Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: ______ B. WING ______	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	**2041 NC 210 NORTH LILLINGTON, NC 27546**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 19, 2022 through April 21, 2022.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure all washers and dryers were maintained in a safe and operating condition resulting in residents not having clean linen and clean clothes available at all times. The findings are: Interview with a resident on 04/19/22 at 9:00am revealed: -The big washer (industrial) had been broken for several months. -It leaked and staff used bed sheets to mop up the water on the floors and just dry them without washing the dirty wet sheets that had been used. -The staff used the small (residential) washers, used by the residents, to try and keep up with the laundry that was normally done in the big washer. -That would tie up the small washer and the overloading and overuse caused the small ones to break as well. -The facility did not have enough clean linen to keep the beds changed. - Her bed linen had not been changed in about 3	D 105		

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weeks to a month.

Interview with a second resident on 04/19/22 at 9:15am revealed:
-The residents were not able to use the washer in their laundry room since the staff used it to wash the facility's linen.
-The staff laundry room had one big washer and one big dryer (industrial).
-The big washer had been leaking for some time, about a month or so.
-The residents' washer had worked fine until the staff started using it to wash the facility's linen when the big washer broke.

Interview with a third resident on 04/19/22 at 9:36am revealed:
-The facility's laundry room had been shut down for a couple of days.
-The only clean clothes he had was the ones he was currently wearing.
-He had a bag of clothes in a chair in his room that needed washing.
-He was not sure why staff was not doing his laundry but he heard the washing machine and dryer were "down".

Interview with a fourth resident on 04/19/22 at 10:18am revealed:
-The facility's laundry was not working.
-Recently water flooded the hall next to the laundry room.
-Her laundry had not been done in a few days.

Interview with a fifth resident on 04/19/22 at 10:36am revealed:
-The laundry had not been washed that week.
-The washing machine had broken down.

Observation on 04/19/22 at 10:05am of the

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resident laundry room revealed:
-A 32-gallon large yellow plastic soiled linen receptacle on caster wheels filled to the top and overflowing with wet linen.
-There were dark green bed sheets on the floor next to the yellow receptacle.
-There was a black plastic bag on the counter top on the right-hand side of the laundry room.
-There were two white residential washers on the left side of the laundry room.
-There was a hand printed sign taped with blue tape to the top of the washer on the left-side that documented "small loads only no large items no rugs allowed".
-This washer had manual control knobs and was missing the control knob for the load size selection.
-There were two white residential dryers on the window side of the laundry room straight across from the door.
-There were no washing machines or dryers operating (i.e. washing or drying clothes) at the time of the observation.

Observation of the facility laundry room on 04/19/22 at 10:05am revealed:
-One large silver industrial washer in front of the window.
-There was a hand printed sign on the washer that documented "out of service, don't touch" taped on the front of the washer door with blue tape.
-Around the base of the washer on the floor were numerous wet white sheets.
-There was a large white industrial dryer to the right-hand side of the washer.

Interview with laundry staff on 04/20/22 at 8:16am revealed:
-The facility had two residential washers and two

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residential dryers for the residents to use to wash their personal clothes.
-There was one industrial washer and one industrial dryer that laundry staff used for laundrying facility items such as bed linen, towels and wash clothes.
-Some of the residents did their own personal laundry in the residential laundry room.
-The industrial washer had been broken since she started in December 2021; it leaked.
-Staff did not use the industrial washer after it started started to leak, but some staff still used it and that was why there were piles of dirty wet linen.
-She was not sure why the linen was not being washed and just left out to mildew.

Observation of the soiled linen closet on 04/20/22 at 9:58am revealed:
-There were approximately 15 black plastic bags full of wet linen on the floor of the closet.
-There was a slight stale musty odor noted in the soiled linen closet.

Observation of the clean linen closet on 04/20/22 at 8:28am revealed there were housekeeping staff putting out new bed linen and a few towels and washcloths.

