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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(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 Guilford County Department of Social Services conducted a follow-up survey and complaint investigation on 03/02/22, 03/03/22, and 03/04/22.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure there were no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR) for 3 of 6 sampled staff (Staff C, D and E). The findings are: 1. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff D was hired on 12/14/21. -There was a HCPR check completed on 01/05/22. -Staff D had 1 substantiated finding entered on 08/27/19 for Abuse of a Resident which occurred while the individual was employed in an Adult Care Home. Attempted interview with Staff D on 03/04/22 at	D 137		

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4:05pm was unsuccessful.

Interview with the Business Office Manager (BOM) on 03/04/22 at 4:15pm revealed:
-She was responsible to complete HCPR checks before new staff were hired.
-She missed the substantiated finding on Staff D's HCPR check.
-If she had seen the finding, she would have reported it to the Administrator on 01/05/22.
-She did not audit personnel records regularly but would usually audit quarterly.
-The last audit was completed in the fall of 2021, she did not know the date.

Refer to interview with the Administrator on 03/04/22 at 4:30pm.

2. Review of Staff C's, Memory Care Coordinator (MCC), personnel record revealed:
-Staff C was hired on 01/19/22.
-There was no documentation a Health Care Personnel Registry check was completed.

Interview with Staff C on 03/04/22 at 4:05pm revealed:
-She accepted the MCC position in January 2022 but was hired on 02/08/22 as the MCC and filled in as a medication aide (MA) when needed.
-The Business Office Manager (BOM) told her she would complete a HCPR check on her for hiring.
-The BOM told her the report would be in her personnel record.
-She did not know if her HCPR check was completed.

Interview with the BOM on 03/04/22 at 4:15pm revealed:
-She was responsible to complete HCPR checks

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before new staff were hired.
-She missed completing Staff C's HCPR check, she did not have a reason.
-She did not audit personnel records regularly but would usually audit quarterly.
-The last audit was completed in the fall of 2021, she did not know the date.

Refer to interview with the Administrator on 03/04/22 at 4:45pm.

3. Review of Staff E's,medication aide (MA), personnel record revealed:
-Staff C was hired on 01/24/22.
-There was no documentation a HCPR check was completed.

Attempted telephone interview with Staff E on 03/04/22 at 4:30pm was unsuccessful.

Interview with the Business Office Manager (BOM) on 03/04/22 at 4:15pm revealed:
-She was responsible to complete HCPR checks before new staff were hired.
-She missed completing Staff E's HCPR check before hire.
-She had not completed the HCPR check because she thought Staff E had terminated her employment shortly after 01/24/22.
-She did not audit personnel records regularly but would usually audit quarterly.
-The last audit was completed in the fall of 2021, she did not know the date.

Refer to interview with the Administrator on 03/04/22 at 4:30pm.

_____

Interview with the Administrator on 03/04/22 at 4:30pm revealed:
-The BOM was responsible for ensuring HCPR

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D 137	Continued From page 3 checks were completed on staff upon hire. -The Administrator assumed all staff had the HCPR check completed at time of hire. -She currently did not have a system in place to routinely audit staff personnel records for completeness. _____ The facility failed to ensure 3 of 6 sampled staff (Staff C, D and E) had a HCPR check completed prior to hire. This failure resulted in the facility not knowing if 2 staff (Staff C and E) had substantiated findings on the HCPR and 1 staff (Staff D) had substantiated findings resulting from allegations of resident abuse in an Adult Care Home which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/04/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, APRIL 18, 2022.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (Staff	D 139		

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D 139	Continued From page 4 C and E) had a statewide criminal background check completed upon hire. The findings are: 1. Review of Staff C's, Memory Care Coordinator (MCC), personnel record revealed: -Staff C was hired on 01/19/22. -There was no documentation of a state wide criminal background check. -There was no signed consent for a criminal background check. Interview with Staff C on 03/04/22 at 4:05pm revealed: -She accepted the MCC position in January 2022 but was hired 02/08/22 as the MCC and filled in as a medication aide(MA) when needed. -The Business Office Manager (BOM) told her she would complete a criminal background check on her upon hire. -The BOM told her the report would be in her personnel record. -She did not know if her background check was completed. Interview with the BOM on 03/04/22 at 4:15pm revealed: -She was responsible to complete state wide criminal background checks before new staff were hired. -She just missed completing Staff C's criminal background check. -She did not audit personnel records regularly but would usually audit quarterly. -The last audit was completed in the fall of 2021, she did not know the date. Refer to interview with the Administrator on 03/04/22 at 4:30pm.	D 139		

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D 139	Continued From page 5 2. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E was hired on 01/24/22. -There was no documentation of a state wide criminal background check. -There was no signed consent for a criminal background check. Attempted telephone interview with Staff E on 03/04/22 at 4:45pm was unsuccessful. Interview with the Business Office Manager (BOM) on 03/04/22 at 4:15pm revealed: -She was responsible to complete state wide criminal background checks before new staff were hired. -She just missed completing Staff E's criminal background check. -She did not audit personnel records regularly but would usually audit quarterly. -The last audit was completed in the fall of 2021, she did not know the date. Refer to interview with the Administrator on 03/04/22 at 4:30pm. _____ Interview with the Administrator on 03/04/22 at 4:30pm revealed: -The BOM was responsible for ensuring the statewide criminal background checks were completed on staff upon hire. -The Administrator assumed all staff had the backgrounds completed at time of hire. -She currently did not have a system in place to routinely audit staff personnel records for completeness. _____ The facility failed to ensure 2 of 6 sampled staff (Staff C and E) had a state wide criminal	D 139		

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D 139	Continued From page 6 background check completed prior to hire. This failure resulted in the facility not knowing if 2 staff (Staff C and E) had a criminal record history which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/04/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, APRIL 18, 2022.	D 139		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure supervision was provided for 1 of 5 sampled residents (Resident #5) resulting in 10 falls in 3 months. The findings are: Review of Resident #5's current FL2 dated 11/18/21 revealed: -Diagnoses included dementia, seizures,	D 270		

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epilepsy, delusional disorder, and traumatic brain injury.
-He was semi-ambulatory.
-He needed personal care assistance with bathing, feeding, and dressing.

Review of Resident #5's care plan dated 11/18/21 revealed:
-He required limited assistance with eating, ambulation, and transferring.
-He required extensive assistance with toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #5's care plan dated 02/15/22 revealed:
-He required extensive assistance with ambulation and transferring.
-He was totally dependent with eating, toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #5's licensed health professional support (LHPS) evaluation dated 11/01/21 revealed he ambulated using an assistive device, a walker.

1. Review of Resident #5's incident and accident report dated 11/24/21 revealed:
-Resident #5 had a fall in his room at 10:40pm.
-His head and shoulder were injured.
-Resident #5 was transferred to the hospital via emergency medical service (EMS).
-The fall follow-up was a referral to orthopedics due to shoulder fracture.
-There were no documented fall prevention interventions.

Review of Resident #5's emergency department (ED) visit note dated 11/25/21 revealed:

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-Visit diagnoses included fall and shoulder pain.
-Shoulder x-ray was abnormal and showed a closed nondisplaced fracture of the surgical neck of the right humerus (upper arm).
-Oxycodone (a narcotic pain relief medication) and an arm sling were prescribed to help with pain relief.

Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 5:15pm revealed the medication aide (MA) who completed the incident and accident report dated 11/24/21 no longer was employed at the facility.

2. Review of Resident #5's ED visit note dated 01/01/22 revealed:
-Visit diagnoses included fall, initial encounter.
-Testing performed included a CT scan of the head and cervical spine, and x-rays of the hip, humerus and shoulder.
-Discharge instructions were to keep Resident #5 in a sling for his known right humerus fracture and to continue to follow up with orthopedics.

Review of Resident #5's incident and accident reports revealed there was no incident and accident report for the fall on 01/01/22.

Review of Resident #5's Physical Therapy (PT) evaluation note dated 01/03/22 revealed:
-Facility staff reported to the PT on 01/03/22 that Resident #5 had went to the hospital over the weekend due to a fall.
-Staff were unaware of what happened to cause the fall but thought he might have fallen out of his bed, so PT ordered a halo for his bed to assist with bed mobility.

3. Review of Resident #5's incident and accident report dated 01/05/22 revealed:

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-Resident #5 had an unwitnessed fall in his room on 01/05/22 at 3:45pm.
-There were no apparent injuries noted; he was not sent to the hospital.
-The fall follow-up was to continue monitoring, but did not specify how often to monitor Resident #5.

Review of Resident #5's physician order form dated 01/06/22 revealed:
-There was an order to place right arm in a sling secondary to humerus fracture
-There was an order for home health PT to evaluate and treat as indicated due to diagnoses of dementia, gait instability, and multiple falls.

Interview with the RCC on 03/03/22 at 5:15pm revealed the MA who completed the incident and accident report dated 01/05/22 no longer was employed at the facility.

4. Review of Resident #5's ED visit note dated 01/09/22 revealed:
-Diagnoses included fall- initial encounter, dementia, and injury of head.
-Testing performed included CT-scans of the head and cervical spine but there were no results listed.

Review of Resident #5's incident and accident reports revealed there was no incident and accident report for the fall on 01/09/22.

Interview with a MA on 03/03/22 at 10:20am revealed:
-Resident #5 had fallen while she was working but she could not remember the specific day.
-She thought the fall had been in January 2022 and he had been sent to the ED due to hitting his head.
-It was the facility's policy that any time a resident

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had a fall where the resident hit their head, the resident needed to be evaluated in the ED.

5. Review of Resident #5's PT evaluation note dated 01/11/22 revealed:
-The PT entered Resident #5's room to find him laying on the floor with his walker beside him.
-Resident #5 reported that he had fallen backwards while taking off his shirt.
-Resident #5 was sent to the ED.

Review of Resident #5's ED visit note dated 01/11/22 revealed diagnoses included fall- initial encounter and one right rib fracture.

Review of Resident #5's incident and accident reports revealed there was no incident and accident report for the fall on 01/11/22.

6. Review of Resident #5's PT evaluation note dated 01/31/22 revealed:
-Resident #5 reported to the PT that he had fallen in his bathroom that morning.
-Facility staff stated they were unaware of Resident #5 having a fall that day.
-Resident #5 demonstrated signs of a fall due to an actively bleeding scrape on the left knee.

