STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 and the Currituck County Department of Social Services conducted a follow-up survey and complaint investigation on 01/04/22 to 01/06/22.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to 10 residents including several hazardous items in an unsecured nurses station, laundry room, and a kitchen not monitored by staff. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed with a capacity of 90 residents with a Special Care Unit (SCU) capacity of 48 residents. The facility's census in the SCU was 10 residents. Review of the facility's policy for SCU Safety Measures for Accidental Ingestion dated	D 079		

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D 079	Continued From page 1 September 2021 revealed: -The facility had a quality assurance program for accidental ingestion which included assessments to identify potential ingestion risks, and interventions to reduce the risks. -Facility staff would conduct periodic screening of personal items that could be ingested including all liquid personal items and aerosols were in a secure location until needed for resident use. -All utility and laundry closets were to remain locked unless under direct supervision by staff. -All toxic substances should be secured in a locked area unless under direct supervision by staff. -Items used for activities which could be ingested would only be used while under direct supervision. -Staff training included the identification and controlling of potential ingestible hazards which included monitoring the facility for substances that could be accidentally ingested. Observation of the SCU nurse's station on 01/04/22 at 9:45am revealed: -There was no door to the entrance of the nurse's station. -There were no staff present. -There was a counter on the left and right side of the nurse's station with drawers and cabinets below both counters. -There was a keyhole on each cabinet and drawer to secure them; none of the cabinets or drawers were locked. -One unlocked cabinet had a 14 ounce aerosol spray can of insect killer with a warning that it was hazardous to humans, avoid contact with skin, eyes, or clothing, wash hands thoroughly with soap and water after handling; if swallowed immediately call a poison control center or doctor, if on skin or clothing take off contaminated	D 079		

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D 079	Continued From page 2	D 079		

clothing, rinse skin immediately with water for 15-20 minutes and call a poison control center or doctor for treatment advice. .
-A second unlocked cabinet had a plastic storage basket with four bottles of body lotion that were 4 ounces each and a bottle of 10.1 ounce bottle of nail polish removal with a warning to keep out of reach of children, harmful if ingested, it was extremely flammable, keep away from heat or flame, liquid vapors may ignite, keep out of eyes, and in case of eye contact immediately flush eyes with water.
-A third unlocked cabinet contained a plastic bin with approximately 25 nail polishes that were beside a plastic container that contained puzzles, a bingo game and word search book.
-A fourth unlocked cabinet contained an aerosol disinfectant spray on the top shelf with a warning to keep out of reach of children, causes eye irritation, if in eyes rinse with water for several minutes, get medical attention, call poison center or doctor for treatment advice, flammable aerosol, contains gas under pressure, may explode if heated.
-A fifth unlocked cabinet had three 4 ounce glue bottles with a warning of choking hazard/small parts, not for children under 3 years and a bottle of lotion with a warning for external use only, avoid contact with eyes, keep out of reach of children, three 4 ounce containers of paint with a warning of choking hazard; small parts not for children under 3 years old and for glue sticks with a warning of choking hazard; small parts.
-There was an unlocked drawer with a 12 ounce can of shaving cream without a lid with a warning to keep out of reach of children.
-There were pork rinds in the drawer scattered around the 12 ounce can of shaving cream.
-A second unlocked drawer had a package of 100 balloons that was open with a warning of choking

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hazard; adult supervision required; children under 8 years can choke or suffocate on deflated or broken balloons; discard broken balloons at once.
-There was one deflated balloon lying in the drawer outside of package and one pair of scissors beside the opened package of balloons.
-A third unlocked drawer contained two COVID-19 rapid nasal swabs in their original packaging, use with caution if allergic to foam.
-A fourth unlocked drawer contained a clear container that contained staples.

Observation of a personal care aide (PCA) on 01/04/22 at 10:00am revealed she removed the scattered pork skins from an unlocked drawer, but she did not remove any other hazards from the unsecured nurse's station.

Second observation of the nurse's station on 01/04/22 at 1:27pm revealed:
-There was no door at the entrance.
-All cabinets and drawers were still unlocked.
-There were no staff present.
-None of the hazardous items had been removed from the room.

Third observation SCU nurse's station 1/5/22 at 12:22pm revealed:
-There was no door at the entrance.
-All cabinets and drawers were unlocked.
-There was no staff present.
-The insect spray, a disinfectant spray, a can of shaving cream and a bag of balloons were removed.
-All of there hazards remained in the drawers.

Fourth observation of the SCU nurse's station on 01/05/22 at 1:27pm revealed:
-There was no door at the entrance.
-All cabinets and drawers were unlocked.

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D 079	Continued From page 4 -There was no staff present. -There were no additional hazards removed. Fifth observation of the SCU nurse's station on 01/06/22 at 8:45am revealed: -There was no door at the entrance. -All cabinets and drawers were unlocked. -There was no staff present. -No additional hazards were removed. Observation of the SCU kitchen on 01/04/22 at 10:03am revealed: -There was no door to the entrance of the kitchen. -The kitchen area opened to the SCU dining room. -There was no staff present in the SCU kitchen. -There were 4 residents in the dining room adjacent to the SCU kitchen. -There was a one-quart disinfectant spray bottle on the kitchen counter with a warning to keep out of reach of children. -A PCA entered the kitchen and removed the disinfectant spray bottle to a secured location after the surveyor brought it to her attention. Observation of the laundry and linen storage room on the SCU on 01/04/22 from 10:11am-10:18am revealed: -The door was closed but unlocked. -There was a counter to the left of the laundry room with cabinets above the counter, drawers and cabinets below the counter. -There was a keyhole on each cabinet and drawer to secure them; none of the cabinets or drawers were locked. -There was a sign on 2 cabinet doors "please keep linen room clean. Nothing should be on the counter, no baskets of clothing or linens are to be left, they need to be put away!	D 079		

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D 079	Continued From page 5 -There were several unsecured items on the counter which included a bottle of lotion with a warning to avoid contact with eyes; if contact occurs rinse thoroughly with water, a container of petroleum jelly with a warning to keep out of reach of children; if swallowed get medical help or contact the poison control center, one tube of denture adhesive with a warning do not use more than directed, contains zinc, excessive and prolonged zinc intake is reported to be associated with serious health problems, a pair of electric hair clippers, 3 bottles of shampoo, 2 bottles of liquid body wash and three deodorant sticks with a warning for external use only, ask doctor before use if you have kidney disease, if swallowed get medical help or contact a poison control center. -One unlocked cabinet above the counter had three shelves and was not locked. -The first shelf had 2 open plastic containers with handles that contained shampoos, conditioners and lotions. -The second shelf had 3 open plastic containers with handles that contained shampoos, conditioners and lotions. -The third shelf had 2 open plastic containers with handles that contained shampoos, conditioners and lotions. -A second cabinet above the counter had three shelves and was not locked. -The second shelf had 3 open plastic containers with handles that contained shampoos, conditioners and lotions. -The third shelf had 3 open plastic containers with handles that contained shampoos, conditioners and lotions. -A third cabinet above the counter had three shelves and was not locked. -The first shelf had a bottle of lotion with a warning to avoid contact with eyes; if contact occurs rinse thoroughly with water and a	D 079		

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container of petroleum jelly with a warning to keep out of reach of children; if swallowed get medical help or contact the poison control center.
-The second shelf had 2 containers of lotion, one body wash and six deodorant sticks.
-The third shelf had 2 bars soap, 2 body wash containers, 4 shampoo, 1 container of lotion and 2 boxes of denture cleaning tablets with a warning to keep out of reach of children, do not put tablets or solution directly in mouth.
-There was a drawer below the counter that contained 4 disposable razors and one pair of electric hair clippers.

Second observation of the laundry room on 1/5/22 at 12:27pm revealed:
-The door was cracked and not locked.
-All cabinets and drawers remained unlocked.
-No hazardous items had been removed from the cabinets, drawers or counter.
-There was no staff present in the laundry room and no staff present on the hallway.

Interview with the PCA on 01/04/22 at 10:02am revealed:
-She was shocked to see the scattered pork skins in the drawer.
-She did not know who was responsible for ensuring that hazardous items were secured and away from residents on the SCU.
-There had not been a door on the SCU nursing station for several months.
-There were at 4 residents that wandered every day.
-One resident loved snacks and would look for them everywhere.
-She, the housekeeper and the medication aide (MA) monitored the residents to be sure they were safe.

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Interview with a housekeeper on the SCU on 01/04/22 at 1:15pm revealed:
-Several of the residents on the SCU wandered during the day.
-Two residents liked to look for snacks during the day and would wander into rooms looking for snacks.
-One resident would dig through items in rooms and was always walking the halls.

Interview with a medication aide (MA) on the SCU on 01/04/22 at 1:40pm revealed:
-Two of the male residents were always wandering into rooms looking for snacks and drinks.
-The residents on the SCU wandered frequently and staff had to constantly redirect them.

Interview with the facility's primary care provider (PCP) on 01/06/22 at 11:18am revealed:
-She was not aware that there was no door at the entrance of the SCU nurse's station or the SCU kitchen.
-She was not aware that the laundry room door was unlocked and accessible to residents.
-She was not aware that there were hazardous items in unlocked drawers and cabinets in the nurse's station or the laundry room.
-She was concerned that one resident on the SCU had frequent angry outbursts and could use an unsecured item to harm another resident or a staff member.
-She expected all hazardous items to be secured in a locked area to ensure the safety of the residents.
-Under no circumstances should residents on SCU that wander have access to hazardous materials.
-It was the responsibility of the facility staff to ensure each residents' safety and it was

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unacceptable that any hazardous items had been left unsecured on the SCU unit.
-Residents on the SCU were admitted to that unit to ensure their safety and it was the responsibility of the facility to ensure the resident's safety.

Interview with the Administrator on the SCU on 01/04/22 at 2:30pm revealed:
-She did not know why there was not a door securing the entrance of the nursing station or the kitchen on the SCU.
-She was not aware that the drawer and cabinets were not locked in the nurse's station.
-She expected staff to keep all drawers and cabinets locked in the nurse's station.
-She did not know where the key was located to lock the drawers and cabinets in the nurse's station.
-She would remove all hazardous items from the nurse's station to ensure the residents safety.
-She was not aware that the door to the laundry room was unlocked and accessible to residents.
-She expected staff to keep the laundry room locked unless there was a staff member in the room to supervise residents.
-She did not know why there was not an entrance door to secure the SCU kitchen.
-It was the responsibility of all staff to ensure there were no hazardous items accessible to residents on the SCU.

_____

The facility failed to secure hazardous substances and items to protect the 10 residents diagnosed with dementia residing in the Special Care Unit (SCU) with five of those residents with wandering behaviors including toiletries consisting of liquids, paste, lotions, deodorants and aerosols, insect spray, disinfectant spray, scissors, and hair clippers. This failure was detrimental to the health, safety, and welfare of

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D 079	Continued From page 9 the residents in the SCU and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 01/06/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 20, 2022.	D 079		
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 record reviews and interviews, the facility failed to ensure 1 of 9 sampled staff (Staff H) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff H, receptionist, personnel record revealed: -Staff H was hired on 05/06/21. -There was no documentation of a Health Care Personnel Registry check (HCPR) being completed upon hire. -There was documentation a HCPR check was completed on 01/06/22.	D 137		

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D 137	Continued From page 10 -There were no findings on Staff H's HCPR that was completed on 01/06/22. Interview with Staff H on 01/05/22 at 10:15am revealed: -Her main duties included front desk reception where she answered the telephone and completed visitor screenings. -She was responsible for transporting residents to their medical appointments. Interview with the Business Office Manager (BOM) on 01/06/22 at 3:45pm revealed: -She and the Administrator were responsible for ensuring that HCPR checks were completed for staff upon hire. -Staff H was hired prior to her starting as the BOM. -She was not aware that Staff H did not have a HCPR check upon hire. Interview with the Administrator on 01/06/22 at 4:05pm revealed: -The BOM was responsible for ensuring that the HCPR check was completed upon hire. -She was not aware that Staff H did not have a HCPR check completed upon hire. -Staff H was alone with residents during transportation to appointments.	D 137		
D 181	10A NCAC 13F .0602 Management Of Facilities WIth A Capacity Or 10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents (a) In facilities with a capacity or census of 31 to 80 residents, there shall be an administrator on	D 181		

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call, which means able to be contacted by telephone, pager or two-way intercom, at all times when not in the building. (For staffing chart, see Rule .0606 of this Subchapter.)

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations and interviews, the facility failed to ensure the Administrator was responsible for the total operation of the home, to meet and maintain the rules in rules areas of Personal Care and Supervision, Health Care, Housekeeping and Furnishings, Medication Administration and Declaration of Resident Rights.

The findings are:

Review of the facility's current license effective 01/01/21 revealed the facility was licensed with a capacity of 90 residents with a Special Care Unit (SCU) capacity of 48 residents, and a current census of 35 residents, 10 residing in the SCU.

Telephone interview with a resident's family on 01/05/22 at 8:20am revealed:
-When she tried calling the facility to speak with the Administrator, it was often difficult to get someone to answer the telephone.
-She left multiple messages with 3 different staff members, on a Thursday before 5:00pm, to have the Administrator call her back regarding urgent care concerns for her family member and received no return phone call.

Telephone interview with a second resident's family on 01/06/22 at 12:00pm revealed:
-She was not able to reach any staff at the facility

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via telephone after 4:00pm when the receptionist would leave for the day.
-There were numerous times that she had to drive to the facility to relay a message to staff because she could not get a hold of facility staff members.
-She was very frustrated with the Administrator and her lack of communication in returning messages.

Telephone interview with a third resident's family member on 01/06/22 at 3:00pm revealed:
-The resident was at a family member's house on leave from the facility.
-The facility tried to contact this resident with a concern about this resident's spouse who also resided at the facility.
-When they tried to return the call to the facility about the concern, no one answered.
-When she tried to return the facility's call "over 50" times, the phone rang over and over and no one ever answered.
-She then called the police to go and perform a well-check on the resident at the facility because she was concerned.
-While she was on the phone with the operator and police officer, the police officer stated that he was watching through a window while trying to call the facility on another line and could hear the phone ringing and no one would pick it up.
-The police officer was finally able to get someone's attention at the door to let him in.
-She received a call from a representative at the facility's corporate office the next morning who promised to investigate the incident but she never heard back from her.

Interview with a resident on 01/05/22 at 9:20am revealed:
-She attempted to call the Administrator via

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telephone last week at the facility to express concerns about staff's disrespectful behavior but she was not able to get anyone to answer the telephone at the facility.
-She never saw the Administrator since she was admitted to the facility.

Telephone interview with a resident's limited guardian on 01/06/21 at 8:33am revealed:
-She served as the resident's full guardian until July 2021 when the resident was granted independence to be able to make all of her own decisions except regarding the location she lived.
-The resident was initially admitted to the facility to assist her with medication management.
-Lack of communication from the facility had been her biggest concern over the last year and she routinely had difficulty getting someone at the facility to answer the phone when she called.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:20am revealed:
-She had difficulty getting a staff member to answer the telephone when she would call the facility to respond to a staff member's concern about a resident.
-Staff would call her personal cell phone and leave a message from the facility for a return call but would not answer the telephone when she called back.

Telephone interview with a hospice agency employee on 01/06/21 at 8:30am revealed she resorted to calling staff member's personal cell phones after 5:00pm and on the weekends to contact them regarding resident care because she was not able to get an answer on the facility phone.

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D 181	Continued From page 14 Interview with the receptionist on 01/05/22 at 10:15am revealed: -She was responsible for answering the telephones at the facility when she was in the office, Monday through Friday until 4:00pm. -She transferred the phone calls to the department the call concerns or took a message and delivered it to the department. -The telephone rings throughout the facility. -The facility recently received a new phone system and she was learning the different capabilities of the system including message retrieval. -If the caller requested to speak with the Administrator, she would transfer the call to the Administrator's office. -She received repeat phone calls from frustrated family members who did not receive return phone calls from the Administrator and would often personally deliver written messages to the Administrator. -If she was not at her desk or on another telephone call the Business Office Manager (BOM) would help answer the telephone during the day. Interview with the BOM on 01/05/22 at 10:50am revealed: -She helped answer the telephone at the facility if the receptionist was busy. -She transferred the telephone calls to the department the call was concerning. -She would often receive frustrated family members who did not receive a return call from the Administrator. Interview with the Administrator on 01/05/21 11:25am revealed -The Resident Care Coordinator (RCC) was responsible for returning family member's	D 181		

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telephone calls regarding resident concerns.
-She was not responsible for returning telephone calls to family members in the RCC's absence because the RCC had a cell phone that staff including the receptionist and BOM were aware of.
-The previous lead medication aide (MA) dealt with residents' family members concerns.
-If a resident's family wanted to speak with her regarding additional matters, non-clinical, they left a voicemail and she tried to respond the same day.

Attempted telephone interview with the RCC on 01/06/21 at 9:02am was unsuccessful.

Interview with a resident on 01/05/22 at 10:22am revealed:
-The Administrator should be present and available in the facility more that she was.
-The Administrator was usually present in the facility Monday through Friday from about 9:30am to 5:00pm and infrequently came in when the facility was short staffed after hours and on weekends.
-She could only remember 1 or 2 instances when the Administrator helped staff perform resident care in the last 1 ½ years she had resided within the facility.
-She reported a serious concern to the Administrator and never received any follow-up.

