since her admission that he needed to bring in the Prostat 30ml 2 times a day, but she could not remember the dates. -She last spoke to him in person 11/01/21 and he said he would bring the rest of her missing medications to the facility. -He had not yet delivered the Prostat 30ml 2 times a day to the facility. -MAs were responsible to inform the WC when medications were not in the facility or that residents had missed taking medications. -She notified the WC that Resident #1 did not have Prostat 30ml 2 times a day, but she could not remember the dates she informed her of the missing medication. -She did not know who her PCP was and had not notified the PCP that she had missed doses of Prostat 30ml 2 times a day.	D 358		

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D 358	Continued From page 116 -She did not know if Resident #1's PCP was notified that she did not have Prostat 30ml available for administration. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facility. -She was unable to name all her medications and was unsure if her family member brought in Prosat for to take. -She did not remember drinking any syrup medication to help her wounds to heal. -She had never refused any medication at the facility. -She had a wound on her heel that the home health nurse was coming in to treat. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -Her PCP from the previous facility followed her and ordered her medications. -He filled her medications at their family pharmacy. -He asked the MAs or WC to give him the medication prescription numbers when they needed to be filled. -He last spoke to an MA and the WC on 10/29/2021 and 11/01/21 but was not asked to bring in any medications. -He did not fill Prostat because he did not have a prescription for it and did not know she had an order for it. Interview with the WC on 11/02/21 at 4:45pm revealed: -MAs were responsible to report to her concerning residents' missed medications and notify the PCP. -MAs or herself ordered resident medications	D 358		

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D 358	Continued From page 117 from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew was missing Prostat 30ml since her admission on 10/18/21. -She had not requested Prostat 30ml from the emergency pharmacy because the family member said he would bring it in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications including Prostat for her. -She had not followed up with him to see if he brought in her missing medications. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed: -There was a profile on file for Resident #1, but the pharmacy only provided emergency pharmacy services for her. -The FL2 on file dated 10/08/2021 had an order Prostat 30ml 2 times a day. -There was no request to fill Prostat 30ml for Resident #1 before 11/03/21. -The facility pharmacy did not provide Prostat, it would have to be requested by a medical equipment provider or a home health provider. Telephone interview with a representative from Resident #1's PCP's office 11/04/21 at 8:35am revealed: -He followed her care since her admission to this facility. -The PCP expected all medications to be available and administered as ordered. -He had not had a face to face visit since her admission on 10/18/21. -There was no record of communication from the	D 358		

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D 358	Continued From page 118 facility of missed doses of Prostat 30ml. -He did not know that she had not been administered Prostat 30ml 2 times a day since she was admitted. -The representative could not speak to the result of not taking Prostat 30ml. Telephone interview with Resident #1's family pharmacy on 11/04/21 at 9:05am revealed: -The was no FL2 or medication orders on file for Prostat 30ml for Resident #1. -If the resident had not taken Prostat 30ml she could have delayed wound healing. Telephone interview with Resident #1's home health nurse on 11/04/21 at 9:19am revealed: -They provided medication or supplement recommendations for clients with non-healing wounds. -Resident #1's left heel was almost healed and she did not make any medication or supplement recommendations for her. -If the PCP ordered Prostat for her client, she would expect it to be administered as ordered. -They did not supply Prostat for clients, but it could usually be bought at local pharmacies. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The RCC or WC process orders on admission, including faxing orders to pharmacy and writing medication orders on the MAR. -He expected MAs to administer medications as ordered by the PCP. -MAs were to fax the pharmacy to refill needed medications. -MAs were to report to him, the WC or RCC if medications were not in the facility to administer to residents. -If a family member did not bring in needed	D 358		

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D 358	Continued From page 119 medications, the facility would order and pay for medications from the facility's pharmacy or the back-up pharmacy. -Resident #1's family member chose to use their own pharmacy and only used the facility's contracted pharmacy for emergency pharmacy needs. -He did not know Resident #1's family member did not bring in her Prostat to administer in the facility. f. Review of Resident #1's current FL2 dated 10/08/21 revealed there was an order for multivit-minerals take 1 tablet every day to promote wound healing.(used to help with wound healing). Review of Resident #1's Resident Register revealed Resident #1 was admitted on 10/18/21. Review of Resident #1's MAR for October 2021 revealed: -There was an entry for multivit-minerals take 1 tablet every day to promote wound healing. -There were 12 out of 13 doses of multivit-minerals documented as not administered (initials circled) and 1 space on 10/19/21 which was left blank. -Reasons documented on back of the MAR on 10/21/21 and 10/25/21 was "on order" as why multivit-minerals was not administered. Observation of Resident #1's medication on hand on 11/02/21 at 4:00 pm revealed there was no multivit-minerals tablets available for administration. Interview with a MA on 11/02/21 at 4:05pm revealed: -MAs were responsible for ordering medication	D 358		

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D 358	Continued From page 120 from the pharmacy. -Resident #1's family member brought in all of her medications himself. -She had not requested Resident #1's multivit-minerals from the pharmacy because her family member said he would bring in her missing medications. -She had reminded him multiple times since her admission that he needed to bring in the multivit-minerals tablet, but she could not remember the dates. -She last spoke to him in person 11/01/21 and he said he would bring the rest of her missing medications to the facility. -He had not yet delivered the multivit-minerals tablet to the facility. -MAs were responsible to inform the WC when medications were not in the facility or that residents had missed taking medications. -She notified the WC that Resident #1 did not have multivit-minerals, but she could not remember the dates she informed her of the missing medication. -She did not know who her PCP was and had not notified the PCP that she had missed doses of multivit-minerals. -She did not know if Resident #1's PCP was notified that she did not have multivit-minerals available for administration. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled all her medications at their own pharmacy and brought them to the facility. -She was unable to name all her medications and was unsure if her family member brought in a multivit mineral tablet for her to take. -She did not remember taking a vitamin or mineral tablet for her wounds to heal.	D 358		

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D 358	Continued From page 121 -She never refused any medication at the facility. -She had a wound on her heel that the home health nurse was coming in to take care of. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -Her PCP from the previous facility followed her and ordered her medications. -He filled her medications at their family pharmacy. -He asked the MAs or WC to give him the medication prescription numbers when they needed to be filled. -He last spoke to a MA and the WC on 10/29/2021 and 11/01/21 but was not asked to bring in any medications. -He did not fill multivit mineral tablet because he did not have a prescription for them and did not know she had an order for it. Interview with the WC on 11/02/21 at 4:45pm revealed: -MAs were responsible to report to her concerns residents' missed medications and notify the PCP. -MAs or herself ordered resident medications from the facility pharmacy but Resident #1's family member had chosen to use them as her emergency pharmacy. -The emergency pharmacy could only fill a 3-day supply for a resident. -She knew Resident #1 was missing multivit minerals tablet since her admission on 10/18/21. -She had not requested multivit minerals from the emergency pharmacy because the family member said he would bring them in. -She spoke to Resident #1's family member the week of 10/25/21-10/29/21 and gave him a list of needed medications including multivit minerals tablet.	D 358		

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D 358	Continued From page 122 -She had not followed up with the family member to see if he brought in her multivit minerals tablet. Telephone interview with a representative from Resident #1's PCP's office 11/04/21 at 8:35am revealed: -He followed her care since her admission to this facility. -The PCP expected all medications to be available and administered as ordered. -He had not had a face to face visit since her admission on 10/18/21. -There was no record of communication from the facility of missed doses of multivit minerals. -He did not know that she had not been administered multivit-minerals since she was admitted. -The representative could not speak to the result of not taking multivit-minerals. Interview with a MA on 11/02/21 at 4:05pm revealed: -MAs were responsible for ordering medication from the pharmacy. -Resident #1's family member brought in all of her medications himself. -She had not requested Resident #1's multivit-minerals tablet from the pharmacy because her family member said he would bring in her missing medications. -She had reminded him multiple times since her admission that he needed to bring in the missing medications, but she could not remember the dates. -She last spoke to him in person on 11/01/21 and he said he would bring the rest of her missing medications to the facility. -He had not yet delivered the multivit-minerals tablets to the facility. -MAs were responsible to inform the WC when	D 358		