Review of Resident #5's incident and accident reports revealed there was no incident and accident report for the fall on 01/31/22.

7. Review of Resident #5's PT evaluation note dated 02/02/22 revealed:
-Facility staff reported Resident #5 had an unwitnessed fall that morning.
-Staff heard him yelling for help and found him on the bathroom floor in a seated position against the wall.

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Review of Resident #5's physician order dated 02/02/22 revealed there was an order for a right shoulder x-ray for diagnoses of fall, pain and bruising.

Review of Resident #5's incident and accident reports revealed there was no incident and accident report for the fall on 02/02/22.

Review of Resident #5's right shoulder x-ray result dated 02/03/22 revealed there was an acute moderately displaced fracture of the surgical neck of the right humerus and a mildly displaced fracture of indeterminate age at the distal right clavicle (collar bone).

Review of Resident #5's physician order dated 02/08/22 revealed:
-There was an order to keep Resident #5's right arm in a sling at all times due to result of right shoulder x-ray.
-There was an order for an immediate appointment with orthopedics.

Interview with the RCC on 03/03/22 at 5:15pm revealed:
-The PCP wrote the order to x-ray Resident #5's right arm on 02/01/22 because he had been complaining of pain and she thought he might have re-fractured it with one of his subsequent falls, and he had.
-The PCP then ordered for him to see the orthopedic doctor again, as he had following his fall with the shoulder fracture on 11/24/21.

8. Review of Resident #5's PT evaluation note dated 02/14/22 revealed that facility staff reported Resident #5 had fallen the day prior (02/13/22), but did not seem to hurt anything so the resident was not sent to the hospital.

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D 270	Continued From page 12 Review of Resident #5's incident and accident reports reveals there was no incident and accident report for the fall on 02/13/22. Interview with a MA on 03/04/22 at 9:40am revealed: -He worked on 02/13/22 when Resident #5 had a witnessed fall in the dining hall at 11:30am. -He was aware that Resident #5 received PT to help with his balance and prevent falls but did not know of any additional interventions or increased supervision for Resident #5. 9. Review of Resident #5's incident and accident report dated 02/18/22 revealed: -Resident #5 had a fall in his room at 5:50pm. -There were no injuries. -Resident #5 was not sent to the hospital. -The fall follow-up was that there were no new orders. -There were no documented fall prevention interventions. Interview with a second MA on 03/04/22 at 9:45am revealed: -She worked on 02/18/22 when Resident #5 had fallen. -The fall was unwitnessed. -On 02/18/22, Resident #5 had told her that he fell trying to get out of bed because he had one shoe on and one shoe off. -When a resident fell, it was the facility policy for the MA to check vital signs, do range of motion (ROM), notify the PCP and power of attorney (POA), and add the resident to the 72-hour supervision log which was recently started in the last couple of weeks by the new Memory Care Coordinator (MCC). -During the 72 hours following a fall, MAs were	D 270		

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supposed to be monitoring the resident for any change in behavior, health status, medications or meal refusals.

Observation of 72-hour supervision log revealed it was implemented after the fall on 02/18/22 had occurred.

10. Review of Resident #5's incident and accident report dated 02/24/22 revealed:
-Resident #5 had an unwitnessed fall in his room on 02/24/22 at 11:15am.
-The resident reported he had fallen backwards but did not hit his head.
-The staff completed ROM exercises, checked vital signs, and noted an abrasion but did not specify where.
-The fall follow-up was that the PCP evaluated and gave no new orders.
-There were no documented fall prevention interventions.

Interview with the second MA on 03/04/22 at 9:45am revealed:
-She had worked on 02/24/22 when Resident #5 had fallen.
-The fall had been unwitnessed.
-On 02/24/22, Resident #5 had told her that he had fallen backwards; she did not know what caused Resident #5 to fall backwards.
-To prevent Resident #5 from having falls, staff assisted Resident #5 with all his activities of daily living (ADLs), and they made sure he wore a belt on his pants every day to avoid tripping over his pants.
-Staff also were responsible to check on Resident #5 every two hours, but they usually checked on him more frequently than that.
-They did not have a place where they documented two-hour checks or more frequent

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checks.

Interview with Resident #5's outpatient PT on 03/02/22 at 11:03am revealed:
-She had been going to the facility and providing PT services to Resident #5 since he was admitted to the facility in October 2021.
-She had recently discharged him to home health PT because he was no longer making progress towards his goals.
-His PT admission diagnoses included weakness, poor balance, history of falls, anemia and history of seizures.
-He was currently receiving PT services through home health.
-She had no recommendations for staff for fall prevention for Resident #5 other than to monitor him during transfers and ambulation.

Interview with Resident #5's PCP on 03/03/22 at 8:50am revealed:
-She was aware of his multiple falls because the facility notified her when they occurred.
-She thought his falls were caused from his dementia, poor balance and seizure disorder.
-Fall interventions the facility had done included referrals to PT and having him use a walker.
-She did not know what else the facility could do to prevent his falls.
-She did not think all of his ED visits were for new falls, just ongoing pain from previous falls.

Interview with a MA on 03/03/22 at 10:20am revealed:
-The personal care aides (PCA) usually had Resident #5 sit in the common living area in the Special Care Unit (SCU) so they could keep a closer watch on him, but when he was in his room they checked on him every two hours.
-They did not implement new interventions after

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each of Resident #5's falls.
-They had not placed Resident #5 on increased supervision checks that she was aware of.

Interview with a PCA on 03/03/22 at 10:20am revealed:
-She usually worked on the assisted living side and not the SCU.
-She was aware of Resident #5 and his history of falls.
-PCAs checked on him every two hours as they did for all the residents.
-He was not on any increased supervision.

Interview with a second PCA on 03/03/22 at 3:05pm revealed:
-She was aware of Resident #5's history of falls.
-The fall interventions the facility had put into place for Resident #5 that she was aware of included giving him a bell to ring whenever he needed assistance in his room, for all staff to make sure he had his walker with him while transferring and ambulating, checking on him at a minimum of every two hours but most staff checked on him more often than that due to his fall history.
-The MA or supervisors did not notify her of new fall prevention interventions each time Resident #5 had a fall.
-The PCAs always assisted Resident #5 with his transfers, ambulation and toileting because he needed the help from staff and would sometimes fall if he tried to transfer or walk without assistance from staff.

Interview with the RCC on 03/03/22 at 5:15pm revealed:
-The MAs did not implement a new fall intervention after every fall that Resident #5 had.
-All of Resident #5's visits to the ED were not due

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to new falls; some of them were for ongoing complaints of pain from previous falls. She did not know why the ED diagnosed the visits as falls.
-His current fall preventions measures included PT and staff monitoring him every two hours.
-The facility did not have a written fall policy, they just educated staff about what was expected from them if a resident fell.

Review of Resident #5's 72-hour supervision log revealed:
-There was one page with fall documentation for Resident #5 dated 02/24/22.
-The documentation included that Resident #5 had a fall and that vital signs and ROM were checked and the POA and PCP were updated.
-There was no place to document each individual supervision check on Resident #5.
-There was no other documentation regarding falls for Resident #5.

Telephone interview with Resident #5's POA on 03/04/22 at 10:00am revealed:
-She did not think the facility called her every time Resident #5 fell, because she had access to his health portal online and could see visits to the ED for falls when she had not received a call.
-Aside from discontinuing his prescription for oxycodone she did not know what else could be done to prevent him from falling.
-She was unaware of any fall interventions the facility had implemented.
-She thought the staff just did not help Resident #5 enough and that was why he fell so often.

Telephone interview with the home health PT on 03/04/22 at 10:33am revealed:
-Resident #5 was admitted to home health PT due to frequent falls.
-He did an evaluation on Resident #5 the

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previous weekend.
-He thought the reason Resident #5 was falling was due to balance deficits and an abnormal sense of his body's movement and location.
-He felt he would be able to help Resident #5 with these issues by working to improve his lower body strength.
-He thought the best thing staff would be able to do to prevent Resident #5 from falling would be to ensure he always had his walker in front of him so he would not forget to use it; aside from that he did not know what else staff could do to prevent him from falling.

Interview with the Administrator on 03/04/22 at 4:45pm revealed:
-She was aware that Resident #5 had multiple falls.
-They did not have a specific policy on falls.
-The staff knew if a resident fell, the MA needed to do a full body assessment, check vital signs, complete ROM exercise to test for pain or injury, and update the PCP and POA.
-If a resident had a fall with any type of head injury the MAs needed to send the resident to the ED for evaluation.
-She expected staff to check on all the residents every two hours and to follow each resident's specific care plan of individualized needs.
-There was no specific place for staff to document fall interventions or the every two-hour supervision checks.

Interview with the MCC on 03/04/22 at 5:45pm revealed:
-She was aware that Resident #5 had a history of falls.
-Since she started her position as MCC in February 2022, she implemented the 72-hour monitoring system.

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D 270	Continued From page 18 -The 72-hour monitoring included a full body assessment after each fall followed by hourly checks rather than every two hours. -There was currently no place for MAs to document staff were doing the hourly checks or to document any concerns or changes they noticed about the resident, but she was in the process of working on those forms. -Fall interventions for Resident #5 included PT, and she recently reviewed his medications with his POA and got the oxycodone discontinued because a side effect of that medication was dizziness. -She also scheduled a day the following week to go through Resident #5's closet with his POA to remove all of his pairs of pants that were too long so the POA could hem the pant legs; he had reported tripping over his pant legs during one of his falls. -She also asked the PCAs to always be within an arm's reach of Resident #5 when he was ambulating to provide stability if he needed it; there was no place available at that time for staff to document this intervention. Based on observation, record review and interview, it was determined Resident #5 was not interviewable. _____ The facility failed to provide supervision to 1 of 5 sampled residents (#5) resulting in ten falls within three months which required emergency department (ED) visits resulting in injuries of a fractured right shoulder, a dislocated right shoulder and fractured right clavicle. This failure placed the resident at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in	D 270		

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D 270	Continued From page 19 accordance with G.S. 131D-34 on 03/04/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 3, 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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to contact the primary care provider (PCP) for 2 of 5 sampled residents (#1 and #5) related to episodes of nausea and vomiting and abdominal pain (#1) and a missed laboratory order (#5). The findings are: 1. Review of Resident #1's current FL2 dated 07/29/21 revealed: -Diagnoses included hypertension and mild intellectual disabilities. -There was no documentation in regards to disorientation. Telephone interview with a representative from the local fire station from a call placed on 03/04/22 at 4:47pm with a return call on 03/10/22 at 8:24am revealed: -The fire crew responded to the facility on 02/16/22 in the morning for a medical call due to	D 273		

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Resident #1's complaint of abdominal pain.
-She appeared uncomfortable, readjusting herself in bed and shouting.
-The facility's staff advised the fire crew that she had a low blood pressure.
-Fire crew staff checked the resident's vital signs including blood pressure, pulse oximetry, radial and brachial pulses, but were unable to obtain any blood pressure readings, pulse oximetry reading, or radial and brachial pulses on Resident #1.
-The local county EMS then came on scene and transported Resident #1 to the local ED.