Telephone interview with a resident's limited guardian on 01/06/21 at 8:33am revealed:
-She had previous wards at the facility with issues and concerns to the point that she ultimately had to move them to another facility.
-Due to previous issues and concerns at the facility, she was careful to bring her current resident's concerns to a regional representative

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who would take the concerns to the facility in an anonymous fashion and indirect way because she was afraid of retaliation from the facility against her residents and their safety if the facility knew the residents had complained.
-Many of her residents that she was guardian over that had resided at the facility were afraid of retaliation when they expressed concerns and knew to "tread lightly".
-The facility had a lot of staff turn-over and had experienced several interactions in which staff had been unprofessional with her

Telephone interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am revealed:
-This facility had the most issues and concerns than any other facility she was contracted with for the last 1 1/2 years.
-She thought all of the residents should be moved out of the facility and the facility needed to start over with all new staff.
-She was currently working on moving two of the facilty's residents to another facility due to their social worker's concerns regarding their care and safety.
-She was also concerned with how many hours staff member were allowed to work in a row.
-She had spoken with a staff member that morning who reported working 22 hours straight; she felt that mismanagement of staff's time was unsafe for the residents and the staff and could lead to potential life-threatening mistakes.

Interview with the Administrator on 01/06/22 at 2:44pm revealed:
-She was on call 24 hours a day and available to facility staff if a problem arose.
-She had two cell phones because one did not receive good reception; she was always available

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for staff.
-She was also a medication aide (MA) and had been working Saturdays and Sundays several times a month since October 2021.
-This past Saturday there was not a MA for 1st shift on the Special Care Unit (SCU) and she helped with passing medications.
-Each morning she reviewed the census and activity report which included any incidents to see if any problems occurred and needed to be addressed.
-She made rounds in the facility each morning to talk with residents and staff to see if they had any concerns.
-She was available for residents and staff 24 hours a day and worked to ensure anyone could speak with her about any concerns.
-She had taken corrective action with staff when it was necessary to ensure residents were treated properly.
-When a resident had a concern that they brought to her attention she did not "just blow it off," she listened to the resident, addressed the concern with the staff and took corrective action as needed.
-She did not provide residents with the specific correction action taken but would inform them that the issue had been addressed.
-When she had a family member express a concern of how a resident was treated she also addressed the concern with the staff, took corrective action as needed and followed up with the family to let them know the issue had been addressed with staff.
-She held morning meetings to address reports for the facility of falls, injuries, admissions, discharges, changes in status or changes in medications.
-She used a tracking system to track any problem areas from the morning meetings.

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D 181	Continued From page 18 -She supervised staff 80% of the time, while she was on the floor she supervised staff to ensure staff were following the facility's policies and procedures. -She had worked more as a PCA and MA on the floor, cook in kitchen as well. Interview with the Area Director of Operations on 01/06/22 at 3:40pm revealed: -There was no organization in the facility under the current leadership. -The Administrator had created division among the staff which created a difficult environment for staff to feel comfortable reporting concerns when residents did not receive the appropriate care and services. Second interview with the Area Director of Operations on 01/06/22 at 4:18pm revealed: -Residents and staff should not be afraid to share their concerns with the Administrator. -The Administrator had relied on staff that were part of the problem in the facility and the staff that were not treating residents correctly were leading the Administrator and the Administrator was following staff instead of leading them. -The Administrator and some of the staff had neglected the residents and had not provided appropriate and respectful services. -The problem was systemic throughout the building and it was from the poor leadership. 1. Based on observations and interviews, the facility failed to ensure the Administrator was responsible for the total operation of the home, to meet and maintain the rules in rules areas of Personal Care and Supervision, Health Care, Housekeeping and Furnishings, Medication Administration and Declaration of Resident Rights [Refer to Tag D0181 10A NCAC 13F .0602	D 181		

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Management of Facilities with a Capacity of 31 to 80 Residents (Type A1 Violation)].

2. Based on interviews and record reviews, the facility failed to provide supervision to 1 of 5 sampled residents (#2) in accordance with their current diagnoses and assessed needs, resulting in the resident (#2) having 5 unwitnessed falls in a 9 week time-frame in which she sustained a injury from the final fall [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].

3. Based on interviews and record reviews, the facility failed to ensure provider notification and for follow-up for 2 of 5 sampled residents (#2, #3) related to a resident (#2) experiencing 5 falls in a 9-week period in which the facility did not notify the resident's primary care provider (PCP) of 4 of the 5 falls, and failing to schedule and ensure specialty follow-up medical appointment referral orders were made for a resident who required medical care for a surgical procedure (#3) [Refer to Tag D0273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

4. Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to 10 residents including several hazardous items in an unsecured nurses station, laundry room, and a kitchen not monitored by staff [Refer to Tag D0079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered for 2 of 4 residents (#8, #9) observed during the morning medication pass

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including errors involving medications used for blood pressure, fluid retention, and a blood thinner (#9), and asthma and a vitamin supplement (#8); and for 2 of 5 sampled residents for record review including errors involving medications used to regulate blood sugar (#3) as well as medications used to treat pain, fever, blood pressure, heart failure, depression, and Parkinson's disease (#1) [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].

6. Based on interviews, and record reviews, the facility failed to ensure all residents were treated with respect and dignity related to staff behavior towards 4 residents and related to meal service when residents were not provided tables for in-room dining after stopping communal dining [Refer to Tag 0911 10A NCAC 13F G.S. 131D-21(1) Declaration of Resident Rights (Type A2 Violation)].

7. Based on interviews, and record reviews, the facility failed to ensure 4 residents (#1, #3, #6, and #7) were free of mental and physical abuse by staff including Staff G who was permitted continued employment at the facility by the Administrator after previous allegations of physically abusive behavior towards residents [Refer to Tag 0914 10A NCAC 13F G.S. 131D-21(4) Declaration of Resident Rights (Type A2 Violation)].

_____

The Administrator failed to ensure that the management, operations, and policies of the facility were implemented to ensure services necessary to maintain the residents' physical and mental health were provided as evidenced by the failure to maintain compliance with the rules and

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D 181	Continued From page 21 statutes governing adult care homes, which is the responsibility of the Administrator. The failure to ensure incoming and out-going communication with the facility, residents, resident family members, and primary care provider (PCP), personal care and supervision resulting in recurrent falls and injuries, provider notification and follow-up resulting recurrent falls without interventions and missed referral appointments delaying a surgical procedure, hazards on the Special Care Unit (SCU) risking resident safety, failure to administer medications as ordered risking resident safety, failure to ensure residents were treated with dignity and respect without fear of retaliation, mental, and physical abuse resulted in serious physical harm and neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 01/06/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2022.	D 181		
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and	D 189		

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D 189	Continued From page 22 limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty. (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 189		

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failed to ensure housekeeping duties performed by medication aides and personal care aides between the hours of 7:00am and 9:00pm were limited to occasional non-routine housekeeping tasks.

The findings are:

Observation of the hallway on the assisted living (AL) side of the facility on 01/04/22 at 10:45am revealed a personal care aide (PCA) was returning laundered clothing to multiple resident's rooms from the laundry area.

Interview with a personal care aide (PCA) 01/04/22 at 11:00 am revealed:
-The third shift staff was responsible for washing the laundry.
-Routinely the second shift staff placed the laundry that needed to be washed outside of the resident's door.
-Laundry days coincided with the resident's shower schedule.
-Housekeeping washed the sheets and linens and put them away.
-PCAs were expected to clean and sanitize the dining room after residents were done eating after all meals.

Telephone interview with a PCA on 01/05/22 at 10:34am revealed:
-There were times when there was only one PCA on the Special Care Unit (SCU) if the medication aide (MA) was pulled off the SCU to pass medications on the assisted living (AL) side of the facility.
-She was not able to properly supervise the residents on the SCU when she was expected to do additional cleaning duties such as cleaning the dining room after meals on first shift.

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D 189	Continued From page 24 -She was not able to properly provide personal care to the residents on the SCU when she was expected to do additional cleaning duties such as cleaning the dining room after meals on first shift. Interview with a housekeeper on the SCU on 01/04/22 at 10:20am revealed: -There were two housekeepers at the facility, and they were responsible for cleaning resident's rooms, hallways, common areas and wash resident's laundry. -The PCAs cleaned up the dining room on the SCU after meals if needed. -There were times when the PCAs had to do small housekeeping duties when there was only one housekeeper for the entire building. Interview with the Administrator on 01/05/22 at 11:25am revealed: -PCAs and MAs were expected to help "tidy up" the dining room if it was needed after a meal which she did not believe happened "that often". -Second and third shift staff members were expected to complete the laundry when the housekeepers were not able to finish it.	D 189		
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 A1 VIOLATION	D 270		

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D 270	Continued From page 25 Based on interviews and record reviews, the facility failed to provide supervision to 1 of 5 sampled residents (#2) in accordance with their current diagnoses and assessed needs, resulting in the resident (#2) having 5 unwitnessed falls in a 9 week time-frame in which she sustained a injury from the final fall. The findings are: Review of the facility's Safety Measures for Fall Reduction policy revealed: -The goal was for the community to evaluate fall risk on admission and readmission. -A fall risk admission evaluation was to be completed on all residents to identify individual risks and needs upon admission and or day of return from the hospital (not an emergency room (ER) visit). -Resident Care Coordinator (RCC) was to complete fall related incident and accident report and a 72-hour fall management follow up (to include notifying the resident's family, primary care provider (PCP), and department of social services (DSS) as indicated). -Vital signs and observations for any changes were to be completed every shift my medication aides post fall and documented by using the shift progress note. -Within 24-48 hours of each fall a manager will complete the post fall care plan evaluation for interventions; a new intervention was required to be added for each additional fall. -The RCC or designee will add the fall risk banner to the face sheet in matrix care. -The RCC or designee will add the fall risk emblem to the door name plate. -Communication was expected with the resident's PCP, family, and facility staff members as needed	D 270		

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to reduce falls.

Review of Resident #2's current FL-2 dated 12/13/21 revealed:
-Diagnoses included dementia without behavioral disturbance, cognitive communication deficit, seizures, hypertension, hyperlipidemia, insomnia, anemia, muscle weakness, unsteady on feet, difficulty walking, fracture of left femur.
-She was constantly disoriented, semi-ambulatory with a walker, and had wandering behaviors.
-The resident's recommended level of care was special care unit (SCU).

Review of Resident #2's previous FL-2 dated 02/24/21 revealed:
-Diagnoses of dementia without behavioral disturbance, cognitive communication deficit, seizures, hypertension, hyperlipidemia, insomnia, anemia, muscle weakness, unsteady on feet, difficulty walking, fracture of left femur.
-She was constantly disoriented, semi-ambulatory with a walker, and had wandering behaviors.
-The residents recommend level for care was special care unit (SCU).

Review of Resident #2's current assessment and care plan dated 07/01/21 revealed:
-The resident had wandering behaviors, was sometimes disoriented, and had significant memory loss requiring direction.
-She required assistance with ambulation and needed reminders to use her walker.
-She required extensive assistance with dressing, and bathing, grooming/personal hygiene, and toileting.

Review of Resident #2's Accident/Incident report dated 09/09/21 revealed:
-The resident had a fall without injury at

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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
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approximately 2:26pm.
-The resident was found on the floor in the dayroom.
-The medication aide (MA) on duty reported and completed the incident report.
-The resident did not complain of pain related to the fall and was arousable when name called.

Review of Resident #2's progress notes dated 09/09/21 revealed:
-The resident experienced a fall; no other details were provided.
-No fall prevention interventions or increased supervision were documented.

Review of Resident #2's Accident/Incident report dated 09/20/21 revealed:
-The resident fell at approximately 1:17pm.
-The resident was found on her knees in the hallway.
-The resident stated she lost her balance and complained of right knee pain.
-The resident was to follow up with her primary care provider (PCP).

Review of Resident #2's progress notes dated 09/20/21 revealed:
-The resident experienced a fall; no other details were provided.
-No fall prevention interventions or increased supervision were documented.

Review of Resident #2's Accident/Incident report dated 10/24/21 revealed:
-The resident fell at approximately 8:37am.
-The resident was alone in the hallway when she fell and lost her balance and hit the wall.
-The personal care aide (PCA) reported the incident to MA who completed the incident report.
-The resident did not complain of pain related to

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D 270	Continued From page 28 fall and was arousable when named called. Review of Resident #2's progress notes dated 10/24/21 revealed: -The resident experienced a fall; no other details were provided. -No fall prevention interventions or increased supervision were documented. Review of Resident #2's Accident/Incident report dated 11/25/21 revealed: -The resident experienced an unwitnessed fall at approximately 6:55pm. -Incident was reported by a PCA and the incident report was completed by a MA. -The resident was in her room when she fell. -The resident said she fell out of bed. -PCA stated they heard a noise and went into the resident's room. -The resident did not complain of pain related to the fall and was arousable when name called. Review of Resident #2's progress notes dated 11/25/21 revealed: -The resident experienced a fall; no other details were provided. -No fall prevention interventions or increased supervision were documented. Review of Resident #2's Accident/ Incident report dated 12/11/21 revealed: -The resident had an unwitnessed fall at approximately 9:30pm. -The fall was reported by a PCA in the SCU and incident report was completed by a MA in the SCU. -The resident was found on the floor of another resident's room holding her right hip. -The resident complained of pain in hip related to the fall.	D 270		

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-The resident was sent to hospital on 12/10/21 at approximately 9:50pm.
-There was an evaluation note stating once patient was discharged from hospital, a fall prevention program would be put into place, and the facility would monitor the resident for 72 hours for physical and mental status changes and follow-up with her primary care provider (PCP).

Review of Resident #2's progress notes dated 12/11/21 revealed:
-The resident experienced an unsupervised fall and was found on the floor; no other details were provided.
-She was transported to the hospital via ambulance for further evaluation and care.
-No fall prevention interventions or increased supervision were documented.

Review of Resident #2's progress notes dated 12/13/21 revealed:
-The resident had broken her left hip and was scheduled for surgery that day.
-The resident remained in the hospital.

Review of Resident #2's Post Fall Care Plan Evaluation for Interventions dated 12/16/21:
-The resident was not able to transfer.
-The recommended interventions suggested for a fall from the bed were fall mat, increased supervision, and a medication review.
-The recommended interventions suggested for a fall for residents with cognitive impairments were appropriate footwear, fall mat, increased supervision, and medications review (these interventions had not been implemented yet because the resident was still recovering from her injury from the fall outside of the facility).

Review of Resident #2's record revealed:

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D 270	Continued From page 30 -There was no fall risk evaluation documented for the resident. -There was no increased supervision documented for the resident. -There was no fall prevention plan documented for the resident. -There was no documentation that the resident followed up with her PCP after any of the falls. -There was no documentation of communication with the resident's PCP, family, or facility staff members to reduce falls. -There were no post-fall care plan evaluations with new interventions documented after each fall, except for the one dated 12/16/21, in which the resident had not returned to the facility as of 01/06/22. Review of Resident #2's emergency room (ER) visit note dated 12/10/21 revealed: -The resident was sent from the facility via ambulance due to a fall. -Staff heard a thump in the resident's bedroom and when they went to check on her, she was on the floor. -Staff did not know how she fell, but thought she had been wandering in her room and fell. -The resident complained of pain in her left hip. Review of Resident #2's Orthopedic provider note dated 12/12/21 revealed: -The resident sustained a fracture to the femur. -Surgical treatment was recommended. -Risks of the procedure to repair the femur included risk of infection, risk of phlebitis (vein inflammation), risk of neurovascular injury, risk of post operative stiffness, risk of nonunion, worsening condition, blood transfusion, dislocation, pneumonia, or UTI's which could lead to sepsis, risk of a heart attack or stroke, risk of death and all potential sequela.	D 270		

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-The procedure was carried out and required 2-3 days of post-operative care prior to being discharged to a skilled nursing facility (SNF).

Interview with Resident #2's responsible party on 01/05/22 at 9:57am revealed:
-It was difficult because she had been unable to visit the resident since September 2021 due to the COVID-19 pandemic.
-The facility had made her aware of some falls experienced by the resident, but she could not recall how many.
-The resident had a history of so many falls, she expected the facility to provide her with increased supervision to prevent future falls.
-The facility contacted her on 12/11/21 around 1:00am to notify her that the resident had fallen and was being sent to the hospital for hip pain.
-The facility was unable to explain how the fall happened except that they heard a big "thump" and found her on the floor.
-The resident suffered a fracture of her femur and required surgical intervention.
-After surgery, the resident was transferred from the hospital after surgery to a rehabilitation center to undergo physical and occupational therapy for recovery.
-According to the resident's doctors, the resident's prognosis and probability of recovery were poor.

Interview with personal care aide (PCA) on 01/06/22 at 4:00pm revealed:
-Resident #2 was usually disoriented and confused at all times.
-Resident #2 used a walker with a fairly steady gait but required constant reminders to use her walker.
-Resident #2 was often observed wandering into other residents' rooms and often used the

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handrail when walking in the hall.
-She never witnessed any of Resident #2's falls and was not aware she had a history of falls.
-She tried to supervise the Resident #2 as much as she could but was unaware that the resident was a fall risk and there were no specific instructions regarding a safety and supervision plan communicated to her for the resident to prevent falls and keep her safe.
-She was never made aware of a fall intervention program and had never seen one implemented for Resident #2.
-It was the duty of the PCAs to ensure all resident rooms were free of clutter to and residents could ambulate safety.
-It was the duty of all staff on the unit to assist in supervising residents to prevent injury and harm.

Interview with medication aide (MA) on 01/06/22 at 4:30pm revealed:
-She was familiar with Resident #2 and had worked with her often on the Assisted Living (AL) unit before she was moved to the SCU sometime after February 2021.
-Resident #2 often required 1 on 1 care and was constantly disoriented, frequently confused, and needed constant redirection and felt like she needed supervision with safety checks at least every 10 minutes.
-Resident #2 showed signs of advanced dementia, was not aware of her limitations, was forgetful, and suffered from insomnia.
-Resident #2 was observed constantly walking and would often have to be convinced to sit down due to leg swelling.
-Resident #2 would often be observed packing up and saying she would be leaving the facility.
-She had never witnessed any of Resident #2's falls and was unsure what the facility had put into place regarding increased supervision or fall

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interventions as it had never been communicated to her.
-Resident #2 needed increased supervision but she had never been told how often to check on the resident and they did not document supervision rounds anywhere.
-There was usually only 1 PCA and 1 MA for the 10 residents on the SCU unit which was not enough staff to meet and supervise the resident's specific needs.

