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	FCL092153	A. BUILDING: _____ B. WING _____	06/30/2022

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THE MANOR AT EDGEWATER	1038 STORMY LANE RALEIGH, NC 27610

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 06/29/22 - 06/30/22.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) for 1 of 3 sampled residents (#1) related to a fall resulting in arm pain and multiple bruises on the face, hip, leg, and elbow and notifying the PCP and wound care provider of redness, swelling, and open wounds with drainage on the resident's left leg. The findings are: Review of Resident #1's current FL-2 dated 03/29/22 revealed diagnoses included gait instability, frequent falls, history of stroke associated with blood clotting tendency, venous insufficiency, rotator cuff syndrome of both shoulders, insomnia, essential hypertension, hypothyroidism, and history of unintentional weight loss. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 04/01/22. -The resident required assistance with dressing (if asks), bathing, nail care, hair/grooming, skin	C 246		

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care, cutting up food, and scheduling appointments.
-The resident was forgetful and needed reminders.
-The resident used a walker for ambulation.

Review of Resident #1's current assessment and care plan dated 04/04/22 revealed:
-The resident was ambulatory with aide or device (not specified) and had limited strength in her upper extremities.
-The resident had a wound on her front left shin; apply non-stick gauze pad and affix with a cloth bandage.
-The resident was oriented and her memory was adequate.
-The resident required limited assistance by staff with eating, toileting, ambulation, grooming, and transferring.
-The resident required extensive assistance by staff with bathing and dressing.

a. Observation of Resident #1 on 06/29/22 at 10:31am revealed:
-The resident's left lower leg was bright red and swollen with the redness extending above the knee.
-There were two large bandaids applied to the outer side of the lower left leg.
-There were multiple areas up and down her left lower leg with healed scars.

Interview with Resident #1 on 06/29/22 at 10:26am revealed:
-She fell on the floor on Saturday (06/25/22) and the wound on her left leg started bleeding again.
-The Supervisor-in-Charge (SIC) put bandaids on her leg when it started bleeding.
-Her left leg had been red and swollen for 3 to 4 months.

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C 246	Continued From page 2 -She had been going to a wound care center but she had not been in at least a few weeks. Review of Resident #1's after visit summary for the wound care center dated 05/10/22 revealed: -The resident's left leg was to be washed with soap (Hibiclens) and water and patted dry. -The wound was to be covered with a piece of Xeroform and gauze and changed every 2 to 3 days. -The resident was to return to the wound center in 4 weeks on 06/07/22 if the wound was not healed. -The wound center was to be contacted with any signs or symptoms of infection or complications. -If the wound center was closed then immediate medical attention should be sought at the nearest emergency room or urgent care. Review of Resident #1's outside provider visit notes revealed no documentation of the resident being seen at the wound clinic on 06/07/22. Review of Resident #1's progress notes for April 2022 - June 2022 revealed: -There was no documentation regarding the condition of the resident's leg. -There was no documentation of when the current bandaids were applied to the resident's lower left leg or the reason the bandaids were applied. -There was no documentation the resident's primary care provider (PCP) or the wound care center provider were notified of the current redness, swelling, or open areas on the resident's left leg. Interview with the SIC on 06/29/22 at 2:30pm revealed: -Resident #1 had bandaids on her left lower leg	C 246		

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because the resident had scratched herself and there was blood on her leg.
-She could not say how long the bandaids had been on the resident's leg.
-The resident's leg had a big wound previously and the resident's leg had always been red and swollen.
-She did not answer when asked if the resident's leg was more red or more swollen than normal.
-She did not notify the resident's PCP of the condition of the resident's leg.
-She did not notify the resident's wound care center provider of the condition of the resident's leg.
-She did not communicate with the resident's PCP or wound care provider because the resident took care of that herself.
-She did not recall getting any paperwork from the resident's medical providers when the resident returned from appointments.
-She did not attempt to get any paperwork from the resident's providers because the resident went to her appointments on her own.

A second interview with the SIC on 06/29/22 at 2:48pm revealed:
-She did not know if the resident went to the follow-up appointment with the wound care center on 06/07/22.
-The resident's wound had healed but she could not recall when it healed.
-She was responsible for making sure residents went to their appointments.
-She did not know about Resident #1's appointment on 06/07/22 because the resident "does things for herself".