Review of Resident #1's emergency medical services (EMS) record revealed:
-EMS arrived at Resident #1's bedside in the facility on 02/16/22 at 8:04am responding to a medical call for hypotension and abdominal pain for 2 weeks.
-Resident #1 was accompanied in her room in the facility by local fire department staff that reported she complained that she didn't feel well.
-There were no facility staff person available for report on the patient's condition.
-Resident #1 reported general abdominal pain with nausea, vomiting, diarrhea for 2 weeks and dizziness with movement.
-EMS staff obtained a manual blood pressure of 60/32 and recorded absent left and right radial pulse at 8:04am.
-EMS staff inserted an intravenous catheter and administered an unknown amount of intravenous fluids for hypotension and zofran for nausea.
-Resident #1 was then transported to the local ED at 8:41am.

Review of Resident #1's hospital records revealed:
-She arrived at the emergency department (ED)

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on 02/16/22 at 8:43am with complaints of abdominal pain, nausea and vomiting for 2 weeks.
-She was evaluated by the ED provider on 02/16/22 at 9:29am for abdominal pain, hypotension and dehydration.
-Her initial assessment diagnoses included possible diagnoses of "...severe sepsis or acidosis secondary to medication with acute renal failure.." (severe infection, abnormally high acidity of the blood/body fluids and kidney failure).
-Initial emergency room blood pressure was documented as 88/48 and a heart rate of 106 after "a small fluid bolus".
-She went into cardiac arrest in the ED and was intubated and successfully resuscitated.
-She was then admitted to the intensive care unit where on 02/26/22 she went into cardiac arrest again but was not able to be revived and was pronounced dead at 2:22pm.

Telephone interview with Resident #1's guardian on 03/02/22 at 11:07am revealed:
-She had visited Resident #1 last on 11/21/21.
-She had no report from staff or the PCP of low blood pressures or complaints of abdominal pain, nausea and vomiting.
-She was notified on the morning of 02/16/22 that Resident #1 "felt bad" and looked pale so the facility was sending her to the ED for evaluation.
-She was not informed of any condition that would cause her to decline rapidly.
-The hospital reported to her that Resident #1 went into cardiac arrest in the ED on 02/16/22 and was then admitted to the intensive care unit.
-She passed away in the intensive care unit on 02/26/22.

Interview with a medication aide (MA) on 03/02/22 at 11:00am revealed:

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-He sent Resident #1 to the ED the morning of 02/16/22 because she looked pale and complained of abdominal pain.
-He did not know if she had any abdominal pain or nausea and vomiting before 02/16/22.
-She was up walking around while she was waiting for emergency medical services (EMS) to pick her up.
-She took herself to the restroom, so he did not know if she had any vomiting or diarrhea that morning.

Interview with a second MA on 03/03/22 at 9:15am revealed:
-She complained of abdominal pain on 02/11/22 and was not eating normal but was drinking liquids.
-She did not inform the PCP of Resident #1's complaint of abdominal pain and not eating well.
-She informed the RCC so that she could be seen on 02/15/22 when the PCP visited.

Interview with a third MA on 03/03/22 at 12:10pm revealed:
-She notified the RCC when Resident #1 was not eating well and had an episode of vomiting on 02/11/22 during day shift.
-The RCC instructed her to encourage her to drink fluids and to eat and she would have the PCP see her on her next visit on 02/15/22.
-She assumed the RCC reported the vomiting to the PCP and she did not call the PCP herself.
-She did not receive any new orders from the PCP from 02/12/22-02/13/22.
-She did not call the guardian or the PCP to ask to send her out for vomiting because Resident #1 repeatedly said she did not want to go to the hospital.

Interview with Resident #1's PCP on 03/03/22 at

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10:35am revealed:
-She saw the resident in the facility on 02/15/22 for nausea and vomiting for 2 days.
-She assessed her mucous membranes for moisture and they were only "a little dry".
-She would have expected the facility staff to notify her of any abdominal pain with nausea and vomiting for 2 weeks.

Interview with the RCC on 03/03/22 at 10:45am revealed:
-She was notified by a MA on 02/11/22 of Resident #1's complaint of abdominal pain.
-She did not contact the resident's PCP, but she added Resident #1's name to the PCP's list to be see when the PCP visited the facility on 02/15/22.
-Resident #1 was positive for COVID-19 in January 2022 and had some residual gastrointestinal symptoms off and on since then.
-The PCP evaluated her on 02/15/22 and ordered laboratory work and Zofran (used to treat nausea and vomiting).
-Staff encouraged her to drink and offered her gelatin and soup throughout the day.
-On 02/16/22, the MA reported he was concerned because she was pale and convinced her to go to the ED to be checked.

Interview with the Administrator on 03/03/22 at 4:00pm revealed:
-On 02/11/22, the RCC put Resident #1 on the PCP visit list to be seen on 02/15/22 due to complaints of abdominal pain, nausea and vomiting for a couple of days.
-The PCP saw her in the facility on 02/15/22 and felt her symptoms were from a stomach virus and ordered laboratory work, nausea medication and requested staff to monitor her symptoms.
-Staff encouraged her to take fluids, gelatin and soups for several days before she was sent to the

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ED.
-She refused multiple times to be sent to the ED but was finally convinced by the MA to go and be assessed because she was pale and complained of abdominal pain.

Attempted telephone interviews with Resident #1's ED provider on 03/04/22 at 5:00pm and at 5:15pm was unsuccessful.

2. Review of Resident #5's current FL2 dated 11/18/21 revealed:
-Diagnoses included dementia, seizures, epilepsy, delusional disorder, traumatic brain injury, anemia and major depression.
-There were medication orders for ferrous sulfate 325mg daily (iron supplement), and phenytoin (use to treat seizures) 125mg/5ml solution- administer 5mL twice daily.

Review of Resident #5's physician order form dated 01/13/22 revealed:
-There was an order to decrease phenytoin to 100mg (4mL) twice daily.
-There was an order to recheck phenytoin level along with hemoglobin A1c (a blood lab that tests average blood glucose levels from the past three months), complete blood count (CBC), iron, total iron binding capacity (TIBC), and ferritin levels on 01/23/22.

Review of Resident #5's record revealed there were no laboratory results for 01/23/22.

Interview with Resident #5's primary care provider (PCP) on 03/03/22 at 8:50am revealed:
-She had ordered the lab work due to the dosage decrease of phenytoin and because he was previously diagnosed as anemic and was taking iron supplements.

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-She did not know if the lab work had been collected or not because the facility had not sent her the results from 01/23/22 or notified her that the facility were unable to collect the blood specimen to run the lab work.
-She had re-ordered lab work in February 2022 and had results in her computer dated 02/10/22 for the CBC, iron, and TIBC.
-There was no documentation that the facility had notified her the lab order from 01/23/22 was not completed.
-It was her expectation that staff complete lab work as ordered and send her the results or notify her of missed lab work and the reason why it was missed.

Interview with the Resident Care Coordinator (RCC) on 03/04/22 at 11:25am revealed:
-She was not able to find results from Resident #5's lab order dated 01/23/22, which indicated it was not done.
-She would have been responsible for faxing the PCP order for lab work to the PCP's office, who would then forward the order to lab staff to come to the facility and collect the specimen from Resident #5.
-She did not have a system in place for following up on lab orders to ensure they were collected and had not noticed that the lab work was not completed.

Telephone interview with a representative from Resident #5's PCP's office on 03/04/22 at 4:15pm revealed:
-They had never received a fax from the facility with the order dated 01/13/22 to collect labs on 01/23/22.
-They sometimes had trouble receiving faxes and orders were missed, but it was the facility's responsibility to ensure their orders were

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D 273	Continued From page 26 completed as requested by the PCP. Interview with the Administrator on 03/04/22 at 4:45pm revealed: -She was not aware Resident #5 had a lab order that was missed. -She expected the RCC to track faxed lab orders and to follow up with the PCP's office if the lab was not drawn. Based on observation, record review and interview, it was determined Resident #5 was not interviewable. The facility failed to ensure referral and follow up for 2 of 5 sampled residents (#1 and #5), related to a resident who had complained of nausea, vomiting and abdominal pain resulting in the resident being hospitalized for hypotension, dehydration and acute kidney failure (#1); and a resident with a missed laboratory work order who had a previous diagnosis of anemia and seizures (#5). This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/03/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, APRIL 18, 2022.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

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

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#6 and #7) observed during the medication pass including errors with a blood pressure medication, medication for circulation, and medication to control behaviors (#6), and a vitamin supplement (#7); and for 2 of 5 residents sampled (#1 and #5) for record review including errors with medications to treat seizures and mental disorders (#5); and not holding blood pressure medication according to ordered parameters (#1).

The findings are:

1. The medication error rate was 16% as evidenced by the observation of 4 errors out of 25 opportunities during the 8:00am medication passes on 03/03/22.

a. Review of Resident #6's current FL2 dated 11/17/21 revealed diagnoses included dementia, major depressive disorder, hypertension, and high cholesterol.

1. Review of Resident #6's current FL2 dated 11/17/21 revealed an order for aspirin (used to thin the blood) 81mg one tablet daily.

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Review of Resident #6's signed physician's orders dated 12/09/21 revealed an order for aspirin 81mg enteric coated (EC) one tablet daily (DO NOT CRUSH). (Enteric coated tablets are designed to dissolve in the intestine, not the stomach, and should not be crushed).