Interview with the Administrator on 01/06/22 at 3:54pm revealed:
-Resident #2 walked and wandered the halls all the time making it difficult for staff to supervise her.
-She was aware of all of Resident #2's falls and had discussed increased supervision with the Special Care Coordinator (SCC) during morning stand-up meetings.
-It was concerning that Resident #2's PCP had not been made aware of her falls because that prevented the PCP from being able to assess the resident and try to understand why she had been falling to include performing a medication review and providing orders things such as for fall prevention interventions, increased supervision, increased vital signs and monitoring or any tests the resident might have needed.
-She expected Resident #2 to have supervision and safety rounds at least every 30 minutes after the first fall and every 15 minutes after the second and subsequent falls; the SCC had been responsible for communicating this to the staff.
-There were no other fall interventions put into place, she did not know why.
-The RCC and the SCC were responsible to notify the staff of safety and supervision expectations; the RCC finished her training in November and the SCC recently quit.

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D 270	Continued From page 34 -It was her responsibility to supervise and oversee the RCC and SCC but she was not aware that there were no fall interventions or increased supervision in place for Resident #2 and had been told it had been implemented by the previous SCC. -She did not ensure the increased supervision and fall interventions had been carried out for Resident #2 because she trusted and assumed staff were doing it in morning stand-up meetings. -It was concerning that Resident #2 did not receive increased safety checks and supervision as she expected because the last fall resulted in the resident being severely injured. -The staff had never expressed any concerns to her about Resident #2 requiring more supervision or care than they were able to provide. -If there had been interventions and increased supervision in place for Resident #2 the facility might have been able to prevent the resident from falling and experiencing severe injury. Telephone interview with Resident #2's PCP on 1/6/2022 at 11:50 revealed: -Resident #2 had advanced dementia and was constantly disoriented, very impulsive, needed constant redirection, and reminders to use her walker while ambulating. -The resident would frequently have swelling in her limbs and has had a previous left femur fracture that had required surgical intervention. -The resident was a fall risk due to her cognitive status because of her history of left hip fracture. -She had not been made aware by the facility of 4 of 5 falls documented for the resident. -The only fall she had been notified of was the 12/11/21 fall in which the resident sustained injury. -She would have ordered more frequent blood pressure checks for the resident to try and	D 270		

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D 270	Continued From page 35 assess the reason for her frequent falls if she had been made aware. -If she was made aware of all falls by the facility that she would expected and ordered for the resident to have increased supervision consisting of 15-minute safety checks and a bed alarm due to her being high fall risk. _____ The facility failed to provide supervision to 1 of 5 sampled residents (#2) in accordance with their current diagnoses, assessed needs, and facility policy resulting in the resident (#2) having 5 unwitnessed falls in a 9 week time-frame (09/09/21-12/11/21) in which she sustained a severe left femur fracture requiring surgical intervention on 12/11/21 resulting in an increased level of care and rehabilitation services. The failure of the facility to supervise the resident and provide interventions according to the facility's policy resulted in serious harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 01/06/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2022.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 273		

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Based on interviews and record reviews, the facility failed to ensure provider notification and for follow-up for 2 of 5 sampled residents (#2, #3) related to a resident (#2) experiencing 5 falls in a 9-week period in which the facility did not notify the resident's primary care provider (PCP) of 4 of the 5 falls, and failing to schedule and ensure specialty follow-up medical appointment referral orders were made for a resident who required medical care for a surgical procedure (#3).

The findings are:

1.Review of Resident #2's current FL-2 dated 12/13/21 revealed:
-Diagnoses included dementia without behavioral disturbance, cognitive communication deficit, seizures, hypertension, hyperlipidemia, insomnia, anemia, muscle weakness, unsteady on feet, difficulty walking, fracture of left femur.
-She was constantly disoriented, semi-ambulatory with a walker, and a wanderer.
-The residents recommend level for care was special care unit (SCU).

Review of Resident #2's current assessment and care plan dated 07/01/21 revealed:
-The resident had wandering behaviors, was sometimes disoriented, and had significant memory loss requiring direction.
-She required assistance with ambulation and needed reminding to use her walker.
-She required extensive assistance with dressing, and bathing, grooming/personal hygiene, and toileting.

Review of Resident #2's Accident/Incident report dated 09/09/21 revealed:
-The resident fell on 09/09/21 without injury at

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approximately 2:26pm.
-The resident was found on the floor in the dayroom.
-The MA on duty reported and completed the Incident report.
-The recommended level of care was Special Care Unit.
-The resident did not complain of pain related to the fall and was arousable when name called.

Review of Resident #2's Accident/Incident report dated 09/20/21 revealed:
-The resident fell on 09/20/21 without injury at approximately 1:17pm.
-The resident was found on her knees in the hallway.
-The resident stated she lost her balance.
-The recommended level of care was Special Care Unit.
-The resident did not complain of pain related to fall and was arousable when name called.

Review of Resident #2's Accident/Incident report dated 10/24/21 revealed:
-The resident fell on 10/24/21 no time was documented on report.
-The resident was alone when she fell and lost her balance and hit the wall.
-A personal care aide (PCA) reported the incident to the medication aide (MA) who completed the incident report.
-The recommended level of care was Special Care Unit.
-The resident did not complain of pain related to fall and was arousable when named called.

Review of Resident #2's Accident/Incident report dated 11/25/21 revealed:
-The resident fell on 11/25/21 at approximately 6:55pm.

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-Incident was reported by a PCA and Incident report was completed by a MA.
-The resident was in her room when she fell.
-The resident said she fell out of bed.
-PCA stated they heard a noise and went into the resident's room.
-The recommended level of care was Special Care Unit.
-The resident did not complain of pain related to the fall and was arousable when name called.

Review of Resident #2's Accident/Incident report dated 12/11/21 revealed:
-The resident fell on 12/10/21 at approximately 9:30pm. Fall was not witnessed.
-Fall was reported by PCA in SCU and incident report was completed by a MA in SCU.
-The resident was found on the floor of another resident's room holding her right hip.
-The resident complained of pain in hip related to the fall.
-The resident was sent to hospital on 12/10/21 at approximately 9:50pm.
-The recommended level of care was Special Care Unit.
-Evaluation Note: once patient is discharged from hospital will put fall prevention program in place, monitor for 72 hours for physical and mental status changes and follow-up with PCP.

Telephone interview with Resident #2's primary care provider (PCP) on 01/06/22 at 11:50am revealed:
-Resident #2 had dementia, was constantly disoriented, very impulsive, needed constant redirection, and required reminders to use her walker while ambulating.
-The facility failed to notify her of 4 of 5 falls documented for Resident #2.
-If she had been made aware of all falls by the

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facility, she would ordered Resident #2 to have increased supervision, 15-minute safety checks, and a bed alarm due to her being high fall risk.
-She also would have ordered more frequent BP checks to see if that was the reason for the resident's frequent falls.

2. Review of Resident #3's current FL-2 dated 10/19/21 revealed:
-Diagnoses included hypertension, chronic pancreatitis, diabetes type 2, gastroesophageal reflux disease (GERD), hyperthyroidism, chronic obstructive pulmonary disease (COPD), chronic kidney disease stage III, and pernicious anemia.
-She was intermittently disoriented, was on a regular diet, and had an order for a supplement once daily.
-There was an order for her to see her primary care provider (PCP) every 30 days.

Review of a specialty physician's visit note for Resident #3 dated 12/01/21 revealed:
-The resident had a large abdominal mass from a hernia involving small and large bowel causing chronic back pain.
-Due to other co-existing medical conditions that needed to be addressed, she was not a surgical candidate at that time.
-There was an order for her to follow up with her PCP, a cardiologist, engage in low impact exercise, and to receive a colonoscopy.
-The resident was to follow up in 3-4 months after the orders had been completed to be considered as a candidate for the ventral hernia repair surgery.

Review of a PCP progress note for Resident #3 dated 12/14/21 revealed:
-She was seen for a follow-up for her hernia specialty physician's visit.

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D 273	Continued From page 40 -There were some cardiac concerns and there was an order for the resident to be referred to gasteroentoerology for a colonoscopy. Review of Resident #3's record revealed she had no documentation of seeing a cardiologist, engaging in exercise, or receiving a colonoscopy. Interview with Resident #3 on 01/05/22 at 10:22am revealed: -The facility coordinated and transported her to all her appointments. -As far as she knew, she had attended all her appointments as scheduled but was not sure what she was supposed to have done and relied on the facility to keep track of that for her. Interview with a Resident Care Coordinator (RCC) from a sister facility on 01/05/22 at 3:13pm revealed: -She was helping at the facility that day because the facility's RCC was out sick. -If Resident #3 had referrals for a cardiologist, exercise, and a colonoscopy from 12/01/21 and 12/14/21 they should have been completed by now; an exercise referral meant the resident needed to be referred to physical therapy (PT) and that order should have been clarified. -Resident #3's colonoscopy, cardiology and exercise/PT referral appointments that had been ordered on 12/01/21 and 12/14/21 had not been made or followed up on, she was unsure why. -She had recently finished training the facility's RCC in early November 2021 and was familiar with the facility's processes. -The RCC was responsible to implement orders and schedule appointments, and ensure residents attended all appointments as ordered. -All resident appointments were expected to be scheduled within one business day of being	D 273		

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ordered to include transportation coordination.
-If the RCC was unable to complete her work and implement orders or make appointments in a timely manner as trained, she was expected to notify and delegate the task to the supervisor or the Administrator to ensure it was completed.
-The Administrator was responsible to oversee the supervisor and the RCC to ensure orders and appointments were implemented and followed up on in a timely manner.

Interview with the Administrator on 01/05/22 at 4:03pm revealed:
-The RCC was responsible to implement orders for appointments, referrals, and follow-ups within one business day of receiving the order and coordinate transportation as needed.
-She was not aware that Resident #3's referral appointments ordered on 12/01/21 and 12/14/21 for the colonoscopy, cardiologist, and PT had not been completed or needed to be completed until brought to her attention that day.
-If the RCC was unable to make the appointments, she expected her to delegate the task to the supervisor; if neither of them was able to make the appointments, she expected them to notify her and she would have completed it.
-She was responsible for overseeing the RCC and the Supervisor to ensure orders and appointments were being implemented and carried out, but she was unaware they were not getting done.

Interview with Resident #'3's PCP on 01/06/22 at 11:19am revealed:
-She was not aware that Resident #3's referral appointments to see cardiology, PT, and gastroenterology had not been done.
-She expected all orders and referrals to be implemented and carried out as ordered within

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one week of the order being written.
-Resident #3 had underlying abdominal issues her entire life and required specialty physicians to treat her and help guide her care as ordered.
-She expected the facility to notify her if they were unable to make the referral appointments for the resident as ordered.
-Resident #3's medical and health issues were preventing her from having a surgery she needed which was why she was referred for specialty appointments and care.

Attempted interview with the RCC for this facility on 01/06/22 at 9:02am was unsuccessful.

The facility failed to ensure provider notification and follow-up for 2 of 5 residents in which Resident #2 experienced 5 falls from 09/09/2021 through 12/11/21 in which the primary care provider (PCP) had not been notified of the falls until the resident experienced severe injury on 12/11/21 and subsequently hospitalized after requiring surgery and an increased level of care. Resident #3 had an abdominal hernia in which surgery was required to correct and had orders to follow up with a cardiologist, a colonoscopy, and physical therapy, and those appointments were never made preventing the resident from addressing medical conditions preventing the surgery required. The facility's failure to provider notification and follow-up as ordered resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation.

The facility provided a plan of correction in accordance with G.S. 131D-34 on 01/06/22 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY

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D 273	Continued From page 43 5, 2022.	D 273		
D 293	10A NCAC 13F .0904(c)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Home: (4) Menus shall be planned to take into account the food preferences and customs of the residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to plan and serve menus that accommodated the residents' preferences and considered the residents' likes and dislikes. The findings are: Interview with a resident on 01/05/21 at 10:22am revealed: -She had diabetes and routinely did not eat things served to her on her plate such as potatoes, bread, and sugary drinks because she really was not supposed to have it, but the facility did not offer a diabetic diet or a substitute for those items. -She felt like some of the older residents in the facility has lost weight because they did not always like the food they were served. -She had previously spoken to the facility's dietician about adding some food preferences she and the other residents would like to have, but nothing ever came from that conversation. -She had also previously spoken to the kitchen manager about adding some fresh items to the menu such as salads and fresh fruits and vegetables, but they were never on the menu.	D 293		

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-Sometimes she would get hungry in between meals because she was not always able to eat the items she was served.

Interview with a second resident on 01/05/22 at 7:45am revealed:
-She did not like the food served at the facility because it did not taste good.
-It was the same food repeatedly with no flavor.
-The residents had sent a request to corporate for improved menu items through the Administrator and have yet to hear a response.

Interview with a third resident on 01/05/22 at 9:20am revealed:
-He was "not impressed" with the food at the facility.
-He understood that it was an "intuitional type food menu" but that did not mean that there can't be some variety or fresh food items available for residents.

Interview with the cook on 01/06/22 at 3:55pm revealed:
-The Dietary Manager quit about three weeks ago.
-The residents complained frequently about the food served, mainly the repetitive menu for example the residents were served a type of rice at 5 meals this week.
-She was not allowed to do alternative menu options per the previous Dietary Manager.
-She was told she had to stick to the menu by management.
-She was aware that residents were frustrated by the menu at the facility because it lacked variety.

Interview with the Administrator on 01/06/22 at 12:10pm revealed:
-She was not aware that the residents were not

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D 293	Continued From page 45 happy with the menu. -She speaks to the residents daily and had never heard concerns about the menu. -She did not recall residents requesting corporate action about the menu but she would suggest that residents speak with corporate because the menu comes set from their food distributors.	D 293		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to serve therapeutic diets as ordered by the primary care provider (PCP) for 1 of 5 sampled residents who had diet orders for a pureed diet (#4). The findings are: Review of Resident #4's current FL-2 dated 06/15/21 revealed a diagnosis of dementia. Review of a physician order for Resident #4 dated 10/19/21 revealed a pureed diet. Review of a printed diet order list in the main kitchen on 01/06/22 at 9:30am revealed:	D 310		

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-There was a printed diet order list for all residents in a binder dated 01/05/22.
-Resident #4 was not listed on the printed diet order list.

Review of a handwritten therapeutic diet menu in the main kitchen on 01/06/22 at 9:33am revealed:
-Resident #4 was listed as a mechanical diet.
-The handwritten therapeutic diet menu had "updated" at the top of the list; there was no date on the list.

Observation of Resident #4 during breakfast in the Special Care Unit (SCU) dining room on 01/05/22 at 9:08am revealed:
-Resident #4 was alone at a table and ate independently.
-She had scrambled eggs, chopped ham and chopped potatoes.
-There was no coughing noted.

Observation of Resident #4 during lunch in the SCU dining room on 01/05/22 at 12:32pm revealed:
-Resident #4 was alone at a table and ate independently.
-She had a chopped turkey and cheese sandwich, garden peas and pasta.
-There was no coughing noted.

Observation of Resident #4 during breakfast on 01/06/22 at 8:30am revealed:
-Resident #4 was alone at a table and ate independently.
-She had a scrambled eggs and smoked sausage.
-There was no coughing noted.

Interview with a cook on 01/06/22 at 9:36am revealed:

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-The dietary manager had resigned, and she was filling in until a replacement could be hired.
-She used a handwritten list on the kitchen wall to follow therapeutic diet orders.
-She also used a printed dietary order report in a binder to ensure therapeutic diet orders were followed.
-She was not sure why Resident #4 was not listed on the printed dietary order report dated 01/05/22.
-She had prepared Resident #4 a chopped diet as written on the therapeutic diet order list on the wall.

Interview with a personal care aide (PCA) on 01/06/22 at 9:00am revealed:
-She worked on the SCU and served meal trays that had resident names written on the styrofoam container from dietary.
-She was usually the last to know if a resident had a dietary order changed.
-The medication aide (MA) would inform her or she would notice the change when she opened a resident's styrofoam tray.
-She knew there was a printed list posted in the SCU of resident diet orders, but it was an old list.

Telephone interview with the Clinical Manager of a local hospice agency on 01/06/22 at 3:36pm revealed:
-Resident #4 was on a pureed diet.
-Resident #4 was at risk of aspiration and choking due to Alzheimer's disease, which could lead to pneumonia and death.
-She expected the facility to follow the diet order provided by the PCP.

Telephone interview with the PCP on 01/06/22 at 11:18am revealed:
-Resident #4 should not have received a regular diet.

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-Resident #4 had a risk of aspiration and choking and was ordered a pureed diet.
-She expected staff to follow her orders as directed to ensure the safety of residents.
-Resident #4 could have aspirated or choked due to the facilities failure to provide her with a pureed diet.

Interview with the Area Director of Operations on 01/06/22 at 4:18pm revealed:
-She was not aware that Resident #4 did not receive a therapeutic diet as ordered by her PCP.
-It was unacceptable and there were no organization or systems in place by the Administrator to ensure therapeutic diet orders were followed as ordered by the PCP.
-There were communication systems in place that the Administrator and the lead supervisor should have followed to ensure Resident #4 received the correct therapeutic diet.
-Resident #4 was at risk of losing weight, choking and death due to not receiving the correct diet.