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D 358	Continued From page 123 medications were not in the facility or that residents had missed taking medications. -She notified the WC that Resident #1 did not have some medications, but she could not remember the dates she informed her of the missing medications. -She did not notify Resident #1's PCP that she had missed medications and did not know who her PCP was. -She did not know if Resident #1's PCP was notified that she did not have all of her medications available at the facility. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy. -She could not name all her medications. -She did not remember taking a vitamin tablet for her heel wound to heal. -She had never refused any medication at the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/03/21 at 12:05pm revealed: -There was a profile on file for Resident #1, but they only provided emergency pharmacy services for her. -The FL2 on file dated 10/08/21 had an order multivit-minerals tablet take one ever day. -There was no request to fill multivit-minerals for Resident #1 before 11/03/21. Telephone interview with Resident #1's family pharmacy on 11/04/21 at 9:05am revealed: -The was no FL2 or medication orders on file for multivit-minerals tablets for Resident #1. -If the resident had not taken multivit-minerals she could have vitamin/mineral deficiencies.	D 358		

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D 358	Continued From page 124 Telephone interview with Resident #1's home health nurse on 11/04/21 at 9:19am revealed: -They provided medication or supplement recommendations for clients with non-healing wounds. -Resident #1's left heel was almost healed and she did not make any medication or supplement recommendations for her. -If the PCP ordered multivit-minerals for Resident #1 for wound healing, she would expect medication to be administered as ordered. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The RCC or WC processed orders on admission, including faxing orders to pharmacy and writing medication orders on the MAR. -He expected MAs to administer medications as ordered by the PCP. -MAs were to fax the pharmacy to refill needed medications. -MAs were to report to him, the WC or RCC if medications were not in the facility to administer to residents. -If a family member did not bring in needed medications, the facility would order and pay for medications from the facility's pharmacy or the back-up pharmacy. -Resident #1's family member chose to use their own pharmacy and only used the facility's pharmacy for emergency pharmacy needs. -He did not know Resident #1's family member did not bring in her multivit-minerals to administer in the facility. The facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents including a resident who was not administered her eye drops twice daily as ordered	D 358		

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D 358	Continued From page 125 which could result in increased pressure in the eyes, pain, and vision loss (#2); multiple doses of a blood thinner which could result in a blood clot in the leg(s) or chest (#5); a resident who was not administered an oral and a topical pain medication which could result in increased pain, a muscle relaxer which could result in increased muscle spasms, a cholesterol lowering medication which could result in increased cholesterol levels, and a behavior medication which could result in increased aggression and behaviors (#4). This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 11/04//21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2021.	D 358		
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;	D 367	1.Audit of residents medication completed 11/4/21 by Director of clinical services to ensure medications ordered, are on the medication carts. 2. Education provided to MAs by RSD on 12/13/21 about receiving orders and following up to ensure medications/order are received and followed through within a timely manner. 3. RSD or Designee to complete audits of MAR to ensure accuracy daily for 30 days and weekly thereafter.	12-20-21

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D 367	Continued From page 126 (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the electronic Medication Administration Records (MAR) for 3 of 5 sampled residents (#1, #4, and #7) regarding a pain medication (Resident #1), documentation of fingerstick blood sugars (FSBS) (Residents #4 and #7) and documentation of blood pressure (BP) readings (Resident #4). The findings are: 1.Review of Resident #1's current FL2 dated 10/08/21 revealed: -There were diagnoses of muscle weakness and urinary tract infections. -There was an order for acetaminophen 500mg take one every 6 hours. Review of Resident #1's November 2021 medication administration record(MAR) revealed: -There was an entry for acetaminophen 500mg take 1 tablet every 6 hours. -There were spaces to document administration at 8:00am, 2:00pm and 8:00pm but there was not a fourth space for documentation every 6 hours, there was no 2:00am space to document. Interview with a medication aide (MA) on 11/02/21	D 367	4.RSD or designee to complete daily monitoring of Medication administration for 30 days and then weekly thereafter to ensure all medications are in the community and on the medication cart.	

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D 367	Continued From page 127 at 4:05pm revealed: -She knew Resident #1 had an order for acetaminophen 500mg. -Her family member supplied her medications and had not brought in acetaminophen, so she had not administered it to the resident. -She circled her initials to show that she did not administer acetaminophen but did not pay attention to if it was timed correctly. Interview with Resident #1 on 11/02/21 at 4:15pm revealed: -Her family member filled her medications at their own pharmacy and brought them to the facility. -She was did not know if her family member brought in acetaminophen 500mg for her or how often she was to take it. -She did not remember taking acetaminophen 500mg but needed something occasionally for a headache. Telephone interview with Resident #1's family member on 11/02/21 at 4:19pm revealed: -He filled her medications at their family pharmacy. -He did not bring in the acetaminophen because she had aspirin for pain. -He did not know how often she was supposed to take acetaminophen 500mg. Interview with the Wellness Coordinator (WC) on 11/02/2021 at 4:45pm revealed: -She was responsible to add orders to the residents' MARs. -She added Resident #1's acetaminophen 500mg every 6 hours but missed adding a fourth space for documenting administration every 6 hours, there was no space to document a 2:00am dose. Telephone interview with a pharmacist from the	D 367		

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D 367	Continued From page 128 facility's contracted pharmacy on 11/03/2021 at 12:05pm revealed: -There was a profile on file for Resident #1, but they provided emergency pharmacy services only for her. -The FL2 on file dated 10/08/2021 had an order for acetaminophen 500mg every 6 hours. Telephone interview with a representative from Resident #1's primary care provider's (PCP) office 11/04/2021 at 8:35am revealed: -There was an order for acetaminophen 500mg every 6 hours. -He expected all medications to be administered as ordered. -She could not speak to the result of missing a scheduled dose of acetaminophen 500mg every 6 hours. Interview with the Administrator on 11/04/21 at 10:15am revealed: -The Resident Care Coordinator (RCC) or WC processed orders on admission, including faxing orders to pharmacy and enterring medication orders on the MAR. -He expected orders be written on the MAR as ordered by the PCP. 2. Review of Resident #7's current FL2 dated 10/13/21 revealed: -Diagnoses included diabetes, hyperlipidemia, hypertension and dementia. -There was an order to check blood sugar twice daily. -There was an order for humalog insulin (fast acting insulin used to treat high blood sugar) inject 6 units with breakfast and after supper as needed for blood sugar greater than 300. Review of Resident #7's August 2021 MAR	D 367		

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D 367	Continued From page 129 revealed: -There was an entry to check blood sugar twice daily at 8:00am and 8:00pm. -There were 1 entry left blank for 8:00am and 15 entries left blank for 8:00pm. -There were no documented reasons for the omissions. -The FSBS ranged from 91 to 189. -There was an entry for humalog insulin inject 6 units with breakfast and after supper as needed for blood sugar greater than 300. -There was no documentation of administration of humalog insulin inject 6 units with breakfast and after supper as needed for blood sugar greater than 300. Review of Resident #7's September 2021 MAR revealed: -There was an entry to check blood sugar twice daily at 8:00am and 8:00pm. -There were 10 entries left blank for 8:00pm. -There were no documented reasons for the omissions. -The FSBS ranged from 77 to 169. -There was an entry for humalog insulin inject 6 units with breakfast and after supper as needed for blood sugar greater than 300 -There was no documentation of administration of humalog insulin inject 6 units with breakfast and after supper as needed for blood sugar greater than 300. Review of Resident #7's October 2021 MAR revealed: -There was an entry to check blood sugar twice daily at 8:00am and 8:00pm. -There were 17 entries left blank for 8:00pm. -There were no documented reasons for the omissions. -The FSBS ranged from 91 to 159.	D 367		