Observation of the 8:00am medication pass on 03/03/22 revealed:
-The medication aide (MA) prepared 3 medications to administer to Resident #6 at 8:25am.
-The medications, including one aspirin 81mg EC, were crushed and added to yogurt for administration to Resident #6.
-The administration was stopped prior to the MA administering crushed EC aspirin.

Observation of the MA on 03/03/22 at 8:28am revealed:
-The MA prepared 3 medications a second time by crushing one medication and placing 2 intact medications in 1 teaspoonful of yogurt.
-Resident #6 consumed the medications mixed in yogurt without incident.

Interview with the MA on 03/03/22 at 8:25am revealed:
-She was the Memory Care Coordinator (MCC).
-She had been in her current position for 3 weeks.
-She had passed medication only 2 or 3 times due to staff shortages.
-Resident #6 had an order to crush medications appearing on the electronic medication administration record (eMAR) computer screen.
-She focused on the crushing of medication order instead of the individual medications that should not be crushed.
-Resident #6 did not like to take her medication

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unless mixed in yogurt.
-She had not tried to administer aspirin 81mg EC without crushing the tablets.
-She had not contacted the contracted pharmacy for alternative medications that could be crushed in place of Resident #6's aspirin 81mg EC.

Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for aspirin 81mg EC take 1 tablet once daily (DO NOT CRUSH) scheduled for administration at 8:00am.
-Aspirin 81mg EC was documented as administered on 03/03/22 at 8:00am.

Observation of Resident #6's medications on hand on 03/03/22 at 8:40am revealed there was a partial bulk container of aspirin 81mg EC dispensed for Resident #6. The bulk container was labeled DO NOT CRUSH.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Interview with Resident #6's primary care provider (PCP) on 03/03/22 at 10:50am revealed:
-She had been seeing residents at the facility since January 2022.
-She had seen Resident #6 maybe one time.
-She expected the facility staff to administer medications according to the directions on the medication orders.
-Tablets that should not be crushed should be administered whole or changed to a comparable medication to provide the desired effectiveness and avoid side effects like increased absorption affecting desired therapeutic levels, and risk of increased side effects like stomach distress from

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aspirin.

Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 4:15pm revealed she expected medications that were not crushable to be changed to a different medication or administered whole.

Interview with the Administrator on 03/04/22 at 4:39pm revealed:
-The MAs were responsible for administering medications according to the orders and instructions on the medication labels.
-MAs should not be crushing medications that were not crushable because of the way the medication was manufactured.

2. Review of Resident #6's signed physician's orders date 12/09/21 revealed an order for metoprolol succinate 100mg extended release (ER) (used to treat high blood pressure) one tablet daily (DO NOT CRUSH). (Extended release tablets are designed to dissolve or release medication at a slower rate and should not be crushed).

Observation of the 8:00am medication pass on 03/03/22 revealed:
-The medication aide (MA) prepared 3 medications to administer to Resident #6 at 8:25am.
-The medications, including one metoprolol succinate 100mg ER, were crushed and added to yogurt for administration to Resident #6.
-The administration was stopped prior to the MA administering crushed metoprolol succinate 100mg ER.

Observation of the MA on 03/03/22 at 8:28am revealed:

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-The MA prepared 3 medications a second time by crushing one medication and placing 2 tablets in 1 teaspoonful of yogurt.
-Resident #6 consumed the medications mixed in yogurt without incident.

Interview with the MA on 03/03/22 at 8:25am revealed:
-She was the Memory Care Coordinator (MCC).
-She had been in her current position for 3 weeks.
-She had passed medication only 2 or 3 times due to staff shortages.
-Resident #6 had an order to crush medications appearing on the electronic medication administration record (eMAR) computer screen.
-She focused on the crushing of medication order instead of the individual medications that should not be crushed.
-Resident #6 did not like to take her medication unless mixed in yogurt.
-She had not tried to administer metoprolol succinate 100mg ER without crushing the tablets.
-She had not contacted the contracted pharmacy for alternative medications that could be crushed in place of Resident #6's metoprolol succinate 100mg ER.

Review of Resident #6's March 2022 eMAR revealed:
-There was an entry for metoprolol succinate 100mg ER take 1 tablet once daily (DO NOT CRUSH) scheduled for administration at 8:00am.
-Metoprolol succinate 100mg ER was documented as administered on 03/03/22 at 8:00am.

Observation of Resident #6's medications on hand on 03/03/22 at 8:40am revealed there 27 tablets remaining of 28 tablets of metoprolol

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succinate 100mg ER dispensed on 03/03/22 for cycle fill. The bubble card was labeled DO NOT CRUSH in the printed directions.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Interview with Resident #6's primary care provider (PCP) on 03/03/22 at 10:50am revealed:
-She had been seeing residents at the facility since January 2022.
-She had seen Resident #6 maybe one time.
-She expected the facility staff to administer medications according to the directions on the medication orders.
-Tablets that should not be crushed should be administered whole or changed to a comparable medication to provide the desired effectiveness and avoid side effects like increased absorption affecting desired therapeutic levels, and risk of increased side effects like stomach distress from aspirin.

Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 4:15pm revealed she expected medications that were not crushable to be changed to a different medication or administered whole.

Interview with the Administrator on 03/04/22 at 4:39pm revealed:
-The MAs were responsible for administering medications according to the orders and instructions on the medication labels.
-MAs should not be crushing medications that were not crushable because of the way the medication was manufactured.

3. Review of Resident #6's signed physician's

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orders dated 12/09/21 revealed an order divalproex (used to treat mental health disorders and behaviors) sprinkle 125mg take two capsules twice a day with meals.

Observation of the medication aide (MA) on 03/03/22 at 8:28am revealed:
-The MA prepared 3 medications by crushing one medication and placing 2 tablets in 1 teaspoonful of yogurt.
-Divalproex Sprinkle 125mg was not one of the medications.
-Resident #6 consumed the medications mixed in yogurt without incident.

Interview with the MA on 03/03/22 at 8:25am revealed:
-She was the Memory Care Coordinator (MCC).
-She had been in her current position for 3 weeks.
-She had passed medication only 2 or 3 times due to shaft shortages.
-Resident #6 did not have divalproex sprinkle 125mg on the medication cart, or in overstock to administer during the medication pass.
-Today was the first day of the current cycle fill for residents' routine medications.
-She was going to call the pharmacy to see why divalproex sprinkle 125mg did not come with the other cycle fill medications received for 03/03/22.

Review of Resident #6's March 2022 eMAR revealed:
-There was an entry for divalproex sprinkle 125mg take 2 capsules twice a day with meals (DO NOT CRUSH) scheduled for administration at 8:00am and 8:00pm.
-Divalproex sprinkle 125mg was not documented as administered on the eMAR on 03/03/22 at 8:00am.

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D 358	Continued From page 34 Observation of Resident #6's medications on hand on 03/03/22 at 8:40am revealed there was no divalproex sprinkle 125mg available for administration. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. Interview with Resident #6's primary care provider (PCP) on 03/03/22 at 11:50am revealed: -She had been seeing residents at the facility since January 2022. -She had seen Resident #6 maybe one time. -She expected the facility staff to administer medications according to the directions on the medication orders. -The facility was responsible to order medications on time to prevent residents from being out of medication. Telephone interview with the pharmacist at the contracted pharmacy on 03/03/22 at 9:50am revealed: -Resident #6 had a cycle fill of divalproex sprinkle 125 mg quantity of 112 documented as prepared on 02/24/22 for the cycle fill dated 03/03/22. -The facility should have received the divalproex along with the residents's other cycle filled medications. Interview with the MCC on 03/03/22 at 10:45am revealed: -The delivery ticket for cycle filled medication showed Resident #6's divalproex sprinkle 125mg was delivered with the other cycle filled medications for 03/03/22. -She could not locate the medication in the facility.	D 358		

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D 358	Continued From page 35 -The contracted pharmacy delivery driver had incorrectly taken one of the current cycle fill medication totes back to the pharmacy along with the pharmacy returns from the facility's last delivery. -Resident #6's divalproex sprinkle 125mg cycle fill for 03/03/22 may be in that tote. -The contracted pharmacy delivery driver was returning the cycle tote late this morning on 03/03/22. Observation on 03/03/22 at 11:55am revealed there was a delivery of one pharmacy tote through the front door. Interview with the MCC on 03/03/22 at 3:00pm revealed Resident #6's divalproex sprinkle 125mg was not included in the medications received in the delivery tote on 03/03/22 at 12:00pm. Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 4:15pm revealed: -She expected medications to be administered as ordered. -The contracted pharmacy sometimes had to be contacted for medications not included in the cycle fill totes. -The cycle filled medications appeared a few days later in a different batch of residents' medications. Interview with the Administrator on 03/04/22 at 4:39pm revealed: -The MAs were responsible for administering medications according to the orders and instructions on the medication labels. -The facility was working with the contracted pharmacy to minimize the number of residents' medications not sent correctly on cycle fills.	D 358		

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b. Review of Resident #7's current FL2 dated 11/29/21 revealed:
-Diagnoses included dementia, chronic kidney disease, and deficiencies of specified B group vitamins.
-There was an order for cyanocobalamin (a vitamin B12 supplement) 1000mcg 2 tablets daily.

Observation of the 8:00am medication pass on 03/03/22 revealed:
-The medication aide (MA) prepared 6 medications to administer to Resident #7 at 8:41am.
-The medications, including one cyanocobalamin 1000mcg were administered to Resident #7 in the dining room area.

Review of Resident #7's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for cyanocobalamin 1000mcg take 2 tablets daily scheduled for administration at 8:00am and 8:00pm.
-Cyanocobalamin 1000mcg was documented as administered for 2 tablets on the eMAR on 03/03/22 at 8:00am.

Observation of Resident #6's medications on hand on 03/03/22 at 8:40am revealed there was a partial bulk package of cyanocobalamin 1000mcg dispensed on 11/29/21 with instructions to give 2 tablets daily.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Interview with Resident #7's primary care provider (PCP) on 03/03/22 at 11:50am revealed:
-She had been seeing residents at the facility

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since January 2022.
-She had seen Resident #7 maybe one time.
-She expected the facility staff to administer medications according to the directions on the medication orders.