Interview with a personal care aide (PCA) on 04/20/22 at 9:52am revealed:
-She needed clean linen so she could give one of her residents their shower.
-This was the only storage for clean linen.
-There were five residents that were scheduled for showers today on her shift.
-First shift PCAs assisted with about 10-15 resident showers daily.
-The laundry staff on first shift washed the soiled linens, towels and washcloths when they came in

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to work every morning.
-Staff had to wait to get towels and washcloths before they could assist the residents with showers, since the washer was broken.
-There were not enough clean towels and wash cloths for all the residents scheduled to get showers.
-There were sometimes no towels or washcloths in the linen closets on first shift.
-There were not enough towels and washcloths available for all of the residents.

Observation of the clean linen closet on 04/20/22 at 9:52am revealed there were approximately 15 bath towels and 15 wash cloths folded on the bottom shelf to the left-hand side of the closet.

Review of the shower schedule on 04/20/22 at 10:18am revealed there were 16 residents scheduled for a shower on first shift and 15 residents scheduled for a shower on second shift on 04/20/22.

Observation on 04/20/22 at 3:50pm of the clean linen closet revealed there were approximately 15 bath towels and 50 wash cloths folded on the bottom shelf to the left-hand side of the closet.

Interview with the housekeeping staff on 04/20/22 at 10:34am revealed:
-The only clean linen was located in the clean linen closet at the nurse's station on C and D hall.
-There were a few small green covered plastic linen carts placed near the ends of the halls but that linen came from the one clean linen closet.
-The clean linen closet located on A hall was used for storage of supplies for the kitchen.
-Adult briefs were stored in the linen closet on B hall.

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D 105	Continued From page 5 Interview with the Maintenance Director on 04/20/22 at 10:51am revealed: -The industrial washer had just broken two days ago. -He came to work yesterday morning (04/19/22) and the laundry room was flooded. -He used a wet to dry vacuum to suck up most of the water that had leaked from the industrial washer after someone had used it Monday night/Tuesday morning (4/18/22-4/19/22). -Someone had used sheets to absorb some of the water and placed the wet linen in the bags in the dirty linen closet. -There were no washers in the facility to wash the wet linen. Interview with the Regional Director of Clinical Services on 04/20/22 at 11:00am revealed: -She expected the facility to follow the proper procedures to keep all equipment in good repair and working order. -If equipment needed to be repaired or replaced, the corporate office would have to be contacted to authorized payment. -She had contacted the corporate office today and was authorized to get a residential washer and dryer from a local home improvement store today. -She would have maintenance staff pick up and install them today. -The wet linen would be taken to the local laundromat to be washed and dried in order to prevent odors, mold, or mildew.	D 105		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care	D 283		

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Homes:
(2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure sanitation and safety guidelines were followed while providing feeding assistance to 2 of 4 residents (#7, #8) who required assistance with their meals.

The findings are:

Observation of the lunch meal on 04/20/22 from 11:30am - 11:59am revealed:
-Resident #7 and Resident #8 were seated at a table in the front hall dining room.
-There was a personal care aide (PCA) seated in a chair between the two residents.
-The PCA was wearing gloves while feeding the lunch meal to Resident #7 and Resident #8 but did not change gloves or wash her hands as she alternated bites of food for each resident.
-The PCA also assisted the residents with drinking liquids by holding each residents' cups to their mouths and at times, her gloved hands came in contact with the residents' faces.
-The PCA did not change her gloves or wash her hands as she alternated sips of drink between the two residents.
-The PCA also used napkins to periodically wipe the residents' mouths without changing gloves her washing her hands between residents.

1. Review of Resident #7's current FL-2 dated 02/14/22 revealed diagnoses of traumatic brain

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injury with changes in mental status, blindness, and gastro esophageal reflux disease.

Review of Resident #7's assessment and care plan dated 02/14/22 revealed the activity of daily living documented Resident #7 as being totally dependent with eating.

Review of Resident #7's Licensed Health Professional Support (LHPS) evaluation dated 02/11/22 revealed:
-The personal care task of feeding techniques for resident with swallowing problems was listed for Resident #7.
-The LHPS recommendation included Resident #7 required feeding assistance.
-Staff competency validation had been documented as yes.