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D 367	Continued From page 130 -There was an entry for humalog insulin inject 6 units with breakfast and after supper as needed for blood sugar greater than 300 -There was no documentation of administration of humalog insulin inject 6 units with breakfast and after supper as needed for blood sugar greater than 300. Interview with a medication aide (MA) on 11/04/21 at 3:50pm revealed: -After the MA checked the FSBS they recorded the results on a blood sugar monitoring (BS) log that was with the MAR. -The MA was supposed to document their initials on the BS log and MAR after obtaining the FSBS. -She knew Resident #7 had a FSBS order for 2 times a day and Humalog insulin if her FSBS was over 300. -She always documented the FSBS but had noticed some FSBS were not documented on the MAR. -Resident #7's FSBS had not been over 300 for several months. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 1:05pm revealed: -She did not add orders to or audit MARs, the WC and nurse were responsible to audit. -She knew Resident #7 had an order for FSBS 2 times a day and humalog insulin order for FSBS over 300. -MAs should document FSBS on the MAR or the FSBS sheet so that insulin would be given appropriately. Interview with the Wellness Coordinator (WC) on 11/04/21 at 4:00pm revealed: -She filled in as MA some shifts on the SCU. -She added orders to the MAR and knew Resident #7 had a FSBS and Humalog insulin	D 367		

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D 367	Continued From page 131 order for FSBS over 300. -She did not remember a FSBS over 300 recently. -She had not been able to audit the MARs weekly like she wanted to. -MAs should document FSBS on the MAR or the FSBS sheet so that she could tell if Humalog was needed for that documented FSBS. Interview with the Administrator on 11//21 at 11:30 am revealed: -The WC and facility nurse were responsible to audit MAR documentation. -MAs should document and initial the MAR or the FSBS sheet after checking a FSBS and administering insulin. -If the FSBS was not documented, then it was not done and it was not known if and how much insulin the resident should have. 3. Review of Resident #4's current FL2 dated 10/06/21 revealed: -Diagnoses included type 2 diabetes mellitus. -There was an order for FSBS check every morning at 6:30am and notify the physician if blood sugar greater than 400 or less than 70. a. Review of Resident #4's physician's orders dated 08/11/21 revealed an order for FSBS checks every morning at 6:30 and record. Notify physician if blood sugar greater than 400 or less than 70. Review of Resident #4's medication administration record (MAR) for August 2021 revealed: -There was an entry for FSBS checks every morning at 6:30am and record. Notify the physician if blood sugar greater than 400 or less than 70.	D 367		

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D 367	Continued From page 132 -There were 2 medication aide (MA) initials documented on the front of the MAR with no documentation of FSBS checks on 08/13/21 and 08/16/21.. -There were 4 spaces left blank on the front of the MAR on 08/18/21, 08/19/21, 08/20/21, and 08/21/21. -There were no FSBS checks documented on the back of the MAR. -There was no reason documented on the back of the MAR why FSBS checks were omitted. -FSBS ranged from 119 to 165. Review of Resident #4's FSBS log for August 2021 revealed: -The log was dated from 08/15/21 through 08/23/21. -There were 3 FSBS documented on the FSBS log and 2 FSBS were duplicate entries from the MAR. Review of Resident #4's MAR for September 2021 revealed: -There was an entry for FSBS checks every morning at 6:30am and record. Notify the physician if blood sugar greater than 400 or less than 70. -There was 2 MA initials documented on the front of the MAR with no documentation of FSBS checks on 09/04/21 and 09/11/21. -There were 2 spaces left blank on the front of the MAR on 09/07/21 and 09/18/21. -There were no FSBS checks documented on the back of the MAR. -There was no reason documented on the back of the MAR why FSBS checks were omitted. -FSBS ranged from 117 to 210. Review of Resident #4's MAR for October 2021 revealed:	D 367		

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D 367	Continued From page 133 -There was an entry for FSBS checks every morning at 6:30am and record. Notify the physician if blood sugar greater than 400 or less than 70. -There was 1 MA initial documented on the front of the MAR with no documentation of FSBS checks. -There were 2 spaces left blank on the front of the MAR on 09/07/21 and 09/18/21. -There were no FSBS checks documented on the back of the MAR. -There was no reason documented on the back of the MAR why FSBS checks were omitted. -FSBS ranged from 115 to 168. Interview with a MA on 11/04/21 at 9:35am revealed: -Resident #4 had an order for to check FSBS daily. -FSBSs should have been documented on the MAR and on a FSBS log. -She did not know why all Resident #4's FSBSs had not been documented on the MAR daily and on the FSBS log. -She did not know if MARs were reviewed for accuracy or who reviewed them. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -MAs should have documented FSBS on the MAR and on a FSBS log. -She did not know there were FSBS readings missing from Resident #4's MAR. -She did not review any of the residents' MARs, but either the Wellness Coordinator (WC) or former facility nurse reviewed them. -In the past, the MAs on each shift conducted a MAR audit, but that was not being done now. Interview with the WC on 11/04/21 at 4:00pm	D 367		

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D 367	Continued From page 134 revealed: -She filled in as a MA some shifts in the SCU. -She assisted with auditing the MAR, but she had not been able to audit the MARs weekly like she wanted to. Interview with the Administrator on 11/05/21 at 10:13am revealed: -FSBS readings should have been documented on the MAR. -He did not know there FSBS entries were missing from Resident #4's MAR. -The WC checked the MARs, but he did not know how often. -He expected for MAs to check for missing documentation and to make sure the MARs were completed prior to the end of their shifts. b. Review of Resident #4's physician's orders dated 08/11/21 revealed an order to check BP every day and call the physician with blood pressure systolic greater than 160 and diastolic greater than 100. Review of Resident #4's medication administration record (MAR) for August 2021 revealed: -There was an entry for BP checks every day. Call the physician with blood pressure systolic greater than 160 and diastolic greater than 100. -There were 26 medication aide (MA) initials documented on the front of the MAR with no documentation of BP checks on 08/02/21, 08/04/21 through 08/08/21, 08/10/21 through 08/13/21, 08/15/21 through 08/25/21, and 08/27/21 through 08/31/21.. -There were 5 spaces left blank on the front of the MAR on 08/01/21, 08/03/21, 08/09/21, 08/14/21, and 08/26/21. -There were no BP checks documented on the	D 367		

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D 367	Continued From page 135 back of the MAR. -There was no reason documented on the back of the MAR why BP checks were omitted. Review of Resident #4's BP log for August 2021 revealed: -The log was dated from 08/01/21 through 08/31/21. -There were 24 BPs documented on the BP log. -Systolic BPs ranged from 100 to 160 and diastolic BPs ranged from 53 to 84 Review of Resident #4's MAR for September 2021 revealed: -There was an entry for BP checks every day. Call the physician with blood pressure systolic greater than 160 and diastolic greater than 100. -There were 9 MA initials documented on the front of the MAR with no documentation of BP checks on 09/02/21, 09/03/21, 09/06/21 through 09/11/21, 09/22/21, and 09/25/21. -There were 6 spaces left blank on the front of the MAR on 09/14/21, 09/21/21, 09/23/21, 09/24/21, 09/28/21, and 09/29/21. -There were 8 BP checks documented on the back of the MAR. -There was no reason documented on the back of the MAR why BP checks were omitted. -Systolic BPs ranged from 109 to 140 and diastolic BPs ranged from 57 to 80. Review of Resident #4's MAR for October 2021 revealed: -There was an entry for BP checks every day. Call the physician with blood pressure systolic greater than 160 and diastolic greater than 100. -There were 12 MA initials documented on the front of the MAR with no documentation of BP on 10/01/21, 10/02/21, 10/05/21 through 10/07/21, 10/09/21, 10/13/21, 10/14/21, 10/20/21, 10/23/21,	D 367		