Interview with the MA on 03/03/22 at 10:45am revealed:
-She was the Memory Care Coordinator (MCC).
-She had been in her current position for 3 weeks.
-She had passed medication only 2 or 3 times due to staff shortages.
-She recalled she preparing Resident #7's cyanocobalamin 1000mcg earlier by removing one tablet from the bulk container.
-She overlooked the instructions for 2 tablets once a day.
-She was not familiar with all the residents' medications since she had only been working in the Memory Care Unit (MCU) for 3 weeks.
-She did not read the instructions on the eMAR's computer screen completely.

Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 4:15pm revealed she expected medications to be administered as ordered.

Interview with the Administrator on 03/04/22 at 4:39pm revealed the MAs were responsible for administering medications according to the orders and instructions on the medication labels.

2. Review of Resident #1's current FL2 dated 07/29/21 revealed:
-Diagnoses included hypertension and mild intellectual disabilities.
-There was an order for metoprolol tartrate 25mg take 1 tablet two times daily (used to treat high

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blood pressure).

Review of Resident #1's physician's order dated 10/28/21 revealed an order for metoprolol 25mg take one half tablet to equal 12.5mg two times a day, hold if heart rate (HR) less than 55 or systolic blood pressure (SBP) less than 100.

Review of Resident #1's January 2022 electronic medication administration record(eMAR) revealed:
-There was an entry for metoprolol 25mg take one half tablet to equal 12.5mg two times a day, hold if HR less than 55 or SBP less than 100.
-Metoprolol 25mg one half (12.5mg) tablet was documented as administered when it should have been held with blood pressure readings documented on 01/29/22 at 8:00am as 87/59, on 01/29/22 at 8:00pm as 97/55 and on 01/30/22 at 8:00am as 80/40.

Review of Resident #1's February 2022 eMAR revealed:
-There was an entry for metoprolol 25mg take one half tablet to equal 12.5mg two times a day, hold if HR less than 55 or SBP less than 100.
-Metoprolol 25mg one half (12.5mg) tablet was documented as administered when it should been held with blood pressure readings documented on 02/01/22 at 8:00pm as 82/47, on 02/02/22 at 8:00pm as 95/56, on 02/05/22 at 8:00pm as 84/54, on 02/06/22 at 8:00pm as 77/41, on 02/07/22 at 8:00pm as 95-65, on 02/10/22 at 8:00pm as 76/54, on 02/12/22 at 8:00am as 63/53, on 02/12/22 at 8:00pm as 73/38, on 02/13/22 at 8:00am as 76/46, on 02/13/22 at 8:00pm as 88/74, on 02/14/22 at 8:00pm as 92/54, and on 02/15/22 at 8:00pm as 77/50.

Review of Resident #1's hospital records

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revealed:
-She arrived at the emergency department (ED) on 02/16/22 at 8:43am with complaints of abdominal pain, nausea and vomiting for 2 weeks.
-She was evaluated by the ED provider on 02/16/22 at 9:29am for abdominal pain, hypotension and dehydration.
-Her initial assessment diagnoses included possible diagnoses of "..severe sepsis or acidosis secondary to medication with acute renal failure.."
-Initial emergency room blood pressure was documented as 88/48 and a heart rate of 106 after "a small fluid bolus".
-She went into cardiac arrest in the ED and was intubated and successfully resuscitated.
-She was then admitted to the intensive care unit where on 02/26/22 she went into cardiac arrest again but was not able to be revived and was pronounced dead at 2:22pm.

Telephone interview with a representative from the local fire station from a call placed on 03/04/22 at 4:47pm with a return call on 03/10/22 at 8:24am revealed:
-The fire crew responded to the facility on 02/16/22 in the morning for a medical call due to Resident #1's complaint of abdominal pain.
-She appeared uncomfortable, readjusting herself in bed and shouting.
-The facility's staff told the fire crew that Resident #1 had a low blood pressure.
-Fire crew staff checked the resident's vital signs including blood pressure, pulse oximetry, radial and brachial pulses, but were unable to obtain any blood pressure readings, pulse oximetry reading, or radial and brachial pulses on Resident #1.
-The local county EMS then came on scene and transported Resident #1 to the local ED.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 40 Interview with a medication aide (MA) on 03/02/22 at 11:00am revealed: -He sent her to the ED the morning of 02/16/22 because she looked pale. -The blood pressure he recorded on 02/16/22 for 8:00am was 133/61. -He knew Resident #1's metoprolol had instructions to hold it if her blood pressure or heart rate were below parameters. -Her blood pressures sometimes recorded low when she was at rest, but while she was active during the day they were usually within parameters for him to administer her metoprolol. -He would not give her metoprolol if her blood pressure or heart rate were below the ordered parameters on the eMAR. -He did not observe Resident #1 having any dizziness, fatigue or other symptoms of low blood pressure. -If her blood pressure was below ordered parameters, he would call the PCP or inform the Resident Care Coordinator (RCC) whom he assumed then notified the PCP. -He never recorded any low blood pressures for his shift. Interview with another MA on 03/03/22 at 9:15am revealed: -She knew Resident #1's metoprolol had instructions to hold it if her blood pressure or heart rate were below parameters. -She remembered holding her metoprolol 2 or 3 times in the past month due to blood pressures below ordered parameters. -She did not observe her having any symptoms of low blood pressure. -When her blood pressure was below ordered parameters, she held the metoprolol and informed the RCC who would inform the PCP.	D 358		

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D 358	Continued From page 41 Interview with Resident #1's PCP on 03/03/22 at 10:35am revealed: -Resident #1 had an order for metoprolol twice a day with parameters to be held if systolic blood pressure was less than 100 or heart rate less than 55. -She would expect the facility staff to hold her metoprolol if her blood pressures were below ordered parameters and notify her of any signs of dizziness or other symptoms of low blood pressure even though there was no order to notify her. -She did not review her eMAR and blood pressures prior to 02/16/22. Interview with the RCC on 03/03/22 at 10:45am revealed: -Resident #1 had an order for metoprolol with parameters to hold for low blood pressure or heart rate. -MAs notified her sometimes when Resident #1's blood pressure was below ordered parameters and they had held her metoprolol. -She did not have any reports of medication errors that MAs had given her metoprolol when her blood pressure was below ordered parameters. -She expected the MAs to hold her metoprolol when her blood pressure or heart rate were below the ordered parameters. Interview with the Administrator on 03/03/22 at 4:00pm revealed: -She was not aware Resident #1 had multiple documented low blood pressures until 02/16/22. -She expected the facility MAs to hold medications when the resident's vital signs were below ordered parameters. -She expected the RCC or MAs to report if they	D 358		

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had given a medication when it should have been held.

3. Review of Resident #5's current FL2 dated 11/18/21 revealed diagnoses included dementia, seizures, epilepsy, delusional disorder, traumatic brain injury, anemia, and major depression.

a. Review of Resident #5's current FL2 dated 11/18/21 revealed there was an order for phenytoin (an anticonvulsant medication used to prevent seizures) 125mg/5ml suspension; give 5ml twice daily.

Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for phenytoin 125mg/5ml suspension, 5ml twice daily scheduled at 8:00am and 8:00pm.
-There was documentation that phenytoin 5ml was not administered at 8:00am on 12/01/21, 12/24/21, 12/25/21, 12/26/21, 12/29/21, 12/30/21, or 12/31/21.
-There was documentation that phenytoin 5ml was not administered at 8:00pm on 12/28/21, 12/29/21, 12/30/21, or 12/31/21.
-The documented reason for not administered was the medication was unavailable and the pharmacy had been faxed and called to deliver medication stat.

Review of Resident #5's January 2022 eMAR revealed:
-There was an entry for phenytoin 125mg/5ml suspension, 5ml twice daily scheduled at 8:00am and 8:00pm.
-There was documentation that phenytoin 5ml was not administered on 01/01/22 and on 01/25/22 at 8:00am.

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D 358	Continued From page 43 -The documented reason for not administered was the medication was unavailable and the pharmacy had been faxed and called to deliver medication stat. Observation of Resident #5's medication on hand on 03/02/22 at 4:15pm revealed there was one bottle of phenytoin 125mg/5ml suspension that was half full with a dispensed date of 02/14/22. Telephone interview with a representative from the facility's contracted pharmacy on 03/03/22 at 9:25am revealed: -On 11/17/21, 01/01/21, and 02/14/22 the pharmacy dispensed one 237ml bottle of phenytoin 125mg/5ml (a 23-day supply). -The facility would have ran out prior to the refill sent on 01/01/21 but the pharmacy had not received a refill request. Based on observations, record reviews and interviews, it was determine Resident #5 was not interviewable. Interview with Resident #5's PCP on 03/02/22 at 8:50am revealed: -She was not aware that Resident #5 had missed 11 doses of phenytoin in December 2021. -The missed doses of phenytoin could have caused Resident #5 to have a seizure. -She expected the MAs to administer each medication as ordered. -The MAs should have notified her if Resident #5 missed more than one day's worth of his medication. Interview with the MCC on 03/03/22 at 10:30am revealed: -The MAs were supposed to reorder medication from the pharmacy before they ran out.	D 358		

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D 358	Continued From page 44 -Most medications were cycle-filled so the pharmacy automatically refilled them without needing a request from the facility. -Since starting her position in February 2022, there had been no delay in receiving medications from the pharmacy. -If a MA had a medication that was due for administration but was not available in the medication cart, they were supposed to call the pharmacy to request it and then document that the refill had been requested. If by the third day a medication still had not arrived from the pharmacy the MA should then let her know and she would call the pharmacy supervisor for more information. -She did not complete eMAR audits and did not know if any other staff were assigned that responsibility. Interview with the RCC on 03/03/22 at 5:15pm revealed: -There was no system in place or anyone who was responsible for completing audits of the eMARs. -She thought the medications that were missed in December 2021 were either available in the medication cart or overstock drawer and the MAs just did not administer them for whatever reason. -They completed medication cart audits; during the audit they checked expiration dates on medication, that medication orders matched the order on the medication card, and that all medications that would be due were on hand. -The RCC, MA and MCC completed the medication cart audits and were supposed to do it weekly, but since they had just terminated several staff and hired new staff, it was getting done less frequently. Interview with the Administrator on 03/04/22 at	D 358		

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D 358	Continued From page 45 4:45pm revealed: -She was not aware that Resident #5 had missed 11 doses of phenytoin in December 2021. -There was no system in place for eMAR audits in December 2021. -Most of the staff who documented medications as not given in December 2021 no longer worked for the facility. -She was not sure why the medication was documented as not available from the pharmacy, and thought it was just user error with the MAs selecting any option from the drop-down menu on the eMAR. -The facility generally did not have any issue getting medication delivered from the pharmacy. -It was her expectation that MAs administer medications as they were ordered. -If a MA did not have a medication available to administer when it was due, they should have called the pharmacy and then let either herself or the RCC know if the pharmacy was not able to deliver it that day. -The MAs should request refills from the pharmacy using the "Reorder" button on the eMAR prior to the medication running out. b. Review of Resident #5's current FL2 dated 11/18/21 revealed there was an order for trazodone (used to treat mood disorders, depression, anxiety and insomnia) 75mg daily. Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for trazodone 75mg daily scheduled at 8:00am. -There was documentation that trazodone 75mg was not administered on 12/13/21, 12/14/21, 12/17/21, 12/18/21, 12/19/21, 12/22/21, or 12/29/21.	D 358		

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-The documented reason for not administered was the medication was unavailable and the pharmacy had been faxed and called to deliver medication.