Interview with the Administrator on 01/06/22 at 12:05pm revealed:
-The dietary staff were expected to follow each resident's therapeutic diet order.
-She was not aware that the printed diet order report in the kitchen did not have Resident #4 listed.
-She was not aware that the handwritten therapeutic diet order list in the kitchen had Resident #4 listed with a chopped diet.
-She was not aware that the printed diet order report posted in the SCU kitchen did not have Resident #4 with a pureed diet.
-Resident #4 should have received a pureed diet per the PCP orders.
-It was the responsibility of the lead MA to update therapeutic diet orders in the electronic medical

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D 310	Continued From page 49 record and provide an updated printout to dietary staff, the MAs and PCAs. -An updated therapeutic diet list should have been posted in the main kitchen and the SCU kitchen. -She was concerned that Resident #4 could aspirate from not receiving a pureed diet as ordered by her PCP.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that the rights of all residents were maintained related to personal care and supervision, health care, residents being treated with respect and dignity and residents being free of mental and physical abuse. The findings are: 1. Based on interviews and record reviews, the facility failed to provide supervision to 1 of 5 sampled residents (#2) in accordance with their current diagnoses and assessed needs, resulting in the resident (#2) having 5 unwitnessed falls in a 9 week time-frame in which she sustained a injury from the final fall [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure provider notification and	D 338		

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D 338	Continued From page 50 for follow-up for 2 of 5 sampled residents (#2, #3) related to a resident (#2) experiencing 5 falls in a 9-week period in which the facility did not notify the resident's primary care provider (PCP) of 4 of the 5 falls, and failing to schedule and ensure specialty follow-up medical appointment referral orders were made for a resident who required medical care for a surgical procedure (#3) [Refer to Tag D0273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 3. Based on interviews, and record reviews, the facility failed to ensure all residents were treated with respect and dignity related to staff behavior towards 4 residents and related to meal service when residents were not provided tables for in-room dining after stopping communal dining [Refer to Tag D 911 G.S. § 131D-21(1) Declaration of Resident Rights (Type A2 Violation)]. 4. Based on interviews, and record reviews, the facility failed to ensure 4 residents (#1, #3, #6, and #7) were free of mental and physical abuse by staff including Staff G who was permitted continued employment at the facility by the Administrator after previous allegations of physically abusive behavior towards residents. [Refer to Tag D 914 G.S. § 131D-21(4) Declaration of Resident Rights (Type A2 Violation)].	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	D 358		

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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:
FOLLOW UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not abated.

Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered for 2 of 4 residents (#8, #9) observed during the morning medication pass including errors involving medications used for blood pressure, fluid retention, and a blood thinner (#9), and asthma and a vitamin supplement (#8); and for 2 of 5 sampled residents for record review including errors involving medications used to regulate blood sugar (#3) as well as medications used to treat pain, fever, blood pressure, heart failure, depression, and Parkinson's disease (#1).

The findings are:

Review of the facility's Medication Management policy dated 07/2020 revealed:
-Medications must be administered within one hour before or one hour after the scheduled medication time as per to state rules and regulations.
-Medication cart audits were expected to be completed once per week on Wednesdays to ensure medications were available for administration.
-The process for medication cart audits included: printing all physician orders, assigning a

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medication aide (MA) on each shift a designated number of audits within 24 hours, remove all expired medications, restock and reorder any needed medications, ensure all "held per MD order" exceptions had a corresponding physician's order, ensure all medications documented as "refused" were available for administration, ensure physician notification and documentation of any medications that had been missed or refused greater than three times.
-Medication refusals were to be faxed to the physician for notification after three refusals and with documentation of the notification to be stored in the resident record.
-Medication errors included incorrect orders, giving medications to the wrong resident, at the wrong time, via the wrong route, administering the wrong medication, giving expired medications, administering medications not prescribed, giving a medications after a discontinue order, omitting a dose, giving an extra dose, or giving an incorrect dose.
-Medication error reports were expected to be completed for every medication error and stored in the resident record and sent to the Divisional Nurse for review.

1. The medication error rate was 16% as evidenced by the observation of 4 errors of 25 opportunities during the morning medication pass on 01/04/22.

a.Review of Resident #9's current FL-2 dated 03/15/21 revealed:
-Diagnoses included dementia, hypertension, atrial fibrillation, and congestive heart failure.
-There was an order for Hydralazine 50mg, take one tablet twice daily (Hydralazine is used to treat high blood pressure).

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Review of Resident #9's physician's orders dated 08/26/21 revealed:
-There was an order for Hydrochlorothiazide 12.5mg once daily (HCTZ is used to treat high blood pressure and fluid retention).
-There was an order for Hydralazine 50mg four times daily.

Review of a physician's order for Resident #9 dated 08/30/21 revealed:
-There was an order to discontinue the Hydralazine 50mg four times daily.
-There was an order to start Hydralazine 50mg twice daily.

Review of a physician's progress note for Resident #9 dated 10/05/21 revealed an order to discontinue the HCTZ on 10/12/21.

Observation of the 8:00am and 9:00am medication pass on 01/04/22 revealed:
-HCTZ 12.5mg was administered to the resident at 9:56am.
-Hydralazine 50mg was not administered or offered to Resident #9 when she received her other morning medications at 9:56am from the medication aide (MA).

Observation of Resident #9's medications on hand on 01/04/22 at 3:32pm revealed:
-There was a bottle of Hydralazine 50mg four times daily filled on 07/21/20 with a starting quantity of 360 pills (90-day supply) with 38 remaining pills.
-There was a bottle of HCTZ 12.5mg once daily filled 10/06/21 with a starting quantity of 90 pills (90-day supply) with over 50 pills remaining.

Review of Resident #9's January 2022 electronic medication administration record (eMAR)

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revealed:
-There was an entry for Hydralazine 50mg with instructions to take one tablet twice a day, scheduled for administration at 9:00am and 9:00pm.
-Hydralazine 50mg was documented as administered on 01/04/22 at 9:00am.
-There was no entry or documentation for HCTZ.

Telephone interview with the MA on 01/05/22 at 9:44am revealed:
-She accidentally administered HCTZ instead of Hydralazine to Resident #9 during the medication pass observation on 01/04/22; she was unsure how many times this mistake could have happened.
-She could have caused Resident #9 to have low blood pressure or some other kind of adverse reaction when she accidentally gave HCTZ instead of Hydralazine as ordered.
-She should have more carefully compared the medication she was administering to the medication ordered on Resident #9's eMAR.
-Resident #9's HCTZ should not have even been on the medication cart because the order had been discontinued; discontinued medications were to be removed immediately or during cart audits, she was not sure why the HCTZ was still on the cart.
-Medication cart audits used to be done by the MAs every week to ensure the carts were stocked with medications per resident's orders, expired and discontinued medications were removed, and the carts were cleaned and stocked with fresh supplies.
-Cart audits had not been done since September 2021 before the previous Administrator left, she did not know why.
-She was not sure who was responsible for ensuring cart audits were done and reviewing the

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documentation from the audits when the new administrator arrived.

Interview with an MA/Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed:
-She expected medications to be administered accurately as ordered to ensure accurate and safe medication administrations were provided to each resident.
-Any time the facility received a discontinue order for a medication, she expected the MA to pull the medication from the cart immediately.
-Someone forgot to pull Resident #9's HCTZ when it had been discontinued, the MAs should have realized it did not belong on the cart during weekly medication cart audits.
-Medication cart audits were expected to be done 1-2 times per week by the MAs to ensure medications were on hand as ordered, there were no discontinued or expired medications on the cart, and to check supplies, restock/reorder as needed, and ensure the cart was clean and in good working order.
-It was her, the supervisor's, and the Administrator's responsibility to oversee medication cart audits and ensure orders were processed accurately, she did not know how Resident #9's HCTZ had been missed or why it was still on the cart.
-She was not sure when the last cart audit was completed or reviewed.

Interview with the facility's regional training nurse on 01/04/22 at 4:10pm revealed:
-Discontinued medications should never be on the medication cart.
-MAs were expected to perform cart audits weekly to ensure discontinued and expired medications were removed from the cart and that ordered medications were on hand.

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D 358	Continued From page 56 -She was not aware that medication cart audits had not been completed since October 2021. Interview with the Administrator on 01/04/22 at 4:10pm revealed: -Discontinued medications should never be on the medication cart. -MAs were expected to perform cart audits weekly to ensure discontinued and expired medications were removed from the cart and that ordered medications were on hand. -The RCC was responsible to oversee medication cart audits and she was unsure when they were last completed. -She was not aware that medication cart audits had not been completed since October 2021. Interview with Resident #9's primary care provider (PCP) on 01/06/22 at 11:19am revealed: -She expected Resident #9 to receive her medications accurately as ordered. -She had discontinued Resident #9's HCTZ because she no longer had fluid overload and was frequently dehydrated from not drinking enough fluids. -Resident #9 had some recent issues with very high blood pressures which is why she had recently increased the dose of her Hydralazine and why it was important that she received it as ordered. -Resident #9 was a small and frail lady and sometimes her blood pressures could be outrageously high requiring her Hydralazine to be dosed and administered carefully. -Hydralazine had a short half-life and if Resident #9 did not get it as scheduled and as ordered it could put her at risk of a heart attack or stroke. Refer to interview with the MA on 01/05/22 at 9:44am.	D 358		

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D 358	Continued From page 57 Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm. b. Review of Resident #9's current FL-2 dated 03/15/21 revealed diagnoses included dementia, hypertension, atrial fibrillation, and congestive heart failure. Review of Resident #9's physician's orders dated 08/26/21 revealed there was an order for Aspirin 81mg chewable once daily (Aspirin is used as a blood thinner). Observation of the 8:00am and 9:00am medication pass on 01/04/22 revealed: -Aspirin 81mg enteric coated (EC) was prepared for administration for Resident #9 at 9:53am (enteric coating is a substance that prevents a medication from being leased until it reaches the small intestine where is can be absorbed). -Aspirin 81mg EC was attempted to be administered at 9:56am but Resident #9 spit the pill out after moving it around in her mouth with a confused look on her face. -The MA caught the Aspirin 81mg EC pill Resident #9 spit out the pill, mixed it with more applesauce, and re-administered the pill to the resident. -Resident #9 was unable to swallow the pill again and spit it out. -The MA wasted the pill and documented a refusal. Review of Resident #9's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg chewable with instructions to take once a day, scheduled	D 358		

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for administration at 9:00am.
-Aspirin 81mg chewable was documented as refused on 01/04/22 at 9:00am.

Observation of Resident #9's medications on hand on 01/04/22 at 3:31pm revealed:
-There was a bottle of over the counter Aspirin 81mg EC with an original count of 36 tablets.
-There were 8 tablets of Aspirin 81mg EC left in the bottle.

Telephone interview with a MA on 01/05/22 at 9:44am revealed:
-She had not realized that the Aspirin she administered Resident #9 was enteric coated instead of chewable as ordered.
-It made sense that Resident #9 would need chewable Aspirin since she had trouble swallowing pills.
-She should have made sure she had the right form of medication prior to administration.

Interview with an MA/Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed:
-She expected medications to be administered as ordered to ensure accurate and safe medication administrations were provided to each resident.
-Resident #9 should have received chewable Aspirin as ordered and not EC Aspirin.
-Resident #9 had a difficult time swallowing pills and should have had the chewable Aspirin as ordered.
-She thought Resident #9's PCP had ordered the chewable Aspirin due to her difficulty in swallowing pills.
-She expected the MA administering medications to compare the medication they are giving to the eMAR prior to administration to ensure accuracy and safety of the residents.
-She had not been made aware that the resident

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received the wrong form of Aspirin and expected the MAs to report medication errors to her as soon as they occurred.
-If she had been notified of the medication error regarding Resident #9's Aspirin, she would have filled out a medication error report and notified the resident's family and PCP as well as DSS.

Interview with the facility's regional training nurse on 01/04/22 at 4:10pm revealed:
-Enteric coated Aspirin should not have been administered to Resident #9 if chewable Aspirin had been ordered.
-Chewable Aspirin was usually ordered when a resident was unable to swallow pills easily.

Interview with the Administrator on 01/04/22 at 4:10pm revealed:
-Enteric coated Aspirin should not have been administered to Resident #9 if chewable Aspirin had been ordered.
-Chewable Aspirin was usually ordered when a resident was unable to swallow pills easily.

Interview with Resident #9's primary care provider (PCP) on 01/06/22 at 11:19am revealed:
-Resident #9 was prescribed chewable Aspirin because she had difficulty swallowing pills and it helped prevent heart attack and stroke.
-She expected the facility to verify accurate administration of the right form of a medication and for Resident #9 to be administered chewable Aspirin as ordered.
-Resident #9 would have likely been able to ingest her Aspirin if she had been given the right form and been able to chew it.

Refer to interview with the MA on 01/05/22 at 9:44am.

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Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

c. Review of Resident #8's current FL-2 dated 03/08/21 revealed diagnoses included senile debility (dementia), hypertension, and weight loss.

Review of Resident #8's physician's orders dated 08/26/21 revealed an order for Symbicort inhaler, 2 puffs twice daily, rinse mouth after use.

Observation of the 8:00am and 9:00am medication pass on 01/04/22 revealed the Symbicort inhaler was new out of the package and four puffs were administered to Resident #8 at 9:33am; the medication aide (MA) did not prime the inhaler before use and administered 2 extra puffs when the resident stated she could not feel the medication going in.

Review of Resident #8's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort inhaler, 2 puffs twice daily, rinse mouth after use, scheduled for administration at 9:00am and 9:00pm.
- Symbicort inhaler, 2 puffs, was documented as administered on 01/04/22 at 9:00am.

Telephone interview with the MA on 01/05/22 at 9:44am revealed:
-She should have primed the Symbicort inhaler because it was new out of the package before using to ensure it was working properly prior to using.
-She should not have given the resident extra doses of the Symbicort and instead should have educated the resident that delivering more puffs

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than ordered was not safe.
-She was expected to administer medications as ordered and could have overdosed the resident which was concerning.
-Giving too much medication was considered a medication error and she should have reported the error to the RCC, Administrator and the resident's primary care provider (PCP).

Interview with Resident #8's PCP on 01/06/22 at 11:19am revealed:
-She expected Resident #8's Symbicort to be administered as ordered.
-If the resident received too high of a dose of Symbicort on a regular basis, she could become dependent on the higher dose and the medication could become ineffective.

Refer to interview with the MA on 01/05/22 at 9:44am.

Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

d. Review of Resident #8's current FL-2 dated 03/08/21 revealed diagnoses included senile debility (dementia), hypertension, and weight loss.

Review of Resident #8's physician's orders dated 08/26/21 revealed an order for Vitamin B-12 500mcg, take one tab every Monday, Wednesday, and Friday.

Observation of the 8:00am and 9:00am medication pass on 01/04/22 (a Tuesday) revealed:
-The medication aide (MA) prepped Resident #8's morning medications for administration at 9:20am

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using the pharmacies pre-filled bubble packs with all of her medications in one bubble dated 01/04/22.
-The MA realized she was missing a pill prior to administration that she had missed in the bubble pack so she wasted and threw away the pills at 9:26am.
-The MA pulled the next day's pill pack dated 01/05/22 and prepared those pills for administration at 9:26am.
-The MA administered the bubble pack of pills dated 01/05/22 at 9:30am.
-There was a Vitamin B-12 listed the bubble pack dated 01/05/22 that was administered to Resident #8.
-There was not a Vitamin B-12 listed on the bubble pack dated 01/04/22 at was supposed to be administered to Resident #8 but had been wasted.

Review of Resident #8's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin B-12 500mcg, take on tablet every Monday, Wednesday, and Friday.
-Vitamin B-12 500mcg was not documented as administered on Tuesday, 01/04/22, at 9:00am.

Telephone interview with the MA on 01/05/22 at 9:44am revealed:
-It was concerning that she administered Resident #8's Vitamin B-12 on a day that it was not ordered.
-Sometimes the multi-bubble packs of medication were hard to follow, and she should have realized she had more pills in the medication cup than ordered medications on the resident's eMAR.