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D 367	Continued From page 136 10/24/21, and 10/28/21. -There were 9 spaces left blank on the front of the MAR on 010/04/21, 10/10/21 through 10/12/21, 10/15/21, 10/19/21, 10/26/21, 10/29/21, and 10/31/21. -There was 1 MA initials circled on the front of the MAR on 10/03/21. -There were 10 BP checks documented on the back of the MAR. -There was no reason documented on the back of the MAR why BP checks were omitted. -Systolic BPs ranged from 102 to 143 and diastolic BPs ranged from 54 to 80 Interview with a MA on 11/04/21 at 9:35am revealed: -Resident #4 had an order for to check BP daily. -BPs should have been documented on the MAR and on a BP log. -She did not know why all Resident #4's BP's had not been documented on the MAR daily and on the BP log. -She did not know if MARs were reviewed for accuracy or who reviewed them. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -MAs should have documented BP on the MAR and on a BP log. -She did not know there were BP readings missing from Resident #4's MAR. -She did not review any of the residents' MARs, but either the Wellness Coordinator or former facility nurse did. -In the past, the MAs on each shift conducted a MAR audit, but that was not being done now. Interview with the Wellness Coordinator (WC) on 11/04/21 at 4:00pm revealed: -She filled in as a MA some shifts in the SCU.	D 367		

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D 367	Continued From page 137 -She assisted with auditing the MAR, but she had not been able to audit the MARs weekly like she wanted to. Interview with the Administrator on 11/05/21 at 10:13am revealed: -BP checks should have been documented on the MAR. -He did not know there was documentation of BP checks missing from Resident #4's MAR. -The WC checked the MARs, but he did not know how often. -He expected for MAs to check for missing documentation and to make sure the MARs were completed prior to the end of their shifts.	D 367		
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: Based on interviews and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 1 of 5 sampled residents (#2) who received a topical pain relief patch and an anxiolytic. The findings are:	D 392	1.Audit of residents medication completed 11/4/21 to ensure medications ordered, are on the medication carts. 2. Education provided to MAs by RSD on 12/13/21 about receiving orders and following up to ensure medications/order are received and followed through within a timely manner. 3. RSD or Designee to complete daily audits of the controlled substance log for 30days and weekly thereafter. 4.RSD or designee to complete daily monitoring of Medication administration of controlled substances for 30 days and then weekly thereafter to ensure all medications are in the community and on the medication cart.	12-20-21

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D 392	Continued From page 138 Review of Resident #2's current FL2 dated 08/29/21 revealed diagnoses included chronic pain, back pain, osteoarthritis of knee, and anxiety. a. Review of Resident #2's signed physician's orders dated 10/06/21 revealed there was an order for fentanyl 25mcg/hr patch (a narcotic pain medication patch), place 1 patch onto the skin every 3 days. Review of Resident #2's August 2021 medication administration record (MAR) revealed: -There was an entry for fentanyl 25mcg/hr patch, apply 1 patch to skin and change every 72 hours at 8:00pm. -There was documentation the fentanyl patch had been applied 6 out of 10 opportunities except on 08/05/21 and 08/08/21 when the facility was completing a prior authorization with Resident #2's insurance company, and on 08/26/21 when Resident #2 was in the Emergency Department. There was one missing application on 08/17/21 that did not have an explanation for why the patch was not applied. Review of Resident #2's controlled substance count sheet (CSCS) received from the pharmacy on 08/17/21 for 4 patches compared to Resident #2's August 2021 MAR revealed: -On 08/17/21, a patch was documented as removed on the MAR but no new patch was signed out on the CSCS; there was no reason documented. -On 08/29/21, a patch was documented as applied on the MAR but not on the CSCS. -On 08/30/21, there was a patch signed out on the CSCS but not documented on the MAR.	D 392		

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D 392	Continued From page 139 Review of Resident #2's September 2021 MAR revealed: -There was an entry for fentanyl 25mcg/hr patch, apply 1 patch to skin and change every 72 hours, 8:00pm. -There was documentation the fentanyl patch had been applied 4 out of 10 opportunities on 09/02/21, 09/11/21, 09/14/21. and 09/26/21. -One application was initialed with a circle around it on 09/23/21 indicating the medication aide (MA) had documented the medication as not administered, but there was no documented reason why the patch was not applied as ordered. -There were 5 doses that were left blank on the MAR on 09/05/21, 09/08/21, 09/17/21, 09/20/21, and 09/29/21. Review of Resident #2's CSCS received from the pharmacy on 08/30/21 for 3 patches compared to Resident #2's September 2021 MAR revealed: -On 09/02/21, there was a patch documented as applied on the MAR, but not signed out as administered on the CSCS. -On 09/21/21, there was a patch signed out on the CSCS but not documented as applied on the MAR. -On 09/23/21, one patch was documented as not administered on the MAR, but there was no documented reason why. It was also not signed out as administered on the CSCS. Review of Resident #2's October 2021 MAR revealed: -There was an entry for fentanyl 25mcg/hr patch, apply 1 patch to skin and change every 72 hours at 8:00pm. -There was documentation the fentanyl patch had been applied 4 out of 10 opportunities on 10/02/21, 10/05/21, 10/20/21, and 10/26/21. -Six missed doses were left blank on the MAR	D 392		

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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 392	Continued From page 140 with no explanation for why they were not applied on 10/08/21, 10/11/21, 10/14/21, 10/17/21, 10/23/21, and 10/29/21. Review of Resident #2's CSCS received from the pharmacy on 09/24/21 for 10 patches compared to Resident #2's October 2021 MARs revealed: -On 10/01/21, there was 1 patch signed out on the CSCS but not documented as applied on the MAR. -On 10/02/21, there was 1 patch documented as applied on the MAR but not signed out on the CSCS. -On 10/08/21, there was 1 patch signed out on the CSCS but not documented as applied on the MAR. -On 10/30/21, there was 1 patch signed out on the CSCS but not documented as applied on the MAR. Observation of medication on hand for Resident #2's fentanyl 25mcg/hr patches revealed the count on the CSCS matched the patches available in the medication cart. Interview with a representative from the facility's contracted pharmacy on 11/04/21 at 10:06am revealed the pharmacy dispensed fentanyl 25mcg/hr patches to the facility as follows: -On 09/24/21, a quantity of 10 patches were dispensed. -On 08/29/21, a quantity of 3 patches were dispensed. -On 08/15/21, a quantity of 4 patches were dispensed. -On 06/09/21, a quantity of 10 patches were dispensed. Interview with Resident #2's primary care provider (PCP) on 11/03/21 at 1:30pm revealed:	D 392		

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	HAL041052	A. BUILDING _____ B. WING _____	R 11/05/2021

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D 392	Continued From page 141 -She was aware the fentanyl patch was not always applied every three days becuse there had been some issues with Resident #2's insurance covering the patches. -She did not know Resident #2 had missed four patches for the month of October 2021 and five patches for the month of September 2021. -She had last assessed Resident #2 two weeks prior and Resident #2 had no increased complaints of pain at that time. -It was her expectation that staff administered all medications as ordered and documented why a medication was not administered. Interview with the Wellness Coordinator (WC) on 11/03/21 at 4:45pm revealed: -Insurance had sometimes caused a delay in the delivery of Resident #2's fentanyl 25mcg/hr patches while the staff completed Prior Authorization requests. -Prior Authorization paperwork was being completed 08/02/21 through 08/11/21 and the insurance approved it on 08/11/21 for the following dates: 07/10/21 through 08/11/22. -She also worked in the role of MA and had never had fentanyl patches unavailable to apply for Resident #2. -She thought the blank spaces on the MAR were from the MAs forgetting to document, rather than not actually applying the patch. Interview with Resident #2 on 11/04/21 at 9:21am revealed: -She used the fentanyl patches for her back pain. -She was unsure when she last went without one of her patches. -She was unsure if her pain was worse on the days where she was due for a patch and did not have one applied. -If she was having pain, she would ask the MA for	D 392		