Telephone interview with the Administrator / Registered Nurse (RN) on 06/29/22 at 3:15pm revealed:

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C 246	Continued From page 4 -She had not seen Resident #1's leg and the SIC had not reported any concerns regarding the resident's leg. -She thought the resident's leg wound was healed -She last saw the resident's leg wound in May 2022 and there was a "tiny, little wound area". -She thought maybe the resident or the resident's power of attorney (POA) had cancelled one of the resident's appointments but she was not sure. -The SIC was responsible for notifying the resident's providers of any concerns with the resident's leg wound, the fall, and any injuries. Observation of Resident #1 with the Administrator/RN on 06/29/22 at 4:33pm revealed: -The Administrator removed both bandaids from the resident's lower left leg. -Both bandaids were saturated with brown drainage. -There was a dime sized open area under one bandage. -There was quarter sized open area below the dime sized open area. -The resident's left lower leg was swollen and red with the redness extending above the knee. Interview with the Administrator/RN on 06/29/22 at 4:33pm revealed: -There were bruises on the resident's left lower leg that had opened up. -There was drainage from the wounds on both bandaids. -She needed to get home health to come to the facility to see the resident for wound care. Interview with the Administrator/RN on 06/29/22 at 5:12pm revealed: -She had just spoken on the phone with an on-call provider at Resident #1's PCP's office.	C 246		

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-The on-call provider was ordering antibiotics and wound care by home health for the resident's leg.
-The provider ordered home health as soon as possible because the resident needed to be seen immediately.

Interview with Resident #1 on 06/30/22 at 11:07am revealed:
-She did not remember if she gave any paperwork from her medical appointment visits to the facility staff but she thought she did.
-She had finished with the wound care center because her wound had healed.
-She did not recall going to the wound care center on 06/07/22 because she thought her wound was healed.

Telephone interview with Resident #1's POA on 06/30/22 at 12:44pm revealed:
-She sometimes took the resident to her medical appointments and sometimes the resident would take local city transportation to her appointments.
-She usually gave any paperwork from the medical visits to the facility staff.
-The resident had a bad fall and cut her leg before she was admitted to the facility on 04/01/22.
-No one at the facility had contacted her about a follow-up appointment with the wound care center on 06/07/22.
-She relied on the facility to follow-up on the resident's appointments.
-The resident had always had some swelling in her ankles and "a little" redness.
-She was not aware of any changes in the condition of the resident's leg.
-It was not normal for the resident's leg to be extremely red and swollen with redness extending above the knee.
-The Administrator called her today, 06/30/22,

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and reported she was going to have home health come and evaluate the resident's leg wound.
-No one from the facility notified her of the condition of the resident's leg prior to today, 06/30/22.

Telephone interview with a nurse at Resident #1's PCP office on 06/30/22 at 12:03pm revealed:
-The resident was last seen by the PCP on 12/15/21.
-Their office was notified yesterday, 06/29/22, that the resident had a fallen 4 days prior and had a "gash" on her leg that was "hot, red, and puffy".
-Their office should have been contacted when the injury occurred, not 4 days later.
-The on-call PCP sent an order for an antibiotic and for home health to evaluate the wound.
-The resident was set up for a video visit on 07/07/22.
-No redness all over the leg from the ankle to above the knee was reported to them.
-The PCP needed to know all of the details of the resident's condition to determine if the resident needed to be seen for her injuries or condition in their same day clinic.

Telephone interview with the Medical Office Assistant at Resident #1's wound care center on 06/30/22 at 12:38pm revealed:
-Resident #1's appointment on 06/07/22 was a "no show", no one canceled or rescheduled the appointment.
-No one had contacted the wound center about any concerns with the resident's leg wound.
-The wound care center should be notified if the resident's leg wound was not healed or if there were any changes in the condition of the resident's leg.
-The wound care center nurse and provider were unavailable for interview.