Refer to interview with the PCA on 04/20/22 at 2:00pm.

Refer to interview with the Resident Care Coordinator (RCC) on 04/20/22 at 1:15 p.m.

Refer to interview with the Interim Administrator on 04/20/22 at 4:30 p.m.

2. Review of Resident #8's current FL-2 dated 03/11/22 revealed diagnoses of dementia, chronic obstructive pulmonary disease, and gastro esophageal reflux disease.

Review of Resident #8's assessment and care plan dated 03/11/22 revealed the activity of daily living documented Resident #8 as being totally dependent with eating.

Review of Resident #8's LHPS evaluation dated

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03/31/22 revealed:
-The personal care task of feeding techniques for resident with swallowing problems was listed for Resident #8.
-The LHPS recommendation included Resident #8 required 1 to 1 feeding assistance.
-Staff competency validation had been documented as yes.

Refer to interview with the PCA on 04/20/22 at 2:00pm.

Refer to interview with the Resident Care Coordinator (RCC) on 04/20/22 at 1:15 p.m.

Refer to interview with the Interim Administrator on 04/20/22 at 4:30 p.m.

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Interview with the PCA on 04/20/22 at 2:00pm revealed:
-She had worked at the facility for two months.
-She did not remember being trained on assisting residents with eating when she first started working at the facility.
-She had been told to sit between both residents and feed the residents at the same time but did not remember who had told her.
-She did not remember being told that gloves needed to be changed between feeding residents.

Interview with the Resident Care Coordinator (RCC) on 04/20/22 at 1:15 p.m. revealed:
-She had been taught by a physical therapist at another facility where she had worked that both residents had to be fed at the same time; since feeding one resident and not feeding the other resident was considered to be neglect.
-She had not thought about the sanitation issue of feeding both residents at the same time.

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D 283	Continued From page 9 Interview with the Interim Administrator on 04/20/22 at 4:30 p.m. revealed: -She was not aware that staff were feeding two residents at the same time. -One staff should not feed two residents at the same time. -Gloves should be worn by staff while assisting with feeding but should be changed between residents. -The RCC was responsible for making sure staff was following sanitation and safety guidelines while aiding with feeding to residents.	D 283		
D 289	10A NCAC 13F .0904(b)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (4) If residents require feeding assistance, food shall be maintained at serving temperature until assistance is provided. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve food at an appropriate temperature for 1 of 4 sampled residents (#1) who required feeding assistance. The findings are: Review of Resident #1's current FL-2 dated 11/05/21 revealed diagnoses of cerebral palsy with contractures, dysphagia and chronic obstructive pulmonary disease. Review of Resident #1's assessment and care	D 289		

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plan dated 01/06/22 revealed the activity of daily living documented Resident #1 as being totally dependent with eating.

Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 02/25/22 revealed:
-The personal care task of feeding techniques for resident with swallowing problems was listed for Resident #1.
-The recommendation in care included Resident #1 needed 1 to 1 feeding assistance.
-Staff competency validation had been documented as yes.

Resident #1 was observed seated in her wheelchair in the television (TV) room on the A/B hall watching TV with 4 other female residents who were seated in wheelchairs on 04/20/22 at 7:32am.

Observation in the kitchen during meal preparation for the residents requiring feeding assistance on 04/20/22 at 7:35am revealed pureed and mechanical soft meals were being placed into sectioned plastic containers.

Observation of the TV room on A/B hall on 04/20/22 at 7:38 am revealed:
-Four of the 5 female residents seated in their wheelchairs were being transported to the dining room on the A/B hall.
-Resident #1 remained in the TV room on A/B hall.

Observation on 04/20/22 at 7:40am revealed four sectioned containers were taken to the A/B hall dining room for the 4 female residents (who had previously been in the TV room with Resident #1) seated together at one table in the dining room

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with a personal care aide (PCA) and the Resident Care Coordinator (RCC).