Interview with Resident #8's PCP on 01/06/22 at

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D 358	Continued From page 63 11:19am revealed: -She expected Resident #8's Vitamin B-12 to be administered as ordered. -Giving the Vitamin B-12 on the wrong day would mess up the order as scheduled and cause her Vitamin B-12 levels to become unstable. Refer to interview with the MA on 01/05/22 at 9:44am. Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm. _____ Interview with the MA on 01/05/22 at 9:44am revealed: -It was concerning that she made so many medication errors during the observation of medication pass. -She should have pain closer attention to what she was doing because she could have hurt someone. -She had worked 22 hours that shift because the facility was short staffed. -She made medication errors because she was tired and that was concerning; she probably should not have been passing medications at all. -She was taught to administer medications as ordered and compare the medication she was administering to the order on the resident's eMAR prior to administering to the resident. -She was taught to administer medications according to the six rights of medication (right patient, right medication, right dose, right route, right documentation). -Medication errors were supposed to be reported to the resident's primary care provider (PCP) and the Resident Care Coordinator (RCC) or Administrator per policy with a medication error report completed at that time in the resident	D 358		

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D 358	Continued From page 64 record. 2. Review of Resident #3's current FL-2 dated 10/19/22 revealed: -She had diagnoses of hypertension, chronic pancreatitis, diabetes type 2, and chronic kidney disease stage III. a. Review of Resident #3's physician orders dated 10/19/21 revealed an order for Novolog (a short-acting insulin used to control high blood sugar) 5 units three times daily with meals (hold if finger stick blood sugar (FSBS) is less than 250 and notify primary care provider). Review of Resident #3's physician orders dated 12/13/21 revealed an order for Novolog 5 units three times daily with meals (hold if FSBS is less than 150 and notify primary care provider). Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 5 units three times daily with meals (hold if finger stick blood sugar (FSBS) is less than 250 and notify primary care provider). -There were 7 of 90 opportunities in which Novolog was documented as administered to the resident with a FSBS less than 250. -Of those 2 of 90 opportunities in which Novolog 40 units was documented as administered instead of the ordered 5 units of Novolog, one time was with a FSBS less than 250. -On 11/03/21 at 5:30pm, the resident had a FSBS of 140 and was documented as administered 5 units of Novolog. -On 11/04/21 at 7:30am, the resident had a FSBS of 143 and was documented as administered 5 units of Novolog.	D 358		

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D 358	Continued From page 65 -On 11/11/21 at 7:30am, the resident had a FSBS of 134 and was documented as administered 5 units of Novolog. -On 11/15/21 at 5:30pm, the resident had a FSBS of 125 and was documented as administered 5 units of Novolog. -On 11/15/21 at 5:30pm, the resident had a FSBS of 137 and was documented as administered 5 units of Novolog. -On 11/17/21 at 5:30pm, the resident had a FSBS of 146 and was documented as administered 40 units of Novolog. -On 11/18/21 at 7:30am, the resident had a FSBS of 270 and was documented as administered 40 units of Novolog. -On 11/26/21 at 7:30am, the resident had a FSBS of 118 and was documented as administered 5 units of Novolog. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for Novolog 5 units three times daily with meals (hold if finger stick blood sugar (FSBS) is less than 150 and notify primary care provider). -There were 1 of 93 opportunities in which Novolog 5 units was held and not administered to the resident with a FSBS of 150 on 12/15/21 at 7:30am. Interview with a pharmacy technician at the facility's contracted pharmacy on 01/06/22 at 10:16am revealed: -The last set of medication orders the pharmacy had on file for Resident #3 were dated 09/03/21, they had not received any orders for the resident dated 10/19/21 or 12/13/21. -Resident #3's active Novolog order from 09/03/21 was to administer three times per day with meals and to hold the medication if FSBS	D 358		

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D 358	Continued From page 66 was less than 150. Interview with a pharmacist at the facility's contracted pharmacy on 01/06/22 at 10:23am revealed: -Resident #3's Novolog should be held for a FSBS less than 150 because if it was administered with a FSBS of less than 150 it could cause the resident to have hypoglycemia (low blood sugar). -If the resident experienced hypoglycemia from receiving Novolog that she did not need, if could cause her to feel shaky, pass out, or cause her to be hospitalized and would be difficult to get her FSBS back up. Interview with Resident #3's primary care provider 01/06/22 at 11:19am revealed: -Resident #3 had a history of uncontrolled FSBS and she expected her Novolog to be administered as ordered. -It was concerning that the resident's Novolog had been administered with FSBS below 150 which could cause hypoglycemia, especially if she did not eat well before going to sleep. -She had ordered a supplement for the resident to drink after she complained of waking up at night hungry and shaky. -If the resident's FSBS dropped too low, the resident could pass out, go into a coma, or die. Refer to interview with the MA on 01/05/22 at 9:44am. Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm. b. Review of Resident #3's physician orders dated 12/13/21 revealed an order for Actos (a	D 358		

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medication used to control blood sugar) 30mg once daily.

Review of a prescription dated 12/16/21 for Resident #3 revealed an order for Actos 15mg once daily.

Review of a physician's order for Resident #3 dated 12/29/21 revealed an order to discontinue Actos.

Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Actos 15mg daily scheduled at 9:00am.
-Actos 15mg was documented as administered to the resident on 01/01/22, 01/03/22, and 01/04/22.

Interview with a pharmacy technician at the facility's contracted pharmacy on 01/06/22 at 10:16am revealed:
-The last set of medication orders the pharmacy on file for Resident #3 were dated 09/03/21, they did not receive any orders for the resident dated 10/19/21 or 12/13/21.
-There was no order on file to discontinue Resident #3 Actos dated 12/29/21.
-The facility was responsible to fax orders to the pharmacy and they would immediately input the orders into the resident's eMAR which would then be sent back to the facility for approval.
-It was the facility's responsibility to approve the orders if accurate so they would become active on the eMAR or contact the pharmacy to correct the order if inaccurate.

Interview with a pharmacist at the facility's contracted pharmacy on 01/06/22 at 10:23am revealed:

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-It was the facility's responsibility to fax medication orders to the pharmacy to be processed.
-The pharmacy had not received an order to discontinue Resident #3's Actos.
-Actos was a medication used to help control blood sugar; if Resident #3 continued to received Actos and it had been discontinued, it could cause hypoglycemia (low blood sugar).
-If the resident experienced hypoglycemia from receiving Actos that she did not need, it could cause her to feel shaky, pass out, or cause her to be hospitalized and would be difficult to get her FSBS back up.

Interview with the Administrator on 01/06/22 at 3:54pm revealed:
-It was the MA, Supervisor, or RCC's responsibility to fax medication orders to the pharmacy for implementation immediately when received or within one business day.
-She was unaware that Resident #3's order to discontinue her Actos had not been faxed to the pharmacy or implemented as ordered.
-It was her responsibility to follow up with staff and oversee that duties were being completed but she was unaware that there was an issue.

Interview with Resident #3's primary care provider on 01/06/22 at 11:19am revealed:
-She was unaware that the facility had not discontinued administration of the resident's Actos as ordered.
-She expected the facility to implement orders and administer medications as ordered.
-It was concerning that the facility continued to administer the resident's Actos despite her discontinuing the order.

Refer to interview with the MA on 01/05/22 at

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9:44am.

Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

3. Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included Parkinson's disease and chronic pain.

a. Review of Resident #1's physician's orders dated 12/03/21 revealed there was an order for Oxycodone-Acetaminophen 5-325mg tablet, take one tablet every 6 hours as needed for pain (Oxycodone-Acetaminophen is a narcotic used to treat pain).

Review of Resident #1's physician's orders dated 12/12/21 revealed:
-There was an order to discontinue Oxycodone-Acetaminophen 5-325mg tablet, take one tablet every 6 hours as needed for pain.
-There was an order to start Oxycodone-Acetaminophen 5-325mg tablet, take one tablet four times a day.

Review of Resident #1's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone-Acetaminophen 5-325mg tablet, take one tablet every 6 hours as needed for pain.
-Oxycodone-Acetaminophen 5-325mg tablet, take one tablet every 6 hours as needed for pain was documented as administered on 11/16/21 at 11:54am, 4:25pm, and 10:11pm, which is more frequently than ordered.
-Oxycodone-Acetaminophen 5-325mg tablet, take one tablet every 6 hours as needed for pain was documented as administered on 11/22/21 at

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D 358	Continued From page 70 11:43am and 4:33pm, which is more frequently than ordered. Review of Resident #1's December 2021 eMAR revealed: -There was an entry for Oxycodone-Acetaminophen 5-325mg tablet, take one tablet every 6 hours as needed for pain with a discontinued date of 12/12/21. -Oxycodone-Acetaminophen 5-325mg tablet, take one tablet every 6 hours as needed for pain was documented as administered on 12/04/21 at 12:28pm and 5:17pm, which was more frequently than ordered. -Oxycodone-Acetaminophen 5-325mg tablet, take one tablet every 6 hours as needed for pain was documented as administered on 12/07/21 at 1:42pm and 6:23pm, which was more frequently than ordered. Interview with a medication aide (MA) on 01/06/22 at 2:40pm revealed: -She was not aware that she had administered Oxycodone-Acetaminophen more frequently than ordered. -She was responsible for checking the order and making sure that there was 6 hours in between doses before administering the next dose. Interview with a Resident Care Coordinator (RCC) from another facility on 01/06/22 at 2:45pm revealed: -The MAs were responsible for ensuring that medications were administered as ordered including Resident #1's Oxycodone-Acetaminophen as needed order. -She was not sure if there was a process in place to audit eMARs to ensure as needed medications were not being administered to frequently.	D 358		

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Interview with Resident #1's primary care provider (PCP) on 01/06/22 at 11:20am revealed:
-She discontinued the Oxycodone-Acetaminophen as needed order on 12/12/21 because she noticed on the eMAR that staff was administering it to frequently.
-She expected staff to administer Resident #1's Oxycodone-Acetaminophen as needed order as prescribed with 6 hours in between the doses.
-If Resident #1 received to much Oxycodone-Acetaminophen to close together it may create an increased risk for liver damage.

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

Refer to interview with the MA on 01/05/22 at 9:44am.

Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

b. Review of Resident #1's physician's orders dated 12/03/21 revealed there was an order for Acetaminophen 500mg, take one tablet every 4 hours as needed for 24 hours (dose not to exceed 2000mg) for fever 99.5 to 101F (Acetaminophen is a medication used to manage fever).

Review of Resident #1's vital signs revealed a temperature of 100.3 degrees on 01/03/22 at 9:58am.

Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Acetaminophen 500mg,

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with instructions to take one tablet every 4 hours as needed for 24 hours for fever 99.5 to 101F.
-There was no documentation of Acetaminophen 500mg being administered.

Observation of Resident #1's medications on hand on 01/06/21 at 9:05am revealed there was Acetaminophen 500mg available for administration.

Attempted telephone interview with the Resident Care Coordinator (RCC) on 01/06/21 at 9:02am was unsuccessful.

Interview with Resident #1's primary care provider (PCP) on 01/06/22 at 11:20am revealed:
-She expected staff to administer Resident #1's Acetaminophen as needed order as prescribed with when the resident has a temperature over 99.5.
-If the resident temperature was not controlled it may cause delirium which could place the resident at an increased risk for fall.

Refer to interview with the MA on 01/05/22 at 9:44am.

Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

c. Review of Resident #1's physician's orders dated 12/03/21 revealed:
-There was an order for Trazodone 50mg, take one tablet at bedtime (Trazodone is a medication used to treat depression).
-There was an order for Coreg 6.25mg, take one tablet twice daily (Coreg is a medication used to treat high blood pressure and heart failure).
-There was an order for Carbidopa-Levodopa

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D 358	Continued From page 73 25-100mg, take 1.5 tablets four times a day (Carbidopa-Levodopa is a medication used to manage Parkinson's Disease symptoms). Review of Resident #1's medications on hand on 01/06/22 at 9:05am revealed -There was no Trazodone 50mg available for administration. -There was no Coreg 6.25mg available for administration. -There was no Carbidopa-Levodopa 25-100mg available for administration. Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Trazodone 50mg, take one tablet at bedtime, scheduled for administration at 8:00pm. -Trazodone 50mg was documented as not administered on 01/05/22 at 8:00pm because the drug was unavailable -There was an entry for Coreg 6.25mg, take one tablet twice daily, scheduled for administration at 8:00am and 8:00pm. -Coreg 6.25mg was documented as not administered on 01/05/22 at 8:00am and 8:00pm because the drug was unavailable. -There was an entry for Carbidopa-Levodopa 25-100mg, take 1.5 tablets four times a day, scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Carbidopa-Levodopa 25-100mg was documented as not administered on 01/05/22 at 8:00pm because the drug was unavailable. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/06/21 at 10:12am revealed: -15 tablets of Trazodone 50mg were dispensed	D 358		

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on 12/17/21 and there was no active refill request by the facility on file.
-60 tablets of Coreg 6.25mg were dispensed on 12/13/21 for a one month-supply.
-90 tablets of Carbidopa-Levodopa 25-100mg were dispensed 12/13/21 for a 15-day supply and there was no active refill request by the facility currently on file.
-The facility was responsible for faxing a refill request to the pharmacy for medications that needed refill.

Interview with an MA on 01/05/22 at 9:44am revealed:
-MAs were responsible to reorder medications every shift and when they completed medication cart audits as needed.
-Medication cart audits used to be done by the MAs every week to ensure the carts were stocked with medications per resident's orders, expired and discontinued medications were removed, and the carts were cleaned and stocked with fresh supplies.
-Cart audits had not been done since September 2021 before the previous Administrator left, she did not know why.
-She was not sure who was responsible for ensuring cart audits were done and reviewing the documentation from the audits when the new administrator arrived.

Interview with an MA/Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed:
-She expected to have medications on hand as ordered for each resident because it had been ordered for a reason and was important to follow the PCP orders.
-The MAs were responsible to reorder medications each shift and perform medication cart audits weekly.

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D 358	Continued From page 75 -Medication cart audits were expected to be done 1-2 times per week by the MAs to ensure medications were on hand as ordered, there were no discontinued or expired medications on the cart, check supplies, restock/reorder supplies and medications as needed, and ensure the cart is clean and in good working order. -It was her, the supervisor's, and the Administrator's responsibility to oversee medication cart audits and ensure orders are processed accurately. -She was not sure when the last cart audit was done or reviewed but thought it had been overlooked recently. Interview with the facility's regional training nurse on 01/04/22 at 4:10pm revealed: -Medications were expected to be on the medication cart and available for administration to residents as ordered. -MAs were expected to perform medication cart audits weekly to ensure discontinued and expired medications were removed from the cart and that residents' ordered medications were available for administration. Interview with the Administrator on 01/04/22 at 4:10pm revealed: -Medications were expected to be on the medication cart and available for administration to residents as ordered. -MAs were expected to perform medication cart audits weekly to ensure discontinued and expired medications were removed from the cart and that residents' ordered medications were available for administration. -She oversaw the RCC who was responsible to oversee medication cart audits, but she was unsure when they were last completed.	D 358		

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D 358	Continued From page 76 Interview with Resident #1's primary care provider (PCP) on 01/06/22 at 11:20am revealed: -She expected Resident #1 to receive all his medications as ordered and for the facility to have the medications on hand for administration. -Resident #1 needed to have his Carbidopa-Levodopa to control his Parkinson's Disease symptoms and not having them consistently will create an exacerbation of symptoms causing an increased risk for falls. Request for medication cart audits on 01/04/22 at 3:08pm were not provided prior to survey exit. Refer to interview with the MA on 01/05/22 at 9:44am. Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm._____ Interview with the MA on 01/05/22 at 9:44am revealed: -She was taught to administer medications as ordered and compare the medication she was administering to the order on the resident's eMAR prior to administering to the resident. -She was taught to administer medications according to the six rights of medication (right patient, right medication, right dose, right route, right documentation). -Medication errors were supposed to be reported to the resident's primary care provider (PCP) and the Resident Care Coordinator (RCC) or Administrator per policy with a medication error report completed at that time in the resident record. Interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm revealed:	D 358		

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D 358	Continued From page 77 -MAs were expected to administer medications as ordered and within 1 hour before or after the medication was scheduled. -MAs were expected to administer medications per the six rights of medication (right patient, right medication, right dose, right time, right route, right documentation). -She was not aware that medications were not administered as ordered because it had not been reported to her. -It was concerning that medications had not been administered as ordered because residents could experience adverse side effects and possible interactions from receiving medications incorrectly. -Any time a medication was not administered as ordered, she expected the MA to report the medication error so that a medication error report could be completed per policy, and the resident's PCP could be notified for further orders. _____ The facility failed to ensure medications were administered as ordered for 2 of 4 residents observed during the medication pass and 1 of 5 sampled residents for record review. Resident #9 did not receive her Hydralazine medication and instead received HCTZ which put her at increased risk for heart attack and stroke, or her Aspirin as ordered. Resident #8 did not receive her Symbicort or Vitamin B-12 as ordered putting her at risk of the medication becoming ineffective and unstable Vitamin B-12 levels. Resident #3 did not receive medications used to control her blood sugars including Novolog insulin and Basaglar Kwikpen insulin, or Actos as ordered putting her at risk of unstable blood sugars to include hypo and hyperglycemia, shakiness, passing out, coma and death. Resident #1 did not receive his oxycodone-acetaminophen pain medication and acetaminophen fever reducer as	D 358		

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D 358	Continued From page 78 ordered, and his Trazodone, Coreg, and Carbidopa-Levodopa were not available for administration putting him at risk of exacerbation for symptoms, delirium, liver damage, and falls. The facility's failure to ensure medications were administered as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 01/06/22 for this violation.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed or scheduled times for 1 of 9 sampled residents observed (#10) on the assisted living (AL) side of the facility potentially putting residents at harm of adverse outcomes. The findings are: Review of the facility's Medication Management policy dated 07/2020 revealed:	D 364		

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-Medications must be administered within one hour before or one hour after the scheduled medication time as per to state rules and regulation regulation.
-Medication errors included incorrect orders, giving medications to the wrong resident, at the wrong time, via the wrong route, administering the wrong medication, giving expired medications, administering medications not prescribed, giving a medications after a discontinue order, omitting a dose, giving an extra dose, or giving an incorrect dose.
-Medication error reports were expected to be completed for every medication error and stored in the resident record and sent to the Divisional Nurse for review.

Review of Resident #10's current FL-2 dated 03/15/21 revealed the resident had diagnoses that included dementia, depression, hypertension, hyperlipidemia, hyperglycemia, and atrial fibrillation.

1.Review of Resident #10's physician's orders dated 08/30/21 revealed there was an order for Eliquis 5mg twice daily for atrial fibrillation (Eliquis helps prevent blood clots in the presence of atrial fibrillation).

Review of Resident #10's January 2022 electronic medication administration records (eMAR) revealed there was an entry for Eliquis 5mg twice daily at 8:00am and 8:00pm.

Observation of the 8:00am and 9:00am medication pass on 01/04/22 at 10:11am revealed the medication aide (MA) administered the Resident #10's 8:00am dose of Eliquis 5mg at that time.