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C 246	Continued From page 7 Attempted telephone interview with Resident #1's wound care center provider on 06/30/22 at 12:38pm was unsuccessful. b. Review of the facility's undated Policy for Sudden Illness, Accident, or Death revealed: -The physician was to be called. -If necessary, call medical rescue at 911. -Document and follow all orders by the physician. -There was no specific information in the policy regarding falls. Observation of Resident #1 on 06/29/22 at 10:17am revealed: -The resident was standing in her room wearing a shirt and an adult incontinence brief. -The resident's right hip had a dark purple bruise about the size of a grapefruit. -The resident's right upper outer leg had a dark purple bruise about the size of an orange. -The resident had dark purple and black bruising and swelling around her right eye, down her right cheek, and on her right forehead. -There was a large reddish, purple bruise on the outer edge of her right elbow. -There were two large bandaids applied to the outer side of the lower left leg. Interview with Resident #1 on 06/29/22 at 10:26am revealed: -She fell on the floor on Saturday (06/25/22) while she was trying to grab a cup from her nightstand. -After the fall, the wound on her left leg started bleeding again. -The Supervisor-in-Charge (SIC) put bandaids on her leg when they started bleeding. -She did not go to the hospital and she did not remember if she was asked by staff if she wanted to go to the hospital.	C 246		

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C 246	Continued From page 8 Observation of Resident #1 on 06/29/22 from 10:46am - 10:52am revealed: -The resident ambulated with a rolling walker independently to the dining room table. -She grimaced multiple times when she was moving her arms to self-transfer from a standing position to a sitting position in the dining room chair. -The resident grimaced again when she repositioned herself in the dining room chair. Interview with Resident #1 on 06/29/22 at 10:52am revealed she was grimacing because her right arm hurt when she moved from her fall on 06/25/22. Review of Resident #1's progress notes for April 2022 - June 2022 revealed no documentation the resident's primary care provider (PCP) was notified of the resident's fall with injuries on 06/25/22. Interview with the SIC on 06/29/22 at 2:55pm revealed: -Resident #1 fell from her bed 4 days ago in the morning. -She heard "a thump" and went to the resident's room and the resident was on the floor. -She helped the resident get up. -She would normally send a resident to the hospital when they hit their head but the resident said "no". -The resident had complained of arm pain since she was admitted so she did not associate it with the fall. -She did not report the fall or arm pain to the resident's PCP. -She reported the fall to the Administrator. -She did not document the fall.	C 246		

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-She just noticed the bruise on the resident's face yesterday (06/28/22).
-She had not noticed the bruising on the resident's hip, leg or elbow.
-She had not reported the bruising to the resident's PCP but she "probably" would need to call the PCP.

Telephone interview with the Administrator / Registered Nurse (RN) on 06/29/22 at 3:15pm revealed:
-Staff reported Resident #1 had a fall recently (she thought last week) and the resident said she did not want to go to the hospital.
-The SIC did not report any bruising from the fall to her.
-The facility's policy was to call 911 if a resident fell and hit their head.
-The SIC observed the resident to see if there was a reason to take her to the emergency room.
-The SIC was responsible for notifying the PCP of the resident's fall and any injuries.

Telephone interview with a nurse at Resident #1's PCP office on 06/30/22 at 12:03pm revealed:
-The resident was last seen by the PCP on 12/15/21.
-Their office was notified yesterday, 06/29/22, that the resident had a fallen 4 days prior and had a "gash" on her leg that was "hot, red, and puffy".
-Their office should have been contacted when the fall occurred, not 4 days later.
-The on-call PCP sent an order for an antibiotic and for home health to evaluate the wound.
-The resident was set up for a video visit on 07/07/22.
-No bruising or pain from the fall was reported to them.
-The PCP needed to know all of the details of the resident's condition to determine if the resident

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C 246	Continued From page 10 needed to be seen for her injuries or condition in their same day clinic. Telephone interview with the Administrator/RN on 06/30/22 at 3:07pm revealed: -The SIC was responsible for notifying the PCP when a resident fell. -She assumed the SIC had notified Resident #1's PCP of the fall. -The SIC reported the resident was "okay" after the fall. -The SIC should have reported the fall to the PCP when the fall occurred. _____ The facility failed to ensure the acute and routine health care needs were met for Resident #1. Resident #1's left leg was swollen, red, and had two open wounds with drainage that had not been reported to the primary care provider (PCP) or the wound care provider after missing an appointment with the wound care provider on 06/07/22, resulting in the on-call provider ordering an antibiotic for infection and home health for wound care. Resident #1's fall on 06/25/22 was not reported to the PCP including arm pain and multiple bruises on the resident's hip, leg, elbow and face. The facility's failure resulted in substantial risk of serious physical harm and serious neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/29/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 30, 2022.	C 246		