Observation of the breakfast meal on 04/20/22 at 8:08am revealed:
-A female resident seated at a dining table near the 4 female residents (who required feeding assistance) asked the RCC and the PCA where Resident # 1 was.
-The RCC stated Resident #1's tray was on the other cart for the C/D hall dining room.
-The female resident informed the RCC that Resident #1 was in the TV room on A/B hall not in the dining room on C/D hall.
-The RCC stated staff have already taken Resident #1 back.

Observation of the TV room on A/B hall on 04/20/22 at 8:09am revealed Resident #1 remained in the TV room on A/B hall.

Observation of Resident #1 on 04/20/22 at 8:12am revealed:
-The resident was being transported to the dining room on C/D hall by staff.
-Resident #1's plastic sectioned dish containing the breakfast meal did not have a heat source to maintain proper temperature after being plated for serving and remained on the serving line table from 7:35am when plated until 8:13am.
-The resident's serving of grits were stiff and stuck together in one big clump.

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

Interview with a resident on 04/19/22 at 9:00am revealed she was not able to eat breakfast this morning since it was cold when it was served in

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those foam trays.

Interview with a second resident on 04/19/22 at 9:15am revealed:
-The breakfast trays set out on the hall in that cart for a while this morning.
-When the resident finally got their tray, the food was cold.

Interview with a PCA on 04/20/22 at 8:35am revealed:
-She had been providing personal care to other residents and had to pass out the other residents' trays to their rooms.
-When she used the spoon to feed the grits to Resident #1 and the entire serving of grits came up in one big clump because they were cold.
-She knew that Resident #1's breakfast was cold so she tried to warm it in the microwave but did not want to get it too hot so Resident #1 would not get burned when trying to eat.
-Breakfast was the busiest since the PCAs had to provide personal care to the residents and deliver the breakfast trays to the residents on the hall who ate in their rooms.
-Most residents ate lunch and dinner in the dining room, but most of the breakfast trays were served to the residents in their rooms.
-Residents started eating in their rooms during the COVID-19 pandemic and just got used to it.

Interview with the Dietary Manager on 04/21/22 at 9:16am revealed:
-She was not aware that Resident #1's breakfast had been delayed yesterday (04/20/22).
-She expected all residents to receive their meals in a timely manner to ensure the proper serving temperature was maintained.
-The residents had been eating in their rooms since COVID-19 and had continued to be served

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D 289	Continued From page 13 breakfast in their rooms. -Residents who required feeding assistance usually ate their meals in the dining rooms. Interview with the Interim Administrator on 04/20/22 at 4:30pm revealed: -She was not aware Resident #1's breakfast was not served when it was first prepared and was served cold. -She expected the residents' food to be served at the appropriate temperatures. -The residents who required feeding assistance should be fed as soon as their plates were prepared. -She had discussed with the Dietary Manager to discontinue the use of the foam compartment trays and to encourage residents to start back eating meals in the dining rooms. -This would help ensure the meals were served at the proper temperatures by allowing staff more time to feed residents who required assistance and decrease the time staff were on the halls serving trays.	D 289		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were served nutritionally adequate and palatable meals.	D 297		

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The findings are:

Observation of the facility on 04/19/22 at 9:12am revealed the facility's menu dated 04/18/22 was posted on the wall across from the nurses' station on A/B hall.

Observation of Resident #1's breakfast served on 04/20/22 at 8:12am revealed the resident's serving of grits were hardened and stuck together in one big clump.

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

Interview with a resident on 04/19/22 at 9:00am revealed:
-She did not like the food.
-She kept soup and peanut butter and jelly in her room.
-The menu was rarely posted and when it was posted, the meals listed were not what was served.
-The deep fryer had been broken for a couple of months.
-We southerners like our fried chicken not that pre-fried stuff they bake in the oven.

Interview with a second resident on 04/19/22 at 9:12am revealed:
-The meals were "abominable" and she did not like the food.
-One evening for supper last week, plain noodles with water were served, there was no broth or other ingredients and the portions were too small.
-At breakfast, she usually got a tablespoon of grits and a spoonful of scrambled eggs and once in a while she got a couple of slices of bacon or

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sausage.
-The meat was cooked tough and not soft.