Review of Resident #5's January 2022 eMAR revealed:
-There was an entry for trazodone 75mg daily scheduled at 8:00am.
-There was documentation trazodone 75mg was administered daily at 8:00am from 01/02/22 through 01/31/22.
-The documented reason for trazodone not administered on 01/01/22 was the medication was unavailable and the pharmacy had been faxed and called to deliver medication.

Review of Resident #5's February 2022 eMAR revealed:
-There was an entry for trazodone 75mg daily scheduled at 8:00am.
-There was documentation trazodone 75mg was administered daily at 8:00am from 02/01/22 through 02/26/22.
-There was documentation that trazodone 75mg was not administered on 02/02/22, 02/27/22 or 02/28/22.
-The documented reason for not administered was the medication was unavailable and the pharmacy had been faxed and called to deliver medication.

Review of Resident #5's March 2022 eMAR revealed:
-There was an entry for trazodone 75mg daily scheduled at 8:00am.
-There was documentation that trazodone 75mg was not administered on 03/01/22 at 8:00am.
-The documented reason for not administered was the medication was unavailable and the

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pharmacy had been faxed and called to deliver medication.

Observation of Resident #5's medication on hand on 03/02/22 at 4:15pm revealed:
-There was no trazodone 75mg tablets available for administration.
-The MA displayed refill requests sent to the pharmacy on the eMAR which were on 02/26/22 and 03/02/22.

Interview with a MA on 03/02/22 at 4:20pm revealed:
-The MAs were supposed to reorder medication when the quantity reached the last column on the medication card.
-The last column on the medication card was shaded blue to indicate it was time to reorder the medication from the pharmacy.
-Not all MAs reordered medication prior to it running out, so sometimes there was a delay between doses.
-Resident #5 rarely refused his medication, so she thought the documentation that his trazodone was not administered due to awaiting on a delivery from the pharmacy was accurate.

Review of a pharmacy packing slip dated 12/07/21 revealed the facility signed for 42 tablets of trazodone 75mg on 12/10/21.

Telephone interview with a representative from the facility's contracted pharmacy on 03/03/22 at 9:25am revealed:
-Most medications for the facility were on cycle fill so the facility should always have enough medication to get through the month unless the PCP increased a medication dosage.
-On 12/02/21, 12/30/21 and 01/27/22, the pharmacy dispensed 42 tablets (a 28-day supply)

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D 358	Continued From page 48 of trazodone 75mg. Interview with Resident #5's PCP on 03/02/22 at 8:50am revealed: -She was not aware that Resident #5 had missed 7 doses of trazodone in December 2021, 1 dose in January 2022, 3 doses in February 2022 and 1 dose in March 2022. -He could have had withdrawal symptoms from missing that many doses of trazodone. -She expected the MAs to administer each medication as ordered. -The MAs should have notified her if Resident #5 missed more than one day's worth of his medication. Interview with the MCC on 03/03/22 at 10:30am revealed: -The MAs were supposed to reorder medication from the pharmacy before they ran out; usually once they were down to 8 tablets or fewer. -She had advised the MAs to check the overstock medication drawer prior to requesting a refill from the pharmacy; sometimes they had another card full of medication on hand when a refill request was sent. -Most medications were cycle-filled so the pharmacy automatically refilled them without needing a request from the facility. -The medications that were on cycle-fill were labeled as such on the medication card. -Since starting her position in February 2022, there had been no delay in receiving medications from the pharmacy. -If a MA had a medication that was due for administration but was not available in the medication cart, they were supposed to call the pharmacy to request it and then document that the refill had been requested. If by the third day a medication still had not arrived from the	D 358		

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pharmacy the MA should then let her know and she would call the pharmacy supervisor for more information.
-She did not complete eMAR audits and did not know if any other staff were assigned that responsibility.

Interview with the RCC on 03/03/22 at 5:15pm revealed:
-There was no system in place or anyone who was responsible for completing audits of the eMARs.
-She thought the medications that were missed in December 2021 were either available in the medication cart or overstock drawer and the MAs just did not administer them for whatever reason.
-They completed medication cart audits; during the audit they checked expiration dates on medication, that medication orders matched the order on the medication card, and that all medications that would be due were on hand.
-The RCC, MA and MCC completed the medication cart audits and were supposed to do it weekly, but since they had just terminated several staff and hired new staff, it was getting done less frequently.

Interview with the Administrator on 03/04/22 at 4:45pm revealed:
-She was not aware that Resident #5 had missed 7 doses of trazodone in December 2021, 1 dose of trazodone in January 2022, 3 doses of trazodone in February 2022 and 1 dose of trazodone in March 2022.
-There was no system in place for eMAR audits.
-Most of the staff who documented medications as not administered in December 2021 and January 2022 no longer worked for the facility.
-She was not sure why the medication was documented as not available from the pharmacy,

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D 358	Continued From page 50 and thought it was just user error with the MAs selecting any option from the drop-down menu on the eMAR. -The facility generally did not have any issue getting medication delivered from the pharmacy. -It was her expectation that MAs administer medications as they were ordered. -If a MA did not have a medication available to administer when it was due, they should have called the pharmacy and then let either herself or the RCC know if the pharmacy was not able to deliver it that day. -The MAs should request refills from the pharmacy using the "Reorder" button on the eMAR prior to the medication running out. _____ The facility failed to administer medications as ordered for 2 of 3 residents (#6 and #7) observed during the medication pass including errors with crushing a blood pressure medication and a medication for circulation, and not having a medication to control behaviors which could result in dizziness and stomach distress (#6); and for 2 of 5 residents sampled for record review including errors with medications for depression, insomnia and seizures which could result in symptoms of withdrawal and seizure activity (#5); and not holding blood pressure medication according to ordered parameters resulting in the resident experiencing episodes of low blood pressures which resulted in hospitalization for hypotension (#1). This failure placed residents at substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/04/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2	D 358		

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D 358	Continued From page 51 VIOLATION SHALL NOT EXCEED APRIL 3, 2022.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 2 of 3 sampled residents (#5 and #8) with physician orders for narcotic pain medications (#5 and #8) and an anti-anxiety medication (#5). The findings are: Interview with the Administrator on 03/04/22 at 3:00pm revealed: -The facility did not have a policy for managing the receipt, administration, and disposition of Controlled Substances available for review. -The Resident Care Coordinator (RCC) and a medication aide (MA) supervisor had audited the controlled substances on hand for administration compared to the controlled substance count	D 392		

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sheets (CSCS) in January 2022 and made adjustments to the CSCS as needed.
-The facility had identified a small variance with a couple of residents' CSCS compared to medications.
-There were some MAs that were released for not following the facility's policy for signing out controlled substances on the CSCS and counting the controlled substances on the medication cart between shifts.
-The facility had not done a reconciliation of controlled substances sent from the contracted pharmacy compared to the CSCS for controlled substances signed out for administration and CSCS for medication available for administration for residents.

1. Review of Resident #5's current FL2 dated 11/18/21 revealed diagnoses included dementia, seizures, epilepsy, delusional disorder, traumatic brain injury, anemia, and major depression.

a. Review of Resident #5's physician's order dated 11/25/21 revealed there was an order for oxycodone 5mg (a Schedule II controlled substance) tablets, take 1 tablet every 6 hours as needed for up to 5 days for moderate or severe pain.

Review of Resident #5's physician's order dated 12/09/21 revealed there was an order for oxycodone 5mg tablets, take 1 tablet every 6 hours as needed for moderate to severe pain.

Review of Resident #5's physician's order dated 12/15/21 revealed there was an order for oxycodone 5mg tablets, take 1 tablet every 8 hours as needed for moderate to severe pain, and discontinue previous order for every 6 hours as needed.

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D 392	Continued From page 53 Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 5mg tablet, give 1 tablet every 6 hours as needed for up to 5 days for moderate or severe pain; with a start date of 11/25/21 and a discontinue date of 12/15/21. -There was documentation oxycodone 5mg was administered 12/01/21 at 12:37pm. -There was documentation oxycodone 5mg was administered 12/03/21 at 2:46pm. -There was documentation oxycodone 5mg was administered 12/06/21 at 8:05am and 12:59pm. -There was documentation oxycodone 5mg was administered 12/07/21 7:58am. -There was documentation oxycodone 5mg was administered 12/08/21 at 12:32am. -There was documentation oxycodone 5mg was administered 12/10/21 at 8:06am and 4:42pm. -There was documentation oxycodone 5mg was administered 12/12/21 at 7:53am and 2:32pm. -There was documentation oxycodone 5mg was administered 12/13/21 at 11:57am. -There was an entry for oxycodone 5mg tablet, give 1 tablet every 6 hours as needed for moderate or severe pain; with a start date of 12/09/21 and a discontinue date of 12/20/21. -There was documentation oxycodone 5mg was administered 12/14/21 at 1:29pm. -There was documentation oxycodone 5mg was administered 12/16/21 at 4:47pm. -There was an entry for oxycodone 5mg tablet, give 1 tablet every 8 hours as needed for moderate or severe pain; with a start date of 12/15/21 and was a current order. -There was documentation oxycodone 5mg was administered on 12/24/21 at 3:26pm.	D 392		

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Review of Resident #5's controlled substance count sheet (CSCS) received from the pharmacy on 11/26/21 for 20 oxycodone 5mg tablets compared to Resident #5's December 2021 eMAR revealed:
-On 12/08/21, there was one tablet signed out at 8:00am on the CSCS but was not documented on the eMAR.
-The remaining tablets signed out were documented on the eMAR.