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D 392	Continued From page 142 a pain medication and they would give it to her. Interview with an MA on 11/05/21 at 4:20pm revealed: -Resident #2 had never requested a medication from her that was not available on the medication cart. -She could not remember a time where Resident #2 did not have fentanyl patches available in the cart or where Resident #2 had refused her fentanyl patch. -Blank spaces on the MAR indicated that a medication was not administered, but she thought the blank spaces for Resident #2's fentanyl patch were from the MAs forgetting to document. -She worked evening shift and had never seen Resident #2 without a fentanyl patch on her. Interview with the Administrator on 11/05/21 at 5:20pm revealed: -The facility had been working to improve their documentation. -If the MA staff did not document each administration, they could not prove that they applied the medication as ordered. -It was his expectation that staff document every medication/treatment they administer or that they offer and is refused. b. Review of Resident #2's signed Physician's Orders dated 10/06/21 revealed there was an order for alprazolam (a controlled medication used to help treat anxiety) 1mg tablet at bedtime, and an order for alprazolam 0.25mg tablet twice daily as needed. Review of Resident #2's August 2021 MAR revealed: -There was an entry for alprazolam 1mg tablet, take 1 tablet once a day at bedtime (8:00pm).	D 392		

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D 392	Continued From page 143 -There was an entry for alprazolam 0.25mg tablet, take 1 tablet twice a day as needed. -There were three days without documentation that scheduled alprazolam 1mg tablet was administered 08/10/21, 08/22/21, and 08/27/21), and one day that it documented as not administered (08/27/21). -There were no documented administrations for the "as needed" alprazolam. Review of Resident #2's September 2021 MAR revealed: -There was an entry for alprazolam 1mg tablet, take 1 tablet once a day at bedtime (8:00pm). -There was an entry for alprazolam 0.25mg tablet, take 1 tablet twice a day as needed. -There were five days without documentation that scheduled alprazolam 1mg tablet was administered (on 09/02/21, 09/05/21, 09/06/21, 09/15/21, and 09/21/21). -On 09/26/21 through 09/30/21 alprazolam 1mg was documented as not administered, with documentation on 09/26/21 stating the medication was on order from the pharmacy. -There were no documented administrations for the "as needed" alprazolam. Review of Resident #2's October 2021 MAR revealed: -There was an entry for alprazolam 1mg tablet, take 1 tablet once a day at bedtime (8:00pm). -There was an entry for alprazolam 0.25mg tablet, take 1 tablet twice a day as needed. -Scheduled alprazolam 1mg was documented as not administered three times (on 10/10/21, 10/19/21 and 10/20/21) with documentation from 10/10/21 stating the medication was on order. -There were no documented administrations for the "as needed" alprazolam.	D 392		

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D 392	Continued From page 144 Review of Resident #2's CSCS received from the contracted pharmacy provider revealed: -There was a CSCS dated 07/18/21 for alprazolam 1mg tablet, take 1 tablet once a day at bedtime with a quantity of 30 tablets received by the facility on 07/19/21. -There was a CSCS dated 08/11/21 for alprazolam 1mg tablet, take 1 tablet once a day at bedtime with a quantity of 30 tablets received by the facility on 08/11/21. -There was a CSCS dated 09/17/21 for alprazolam 1mg tablet, take 1 tablet once a day at bedtime with a quantity of 5 tablets received by the facility on 09/18/21. -There was a CSCS dated 10/20/21 for alprazolam 1mg tablet, take 1 tablet once a day at bedtime with a quantity of 30 tablets received by the facility on 10/20/21. -There were two CSCS dated 08/12/20 for alprazolam 0.25mg tablet, take 1 tablet twice a day at as needed with a quantity of 60 tablets total received by the facility on 08/13/20. -There were two CSCS dated 10/13/21 for alprazolam 0.25mg tablet, take 1 tablet twice a day at as needed with a quantity of 60 tablets total received by the facility on 10/13/21. Review of Resident #2's CSCS received from the pharmacy on 07/19/21 for 30 tablets compared to Resident #2's August 2021 MAR revealed: -On 08/10/21 alprazolam 1mg was documented as administered on the CSCS but not the MAR. -On 08/20/21 alprazolam 1mg was documented as administered on the CSCS two times, at 8:00am and 8:00pm. The 8:00am dose was not documented on the MAR for the scheduled dose or the "as needed" dose. -On 08/22/21 alprazolam 1mg was not documented as administered on the MAR but was written on the CSCS and then crossed out.	D 392		

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D 392	Continued From page 145 Review of Resident #2's CSCS received from the pharmacy on 08/11/21 for 30 tablets compared to Resident #2's August and September 2021 MAR revealed: -Scheduled alprazolam 1mg was documented on the CSCS as administered twice a day, at 8:00am and 8:00pm for the following dates: 08/23/21, 08/24/21, 08/26/21, 08/30/21, 08/31/21, 09/01/21, 09/02/21, and 09/10/21. The 8:00am administrations were not documented on the MAR. -On 08/25/21 scheduled alprazolam 1mg was documented as administered on the CSCS at 8:00am instead of the scheduled time of 8:00pm, and not documented on the MAR. -Alprazolam 1mg was documented as administered on the CSCS but left blank on the MAR for the following dates: 09/02/21, 09/05/21, 09/06/21, 09/15/21. -On 09/17/21 alprazolam 1mg was documented as administered on the MAR but not the CSCS. Review of Resident #2's CSCS received from the pharmacy on 09/18/21 for 5 tablets compared to Resident #2's September 2021 MAR revealed: -On 09/21/21 alprazolam 1mg was documented as administered on the CSCS but left blank on the MAR. The facility was unable to provide the CSCS sheet to cover the dates between 09/23/21 and 10/20/21. Review of Resident #2's CSCS received from the pharmacy on 10/20/21 for 30 tablets compared to Resident #2's October 2021 MAR revealed: --On 10/24/21 alprazolam 1mg tablet was documented as administered on the MAR but not the CSCS.	D 392		

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D 392	Continued From page 146 Review of Resident #2's CSCS received from the pharmacy on 08/13/20 for 60 tablets of alprazolam 0.25mg to take twice a day as needed, compared to Resident #2's August, September and October 2021 MARs revealed: -The only dose of "as needed" alprazolam 0.25mg that was administered between 08/01/21 and 10/31/21 was on 10/14/21 at 8:00pm. Observation of medication on hand for Resident #2's scheduled alprazolam 1mg tablets revealed: -The count on the CSCS matched the quantity of pills available in the medication cart. Observation of medication on hand for Resident #2's as needed alprazolam 0.25mg tablets revealed: -The count on the CSCS matched the quantity of pills available in the medication cart. -There were four cards of alprazolam 0.25mg twice daily as needed; three were full with 30 out of 30 tablets remaining and one with 14 tablets remaining. -Two of the cards were received from the pharmacy on 08/13/20 and had expired on 08/07/21. -The MA removed the expired medication from the cart. Interview with pharmacist at the facility contracted pharmacy on 11/04/21 at 3:20pm revealed: -They had dispensed alprazolam 1mg tablet to take every night at bedtime (8:00pm) on the following dates: 07/18/21 for 30 tablets, 08/11/21 for 30 tablets, 09/17/21 for 5 tablets, and 10/20/21 for 30 tablets. -They had never received an order for Resident #2 to take alprazolam 1mg twice a day at 8:00am and 8:00pm.	D 392		

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D 392	Continued From page 147 -They had dispensed "as needed" alprazolam 0.25mg tablets on the following dates: 08/12/20 for 60 tablets, and 10/13/21 for 60 tablets. Interview with an MA on 11/04/21 at 1:20pm revealed: -She reviewed the CSCS sheet for scheduled alprazolam 1mg every night at bedtime that was received from the pharmacy on 08/11/21 and verified she had administered the 8:00am doses 7 out of the total 9 times. -She did not know why she had administered the alprazolam at 8:00am unless the order had temporarily changed to twice daily or she had been administering the medication "as needed" and documenting on the wrong sheet. -Interview with Resident #2's PCP on 11/05/21 at 3:30pm revealed: -Resident #2 had been prescribed alprazolam to help with her anxiety and insomnia. -It was her expectation that staff administer this medication as she had ordered it. -It was her expectation that staff document every time they administer this medication or to document a reason why this medication was not administered. -She had not been notified that Resident #2 had received alprazolam 1mg twice daily instead of once daily nine times in August. -When she was at the facility, she did not look at the CSCS so had not noticed the 8:00am dose administrations. -She did not feel the extra dosages would have caused harm to Resident #2 as a 2mg daily dose would be within the normal dose range for this medication. Interview with the Administrator on 11/05/21 at 5:20pm revealed:	D 392		