Interview with a third resident on 04/19/22 at 9:15am revealed:
-They did not have eggs served on Sunday.
-The food had gone "down-hill" since he had been here.
-One of the cooks was pretty good but the other one could not cook.
-This morning we were served eggs, oatmeal (that could knock you out with if thrown at you), and a piece of an orange.
-The breakfast trays set out on the hall in that cart for a while this morning.
-When I finally got my tray, my food was cold.
-We eat more salads than we do anything else.
-We had chili beans a few days ago and there was more chili than beans.
-We get fed the same food over and over every week.

Interview with a fourth resident on 04/19/22 at 9:36am revealed:
-He did not eat the food at the facility because it was not good and inedible.
-He kept his own food in a refrigerator in his room.
-The facility's hamburger meat gave him diarrhea.

Interview with a fifth resident on 04/19/22 at 9:47am revealed:
-He did not like the food.
-He no longer ate the food provided by the facility and kept his own food in his room.

Interview with a sixth resident on 04/19/22 at 10:03am revealed:
-The facility served a lot of bread and carbohydrates.

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D 297	Continued From page 16 -There was not enough vegetables served at the facility. -She was hungry and not satisfied after eating her meals. Interview with a seventh resident on 04/19/22 at 10:36am revealed: -The food at the facility was "crap". -The food needed less salt; he could not eat it sometimes because it was too salty. Interview with the cook on 04/20/22 at 7:45am revealed: -She had not had any residents complain about the food served. -If a resident did not like or want what was being served at a meal, they could have something else such as cereal or a sandwich like peanut butter and jelly or pimiento cheese. Interview with the Interim Administrator on 04/20/22 at 4:30pm revealed: -She had not been made aware of any resident complaints about the food served at the facility. -She knew the residents wanted fried foods, like chicken and French fries, but the deep fryer was not working. -Residents were able to get something else to substitute for whatever they did not want or like that was on the menu.	D 297		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	D 358		

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(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:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies and the manufacturer's instructions for 1 of 4 residents (#6) observed during the medication pass including errors with two inhalers for breathing problems.

The findings are:

The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 7:00am/8:00am medication pass on 04/20/22.

Review of Resident #6's current FL-2 dated 12/31/21 revealed diagnoses included chronic obstructive pulmonary disease, dementia with psychosis, traumatic brain injury, anxiety, depression, hypertension, chronic kidney disease, and gastroesophageal reflux disease.

Review of Resident #6's physician's orders dated 03/04/22 revealed:
-There was an order for Breo Ellipta 200-25mcg dose inhaler, use 1 inhalation by mouth once a day, rinse mouth after each use. (Breo Ellipta is used to treat chronic obstructive pulmonary disease.)
-There was an order for Incruse Ellipta 62.5mcg dose inhaler, inhale 1 puff by mouth once a day. (Incruse Ellipta is used to treat chronic obstructive pulmonary disease.)

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(Breo Ellipta and Incruse Ellipta are dry powder inhalers (DPI) used to deliver medications deep into the lungs. These types of inhalers are breath-activated requiring a deep, fast breath to release the medication from the device and into the lungs. According to the manufacturer, Breo Ellipta and Incruse Ellipta require the cover lids to be opened and slid all the way down until a "click" is heard. The "click" will release a dose into the chamber and decrease the counter by 1 number, indicating the inhaler is ready to use. Before using the inhaler, exhale fully, then close mouth around the mouthpiece and take 1 long, steady deep breath through the mouth. Hold breath in for 3 to 4 seconds then breathe out slowly and gently.)

Review of the facilty's Use of Inhaler Policy for DPIs dated 12/16/19 revealed:
-Read and follow the instructions for proper assembly and set up of the type of DPI.
-Make sure to keep the DPI clean and dry.
-Keep the DPI in proper orientation - level during treatment.
-Be sure to puncture the capsule or blister pack.
-Do not exhale into the DPI.
-Inhale with rapid steady breath.
-Hold breath for 10 seconds or as long as possible.
-Replace mouthpiece.
-Store in cool, dry place.