Review of Resident #5's January 2022 eMAR revealed:
-There was an entry for oxycodone 5mg tablet, give 1 tablet every 8 hours as needed for moderate to severe pain.
-There was documentation oxycodone 5mg was administered on 01/03/22 at 6:18pm.
-There was documentation oxycodone 5mg was administered on 01/07/22 at 4:11pm.
-There was documentation oxycodone 5mg was administered on 01/08/22 at 7:38am.
-There was documentation oxycodone 5mg was administered on 01/24/22 at 12:59am and 1:36pm.

Review of Resident #5's February 2022 eMAR revealed:
-There was an entry for oxycodone 5mg tablet, give 1 tablet every 8 hours as needed for moderate to severe pain.
-There was documentation oxycodone 5mg was administered on 02/01/22 at 3:24pm.
-There was documentation oxycodone 5mg was administered on 02/03/22 at 8:17pm.
-There was documentation oxycodone 5mg was administered on 02/05/22 at 11:23am.
-There was documentation oxycodone 5mg was administered on 02/08/22 at 8:30pm.
-There was documentation oxycodone 5mg was

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administered on 02/24/22 at 2:55am.

Review of Resident #5's CSCS received from the pharmacy on 12/09/21 for 30 oxycodone 5mg tablets compared to Resident #5's January 2022 and February 2022 eMAR revealed:
-There was documentation that the CSCS was received with a count of 30 tablets.
-One tablet was signed out on 01/24/22 at 1:00am leaving a count of 29 tablets.
-There was one tablet documented on the eMAR on 01/24/22 at 1:36pm that was not signed out on the CSCS.
-There was an entry on 01/25/22 with documentation the correct count was 21 tablets and signed by the MA supervisor.
-There were 16 tablets remaining.

Review of Resident #5's CSCS received from the pharmacy on 01/08/22 for 30 oxycodone 5mg tablets revealed:
-There was documentation that the CSCS was received with a count of 30 tablets.
-It was documented that the correct count was 29, there was no date specified.
-There were 29 oxycodone 5mg tablets remaining in the medication card.

Observation of medication on hand on 03/02/22 at 4:15pm revealed:
-There was one medication card in the medication cart dated 12/09/21 for oxycodone 5mg tablets, with 16 of 30 tablets remaining.
-There was one medication card in the Resident Care Coordinator's (RCC) office dated 01/08/22 for oxycodone 5mg tablets, with 29 of 30 tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 03/04/22 at

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D 392	Continued From page 56 12:15pm revealed: -On 11/26/21, the pharmacy dispensed 20 tablets of oxycodone 5mg. -On 12/09/21, 12/15/21, 12/28/21, and 01/08/22 the pharmacy dispensed 30 tablets of oxycodone 5mg. -They had not received any full or partial medication cards of oxycodone 5mg returned from the facility back to the pharmacy for Resident #5. -They had not been notified by the facility regarding any concerns of medications unaccounted for. -They had a delivery ticket for oxycodone 5mg from 12/15/21 at 9:00pm and from 12/28/21 at 2:10am indicating it was delivered to the facility. Interview with the Memory Care Coordinator (MCC) on 03/03/22 at 10:30am revealed: -Extra medication cards of oxycodone that were not yet needed for Resident #5 would either be locked in the medication cart in the narcotic drawer or locked in the RCC's office. -The RCC kept all the previous CSCS sheets. -She was not aware of any full cards of oxycodone that were not yet used or that had been sent back to the pharmacy. Interview with the medication aide (MA)/ Supervisor on 03/03/22 at 2:50pm revealed: -She had helped the RCC audit the controlled medication cards in January and updated the count on each CSCS to reflect how many pills remained in each card. -If there were multiple medication cards for the same medication and the same resident, they locked the medication card in the RCC's office. -No medication cards were sent back to the pharmacy. -She did not remember there being any	D 392		

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discrepancies in the counts for Resident #5.
-She had administered oxycodone to Resident #5 on 01/24/22 at 1:36pm and documented administration on the eMAR.
-She did not sign it out on the CSCS because she thought she forgot to.

Interview with the Administrator on 03/03/22 at 3:25pm revealed:
-She was aware of the narcotic audit the RCC and MA Supervisor had done in January 2022.
-Based on the audit and incorrect drug counts, they had terminated several MAs.
-The MAs that they had terminated were probably diverting the narcotics and they had not realized it until that day on 03/03/22.
-They had not done a full medication reconciliation to compare what the pharmacy had dispensed versus what they had available in the facility because she had not thought to do that.
-She was not aware that there were two medication cards each containing 30 tablets of oxycodone 5mg that were not accounted for in the facility.
-She expected the MAs to administer medications as ordered and to keep an accurate count of controlled substances on the CSCS.

Interview with Resident #5's primary care provider (PCP) on 03/03/22 at 8:50am revealed:
-She was not aware of oxycodone counts being incorrect on Resident #5's CSCS sheets.
-She was not aware that the oxycodone received from the pharmacy on 12/15/21 and 12/28/21 was not accounted for in the facility.
-It was her expectation that MAs would administer medication as ordered and keep an accurate account of controlled drugs.

Based on observation, record review and

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interview, it was determined Resident #5 was not interviewable.

Refer to interview with the Resident Care Coordinator (RCC) on 03/03/22 at 11:10am.

Based on observation of medications on hand, reviews of the eMARs, CSCS documentation, and dispensing records and interviews with the contracted pharmacy staff revealed there were a total of 140 oxycodone 5mg tablets dispensed from 11/26/21 to 01/08/22 for Resident #5 with 9 oxycodone 5mg tablets unaccounted for related to the CSCS matching the eMAR; 60 oxycodone 5mg tablets unaccounted for without a CSCS.

b. Review of Resident #5's signed physician's order dated 11/16/21 revealed there was an order for clonazepam 0.5mg (a Schedule IV controlled substance used to treat seizures and panic disorders) twice daily.

Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 0.5mg tablets, take 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation clonazepam 0.5mg was administered twice daily at 8:00am and 8:00pm from 12/01/21 though 12/31/21; except for on 12/11/21 at 8:00pm, 12/12/21 at 8:00am and 8:00pm, and 12/13/21 through 12/15/21 at 8:00am where it was documented that staff were awaiting deliver of medication from the pharmacy.

Review of Resident #5's CSCS received from the pharmacy on 12/12/21 for 60 clonazepam 0.5mg tablets compared to Resident #5's December 2021 eMAR revealed:

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-Two different MAs documented on the CSCS that there were 33 tablets remaining after administering one tablet on 12/28/21 at 7:00pm and 12/28/21 at 8:00pm.
-The remaining tablets were signed out on both the eMAR and the CSCS.

Review of Resident #5's January 2022 eMAR revealed:
-There was an entry for clonazepam 0.5mg tablets, take 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation clonazepam 0.5mg was administered twice daily at 8:00am and 8:00pm from 01/01/22 through 01/31/22.

Review of Resident #5's CSCS received from the pharmacy on 12/12/21 for 60 clonazepam 0.5mg tablets compared to Resident #5's January 2022 eMAR revealed:
-On 01/11/22, there were no tablets signed out as administered on the CSCS for 8:00am or 8:00pm.
-On 01/12/22 at 7:00am, the count was 6 tablets remaining, and on 01/12/22 at 8:00pm the count was 4 tablets remaining; there was no documentation that the 1 missing tablet had been dropped or disposed of.
-The last counted day was 01/12/22 at 8:00pm with 4 tablets remaining.

Review of Resident #5's CSCS received from the pharmacy on 01/06/22 for 56 clonazepam 0.5mg tablets compared to Resident #5's January 2022 eMAR revealed:
-Two medication cards of 28 tablets were dispensed for a total of 56 tablets.
-There was no documentation on the CSCS from 12/12/21 or 01/06/22 of the 8:00am or 8:00pm dose administered on 01/13/22.
-On 01/14/22, there was no clonazepam signed

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out on the CSCS at 8:00pm.
-On 01/15/22, there was no clonazepam signed out on the CSCS at 8:00am or 8:00pm.
-On 01/19/22, there was no clonazepam signed out on the CSCS at 8:00am.
-On 01/17/22, at 8:00am the count remaining was 25, and on 01/17/22 at 8:00pm the count remaining was 23; there was no documentation that the 1 missing tablet was dropped or disposed of.
-On 01/25/22, there was no clonazepam signed out on the CSCS at 8:00pm.
-On 01/27/22, the 8:00am dose of clonazepam was signed out twice.
-On 01/28/22, the 8:00am dose of clonazepam was signed out twice.
-On 01/31/22, there was no clonazepam signed out on the CSCS at 8:00pm.
-The last entry on the CSCS was 02/13/22 at 8:00pm with the count remaining at 0 tablets.

Review of Resident #5's February 2022 eMAR revealed:
-There was an entry for clonazepam 0.5mg tablet take 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation clonazepam 0.5mg was administered twice daily at 8:00am and 8:00pm from 02/01/22 through 02/28/22 except on 02/14/22 and 02/15/22 at 8:00am and 8:00pm.
-The reason documented for clonazepam not administered on 02/14/22 and 02/15/22 at 8:00am and 8:00pm was that the medication was not available, and the pharmacy had been called and faxed to deliver the medication stat.

Review of Resident #5's CSCS received from the pharmacy on 02/03/22 for 56 clonazepam 0.5mg tablets compared to Resident #5's February 2022 eMAR revealed:

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-On 02/14/22 and 02/15/22, there were no clonazepam 0.5mg tablets signed out on the CSCS.
-The first tablet signed out was on 02/16/22 at 8:00am with 27 tablets remaining in the medication card.
-The last tablet signed out was on 03/01/22 at 7:00pm with the count at 0 tablets remaining.

Review of Resident #5's March 2022 eMAR revealed:
-There was an entry for clonazepam 0.5mg tablets take 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation clonazepam 0.5mg had been administered on 03/01/22 at 8:00am and 8:00pm, and 03/02/22 at 8:00am.