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C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the documentation and implementation of physician's orders for 1 of 3 sampled residents (#1) regarding orders for wound care to the left lower leg and an order to wear tubular compression wraps for leg swelling. The findings are: Review of Resident #1's current FL-2 dated 03/29/22 revealed diagnoses included gait instability, frequent falls, history of stroke associated with blood clotting tendency, venous insufficiency, essential hypertension, and hypothyroidism. Review of Resident #1's current assessment and care plan dated 04/04/22 revealed: -The resident was ambulatory with aide or device (not specified) and had limited strength in her upper extremities. -The resident had a wound on her front left shin; apply non-stick gauze pad and affix with a cloth bandage. -The resident was oriented and her memory was adequate.	C 249		

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C 249	Continued From page 12 -The resident required limited assistance by staff with eating, toileting, ambulation, grooming, and transferring. -The resident required extensive assistance by staff with bathing and dressing. -Other tasks or special needs included medication administration daily and wound care. Review of Resident #1's licensed health professional support (LHPS) review dated 04/04/22 revealed the resident required assistance with skin/wound care on her lower extremities. Review of Resident #1's physician's orders from the wound care center dated 04/19/22 revealed: -There was an order to use Xeroform daily for wound; gauze and Xeroform - no adhesive on skin. (Xeroform is a fine mesh gauze occlusive dressing with petrolatum and an antimicrobial ingredient used to treat wounds.) -There was an order for Tubigrips for leg compression. (Tubigrips are tubular elastic bandages/wraps used as compression support to treat swelling.) Review of Resident #1's after visit summary and physician's orders from the wound care center dated 05/10/22 revealed: -There was an order for the resident's left leg was to be washed with soap (Hibiclens) and water and patted dry. (Hibiclens is an antimicrobial and antiseptic skin cleanser used to prevent skin infections.) -There was an order to apply Xeroform and dry gauze or bandaid daily. -The resident was to wear Tubigrips on her legs daily. -The resident was to return to the wound center in 4 weeks on 06/07/22 if the wound was not	C 249		

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healed.
-You may return for any concerns regarding your wound.

Review of Resident #1's April 2022 medication administration record (MAR) revealed:
-There was no entry for wound care with Xeroform as ordered on 04/19/22 on the April 2022 MAR.
-There was no entry for Tubigrips for leg compression as ordered on 04/19/22 on the April 2022 MAR.

Review of Resident #1's May 2022 MAR revealed:
-There was no entry for wound care with Xeroform as ordered on 04/19/22 on the May 2022 MAR.
-There was no entry for wound care with soap and water or Hibiclens and Xeroform as ordered on 05/10/22 on the May 2022 MAR.
-There was no entry for Tubigrips for leg compression as ordered on 04/19/22 on the May 2022 MAR.

Review of Resident #1's June 2022 MAR revealed:
-There was no entry for wound care with soap and water or Hibiclens and Xeroform as ordered on 05/10/22 on the June 2022 MAR.
-There was no entry for Tubigrips for leg compression as ordered on 04/19/22 on the June 2022 MAR.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/30/22 at 11:48am revealed:
-The pharmacy did not receive Resident #1's wound care orders dated 04/19/22 or 05/10/22.
-If the wound care orders had been received, the

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orders would have been added to the MARs.

Review of Resident #1's progress notes for April 2022 - June 2022 revealed:
-There was no documentation regarding the resident's leg wound or wound care provided.
-There was no documentation regarding the use of Tubigrips as ordered for leg compression.

Observation of Resident #1's medications on hand on 06/29/22 at 2:30pm revealed there was no Xeroform or Hibiclens available for the resident.

Observation of Resident #1 on 06/29/22 at 10:31am revealed:
-The resident's left lower leg was bright red and swollen with the redness extending above the knee.
-There were two large bandaids applied to the left outer side of the lower left leg.
-There were multiple areas up and down her left lower leg with healed scars.
-The resident was not wearing Tubigrips on her legs.