Review of Resident #6's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Breo Ellipta 200-25mcg inhale 1 puff once a day, rinse mouth after each use scheduled for administration at 8:00am.
-There was an entry for Incruse Ellipta 62.5mcg inhale 1 puff by mouth once a day scheduled for

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administration at 8:00am.

Observation of the 8:00am medication pass on 04/20/22 revealed:
-At 8:23am, the medication aide (MA) opened the cover lid to Resident #6's Breo Ellipta 200-25mcg inhaler.
-The MA slid the cover lid all the way to the bottom of the device until a click was heard and she handed the inhaler to the resident.
-The MA did not instruct the resident on how to use the inhaler.
-The MA did not instruct the resident to exhale prior to the resident putting his lips around the mouthpiece.
-The resident took two quick shallow breaths in and did not inhale deeply or hold his breath.
-The MA did not instruct the resident to breath in steady and deeply or hold his breath.
-The resident handed the inhaler back to the MA who closed the cover lid on the Breo Ellipta inhaler.
-The resident did not rinse his mouth after using the Breo Ellipta inhaler and was not instructed by the MA to rinse his mouth.
-At 8:24am, the MA opened the cover lid to Resident #6's Incruse Ellipta 62.5mcg inhaler.
-The MA slid the cover lid all the way to the bottom of the device until a click was heard and she handed the inhaler to the resident.
-The MA did not instruct the resident on how to use the inhaler.
-The MA did not instruct the resident to exhale prior to the resident putting his lips around the mouthpiece.
-The resident took two quick shallow breaths in and did not inhale deeply or hold his breath.
-The MA did not instruct the resident to breath in steady and deeply or hold his breath.
-The resident handed the inhaler back to the MA

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who closed the cover lid on the Incruse Ellipta inhaler.

Interview with Resident #6 on 04/20/22 at 11:00am revealed:
-The MAs usually prepared his inhalers and handed them to him once a day.
-He usually took about 2 puffs of each inhaler.
-He sometimes rinsed his mouth after using the inhalers.
-He did not rinse his mouth after receiving his inhalers that morning, 04/20/22.
-He thought the inhalers helped with his breathing and he denied any current issues with shortness of breath or mouth soreness.
-He did not recall if the MAs had instructed him on how to use the inhalers.

Observation of Resident 6's inhalers on 04/20/22 at 11:02am revealed:
-The Breo Ellipta inhaler was dispensed on 03/24/22 with instructions to use 1 inhalation by mouth once a day, rinse mouth after each use.
-The Incruse Ellipta inhaler was dispensed on 03/10/22 with instructions to inhale 1 puff by mouth once a day.
-The back of the boxes for both inhalers had the following instructions for inhaler use: slide the cover down until you hear a "click"; while holding the inhaler away from your mouth, breathe out (exhale) fully; do not breath out into the mouthpiece; put the mouthpiece between your lips and close your lips firmly around it; take 1 long, steady, deep breath in through your mouth; remove the inhaler from your mouth and hold your breath for 3 - 4 seconds; and slide the cover closed.

Interview with the MA on 04/20/22 at 11:02am revealed:

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-Resident #6 could be difficult at times with administering his inhalers.
-She had instructed him on how to use the inhaler in the past but not recently.
-She always opened the inhaler and slid the cover lid until it clicked and then handed it to the resident.
-She had instructed the resident in the past to tilt the inhaler and take a puff then wait a few minutes to catch his breath and take a second puff to make sure he was getting it all.
-She had not noticed the instructions for using the Breo Ellipta and Incruse Ellipta inhalers were printed on the back of the boxes.
-She had not instructed the resident to exhale prior to using the inhalers, to take a long steady, deep breath, or hold his breath after inhaling.
-The resident kept a cup of water in his room and she was "pretty sure" the resident knew to rinse his mouth after using the Breo Ellipta inhaler.
-She had not thought to notify the resident's primary care provider (PCP) of the resident's difficulty with using the inhalers.
-She had never seen the resident short of breath and the resident had never complained of shortness of breath.
-The resident had never complained of mouth soreness from not rinsing his mouth.