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D 392	Continued From page 148 -He had not been made aware that Resident #2 received alprazolam more often than ordered in August. -It was his expectation that MA staff administer medications as ordered and document all medications they administer.	D 392		
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 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 record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 8 of 42 shifts sampled for 14 days from 10/21/21 to 11/03/21. The findings are: Review of the facility's 2021 license from the Division of Health Service Regulation revealed the facility was licensed for a Special Care Unit (SCU) with a capacity of 30 beds. Review of the facility resident census dated 10/22/21 revealed there was a SCU census of 24 residents, which required 19.2 staff hours on third	D 465	1. Audit completed on 12/13/2021 by ED/RSD to ensure all other shifts met staffing requirements. 2. Ads placed on Indeed for all open positions. 3. Wellness Coordinator or Designee will review staffing daily for proper staffing. 4. All shifts shall be staffed according to NC staffing requirements for Long-Term/Special Care units.	12-20-21

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D 465	Continued From page 149 shift. Review of the individual time sheets dated 10/22/21 revealed 12 staff hours were provided in the SCU on third shift, leaving the shift short 7.2 hours. Review of the facility resident census dated 10/23/21 revealed there was a SCU census of 24 residents, which required 19.2 staff hours on third shift. Review of the individual time sheets dated 10/23/21 revealed 12 staff hours were provided in the SCU on third shift, leaving the shift short 7.2 hours. Review of the facility resident census dated 10/24/21 revealed: -There was a SCU census of 24 residents, which required 24 staff hours on second shift. -There should have been a total of 48 hours between the SCU and AL unit on second shift. Review of the individual time sheets dated 10/24/21 revealed: -There were 16 staff hours provided in the SCU on second shift, leaving the shift short 8 hours. -It could not be determined how many of 8 additional staff hours were worked in the SCU or AL on second shift. Review of the facility resident census dated 10/24/21 revealed there was a SCU census of 24 residents, which required 19.2 staff hours on third shift. Review of the individual time sheets dated 10/24/21 revealed 12 staff hours were provided in the SCU on third shift, leaving the shift short 7.2	D 465		

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D 465	Continued From page 150 hours. Review of the facility resident census dated 10/26/21 revealed there was a SCU census of 24 residents, which required 24 staff hours on first shift. Review of the individual time sheets dated 10/26/21 revealed 16.5 staff hours were provided in the SCU on first shift, leaving the shift short 7.5 hours. Review of the facility resident census dated 10/30/21 revealed there was a SCU census of 24 residents, which required 19.2 staff hours on third shift. Review of the individual time sheets dated 10/30/21 revealed 12 staff hours were provided in the SCU on third shift, leaving the shift short 7.2 hours. Review of the facility resident census dated 11/01/21 revealed: -There was a SCU census of 24 residents, which required 19.2 staff hours on third shift. -There should have been a total of 35.2 hours between the SCU and AL unit on third shift. Review of the individual time sheets dated 11/01/21 revealed: -There were 12.25 staff hours provided in the SCU on third shift, leaving the shift short 6.95 hours. -It could not be determined how many of 6.75 additional staff hours were worked in the SCU. Review of the facility resident census dated 11/03/21 revealed there was a SCU census of 24 residents, which required 19.2 staff hours on third	D 465		

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D 465	Continued From page 151 shift. Review of the individual time sheets dated 11/03/21 revealed 14.5 staff hours were provided in the SCU on third shift, leaving the shift short 4.7 hours. Telephone interview with a third shift personal care aide (PCA) on 11/05/21 at 5:00pm revealed: -She worked both the SCU and Assisted Living(AL) units on third shift. -Staff worked short staffed on third shift sometimes, if they had call outs there would only be 2 PCAs in the facility, 1 in AL and 1 in SCU. -She could not remember a specific date that staffing was short on third shift. -She did not feel the facility had safe staffing to meet the needs of the residents even when staffing was full because the residents seem harder to care for. Telephone interview with a first shift personal care aide (PCA) on 11/05/21 at 5:05pm revealed: -She usually worked first shift on both the SCU and AL units and would sometimes work second and third shifts when needed. -First shift was usually staffed with 2 PCAs and a MA. -The Administrator and Wellness Coordinator (WC) would make calls to attempt to get other staff to come in if there were call outs, but most of the time office staff filled in. -The WC filled in several shifts a week on SCU and AL, but she was unable to remember the dates. -The Business Office Manager (BOM) filled in shifts on third shift occasionally. Interview with the WC on 11/05/21 at 4:00pm revealed:	D 465		

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D 465	Continued From page 152 -She was responsible for the staff schedule. -She kept a record of office staff working the floor on SCU or AL as MAs or PCAs when she knew it occurred. -She kept a record on changes to when staff worked and which unit they worked. -There were frequent staff call outs when she and the SCUS would fill in as PCA or MA. -She worked the floor as a MA on the SCU at times when staffing was short. -She worked every other weekend as well as and filled in some shifts during the week. Interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm revealed: -The WC was responsible for staff scheduling. -She would help do a bath occasionally on first shift. -She never worked as a PCA or MA on third shift. Attempted telephone interview with a third shift MA on 11/05/21 at 5:19pm was unsuccessful. Attempted telephone interview with a second shift MA on 11/05/21 at 5:25pm was unsuccessful. Interview with Administrator on 11/05/21 at 5:39pm revealed: -The WC was responsible for staff scheduling. -The SCU was not short staffed because the WC, RCC and SCUS filled in shifts as MAs and PCAs when staffing was not covered, or they had call outs. -There was no other verifiable record of office staff working on SCU or AL as MAs or PCAs except the early in and late out punches on individual time sheets.	D 465		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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D 468	Continued From page 153	D 468		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 6 sampled staff (Staff A and B) who worked in the Special Care Unit (SCU) had completed 6 hours of training within the first week of employment had completed 20	D 468	1. Special Care unit training provided by BTR Director to special care unit staff on 12/13/2021. BTR 2.BTR Director or designee to ensure new hires receive Special care unit training. 3. BTR Director or Designee to complete audit weekly for 30 days of special care unit staff requiring special care unit training.	12-20-21

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D 468	Continued From page 154 hours of training within the first six months of employment. The findings are: 1. Review of Staff A's, medication aide(MA) personnel record revealed: -Staff A was hired on 07/07/20. -There was no documentation Staff A had completed 6 hours of special care unit (SCU) training within her first week of employment. -There was no documentation Staff A had completed 20 hours of SCU training within her first six months of employment. -There was documentation for 1 hour on 03/31/2021 and 1 hour on 05/31/2021 SCU training for dementia care for Staff A. Attempted telephone interview with Staff A on 11/05/21 at 5:19pm was unsuccessful. Refer to interview with the Special Care Unit Coordinator (SCUC) on 11/05/21 at 4:45pm. Refer to interview with the Administrator on 11-05-21 at 5:39pm. 2. Review of Staff B's, medication aide(MA) personnel record revealed: -Staff A was hired on 02/21/11. -There was no documentation Staff B had completed 6 hours of special care unit (SCU) training within her first week of employment. -There was no documentation Staff B had completed 20 hours of SCU training within her first six months of employment. -There was documentation for 17 hours of care of dementia or Alzheimer's residents and SCU training for Staff B from 06/06/2017 to 02/04/2019.	D 468		