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CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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
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Interview with the Resident #10's primary care provider on 01/06/22 at 11:19am revealed:
-Resident #10 was prescribed Eliquis to help treat an irregular heart rhythm and she expected the medication to be administered on time twice daily as ordered.
-Eliquis should be given on time every 12-hours because it had a short-half life.
-Not getting the Eliquis twice daily on time as ordered could put the resident at risk of heart attack or stroke.

Refer to interview with a medication aide (MA) on 01/05/22 at 9:44am.

Refer to interview with the Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm.

Refer to interview with the facility's regional training nurse on 01/04/22 at 4:10pm.

Refer to interview with the Administrator on 01/04/22 at 4:10pm.

Interview with Resident #3's primary care provider (PCP) on 01/06/22 at 11:19am.

2. Review of Resident #10's physician's orders dated 08/30/21 revealed there was an order for Flecainide 100mg twice daily.

Review of Resident #10's January 2022 electronic medication administration records revealed there was an entry for Flecainide 100mg twice daily at 8:00am and 8:00pm.

Observation of the 8:00am and 9:00am medication pass on 01/04/22 at 10:11am revealed the medication aide (MA) administered the Resident #10's 8:00am dose of Flecainide

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D 364	Continued From page 81 100mg at that time. Interview with the Resident #10's primary care provider on 01/06/22 at 11:19am revealed: -Resident #10 was prescribed Flecainide to help treat her high blood pressure and she expected the medication to be administered on time twice daily as ordered. -Flecainide should be given on time every 12-hours because it had a short-half life. -Not getting the Flecainide twice daily on time as ordered could put the resident at of high blood pressure and stroke. Refer to interview with a medication aide (MA) on 01/05/22 at 9:44am. Refer to interview with the Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm. Refer to interview with the facility's regional training nurse on 01/04/22 at 4:10pm. Refer to interview with the Administrator on 01/04/22 at 4:10pm. Interview with Resident #3's primary care provider (PCP) on 01/06/22 at 11:19am. _____ Interview with the MA on 01/05/22 at 9:44am revealed: -MAs were expected to administer medications as ordered within one hour before or after the time the medication was scheduled on the resident's electronic medication administration record (eMAR). -She did not usually administer morning medication and had worked 22 hours that shift (01/03/22 at 5:30pm to 01/04/22 at 3:00pm)	D 364		

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because the facility was short staffed.
-She did not know someone had called out for the next shift until the staff member never showed up, so she was late starting medication pass for the next shift on time.

Interview with an MA/Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed:
-Medications were expected to be administered to residents on time as ordered or withing one hour before or after the scheduled administration time for safety.
-It was especially important to administer extended release medications or medications that are given more than once daily on time to ensure resident safety and prevent a possible adverse reaction, adverse side-effects, or possible over-dose.
-If a medication was administered late, it should be documented on the MAR as being late and reported to her, the Administrator, the resident's family, Department of Social Services (DSS), and the Primary Care Provider (PCP) after completing a medication error report.
-The PCP was not notified, and a medication error report was not done because that was her responsibility and she had not been made aware.

Interview with the facility's regional training nurse on 01/04/22 at 4:10pm revealed:
-MAs were expected to administer medications as ordered and within 1 hour before or after the medication was scheduled.
-MAs were expected to administer medications per the six rights of medication (right patient, right medication, right dose, right time, right route, right documentation).
-She was not aware that medications were not administered on time that day because it had not been reported to her.

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D 364	Continued From page 83 -It was concerning that medications had not been administered on time because residents could experience adverse side effects and possible interactions from receiving medications incorrectly. -Receiving a medication late could cause too much of the medication to be in the resident's system if the next dose was given on time and should be reported to the resident's PCP. -Any time a medication was not administered as ordered, she expected the MA to report the medication error so that a medication error report could be completed, and the resident's PCP could be notified for further orders. Interview with the Administrator on 01/04/22 at 4:10pm revealed: -MAs were expected to administer medications as ordered and within 1 hour before or after the medication was scheduled. -MAs were expected to administer medications per the six rights of medication (right patient, right medication, right dose, right time, right route, right documentation). -She was not aware that medications were not administered as ordered that day because it had not been reported to her. -It was concerning that medications had not been administered as ordered because residents could experience adverse side effects and possible interactions from receiving medications incorrectly. -Receiving a medication late could cause too much of the medication to be in the resident's system if the next dose was given on time and should be reported to the resident's PCP. -Any time a medication was not administered as ordered, she expected the MA to report the medication error so that a medication error report could be completed, and the resident's PCP could	D 364		

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D 364	Continued From page 84 be notified for further guidance. Interview with Resident #10 and Resident #3's PCP on 01/06/22 at 11:19am revealed she expected medications to be administered on time as ordered no more than one hour before or after the scheduled administration time.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 2 of 4 residents (#8, #9) observed	D 367		

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during the morning medication pass including errors involving medications used for blood pressure and fluid retention (#9), and an inhaler and vitamin supplement (#8); and for 1 of 5 sampled residents for record review including errors involving late medication administration (#3).

1. Review of Resident #9's current FL-2 dated 03/15/21 revealed:
-Diagnoses included dementia, hypertension, atrial fibrillation, and congestive heart failure.
-There was an order for Hydralazine 50mg, take one tablet twice daily (Hydralazine is used to treat high blood pressure).

Review of Resident #9's physician's orders dated 08/26/21 revealed:
-There was an order for Hydrochlorothiazide (HCTZ) 12.5mg once daily (HCTZ is used to treat high blood pressure and fluid retention).
-There was an order for Hydralazine 50mg four times daily.

Review of a physician's order for Resident #9 dated 08/30/21 revealed:
-There was an order to discontinue the Hydralazine 50mg four times daily.
-There was an order to start Hydralazine 50mg twice daily.

Review of a physician's progress note for Resident #9 dated 10/05/21 revealed an order to discontinue the HCTZ on 10/12/21.

Observation of the 8:00am and 9:00am medication pass on 01/04/22 revealed:
-HCTZ 12.5mg was administered to the resident at 9:56am.
-Hydralazine 50mg was not administered or

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offered to Resident #9 when she received her other morning medications at 9:56am from the medication aide (MA).

Review of Resident #9's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Hydralazine 50mg with instructions to take one tablet twice a day, scheduled for administration at 9:00am and 9:00pm.
-Hydralazine 50mg was documented as administered on 01/04/22 at 9:00am.
-HCTZ was not documented as administered on 01/04/22.

Refer to interview with the MA on 01/05/22 at 9:44am.

Refer to interview with the facility's Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm.

Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am.

2. Review of Resident #8's current FL-2 dated 03/08/21 revealed diagnoses included senile debility (dementia), hypertension, and weight loss.

Review of Resident #8's physician's orders dated 08/26/21 revealed and order for Symbicort inhaler, 2 puffs twice daily, rinse mouth after use (Symbicort is used to treat Asthma and COPD).

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Observation of the 8:00am and 9:00am medication pass on 01/04/22 revealed the Symbicort inhaler was new out of the package and four puffs were administered to Resident #8 at 9:33am; the medication aide (MA) did not prime the inhaler before use and administered 2 extra puffs when the resident stated she could not feel the medication going in.

Review of Resident #8's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort inhaler, 2 puffs twice daily, rinse mouth after use, scheduled for administration at 9:00am and 9:00pm.
- Symbicort inhaler, 2 puffs, was documented as administered on 01/04/22 at 9:00am instead of 4 puffs as observed.

Refer to interview with the MA on 01/05/22 at 9:44am.

Refer to interview with the facility's Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm.

Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am.

3. Review of Resident #8's current FL-2 dated 03/08/21 revealed diagnoses included senile debility (dementia), hypertension, and weight loss.

Review of Resident #8's physician's orders dated 08/26/21 revealed and order for Vitamin B-12

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500mcg, take one tab every Monday, Wednesday, and Friday.

Observation of the 8:00am and 9:00am medication pass on 01/04/22 (a Tuesday) revealed:
-The MA administered the pre-filled bubble pack of pills dated 01/05/22 at 9:30am.
-There was a Vitamin B-12 listed the bubble pack dated 01/05/22 that was administered to Resident #8.
-There was not a Vitamin B-12 listed on the bubble pack dated 01/04/22 that was supposed to be administered to Resident #8, but she had wasted those pills when she accidentally dropped them in the trash.

Review of Resident #8's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin B-12 500mcg, take on tablet every Monday, Wednesday, and Friday.
-Vitamin B-12 500mcg was not documented as administered on Tuesday, 01/04/22, at 9:30am as observed.

Refer to interview with the MA on 01/05/22 at 9:44am.

Refer to interview with the facility's Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm.

Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am.

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D 367	Continued From page 89 4. Review of Resident #3's current FL-2 dated 10/19/21 revealed: -Diagnoses of hypertension, chronic pancreatitis, diabetes type 2, gastroesophageal reflux disease (GERD), hyperthyroidism, chronic obstructive pulmonary disease (COPD), chronic kidney disease stage III, and pernicious anemia. -She was ambulatory and intermittently disoriented. Interview with Resident #3 on 01/04/2022 at 9:30am revealed: -She usually received her morning medications around 7:00 or 8:00 am. -The resident had not received any morning medications yet that day. Observation of Resident #3 on 01/04/22 at 10:30am revealed: -The resident walked to medication cart to receive her morning medications that she had not been administered yet that day. -The medication aide (MA) administered Resident #3 her morning medications. Interview with Resident #3 on 01/05/22 at 8:45am revealed: -The MA was not there to administer her medications that day and she had not received her morning medications yet. -She normally received her morning medications between 7:30am and 8:00am. -Yesterday (01/04/22) she did not receive her morning medications until almost 11:00am. -The facility was short staffed and late medication administration was an issue since the short staffing had begun. Review of Resident #3's January 2022 electronic	D 367		

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medication administration records (eMARs) revealed:
-She had 3 daily medications due each morning at 8:00am; Glimepiride 4mg twice daily (used to control blood sugars), Clonazepam 0.5mg twice daily (used to treat anxiety), and Oxycodone 5mg four times daily (narcotic used to treat pain).
-She had 1 daily medication due each morning at 8:30am; Novolog 5 units three times daily with meals (insulin used to control blood sugar).
-She had 6 daily medications due each morning at 9:00am; Actos 15mg daily (used to control blood sugars), Tylenol 325mg three times daily (used to treat pain), Aspirin 81mg daily (used as a blood thinner), Buspirone 15mg three times daily (used to treat anxiety), Clonidine 0.2mg twice daily (used to treat anxiety), Duloxetine 30mg daily (used to treat depression).
-Resident #3's medications had been documented as administered on time on 01/04/22.
-There was no documentation of any medications being administered more than one hour after the scheduled administration time.

Refer to interview with the MA on 01/05/22 at 9:44am.

Refer to interview with the facility's Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm.

Refer to interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am.

_____
Interview with a medication aide (MA) on

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01/05/21 at 9:44am revealed:
-MAs were taught to administer medications accurately as ordered according to the six rights of medication (right resident, right medication, right time, right dose, right route, and right documentation).
-She was taught to accurately document medication administration on the eMAR and was expected to do so immediately after administered any medication.
-It was important for resident safety that eMARs were accurate for safe medication administration.

Interview with the Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed:
-Medications were expected to be administered to residents on time as ordered or withing one hour before or after the scheduled administration time for safety.
-MAs were expected to document medication administration accurately on the MAR for the time the medication was administered.
-If a medication was administered late, it should be documented on the MAR as being late and reported to her, the Administrator, the resident's family, Department of Social Services (DSS), and the Primary Care Provider (PCP) after completing a medication error report.
-She was not sure how medications had been documented inaccurately on the eMAR during medication pass and it was not reported to her that medications were administered late that day.

Interview with the facility's regional training nurse and Administrator on 01/04/21 at 4:10pm revealed:
-MAs were expected to administer medications as ordered and within 1 hour before or after the medication is scheduled on the resident's eMAR.
-She expected MAs to document on the eMAR

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D 367	Continued From page 92 accurately and to report medication errors immediately for the safety of the residents. Telephone interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am revealed: -She expected residents to have their medications administered and documented accurately as ordered. -It was important for accurate documentation of medication administration in order to assess, evaluate, and treat residents appropriately and safely.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented per facility policy and procedure during the morning medication pass on 01/04/22 by a medication aides (MAs) observed on the Assisted Living (AL) unit and the Special Care Unit (SCU) who administered medication using expired applesauce, did not perform hand hygiene, and used contaminated and dirty equipment without cleaning it. The findings are:	D 371		

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D 371	Continued From page 93 Review of the facility's Infectious Disease Control and Infection Control policy dated 09/2001 revealed: -Hand hygiene was expected to be used by all staff upon arrival to work and ongoing as instructed: when hands were visibly dirty, before, between, and after resident care, before donning and doffing gloves, and after touching any dirty items. -Staff will clean and decontaminate all surfaces that come into contact with bodily fluids as soon as possible. -Staff will clean contaminated equipment as soon as possible. 1. Observation of the 8:00am and 9:00am medication pass on the AL COVID-19 unit on 01/04/22 revealed: -The medication aide (MA) performed hand hygiene and prepped a resident's medication for administration at 9:53am mixing the pills in a plastic medication cup with approximately 2 ounces applesauce that was dated as being opened on 01/03/22 at 7:00am with no resident name on the label. -The MA administered the applesauce with the medication to the resident at 9:56am using a spoon. -The resident spit one of the pills out and the MA mixed the pill in with the remaining applesauce and re-fed the applesauce with the pill in it to the resident. -The resident consumed all the applesauce. Interview with the MA on 01/05/21 at 9:44am revealed: -She was expected to use a new and unopened applesauce for each resident for medication administration.	D 371		

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D 371	Continued From page 94 -It was concerning that she used expired applesauce in which she did not know what resident it had previously used for to administer medications during the observation of medication pass. -She should have paid closer attention to what she was doing because it could have made the resident ill. Interview with an MA/Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed: -Applesauce used during medication pass to mix with crushed or whole pills should be thrown away after each use and the MA should never turn their back or walk away from the applesauce. -Applesauce should not be used after 4 hours of opening, should be dated, labeled, and timed with the resident's name it was intended for and should never be left out overnight and used after 4-hours. -Expired applesauce after being open for 4 hours should not be used to administer medication because food contamination safety was important, and it could make the resident sick or have pathogens in it, especially on the COVID-19 unit. Interview with the facility's regional training nurse and Administrator on 01/04/22 at 4:10pm revealed: -Applesauce used during medication pass to mix with medications should be single use and resident specific. -Applesauce should be labeled when opened with the resident's name, date, and time opened then thrown away after 4 hours. -The MA should not have used the applesauce for medication pass that had been opened for more than 4 hours and should have thrown it away. -It was concerning that the MA used expired	D 371		

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applesauce on the COVID-19 unit that did not have a resident's name labeled on it because of the safety risk of infection and contamination of the resident.

Interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am revealed:
-It was concerning that a resident had been feed applesauce that had been opened over 24 hours prior.
-She expected resident's to not be fed expired applesauce that had been open longer than 4-8 hours due to the risk of contamination and transfer of pathogens, especially since she was on the COVID-19 unit.

Refer to interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am

2. Observation of the 8:00am and 9:00am medication pass on the non COVID-19 AL unit on 01/04/22 revealed:
-The medication aide (MA) performed hand hygiene and removed a resident's finger stick blood sugar (FSBS) glucometer (device to measure blood sugar) from the medication cart with the associated supplies needed and entered the resident's room at 8:54am.
-The glucometer had an unknown red substance contaminating the device.
-The MA donned gloves, pricked the resident's finger with a lancet, and used a glucometer to collect a blood sample to measure her FSBS at 8:55am; she did not clean the glucometer or the unknown red substance off of the device prior to use.
-The MA exited the resident's room, performed hand hygiene, and returned the resident's FSBS

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glucometer to the medication cart without cleaning or disinfecting the device after use.

Interview with the MA on 01/05/21 at 9:44am revealed:
-She was trained to clean the FSBS glucometer before and after each use and when visibly contaminated.
-She should have cleaned the FSBS glucometer before and after use during the medication observation, but she was tired and nervous and must have forgotten.
-It was important to clean resident equipment to prevent contamination and the spread of germs.

Interview with an MA/Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed:
-She had been at the facility for 2 months and just finished her training as the RCC.
-FSBS glucometer monitors were to be deep cleaned once per week when the MAs did medication cart audits and cleaned before and after each use.
-It was important for staff to clean FSBS glucometer machines before and after each to maintain infection control and prevent the spread of pathogens to staff or residents.
-Not keeping a FSBS glucometer clean could also cause inaccurate FSBS results.
-She expected the MAs to deep clean FSBS glucometers weekly and clean them before and after each use as they were trained upon hire and every six months thereafter.

Interview with the facility's regional training nurse and Administrator on 01/04/21 at 4:10pm revealed:
-MAs were trained upon hire and quarterly thereafter to clean FSBS glucometers before and after every use and anytime the glucometer is

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visibly soiled.
-She expected staff to clean FSBS glucometers as trained per the facility procedure.
-It was concerning that the MA did not clean the resident's glucometer when visibly soiled or before and after use because it put the resident's safety at risk for contamination and infection.

Interview with resident's primary care provider (PCP) on 01/06/22 at 11:19am revealed:
-She expected the facility to clean resident's FSBS glucometers before and after use and anytime there was visible contamination.
-It was concerning that the FSBS glucometer had been used with visual contamination and without proper cleaning and sanitation due to the risk of contamination and transfer of pathogens that could harm the resident.

Refer to interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am

3. Observation of the 8:00am medication pass on the SCU unit on 01/04/22 revealed:
-The medication aide (MA) entered the SCU and approached the medication cart at 8:15am logging into her computer and pulling up resident electronic medication administration records (eMARs).
-The MA did not perform hand hygiene began preparing medications into a plastic medication cup for administration for a resident from the medication cart at 8:20am.
-The MA poured several pills from the medication cup into a plastic bag and crushed the pills and emptied them back into the medication cup at 8:26am.
-The MA donned gloves at 8:27am and opened a capsule into the medication cup.