Interview with the Resident Care Coordinator (RCC) on 04/20/22 at 12:20pm revealed:
-The MAs had not reported any concerns with any resident's use of inhalers.
-Some residents were capable of holding the inhalers themselves for administration of the inhalers but the MAs were supposed to instruct the residents on how to use and to take deep breaths.
-The MA should have instructed Resident #6 on how to properly use the Breo Ellipta and Incruse

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D 358	Continued From page 22 Ellipta each time the inhalers were administered. -The MA should have instructed and observed Resident #6 rinse his mouth with water after using the Breo Ellipta inhaler. Interview with the Administrator on 04/20/22 at 12:36pm revealed: -The MAs had been trained on proper inhaler technique when they were checked off by the registered nurse. -The MAs should instruct residents to use proper inhaler technique. Attempted telephone interview with Resident #6's PCP on 04/21/22 at 2:58pm was unsuccessful.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1	D 375		

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resident sampled (#5) who self-administered medication had a physician's order to self-administer multiple eye drops, anti-fungal powder, hemorrhoid cream, and medicated powder.

The findings are:

Review of the facility's Self-Administration of Medications policy dated 02/09/21 revealed:
-Residents who had the desire to, and who had been assessed to be capable and safe to, may self-administer medications.
-Medications needed a physician's order for self-administration.
-The Resident's Ability to Safely Self-Administer Medications Assessment must be completed.
-If the resident was assessed to be safe to self-administer medications, the resident's care plan would be updated.
-The medication administration record (MAR) must identify medications that were self-administered, and the medication nurse would need to follow-up with the resident as to documentation and storage of medication during each medication pass.
-Medications kept at bedside must be kept in a locked drawer.

Review of Resident #5's current FL-2 dated 10/14/21 revealed diagnoses included atrial fibrillation, hypertension, diabetes, chronic renal insufficiency, and anxiety.

Review of Resident #5's Resident Register dated 01/23/21 revealed the resident was forgetful and needed reminders.

Review of Resident #5's current assessment and care plan dated 10/14/21 revealed:

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-The resident's vision was limited and she used glasses.
-There was no documentation the resident self-administered any medications.

Observation of Resident #5's room on 04/19/22 at 9:13am revealed:
-There was a bottle of Thera Tears, Refresh Tears, and one unit-dose vial of an eye medication on the table beside Resident #5's recliner (Thera Tears and Refresh Tears are used to lubricate dry eyes).
-There was a third bottle of eye drops on the table with the label facing down.
-The resident identified the vial as Restasis eye drops and the other three bottles as lubricating eye drops (Restasis is a prescription medication used to treat chronic dry eye caused by inflammation).
-There was a bottle of Nystatin powder with an expiration date of 11/2019 on her bathroom sink (Nystatin is a prescription powder used for fungal infections).

A second observation of Resident #5's room on 04/21/22 at 11:55am revealed:
-There was a box on her dresser that contained Systane eye drops, Artificial Tears with a prescription label, Blink eye drops, and Soothe eye drops (Systane, Artificial Tears, Blink, and Soothe eye drops lubricate dry eyes).
-There was the bottle of Nystatin powder, a tube of Preparation H Hemorrhoid Relief cream next to her toothbrush, a bottle of Lotrimin Antifungal Powder, and a bottle of Gold Bond Medicated Foot Powder (Preparation H is used for hemorrhoid pain, Lotrimin is used for fungal infections, and Gold Bond Medicated Foot Powder is used for itching and moisture control).

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Interview with Resident #5 on 04/19/22 at 9:14am revealed:
-She was diagnosed with macular degeneration in both eyes and could not see well.
-She had medications she purchased on her own.
-She self-administered her eye drops, including the Restasis and the lubricating eye drops.
-She used the Thera Tears and Refresh Tears whenever her eyes were dry, which was "a lot," and used a couple of drops in each eye.
-She administered a "good drop" of Restasis in each eye twice a day.
-She did not tell the medication aides (MAs) when she administered the medications she had in her room.