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D 468	Continued From page 155 Attempted telephone interview with Staff B on 11/05/21 at 5:25pm was unsuccessful. Refer to interview with the Special Care Unit Coordinator (SCUC) on 11/05/21 at 4:45pm. Refer to interview with the Administrator on 11-05-21 at 5:39pm. Interview with the Special Care Unit Coordinator (SCUC) on 11-05-21 at 4:45pm revealed: -She recently took the position as the SCUC. -She was responsible to make sure all staff completed SCU training before working with residents in the SCU. -She was unsure of any staff in the SCU had completed SCU training . Interview with the Administrator on 11-05-21 at 5:39pm revealed: -He could not find the missing documentation where Staff A and B completed the 6 hours and 20 hours of SCU training. -He did not know if Staff A and B completed the initial 6 hours and 20 hours within 6 months of SCU training. -All staff were required to have the initial 6 hours SCU training before working in the SCU and 20 hours of SCU training within 6 months. -The SCUC was responsible to audit staff SCU training and ensure that staff completed the SCU training before they worked in the SCU with residents.	D 468		
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION	D 611	1. All staff and visitors to follow the policies and procedures of COVID screening. All staff are required to receive COVID vaccine as well as booster dose.	12-20-21

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D 611	Continued From page 156 PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of	D 611	2.Staff to receive continuous training on COVID-19 as new guidelines are presented. 3. Staff and visitors screened with temperature check and COVID exposure related questions upon entering the building. All staff and visitors must wear a mask. 4.Front desk staff or designee to complete COVID screening on all visitors/employees/vendors entering the building with no exception.	

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D 611	Continued From page 157 transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) were maintained to provide protection of the residents	D 611		

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D 611	Continued From page 158 during the global coronavirus (COVID-19) pandemic as related to appropriate screening of visitors and use of personal protective equipment (PPE) by visitors. The findings are: Review of the CDC guidelines for the prevention and spread of COVID-19 in long term care (LTC) facilities, updated on 09/10/21 revealed: -Personnel and visitors should always wear a facemask in the facility. -All visitors should be screened for the presence of fever and symptoms of the virus when entering the building. Review of the CDC guidelines for infection control recommendations to prevent COVID-19 spread in nursing homes and long-term care facilities, updated on 09/10/21 revealed: -Residents should be evaluated at least daily. -Staff should ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. a. Observation at the entrance of the facility on 11/02/21 between 9:25am and 9:35am revealed: -There was a receptionist sitting at a desk in the front hallway. -There was a separate sign-in books for visitors, staff and for healthcare providers sitting on the desk. -The sign-in books for staff and healthcare providers had entries to document temperature reading, COVID-19 vaccination, signs and symptoms of COVID-19 within the past 14 days, and exposure risk within the past 14 days. -The sign-in book for visitors had entries for the date, the visitors name, and who the visitor was visiting.	D 611		

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D 611	Continued From page 159 -There was no entry to document temperature reading, signs and symptoms of COVID-19, or exposure risk. -There was a wall-mounted non touch thermometer on the wall to the right. -The surveyors were asked to self-screen for temperature upon entrance and to sign-in using the visitor log. -Surveyors were not asked any screening questions or asked to document using a screening questionnaire. -The receptionist looked at each of the surveyors' temperatures as she sat at the desk, but she did not document them anywhere. -There was a sign on the desk which read, "Greetings please sign in/out. Please be sure to wear your mask while in common areas of the community. Once at your destination you may remove mask." Interview with the receptionist on 11/02/21 at 9:27am revealed: -Visitors were required to sign in on the visitor sign-in book and take their temperatures on the wall-mounted thermometer. -Visitors were not asked screening questions or asked to document answers to screening questions anywhere. -Staff and healthcare providers documented answers to screening questions when they signed in. Observation of the facility on 11/02/21 at 9:52am revealed: -The Administrator walked in the facility and he did not sign-in and assess for symptoms and exposure in the staff sign-in book. -The Administrator told the receptionist his temperature was 98.2 and then went to his office.	D 611		

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D 611	Continued From page 160 Observation of the facility on 11/02/21 at 2:21pm revealed: -A visitor entered the facility, signed-in in the visitor log, and self-screened for temperature only. -Staff did not ask the visitor any screening questions. -The visitor was wearing a mask. Interview with the visitor on 11/02/21 at 2:23pm revealed: -Staff made the visitor wear a mask and screen for temperature. -Staff used to ask visitors screening questions at the beginning of the pandemic, but they did not anymore. -Visitors were not required to document answers to screening questions on the sign-in book. Observation of the facility on 11/03/21 at 11:57am revealed a visitor screened for temperature, signed in on the visitor sign-in book and then proceeded into the facility. Interview with the second visitor on 11/03/21 at 11:58am revealed: -She visited the facility every day. -When she visited, she signed in and took her temperature. -For a while, visitors did not have to take their temperatures, but staff started requiring visitors' temperatures to be taken again about 3 weeks ago. -Staff used to ask screening questions, but they stopped, and she did not remember when. Interview with another receptionist on 11/02/21 at 5:19pm revealed: -When visitors entered the facility, she made sure they had their mask on, they took their	D 611		

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D 611	Continued From page 161 temperature, and they signed in on the visitor log. -The visitors only documented the date, time, and the resident whom they were visiting in the visitor's log. -She looked to see what the visitors' temperatures were, but she did not document the temperatures anywhere. -She sometimes asked screening questions, but she did not go into details. Interview with the Administrator on 11/04/21 at 8:22am revealed: -He did not screen for temperature or symptoms of COVID-19 when he entered the facility on 11/02/21 because he was screened at another facility before entering the facility. -The other facility was in his car. -All residents except for 2 were vaccinated. -All staff were vaccinated. -Staff and healthcare providers took their temperature and documented answers to screening questions when they came into the facility. -He did not know why visitors were not screened for signs and symptoms and exposure risk to COVID-19. b. Review of 5 sampled resident records from 11/02/21 through 11/05/21 revealed there was no documentation of daily screening of residents for COVID-19. Review of August, September, and October 2021 medication administration records (MARs) for 5 sampled residents from 11/02/21 through 11/05/21 revealed there was no documentation of daily temperature checks or daily screening of residents for COVID-19. Interview with a resident on 11/03/21 at 12:23pm	D 611		

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D 611	Continued From page 162 revealed staff did not take her temperature daily or ask her any COVID-19 screening questions. Interview with a second resident on 11/04/21 at 3:41pm revealed staff did not take her temperature daily or ask her any COVID-19 screening questions. Interview with the Special Care Unit Coordinator (SCUC) on 11/04/21 at 12:47pm revealed: -Staff used to screen residents for COVID-19 about a couple months ago. -Daily screenings stopped after the residents received their vaccinations. -There were still 1 or 2 residents in the SCU who were not vaccinated and 1 of those residents had visitors in the facility. -Residents' vitals, including temperature, were taken between the first and second of each month, but temperature was not taken daily. -If a resident had a runny nose, was sneezing, or looked clammy, staff would take the resident's vitals, but not unless the resident was showing symptoms. Interview with a medication aide (MA) on 11/05/21 at 11:00am revealed: -Personal care aides (PCA) were taking residents' temperatures daily on first and second shifts, but they stopped. -She did not remember why staff stopped taking residents' temperatures. Interview with a PCA on 11/05/21 at 11:36am revealed: -She did not remember ever taking residents' temperatures. -She had not been instructed as to when she needed to take residents' temperatures or screen for COVID-19.	D 611		