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-The MA doffed gloves at 8:28am and mixed a heaping spoonful of applesauce into the medication cup with the medication.
-The MA administered the medications to the resident at 8:30am the returned to the medication care and documented the medication administration in her computer by 8:34am.
-The MA then administered a supplement shake to the resident at 8:38am.
-The MA did not perform hand hygiene during the entire observation and began prepping another resident's medication at 8:40am.

Interview with the MA on 01/05/22 at 7:25am revealed:
-She was trained to use hand sanitizer before and after interaction with each resident and to wash her hands with soap and water after every three residents or when visibly soiled.
-It was her normal process to perform hand hygiene before and after administering medications to each resident, but she was nervous about being observed and forgot.
-She was usually very careful to perform hand hygiene as she was trained, especially since the COVID-19 pandemic had begun to prevent contamination and transfer of pathogens that could cause infection.
-Sometimes it was hard to perform hand hygiene while working in the SCU because the residents required a lot of attention and sometimes tried to grab her, but she was expected to perform hand hygiene before and after interaction of each resident.

Interview with a MA/Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed:
-She expected staff to perform hand hygiene before and after administration of medications or any interaction between residents to ensure

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safety and prevent contamination and spread of pathogens that might make the residents sick.
-She expected staff to wash their hands with soap and water anytime there was visible contamination on their hands.
-It was concerning that a MA did not wash her hands between residents during medication administration especially because there was a COVID-19 outbreak currently within the facility.

Interview with the facility's regional training nurse and Administrator on 01/04/21 at 4:10pm revealed:
-Staff had been taught upon hire and quarterly thereafter to perform hand hygiene with hand sanitizer before and after each medication pass and interaction with each resident.
-Staff were expected to wash hands with soap and water when hands were visibly soiled or after interaction with every three residents despite hand sanitizer use.
-It was important to perform hand hygiene as appropriate to protect the residents and staff from the risk of contamination and infection.

Interview with the facility's contracted primary care provider (PCP) 01/06/22 at 11:19am revealed:
-She expected the facility staff to perform hand hygiene per the facility policy and at between interaction of each resident.
-It was concerning that the MA did not perform hand hygiene before and after medication administration due to the risk of transfer of pathogens or contamination to the residents.

4. Observation of the 9:00am medication pass on the AL COVID-19 unit on 01/04/22 revealed:
-The medication aide removed the medication cart from a room at the end of the hall and parked

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it in the hallway outside of resident rooms at 9:05am.
-The medication cart had an unknown brown substance splattered along the bottom half of the right side and around the corner toward the front of the cart near the medication drawers.
-The MA proceeded to prepare and administer medications, donning and doffing PPE and using hand hygiene in and out of three COVID-19 positive resident rooms from 9:20am to 10:13am, pulling medications from all drawers within the medication cart.
-The MA never cleaned the substance from the medication cart or disinfected her workspace on the medication after preparing and administer three COVID-19 positive residents' medication during the observation.

Interview with the MA on 01/05/21 at 9:44am revealed:
-She was trained to clean the medication cart before and after each use, to deep clean the medication cart weekly when performing medication cart audits, and to clean equipment anytime visibly contaminated.
-She should have cleaned the medication cart before and after use during the medication observation, and her workspace in between administering COVID-19 residents' medication, but she was tired and nervous and must have forgotten.
-It was important to clean resident equipment to prevent contamination and the spread of germs.

Interview with an MA/Resident Care Coordinator (RCC) on 01/04/22 at 3:08pm revealed:
-She was not sure how long the medication cart had been contaminated and dirty but thought it had happened within the last 1-2 weeks when a resident had fallen, and pudding had been spilled

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D 371	Continued From page 101 on it. -She expected staff to have cleaned the obvious mess on the cart at the time it became contaminated, and to deep clean the cart during medication cart audits. -Medication cart audits were expected to be done 1-2 times per week by the MAs to ensure medications were on hand as ordered, there were no discontinued or expired medications on the cart, and to check supplies, restock/reorder as needed, and ensure the cart was clean and in good working order. -It was important to keep the medication cart clean to prevent contamination of resident's medications and ensure safe medication administration. Interview with the facility's regional training nurse and Administrator on 01/04/21 at 4:10pm revealed: -The MAs were expected to clean the medication cart each shift and any time visibly contaminated. -It was concerning that the medication cart was dirty and contaminated because it put the residents who received medication at risk for contamination and infection. Refer to interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am. _____ Interview with the facility's contracted primary care provider (PCP) on 01/06/22 at 11:19am revealed: -She expected the facility to ensure equipment was cleaned on a regular basis thoroughly. -It was important to keep surfaces and equipment clean to prevent contamination and the transfer of pathogens to the staff and residents that could cause illness and adverse outcomes.	D 371		

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D 371	Continued From page 102 -It was especially concerning that there were issues with the facility performing infection control duties while there was a COVID-19 outbreak active within the facility as it may have contributed to the outbreak. -It was also concerning that there were several residents on the AL and SCU unit who wandered and could get into things that were expired or not properly cleaned by the facility which risked the resident's safety.	D 371		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, and record reviews, the facility failed to ensure all residents were treated with respect and dignity related to staff behavior towards 4 residents and related to meal service when residents were not provided tables for in-room dining after stopping communal dining. The findings are: 1. Staff G, a personal care aide (PCA), was hired at the facility on 08/28/18. Confidential interview with a staff member on 01/05/22 at 9:09am revealed: -She observed a Staff G "bully and fuss" at a resident on the SCU one time.	D911		

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D911	Continued From page 103 -She observed Staff G warn the resident that she would "get in trouble if she did not act right" when her new roommate arrived. -She observed Staff G standing over the resident with her finger in face, speaking to the resident in a loud voice that she "better treat her new roommate right" or she would make Staff G mad. -When the Staff G exited the resident's room the resident began crying. -She had observed a medication aide (MA) that used to work on the SCU but currently worked on the Assisted Living (AL) unit place all SCU residents in the television lounge and lock the door. -The MA was in the television lounge with the residents' but wanted to keep them from wandering. -She had observed the same MA use profanity toward residents on the SCU one time. -She met with the Administrator one time several months ago to discuss her concerns about the abuse she had observed. -She was afraid she was in trouble for sharing the information with the Administrator because to her knowledge nothing was ever done to correct the staff's behavior. -Since meeting with the Administrator to report her concerns she was afraid to report any abuse concerns her for fear of retaliation of reduced working hours or getting fired. -She now reported her concerns from observations of abuse to a department head. Confidential interview with a staff member on 01/05/22 at 9:36am revealed: -She had observed Staff G in a resident's room on the SCU cursing and yelling at the resident; Staff G threw items around the resident's room. Telephone interview with the Activity Director on	D911		

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D911	Continued From page 104 01/05/21 at 8:00am revealed: -She had witnessed Staff G use aggressive, loud and disrespectful verbal tones with residents. -She took her concerns to the Administrator about what she witnessed in the beginning of December 2021 and was told "that is how residents were talked to in facilities like this one". -Multiple residents came to her with reports that the disrespectful behavior towards them was worse when she was not in the facility. Second interview with the Activity Director on 01/06/21 at 11:30am revealed: -Residents reported to her that they were not comfortable bringing complaints to the Administrator and Resident Care Coordinator (RCC) because they were fearful that they would be treated negatively by the staff. -Department Managers were "scolded" by the Administrator via electronic communication telling them to "stay in their lane" when bringing concerns to the Administrator about staff's disrespect, lack of dignity and consideration towards residents. -The Administrator signed acknowledgment of receiving copies of the Resident Council minutes were residents expressed concerns about Staff G returning to the facility in December of 2021. Confidential interview with a staff member on 01/05/22 at 10:15am revealed: -She witnessed Staff G use disrespectful and demeaning tones with residents within the last month. -She previously reported Staff G's behavior to the Administrator and nothing was done by the Administrator. -When she reported the disrespectful behavior of Staff G to the Administrator, she was punished by not being allowed to visit with residents in the	D911		

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office or participate in activities with the resident like she was previously allowed to.
-She was concerned that the residents would be punished if she continued to report the verbal aggression towards residents by Staff G.

Confidential interview with a second staff member on 01/05/22 at 10:50am revealed:
-When she left her office door open she would hear Staff G be demeaning and disrespectful to residents, rushing them and being impatient with them.
-She brought concerns about Staff G's disrespectful behavior towards residents to the Administrator in December of 2021 and she did not feel like she was taken seriously.
-The Administrator undermined her because she was not clinical, but she knew how residents should be treated with dignity and respect and Staff G was not doing that.

Interview with Staff G on 01/05/21 at 12:30pm:
-She received training from another facility about working with elderly residents and dementia residents.
-She was familiar with using soft tones with residents and allowing them to time to complete tasks, so they did not feel rushed.
-She started working at the facility in 2018 and worked both the assisted living (AL) and SCU side.

Interview with the Administrator on 01/05/22 revealed:
-She never had any staff, family or residents bring concerns of disrespect, lack of dignity or consideration by any staff to her attention.
-She was not aware that any residents were spoken to in a degrading or demeaning manor.
-She conducted an internal investigation after

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allegations were brought against Staff G in November 2021 but she unsubstantiated the allegations through interviews with the mentioned resident.

Based on observations and record reviews, the mentioned resident was not interviewable.

a. Review of Resident #7's current FL-2 dated 03/08/21 revealed:
-Diagnoses include unspecified osteoarthritis, dorsalgia, and feeding difficulties.
-Personal care assistance included bathing, feeding, and dressing assistance.

Review of Resident #7's care plan dated 03/08/21 revealed:
-Resident required assistance with activities of daily living.
-Resident required "safe-guard plate" while eating due to tremors.
-Resident required extensive assistance for toileting, ambulation, bathing, dressing, grooming and transferring.

Interview with Resident #7's primary care provider on 01/06/22 at 11:20am revealed Resident #7 was clear in her ability to express her needs and she would trust what she was saying in relation to events that happened to her.

Interview with Resident #7 on 01/05/22 at 10:00am revealed:
-She had been threatened by Staff G that if she ever reported being scared of her to management or other staff that she would give her a cold shower.
-She required specialty utensils for eating assistance due to hand contractors and Staff G threatened to hide her utensils so she was not

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able to eat.
-It made her feel "like less of a human" when Staff G would be impatient with her.
-She was embarrassed having to ask staff for assistance and when she was treated poorly she was afraid to ask for help.

b. Review of Resident #6's current FL-2 dated 11/24/21 revealed diagnoses included anemia, Non-Hodgkin lymphoma, and muscle weakness.

Review of Resident #6's care plan dated 12/14/21 revealed:
-She was oriented.
-She required total assistance from staff for toileting, ambulation, bathing, dressing, grooming, and transferring.

Telephone interview with Resident #6 contracted physical therapist on 01/05/22 at 5:08pm revealed:
-She visited the resident first at the facility on 12/15/21 when the resident told her that she felt like a burden to the staff because of the way they were frustrated with her needs.
-She visited the resident on 12/20/21 where she was told by the resident that the staff was mean to her and degraded her for asking for assistance with her activities of daily living.
-The resident was tearful during both therapy visits when speaking of the staff's treatment.
-She reported the staff's disrespectful and demeaning treatment of the resident to the previous lead medication aide on 12/20/21.

Telephone interview with Resident #6 family member on 01/05/22 at 8:20am revealed she would receive tearful phone calls from the resident reporting feeling sad because staff was impatient with her when it took a while for her to

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D911	Continued From page 108 complete tasks. Telephone interview with Resident #6's primary care provider on 01/06/22 at 11:20am revealed Resident #6 was oriented and clear in her ability to express her needs and she would trust what she was saying in relation to events that happened to her. Interview with Resident #6 on 01/05/22 at 9:20am revealed: -She was starting to feel depressed because she felt belittled when she would have to ask for help. -It was demeaning to be told that she was too much trouble and it was embarrassing to be told that the facility was not equipped to handle her. -She did not want to disclose which staff members were disrespectful and uncompassionate because she was dependent on them for assistance and was fearful that they would be even more angry with her. -She attempted to call the Administrator via telephone last week at the facility to express concerns about staff's disrespectful behavior but she was not able to get anyone to answer the telephone. -She never saw the Administrator since she was admitted to the facility. c. Review of Resident #3's current FL-2 dated 10/19/21 revealed: -She had diagnoses of hypertension, chronic pancreatitis, diabetes type 2, gastroesophageal reflux disease (GERD), hyperthyroidism, chronic obstructive pulmonary disease (COPD), chronic kidney disease stage III, and pernicious anemia. -She was intermittently disoriented, was on a regular diet, and had an order for a supplement once daily.	D911		

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D911	Continued From page 109 Interview with Resident #3 on 01/05/22 at 10:22am and 3:30pm revealed: -She frequently relied on the facility transporter (Staff H) to take her to her scheduled doctor's appointments but was generally uncomfortable having to ride with the Staff H because she could be extremely verbally aggressive by raising her voice and using a condescending tone. -There were several instances when they went through a drive through after an appointment and she felt belittled, talked down to, and berated by Staff H for ordering the food items she wanted and was told that what she wanted was too much money in a negative tone. -In another instance, another staff member (Staff I) witnessed Staff H yelling at her accusing her of having a negative tone of voice, attitude, and something against her, she was confused on why Staff H felt that way because she had never acted that way toward her, the other staff member walked away and ignored the situation; she had never felt so belittled or spoken down to in that manner before. -Another instance involved letting Staff H know she was going to be late for an appointment because they were given a wrong address to travel to for the appointment, when she requested to reschedule the appointment, Staff H belittled and yelled at her telling her not to question her again. -Staff H spoke down to her when she asked her to open the door so she could sit outside and Staff H responded in a snide and rude tone. -She felt like Staff H constantly spoke negatively to her and she was always "walking on eggshells" around her. -She and other residents also did not receive any privacy when discussing money or their bills with the Business Office Manager (BOM) which made her uncomfortable and humiliated.	D911		

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D911	Continued From page 110 -Any time she would go to the Administrator's office to report concerns, the Administrator would bring 3-4 employees in the room with them as "witnesses" which made her uncomfortable. -She didn't feel like she complained very often and always tried to help out around the facility with things like cleaning, serving coffee, and decorating. -Any time staff spoke down to her it made her feel less than respected, sub-human, and confused because she never understood what she did to deserve that treatment. -At this time, the conversations with Staff H, Staff I, and the Administrator had left her feeling targeted, bullied, and discouraged and she did not feel like any of her concerns have been taken seriously. Telephone interview with Resident #3's limited guardian on 01/06/21 at 8:33am revealed: -Resident #3 was going to be motioning to the court to become her own guardian again because she had become well-controlled with her medications, had a lot of moments of wellness, and was very stable. -Resident #3 was very involved at the facility and the other residents and knew a lot about everyone's concerns. -She frequently tried to help the other residents as she was mostly independent and did not need a lot of assistance for herself. -The resident had expressed some concerns and conflict about the facility to her. -She had previous wards at the facility before Resident #3's admission with issues and concerns in which she ultimately had to move them to another facility. -Lack of communication from the facility had been her biggest concern over the last year and she routinely had difficulty getting someone at the	D911		

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facility to answer the phone when she called.
-Due to previous issues and concerns at the facility, she was careful to bring her current resident's concerns to a regional representative who would take the concerns to the facility in an anonymous fashion and indirect way because she was afraid of retaliation from the facility against her residents and their safety if the facility knew the residents had complained.
-She was also recently concerned about retaliation because of an incident that happened in Spring of 2021 when Resident #3 told her she was self-administering her own medications even though she had not been assessed to and had not received an order from her provider to self-administer.
-She called the facility with her concerns of self-administration of medications and shortly thereafter, Resident #3's family called and reported the facility yelled at Resident #3 for not keeping the self-administration a secret.
-Many of her residents that she was guardian of at the facility were afraid of retaliation when they expressed concerns and knew to "tread lightly".
-The facility had a lot of staff turn-over and had experienced several interactions in which staff had been unprofessional with her.

Interview with Staff H on 01/06/22 at 3:23pm revealed:
-Resident #3 had recently filed a complaint on her and alleged that when she transported the resident to her medical appointments, she mistreated her.
-She never yelled, talked down to, or verbally abused Resident #3 as she was accused of doing.
-After taking Resident #3 through a drive through one day when she missed lunch, they had a misunderstanding about a milkshake and asked

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the resident not to take advantage of her when she offered to buy the resident a sandwich and not to ask for the milkshake; the resident assumed she was able to order what she wanted.
-After the drive-through incident, Resident #3 would ask her what she was going to order before ordering something for herself on future drive-through visits.
-On a subsequent visit through a drive through, she had another incident with Resident #3 that became "loud" due to a misunderstanding in what the resident wanted to order.
-Shortly thereafter, the Administrator and Supervisor instructed her to not take Resident #3 through any more drive throughs because she had diabetes.
-Another time she was driving Resident #3 to an appointment, they had been given the wrong address and were late to the appointment.
-Resident #3 was became upset and was worried the doctor's office was going to cancel her appointment because they were late.
-After this incident, the Administrator stated some concerns Resident #3 had in being afraid of her and upset with the way she treated and spoke to her.
-She was confused because she felt like she did not do anything unjust toward Resident #3.
-She and Resident #3 had previous conversations in which they had different points of view, but she perceived the interactions to be respectful.
-She refused to sign the allegation sheet and documentation of the discussion with the Administrator after their conversation.
-Prior to these incidents, she thought she had a good relationship with Resident #3 but the resident was distant toward her now and might feel like she could not trust her anymore.
-She felt that way toward Resident #3 but their

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relationship was purely business so she had not tried to discuss the issues directly with the resident and just gave her space instead.
-She felt like Resident #3 was influenced by the Administrator and the Supervisor to accuse her of those accusations because the Administrator and Supervisor were trying to retaliate against her for refusing to write a statement of defense for a PCA who had been accused of abusing another resident.