A second interview with Resident #5 on 04/20/22 at 10:32am revealed:
-The MAs would give her the vials of Restasis that she self-administered.
-She would not provide any further information about the medications she self-administered.
-She received eye injections every 6 weeks due to her macular degeneration and she did not trust anyone else to administer her eyedrops.
-She did not currently have any skin rashes and used the powders to prevent skin irritation.

A third interview with Resident #5 on 04/21/22 at 10:13am revealed:
-The MAs would not remain in the room to observe the resident administer the medication because she did not like them to.
-If a MA insisted on giving her the eye drops, Resident #5 would refuse to take the eye drops and make the MA leave.

Review of Resident #5's physician's orders dated 03/15/22 revealed:
-There was an order for Restasis one drop in

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each eye twice a day.
-There was not a self-administration order for Restasis.
-There were no orders or self-administration orders for any other eye drops, the Nystatin powder, the Preparation H Hemorrhoid Relief cream, the Lotrimin Antifungal Powder or the Gold Bond Medicated Foot Powder.

Review of Resident #5's March 2022 and April 2022 electronic medication administration records (eMARs) revealed:
-There was an entry for Restasis one drop in both eyes twice a day scheduled at 8:00am and 8:00pm.
-There was no entry for self-administration of Restasis.
-Restasis was documented as administered to the resident by the MAs from 04/01/22-04/19/22.
-There were no entries or self-administration entries for any other eye drops, the Nystatin powder, the Preparation H Hemorrhoid Relief cream, the Lotrimin Antifungal Powder or the Gold Bond Medicated Foot Powder.

Interview with a MA on 04/20/22 at 4:12pm revealed:
-She would hand the Restasis vial to Resident #5, who would administer the eye drops herself.
-She had not seen any medications in Resident #5's room.

Interview with a second MA on 04/21/22 at 7:52am revealed:
-She administered Resident #5's Restasis; the resident did not self-administer them to her knowledge.
-No residents on Resident #5's hall had orders to self-administer medications.
-Medications were not allowed to be in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: ______ B. WING ______	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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resident's rooms.
-Resident #5 had no other orders for eye drops other than Restasis.

Interview with the Resident Care Coordinator (RCC) on 04/21/22 at 5:22pm revealed:
-No residents on Resident #5's hallway had orders to self-administer medication.
-She had spoken with Resident #5 a few months ago when staff reported to her Resident #5 had a supply of Restasis vials in her room.
-She told Resident #5 that she was not allowed to keep medications in her room, and the medication was removed.
-Resident #5 appeared receptive to the rule reminder and the RCC thought the matter was closed but did not check her room afterwards.
-Staff were instructed to notify her or the Administrator about any medications residents had in their rooms.
-She was not aware Resident #5 still had medications in her room.
-Resident #5 had not been assessed for her ability to self-administer her medications.
-Resident #5 was not cognitively impaired so she would ask the facility's registered nurse to do a self-administration assessment for her.
-There had to be a physician's order to keep medications at bedside.

Telephone interview with the facility's contracted pharmacist on 04/21/22 at 10:34am revealed:
-Resident #5 did not have orders for the lubricating eye drops, Nystatin powder, Lotrimin Anti-Fungal Powder, Preparation H Hemorrhoid Cream, or Gold Bond Medicated Foot Powder.
-Restasis was in a class of medication that heightened the risk of injury if used in error but was unable to list what those risks were.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: ______ B. WING ______	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	**2041 NC 210 NORTH LILLINGTON, NC 27546**

(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 375	Continued From page 28 Attempted telephone interview with Resident #5's eye care provider on 04/21/22 at 10:27am was unsuccessful. Attempted telephone interview with Resident #5's primary care provider on 04/21/22 at 10:58am was unsuccessful.	D 375		