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D 611	Continued From page 163 Interview with a MA/PCA on 11/05/21 at 1:30pm revealed: -MA's or PCA's were taking residents' temperatures daily and documenting on a form. -Staff was told in August 2021 by the former facility nurse that resident temperatures no longer had to be taken. -She screened residents for COVID-19 by observing if they had a cough or did not feel well. Interview with the Administrator on 11/04/21 at 8:22pm revealed: -The former Resident Care Director (RCD) was in charge of the infection control and prevention regarding COVID-19. -All residents except for 2 were vaccinated. -He did not think it was a requirement to screen residents for temperature daily. c. Observation of the facility on 11/04/21 between 4:45pm and 5:00pm revealed: -There was a visitor standing at the front desk speaking to the receptionist and she did not have a mask on. -The visitor left the front desk, went outside to her car, and then returned and proceeded into the facility without a mask. -The visitor went into a resident's room unmasked. Interview with the visitor on 11/04/21 at 5:00pm revealed: -She did not wear a mask into the facility because she was just dashing in to drop food off and then dashing back out. -She did not screen with questions or temperature when she entered the facility. -Staff normally requested that she wear a mask, but staff did not ask her to wear a mask today.	D 611		

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D 611	Continued From page 164 Interview with the receptionist on 11/04/21 at 5:02pm revealed: -She asked the visitor to wear a mask, but sometimes visitors wore their masks and sometimes they did not. -She did not ask the visitor screening questions or have her take her temperature. -The visitor had been in the facility earlier and left to take a resident out to eat. -She did not think she needed to ask screening questions or recheck the visitor's temperature if the visitor had previously been in the facility. Interview with the Administrator on 11/05/21 at 10:13am revealed: -He did not realize the visitor was in the facility without a mask on. -The visitor should have had a mask on.	D 611		
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 stat laws and rules and regulations related to personal care and supervision, mediation administration and adult care home medication aide; training and competency	D912	1. A handout listing Resident's Rights given to care staff on 12/16/21. 2. Training on Resident's Right's given to care staff. 3. RSD or Designee to ensure the rights of residents such as Monitoring medication administration, Food and Nutrition, and Personal Care are being followed. 4.RSD or designee to ensure that Resident's Rights declaration being administered daily for 30 days and weekly thereafter.	12-20-21

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D912	Continued From page 165 evaluation requirements. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 residents sampled (#4 and #5) related to a resident who had multiple falls resulting in injuries (#4), a male resident and a female resident (#4 and #5) found undressed and in bed together, the male resident (#4) inappropriately touching the female resident (#5), and the female resident (#5) visiting alone in the male resident's room (#4) without supervision. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 5 residents sampled (Residents #1, #2, #4, and #5) related to a topical pain medication, an antibiotic, an irrigation solution and 2 eye drops (#2); a blood thinner (#5); a mild pain reliever, an expectorant, a bronchodilator, a moderate pain reliever, a protein supplement and a multivitamin (#1); and a topical pain medication, a pain medication, a muscle relaxer, a cholesterol lowering medication, and a behavior medication (#4). [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and D) who administered medications to residents had completed the 5, 10, or 15-hour medication aide training or employment verification and the written medication aide examination. [Refer to Tag D0935 G.S. 131D-4.5B(b)3 Adult care home medication	D912		

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	HAL041052	A. BUILDING: _____ B. WING _____	R 11/05/2021

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D912	Continued From page 166 aides; training and competency evaluation requirements. (Type B Violation)].	D912		
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, 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 observations, interviews, and record reviews, the facility failed to ensure the mandatory annual state approved infection control training for 2 of 3 sampled medication aides (Staff A and D) was completed. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 07/07/20. -There was no documentation Staff A had completed the mandatory annual state approved infection control training.	D934	1. Infection control training provided for MAs requiring training. 2. Care Staff (CNAs, PCAs MAs) to receive Infection Control training from Qualified Healthcare professional. 3. BOM, RSD or designee to ensure Care Staff receive Infection Control training within 30days of hire. 4. LHCP will provide diabetic training for staff within 30 days of being hired and yearly thereafter. Documentation of training will be filed in staff profile charts.	12-20-21

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D934	Continued From page 167 Attempted telephone interview with Staff A on 11/05/21 at 5:19pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm. Refer interview with the Administrator on 11/05/21 at 5:39pm. 2. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff D was hired on 07/06/21. -There was no documentation Staff D had completed the mandatory annual state approved infection control training. Attempted telephone interview with Staff D on 11/05/21 at 5:22pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm. Refer interview with the Administrator on 11/05/21 at 5:39pm. Interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm revealed: -She could not find the documentation in personnel records of completion of the mandatory annual state approved infection control training. -The nurse was responsible to complete the staff's mandatory annual state approved infection control training. Interview with the Administrator on 11/05/21 at 5:39pm revealed: -He could not find documentation in the personnel records where staff had completed the mandatory annual state approved infection control training.	D934		

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D934	Continued From page 168 -He did not know if staff had completed the mandatory annual state approved infection control training. -All MAs were required to have the mandatory annual state approved infection control training. -There was a nurse employed until 10/10/21 that kept track of needed training and helped complete staff mandatory annual state approved infection control training.	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 individual must have completed the following:	D935	1. MAs that did not have the 15-hr training required to be a Med Aide were removed from being able to administer medication immediately. 2. BOM to ensure new MAs have the 15-hr training prior to administering medication or schedule for MAs to receive this 15-hr training before administering medication by checking the NC Med Aide Registry at time of employement. 3. BOM or designee to conduct weekly audits of personnel charts for 30 days. 4.BOM or designee to conduct monthly audits of personnel charts to ensure MAs have the 15-hr MA training and that documentation of that training has been filed in personnel charts	12-20-21

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D935	Continued From page 169 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 2 of 3 sampled staff (Staff A and D) who administered medications to residents had completed the 5, 10, or 15-hour medication aide training or employment verification and the written medication aide examination. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A's date of hire was on 07/07/20. -There was documentation Staff A passed the state written medication aide examination on 06/19/09. -There was no documentation Staff A completed the state approved 5, 10 or 15 hour medication aide training. -There was no documentation of employment for the previous 24 months as a MA.	D935		

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D935	Continued From page 170 Review of a resident's medication administration record (MAR) revealed Staff A administered medication for 14 days in August 2021, 21 days in September 2021 and 24 days in October 2021. Attempted telephone interview with Staff A on 11/05/21 at 5:19pm was unsuccessful. Interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm revealed: -She was responsible to obtain documentation when staff were hired. -The previously employed nurse was responsible to ensure staff completed 5, 10 or 15 hour medication aide training. -Staff A's documentation of completion of the state approved 5, 10 or 15 medication aide training could not be found in the personnel record. Refer to interview with the Administrator on 11/05/21 at 5:39pm. 2. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff D's date of hire was on 07/06/21. -There was no documentation Staff D had passed the state written medication aide examination. -There was no documentation Staff B had completed the state approved 5, 10 or 15 hour medication aide training. -There was no verification of employment as a MA for the previous 24 months. Review of a resident's MAR revealed Staff D administered medication on 7 days in August 2021, 13 days in September 2021 and 9 days in October 2021. Attempted telephone interview with Staff D on	D935		

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D935	Continued From page 171 11/05/21 at 5:22pm was unsuccessful. Interview with the Business Office Manager (BOM) on 11/05/21 at 5:35pm revealed: -She was responsible to obtain documentation when staff were hired. -The previously employed nurse was responsible to ensure staff completed 5, 10 or 15 hour medication aide training. -Staff D told her on 11/05/2021 that she had not taken or scheduled the state written medication aide exam. -Staff D's 5, 10 or 15 medication aide training could not be found in the personnel record. Refer to interview with the Administrator on 11/05/21 at 5:39pm. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. Interview with the Administrator on 11/05/2021 at 5:39pm revealed: -There was a nurse employed until 10/10/21 who was responsible to keep track of needed training and helped train staff for 5, 10 or 15 hour medication aide training. -Completion of training for the medication aide training or employment verification could not be found in Staff A and D's personnel records. -Staff were responsible to schedule their own written medication aide examination. -Staff A and D's medication aide examination results could not be found in her personnel record. The facility failed to ensure the completion of the 5, 10, or 15-hour medication aide training or employment verification for 2 of 3 sampled staff and the written medication aide examination for 1	D935		

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D935	Continued From page 172 staff prior to administering medications to the residents, placing the residents at risk for medication administration errors. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34(2)(b) on 11/04/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 20, 2021.	D935		