Review of Resident #5's CSCS received from the pharmacy on 03/01/22 for 56 clonazepam 0.5mg tablets compared to Resident #5's March 2022 eMAR revealed:
-There were two medication cards with CSCS signed as received with 28 tablets each.
-There was one tablet signed out on 03/03/22 at 8:00am with a count remaining of 27 tablets.

Observation of Resident #5's medication on hand on 03/02/22 at 4:15pm revealed there were no clonazepam 0.5mg tablets available for administration.

Observation of Resident #5's medication on hand on 03/03/22 at 10:40am revealed:
-There were two medication cards in the medication cart of clonazepam 0.5mg with a dispensed date of 03/03/22; one card had 27 of 28 total tablets remaining and the second card had 28 of 28 total tablets remaining.
-There was one medication card in the RCC's

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office of clonazepam 0.5mg with a dispensed date of 02/03/22 with 28 of 28 total tablets remaining.

Telephone interview with a representative from the facility contracted pharmacy on 03/03/22 at 9:25am revealed:
-On 11/16/21, the pharmacy dispensed 46 tablets of clonazepam 0.5mg which would be a 23-day supply.
-On 12/12/21, the pharmacy dispensed 60 tablets of clonazepam 0.5mg which would be a 30-day supply.
-On 01/05/22, 01/27/22 and 02/24/22 the pharmacy dispensed 56 tablets of clonazepam 0.5mg which would be a 28-day supply.

Interview with a MA on 03/02/22 at 4:14pm revealed:
-She had worked that morning and documented Resident #5's clonazepam as administered by mistake.
-There was no clonazepam on the medication cart and she meant to hit the reorder button.
-She had not checked with the RCC to see if there was an overstock card of clonazepam in her office.
-She had forgotten that the RCC kept overstock medications locked in her office.

Interview with the MCC on 03/03/22 at 10:30am revealed:
-Extra medication cards of clonazepam that were not yet needed for Resident #5 would either be locked in the medication cart in the narcotic drawer or locked in the RCC's office.
-The RCC kept all the previous CSCS sheets in her office.

Interview with the MA Supervisor on 03/03/22 at

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D 392	Continued From page 63 2:50pm revealed: -If there were multiple medication cards for the same medication and same resident, they locked the medication cards in the RCC's office for safe keeping. -There had been MAs who were working throughout December 2021 and January 2022 who did not keep the correct count of controlled drugs. Interview with the Administrator on 03/03/22 at 3:25pm revealed: -She was not aware of the discrepancies between Resident #5's eMAR and CSCS for clonazepam. -There was no system in place for staff to complete audits of the eMAR and the CSCS. -They had terminated several MAs in January 2022 due to the MAs not keeping a correct account of controlled medications. -She expected the MAs to administer medications as ordered and to keep an accurate count of controlled medications on the CSCS. Interview with Resident #5's PCP on 03/03/22 at 8:50am revealed: -She was not aware of controlled medication count discrepancies for Resident #5's clonazepam. -It was her expectation that MAs would administer medication as ordered and keep an accurate account of controlled medications. Interview with the RCC on 03/04/22 at 11:25am revealed they did not have a CSCS for Resident #5's clonazepam 0.5mg dispensed on 11/16/22. Based on observation, record review and attempted interview, it was determined Resident #5 was not interviewable.	D 392		

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D 392	Continued From page 64 Refer to interview with the Resident Care Coordinator (RCC) on 03/03/22 at 11:10am. 2. Review of Resident #8's current FL2 dated 10/28/21 revealed: -Diagnoses included spinal stenosis, and weak muscles. -There was an order for oxycodone 5mg one tablet every 3 hours as needed (prn) for pain. (Oxycodone is a Schedule II controlled substance used to treat moderate to severe pain.) Review of Resident #8's physician's orders dated 10/28/21 and 11/18/21 revealed an order for oxycodone 5mg one tablet every 3 hours as needed (prn) for pain. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/04/22 at 12:15pm revealed: -The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used for signing out narcotics because the facility had not requested a CSCS. -Resident #8 had 30 tablets of oxycodone 5mg dispensed on 10/21/21. Review of Resident #8's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 5mg one tablet every 3 hours prn for pain. -There was no scheduled time for administration of oxycodone 5mg. -There were 9 doses on the eMAR documented as administered. Review of Resident #8's November 2021 eMAR compared to Resident #8's CSCS for 30 tablets	D 392		

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	HAL041010	A. BUILDING: _____ B. WING _____	R-C 03/04/2022

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D 392	Continued From page 65	D 392		

of oxycodone 5mg dispensed on 10/21/21 revealed:
-There were 9 tablets signed out on the CSCS from 11/02/21 at 9:00am to 11/29/21 at 9:00pm.
-On 11/15/21 at 9:00am, one oxycodone 5mg was signed out on the CSCS and not documented on the November 2021 eMAR.
-On 11/16/21 at 8:24am, one oxycodone 5mg was not signed out on the CSCS and documented as administered at 8:24am on the eMAR.
-There were 2 tablets oxycodone 5mg tablets not properly accounted for in November 2021.

Review of Resident #8's December 2021 eMAR revealed:
-There was an entry for oxycodone 5mg one tablet every 3 hours prn for pain.
-There was no scheduled time for administration of oxycodone 5mg.
-There were 9 doses documented on the eMAR as administered.

Review of Resident #8's December 2021 eMAR compared to Resident #8's CSCS for 30 tablets of oxycodone 5mg dispensed on 10/21/21 revealed:
-There were 10 tablets signed out on the CSCS from 12/06/21 at 11:00pm to 12/31/21 at 9:00pm.
-On 12/06/21 at 11:00pm, one oxycodone 5mg was signed out on the CSCS and not documented as administered on the eMAR.

Observation of Resident #8's medication on hand on 03/04/22 at 3:00pm revealed Resident #8 had 6 oxycodone 5mg in a bubble card dispensed on 10/21/21 which matched the quantity remaining on the CSCS.

Based on observation of medication on hand, and

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D 392	Continued From page 66 reviews of the eMARs, CSCS documentation, and dispensing records, and interviews with the pharmacy staff revealed Resident #8's oxycodone 5mg was not accurately accounted for 3 out of 24 tablets documented as administered from 11/02/21 at 9:00am to 12/31/21 at 9:00pm as follows: -On 11/15/21 at 9:00am, one oxycodone 5mg was signed out on the CSCS and not documented on the November 2021 eMAR. -On 11/16/21 at 8:24am, one oxycodone 5mg was not signed out on the CSCS and documented as administered at 8:24am on the eMAR. -On 12/06/21 at 11:00pm, one oxycodone 5mg was signed out on the CSCS and not documented as administered on the eMAR. Interview with a medication aide (MA) supervisor on 03/04/22 at 3:20pm revealed: -MAs were supposed to count the controlled substances, using the CSCS and the quantity on hand for comparison at the sift changes. -She had signed out oxycodone 5mg for Resident #8 on the CSCS when she punched the medication from the bubble card, however she must have gotten interrupted or called away to assist with resident care before she returned to the medication cart and documented administration on the resident's eMAR. -There was no system in place to audit the CSCS sign outs compared to residents' eMARs for accuracy. -She concentrated on ensuring all controlled substances were signed out on the CSCS. Refer to interview with the Resident Care Coordinator (RCC) on 03/03/22 at 11:10am. Interview with the RCC on 03/03/22 at 11:10am	D 392		

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D 392	Continued From page 67 revealed: -In January 2022, she had noticed extra medication cards with narcotics in the medication carts, so she removed the cards that were not currently being used and locked them in her office. -The facility previously had MAs employed who did not keep an accurate count of controlled drugs on the CSCS, so they terminated some of those MAs and did training with the remaining MAs. -She and the MA Supervisor went through all the controlled drug medication cards and wrote on the corresponding CSCS what the current count was for each card. -There was nobody at the facility responsible for completing audits of the eMARs or CSCS. -She and the MA or MCC had been trying to complete medication cart audits every week to every other week; during the audit they would check expiration dates of medications, that they had all the ordered medications on hand, and that the orders on the medications matched the orders on the eMAR. -There was no policy for administration of controlled substances. _____ The facility failed to ensure a readily retrievable record of controlled substances for 2 of 3 residents (#5, and #8) by documenting the administration and disposition of 9 oxycodone 5mg not accurately accounted for on the eMARs compared to the CSCS and 60 oxycodone 5mg not accounted for due to missing CSCS (#5); and oxycodone 5mg not accurately accounted for 3 out of 24 tablets documented as administered for on the eMARs compared to the CSCS from 11/02/21 at 9:00am to 12/31/21 at 9:00pm (#8) resulting in inaccurate accounting for oxycodone 5mg which could interfere with the PCP's ability to	D 392		

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D 392	Continued From page 68 monitor residents' pain medication effectiveness. This failure was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/03/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 18, 2022.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, health care, other staff qualifications, medication administration, and controlled substances. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure supervision was provided for 1 of 5 sampled residents	D912		

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D912	Continued From page 69 (Resident #5) resulting in 10 falls in 3 months. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)] 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#6 and #7) observed during the medication pass including errors with a blood pressure medication, medication for circulation, and medication to control behaviors (#6), and a vitamin supplement (#7); and for 2 of 5 residents sampled (#1 and #5) for record review including errors with medications to treat seizures and mental disorders (#5); and not holding blood pressure medication according to ordered parameters (#1). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to contact the primary care provider (PCP) for 2 of 5 sampled residents (#1 and #5) related to episodes of nausea and vomiting and abdominal pain (#1) and a missed laboratory order (#5). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 4. Based on interviews and record reviews, the facility failed to ensure there were no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR) for 3 of 6 sampled staff (Staff C, D and E). [Refer to Tag D0137, 10A NCAC 13F. 0407(a)(5) Other Staff Qualifications (Type B Violatation)]. 5. Based on record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (Staff C and E) had a statewide criminal background	D912		

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D912	Continued From page 70 check completed upon hire. [Refer to Tag D0139, 10A NCAC 13F. 0407(a)(7) Other Staff Qualifications (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 2 of 3 sampled residents (#5 and #8) with physician orders for narcotic pain medications (#5 and #8) and an anti-anxiety medication (#5). [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].	D912		