Telephone interview with Resident #3's primary care provider (PCP) on 01/06/22 at 11:19am revealed:
-She expected all residents to be treated with dignity and respect.
-Resident #3 was alert, oriented, and trustworthy in what she said but she was not aware of the resident's concerns regarding retaliation.
-It was concerning that the residents reported lack of dignity, respect and fear of retaliations and the behavior should not be tolerated.

d. Confidential interview with a resident on 01/05/22 at 7:45am revealed:
-Staff G was often frustrated with her when she was not able to make it to the restroom in time and had an accident.
-Staff G came into the room, threw her hands up and said "uh not again" in a loud voice.
-She tried to do all of her own care but sometimes needed help and was saddened that staff was frustrated with her.

Interview with the Area Director of Operations on 01/06/22 at 3:40pm revealed:
-There was no organization in the facility under the current leadership.
-The Administrator had created division among the staff which created a difficult environment for

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staff to feel comfortable reporting concerns when residents did not receive the appropriate treatment with respect and dignity, care, and services.

Second interview with the Area Director of Operations on 01/06/22 at 4:18pm revealed:
-Residents and staff should not be afraid to share their concerns with the Administrator.
-The Administrator had relied on staff that were part of the problem in the facility and the staff that were not treating residents correctly were leading the Administrator and the Administrator was following staff instead of leading them.
-The Administrator and some of the staff had neglected the residents and had not provided appropriate and respectful services.
-The problem was systemic throughout the building and it was from the poor leadership.

Interview with the Administrator on 01/06/22 at 2:44pm revealed:
-She made rounds in the facility each morning to talk with residents and staff to see if they had any concerns.
-She was available for residents and staff 24 hours a day and worked to ensure anyone could speak with her about any concerns.
-She had taken corrective action with staff when it was necessary to ensure residents were treated properly.
-When a resident had a concern that they brought to her attention she did not "just blow it off".
-She listened to the resident, addressed the concern with the staff and took corrective action as needed.
-She did not provide residents with the specific correction action taken but would inform them that the issue had been addressed.
-When she had a family member express a

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concern of how a resident was treated she also addressed the concern with the staff, took corrective action as needed and followed up with the family to let them know the issue had been addressed with staff.

2. Observation of two residents in room #101 on 01/04/22 at 1:24pm revealed:
-Both residents were laying on their beds.
-The only furniture in the room were the two beds, two wheelchairs, and a table lamp that was sitting on the floor.
-The residents' lunch meal plates and drinks were sitting on the seats of the chairs.
-There were cups sitting on the windowsill, not within reach of the resident.

Interview with a resident in room #101 on 01/04/22 at 1:25pm revealed:
-Both residents were moved to this room yesterday morning because they tested positive for COVID-19.
-She had to sit on the side of her bed and eat her lunch off the seat of her wheelchair which she did not feel was sanitary.
-There was no television in the room and she normally watched television throughout the day.
-She was sad and depressed because she did not have her television.

Observation of two residents in room #102 on 01/04/22 at 1:32pm revealed:
-One resident was sitting in a chair next to his bed and the other resident was laying in bed.
-There were two beds, two dressers and one chair in the room.
-There was a meal container sitting on the ground next to the residents' bed.
-There was a meal container sitting on the corner of a dresser that had a television.

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D911	Continued From page 116 Interview with a resident in room #102 on 01/04/22 at 1:34pm revealed: -He was moved to this room two days ago when he tested positive for COVID-19. -He pulled up his chair to the dresser to eat his meals. -He thought it would be "nice" to have a table that he could place his lunch plate and his drinks on while eating. Interview with a second resident in room #102 on 01/04/22 at 1:36pm revealed: -He would eat his meals sitting on the side of his bed, balancing his container on his knees. -He tried not to spill, but there were times when he was not able to do so. -He would like a bedside table or somewhere to be able to sit things within reach of his bed. Observation of two residents in room #107 on 01/04/22 at 1:39pm revealed: -There were two residents in wheelchairs in the room. -There were two beds and two bedside tables with drawers. -There were meal containers sitting on top of the bedside tables. Interview with one of the residents in room #107 on 01/04/22 at 1:40pm revealed: -She ate her meals twisted sideways in her wheelchair because she could not push under the bedside table where she was expected to eat. -She was moved to this room two days ago because she tested positive for COVID-19. -She wanted to have her television in her room because there was nothing for them to do in there but "lay around" and it was depressing. -She was embarrassed about dropping food	D911		

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D911	Continued From page 117 items when she was trying to eat sideways so she would try and "juggle" some meals on her lap. Interview with the Resident Care Coordinator (RCC) on 01/04/22 at 1:42pm revealed: -They were working on getting more furniture into the residents' rooms that were moved on the COVID-19 hall that were not normally residents on that hallway. -They had to sanitize items such as resident's televisions before they could bring them into their temporary rooms. -The clinical staff at the facility were responsible for relocating any essential items to the resident's rooms. Interview with the Administrator on 01/04/22 at 1:45pm revealed: -She could not recall when communal dining stopped on the assisted living (AL) side but they started moving COVID-19 residents to the 100 hallway about 3 or 4 days ago. -She was not aware that residents on the COVID-19 hallway did not have bedside tables and dressers in some of the rooms. -She could not provide residents with an over the bed table to eat because those were dedicated to residents on hospice. -She was aware that residents would have a difficult time balancing their meal containers on their laps. -She was aware that there were issues with having residents eat meals from their wheelchair and not provide an alternative option. -She was focusing on just moving the "essential" items with the residents. Telephone interview with the facility's contracted primary care provider (PCP) on 01/06/21 at 11:20am revealed:	D911		

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D911	Continued From page 118 -Not having a place for residents to sit properly to eat a meal was disrespectful and demeaning to residents. -Residents that moved to the hall because of testing positive for COVID-19 deserved to have a bedside table and a table that they could sit and properly eat their meals. -Not providing the residents with a proper place to sit and eat their meals could result in a prolonged disease recovery of COVID-19 without proper nutrition. -The facility should provide each resident with their own overbed table, distancing co-horted residents as far apart as possible, and give them plenty of room to eat their food at their own pace; residents should not share overbed tables and it was important for them to have proper nutrition for healing. -It was never acceptable for a resident to use a wheelchair as a table to eat their food; wheelchairs commonly had contamination from incontinent residents and the risk of cross-contamination as well as the lack of dignity and respect was concerning that the facility would allow that. -Overbed tables were easy to obtain and there was no reason each facility was not provided with one. -Having a lamp on the floor instead of a table, dresser, or nightstand was a severe risk for falls when a resident bent over to turn it on, and it was concerning for the facility to allow that. -Many of the residents at the facility were on blood thinners and if they fell and sustained major injuries, they could have severe adverse outcomes. -It was concerning that the residents did not have proper furniture in their rooms while quarantined she was worried many of them would become depressed with a lack of a will to live.	D911		

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D911	Continued From page 119 The facility failed to ensure residents were treated with dignity and respect. There were multiple reports to the Administrator by staff members, guardians/family members, and residents about staff talking to residents in a demeaning, disrespectful manner. One staff members was witnessed talking disrespectfully and inconsiderately to residents was previously investigated by the facility for alleged disrespectful behavior towards residents. The facility's failure resulted in substantial risk of serious harm and constitutes a Type A2 Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 01/05/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2022.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations	D912		

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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
D912	Continued From page 120 related to Housekeeping and Furnishings and Medication Administration. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to 10 residents including several hazardous items in an unsecured nurses station, laundry room, and a kitchen not monitored by staff [Refer to Tag D0079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered for 2 of 4 residents (#8, #9) observed during the morning medication pass including errors involving medications used for blood pressure, fluid retention, and a blood thinner (#9), and asthma and a vitamin supplement (#8); and for 2 of 5 sampled residents for record review including errors involving medications used to regulate blood sugar (#3) as well as medications used to treat pain, fever, blood pressure, heart failure, depression, and Parkinson's disease (#1) [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 121	D914		

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on interviews, and record reviews, the facility failed to ensure 4 residents (#1, #3, #6, and #7) were free of mental and physical abuse by staff including Staff G who was permitted continued employment at the facility by the Administrator after previous allegations of physically abusive behavior towards residents.

The findings are:

Staff G, a personal care aide (PCA), was hired at the facility on 08/28/18.

Confidential interview with a staff member on 01/05/22 at 9:09am revealed:
-She had observed Staff G assist a resident to bed on the Special Care Unit (SCU) approximately 6 months ago.
-She observed the Staff G pick the resident up from her wheelchair and push her down on the bed "hard."
-The resident made a sound like she was hurt when Staff G put her on the bed.
-She observed Staff G "bully and fuss" at a resident on the SCU one time.
-She had observed the same MA use profanity toward residents on the SCU one time.
-She met with the Administrator one time several months ago to discuss her concerns about the abuse she had observed.
-Nothing was ever done to correct the staff's behavior.
-Since meeting with the Administrator to report her concerns she was afraid to report any abuse concerns her for fear of retaliation of reduced

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D914	Continued From page 122	D914		

working hours or getting fired.
-She now reported her concerns from observations of abuse to a department head.

Confidential interview with a staff member on 01/05/22 at 9:36am revealed she had observed Staff G in a resident's room on the SCU cursing and yelling at the resident; Staff G threw items around the resident's room.

1.Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included Parkinson's disease and chronic pain.

Review of Resident #1's care plan dated 11/03/21 revealed:
-He required extensive assistance for toileting.
-He was totally dependent on staff for feeding, ambulating, bathing, dressing, grooming and transferring.

Interview with a resident on 01/05/22 at 10:22am revealed:
-Staff G was a PCA that had been placed on leave by the facility and later brought back even though she rough handled residents.
-There was a instance in which another resident next door to her room had fallen.
-She walked into the room to see if there was anything she could do to help and Staff G told her to get out because it was not her business and slammed the door in her face.
-She could hear the women that had fallen crying and telling the PCA to stop because she was hurting her through the door as the PCA was responding to the incident.
-Resident #1 was frail and on hospice, she had nickname him "Bruiser" because he always had bruises on him - especially his arms.
-When Staff G was gone on leave, Resident #1's

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bruises had significantly improved or disappeared, but within the first week of Staff G returning to the facility, he had a new bruise and a bandage on his arm.

Telephone interview with the Activity Director on 01/05/21 at 8:00am revealed:
-She had witnessed Staff G forcefully remove Resident #1's arm from the railing while transporting him to the dining room on 12/21/21.
-She witnessed Staff G place Resident #1 facing the wall on the 100 hallway because he was being "difficult" transporting to the dining room.

Second interview with the Activity Director on 01/06/21 at 11:30am revealed:
-Department Managers were "scolded" by the Administrator via electronic communication telling them to "stay in their lane" when bringing concerns to the Administrator about staff's aggressive verbal behavior.
-The Administrator signed acknowledgment of receiving copies of the Resident Council minutes in which residents expressed concerns about Staff G returning to the facility in December of 2021 after she was placed on leave because of an investigation into abusive behavior towards residents.

Confidential interview with a staff member on 01/05/22 at 10:15am revealed:
-She witnessed Staff G use aggressive behavior to remove Resident #1's hand from the railing while transporting him to the dining room within the last month.
-She previously reported Staff G's behavior to the Administrator, and nothing was done by the Administrator.
-When she reported the verbally aggressive behavior of Staff G to the Administrator, she was

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punished by not being allowed to visit with residents in the office or participate in activities with the resident as she was previously allowed to.
-She was concerned that the residents would be punished if she continued to report the verbal aggression towards residents by Staff G.

Confidential interview with a second staff member on 01/05/22 at 10:50am revealed:
-When she left her office door open she would hear Staff G yell at residents.
-She brought concerns about Staff G's aggressive verbal and physical behavior to the Administrator in December of 2021 and she did not feel like she was taken seriously.
-She witnessed Staff G forcefully removing Resident #1's hand from the railing in the hallway while she was transporting him to the dining room but could not recall what day that occurred.

Interview with Staff G on 01/05/21 at 12:30pm:
-She received training from another facility about working with elderly residents and dementia residents.
-Resident #1 had a tendency to hold onto the railing while she pushed him down the hallway so she would have to remove his hand but she never did it forcefully.

Refer to the interview with the Administrator on 01/05/22 at 2:40pm.

2. Review of Resident #6's current FL-2 dated 11/24/21 revealed diagnoses included anemia, Non-Hodgkin lymphoma, and muscle weakness.

Review of Resident #6's care plan dated 12/14/21 revealed:
-She was oriented.

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D914	Continued From page 125 -She required total dependency for toileting, ambulation, bathing, dressing, grooming, and transferring. Telephone interview with Resident #6 contracted physical therapist on 01/05/22 at 5:08pm revealed: -She visited the resident first at the facility on 12/15/21 where the rest told her that she felt like a burden to the staff. -Resident #6 complained of chest pain from where the staff was forcefully transferring her. -She visited the resident on 12/20/21 where she noticed bruising on the resident's upper arm that looked like thumb marks. -The resident was tearful during both therapy visits when speaking of the staff's rough physical treatment. -She reported the physical abuse of the resident to the previous lead medication aide on 12/20/21. Telephone interview with Resident #6 family member on 01/05/22 at 8:20am revealed she would receive tearful phone calls where the resident reported feeling sad because staff was mean to her when it took a while for her to complete tasks. Interview with Resident #6 on 01/05/22 at 9:20am revealed: -She did not want to disclose which staff members were "overly aggressive" when transferring her because she dependent on them for assistance and was fearful that they would be even more angry with her. -She attempted to call the Administrator via telephone last week at the facility to express concerns about staff's forceful manner in which they transferred her but she was not able to get anyone to answer the telephone.	D914		

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D914	Continued From page 126 Refer to the interview with the Administrator on 01/05/22 at 2:40pm. Interview with the Administrator on 01/05/22 at 2:40pm revealed: -She never had any staff, family or residents bring concerns of disrespect, lack of dignity or consideration by any staff to her attention. -She was not aware that any residents were spoken to in a degrading or demeaning manor. -She conducted an internal investigation after allegations were brought against Staff G in November but she unsubstantiated the allegations. The facility failed to ensure residents were free of physical, mental and verbal abuse. There were three separate accounts of staff members observing Staff G forcefully remove Resident #1's hand from the railing in the hallway. There were observations by staff of residents being yelled at in both the assisted living side of the facility and the Special Care Unit (SCU). Resident #6 reported aggressive behavior by staff when transferring resulting in bruises and chest pain. The facility's failure resulted in substantial risk of serious harm and constitutes a Type A2 Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 01/05/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2022.	D914		

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D935	Continued From page 127	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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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:
FOLLOW-UP TO TYPE B VIOLATION

The Type B Violation was abated.
Non-compliance continues.

Based on interviews and record reviews, the facility failed to ensure 3 of 6 sampled staff (Staff A, C, and D) who were administering medications had completed the 5, 10, or 15 hour medication aide training prior to administering medications.

The findings are:

1 Review of Staff A, medication aide (MA) personnel record revealed:
-She had a hire date of 06/15/17.
-She was signed off on the Medication Clinical Skills Checklist on 10/12/21.
-There was no documentation of Staff A completing the 5,10, or 15 hour online Medication Administration Training Course for Adult Care Homes.
-There was no documentation of employment verification in Staff A's personnel record.

Refer to interview with the facility's training nurse on 01/06/22 at 3:00pm.

Refer to the interview with the Administrator on 01/06/22 at 3:52pm.

2. Review of Staff C, medication aide (MA) personnel record revealed:
-She had a hire date of 10/24/17.

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-She passed the Medication Aide test for adult care homes on 06/14/17.
-She was signed off on the Medication Clinical Skills Checklist on 10/13/21.
-There was no documentation of Staff C completing the 5,10, or 15 hour online Medication Administration Training Course for Adult Care Homes.
-There was no documentation of employment verification in Staff C's personnel record.

Refer to interview with the facility's training nurse on 01/06/22 at 3:00pm.

Refer to the interview with the Administrator on 01/06/22 at 3:52pm.

3. Review of Staff D, medication aide (MA) personnel record revealed:
-She had a hire date of 10/16/18.
-She passed the Medication Aide test for adult care homes on 11/28/17.
-She was signed off on the Medication Clinical Skills Checklist on 10/20/21.
-There was no documentation of Staff D completing the 5,10, or 15 hour online Medication Administration Training Course for Adult Care Homes.
-There was no documentation of employment verification in Staff D's personnel record.

Refer to interview with the facility's training nurse on 01/06/22 at 3:00pm.

Refer to the interview with the Administrator on 01/06/22 at 3:52pm.

_____

Interview with the facility's training nurse on 01/06/22 at 3:00pm revealed:
-She was not aware that Staff A, C, and D did not

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D935	Continued From page 130 complete the 5, 10, or 15 hour online Medication Administration Training Course for Adult Care Homes. -Staff A, C, and D were hired prior to her starting as the facility's training nurse. -It was her responsibility to ensure that MAs completed the 5, 10, or 15 hour online Medication Administration Training Course for Adult Care Homes. Interview with the Administrator on 01/06/22 at 3:52pm revealed: -She was not aware that Staff A, C, and D had not completed the appropriate training prior to passing medications independently including the 5, 10, or 15 hour online Medication Administration Training Course for Adult Care Homes. -It was the facility's training nurse's responsibility to ensure that all staff completed training prior to passing medications independently.	D935		