Interview with Resident #1 on 06/29/22 at 10:31am revealed:
-She fell on the floor on Saturday (06/25/22) while she was trying to grab a cup from her nightstand.
-After she fell on 06/25/22, a previously healed wound on her left leg started bleeding again.
-The Supervisor-in-Charge (SIC) put bandaids on her leg when it started bleeding.
-Her left leg had been red and swollen for 3 to 4 months.

A second interview with Resident #1 on 06/30/22 at 11:07am revealed:
-She had bandaids and gauze in her room for her

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leg wound.
-The provider at the wound care center had given her some wound care supplies at a past appointment.
-She took care of her leg wound herself but staff had to help sometimes because the gauze was hard to put on.
-She had Tubigrips in her room that she got from the wound care clinic and she could put them on herself.
-She did not know the last time she had worn the Tubigrips.

Interview with the SIC on 06/29/22 at 2:30pm revealed:
-Resident #1 had bandaids on her left lower leg because the resident had scratched herself and there was blood on her leg.
-She could not say how long the bandaids had been on the resident's leg.
-The resident's leg had a big wound previously and the resident's leg had always been red and swollen.

A second interview with the SIC on 06/29/22 at 2:48pm revealed:
-She was not aware of the order for Tubigrips.
-The resident did not have any Tubigrips to her knowledge.
-The resident's previous wound had healed but she could not recall when it healed.

A third interview with the SIC on 06/29/22 at 5:09pm revealed:
-She did not transcribe any wound care orders on the MARs for Resident #2 because she did not realize she needed to document it.
-She was helping the resident with the wound care but she did not document it anywhere.

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C 249	Continued From page 16 Telephone interview with the Administrator/ Registered Nurse (RN) on 06/29/22 at 3:15pm revealed: -The resident had wound supplies when she was admitted to the facility. -The staff reported to her that the resident could do the wound care herself but she thought staff was doing the wound care. -The SIC on duty was responsible for implementing and documenting the wound care orders. -She did not know why the wound care orders were not documented on the MAR. -The SIC was responsible for faxing any orders to the pharmacy and the pharmacy entered the orders onto the MARs. -She thought the resident's leg wound was healed. -She last saw the resident's leg wound in May 2022 and there was a "tiny, little wound area". Observation of Resident #1 with the Administrator/RN on 06/29/22 at 4:33pm revealed: -The Administrator removed both bandaids from the resident's lower left leg. -Both bandaids were saturated with brown drainage. -There was a dime sized open area under one bandage. -There was quarter sized open area below the dime sized open area. Interview with the Administrator/RN on 06/29/22 at 4:33pm revealed: -There were bruises on the resident's left lower leg that had opened up. -There was drainage from the wounds on both bandaids. -She needed to get home health to come to the	C 249		

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C 249	Continued From page 17 facility to see the resident for wound care. Observation of Resident #1 on 06/29/22 at 4:33pm revealed: -The resident was not wearing Tubigrips on her legs. -There was a pair of Tubigrips lying on the floor and the end of the resident's bed. -The resident's left lower leg was swollen and red. Interview with Resident #1 on 06/29/22 at 4:33pm revealed she had not worn the Tubigrips "in a while". Telephone interview with Resident #1's power of attorney (POA) on 06/30/22 at 12:44pm revealed: -The resident had a bad fall and cut her leg before she was admitted to the facility on 04/01/22. -The resident had always had some swelling in her ankles and "a little" redness. -The Administrator called her today, 06/30/22, and reported the resident fell over the weekend and hit her leg again. -Another family member took the resident to the wound care center for the first visit (in April 2022). -The wound care center gave the resident some Xeroform and gauze which the family member put in ziploc baggies and went over the instructions with the SIC and the Administrator. Telephone interview with a Medical Office Assistant at Resident #1's wound care center on 06/30/22 at 12:38pm revealed: -No one had contacted the wound care center about any concerns with the resident's leg wound. -The wound care center should be notified if the resident's leg wound was not healed or if there were any changes in the condition of the resident's leg.	C 249		

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C 249	Continued From page 18 -The wound care center nurse and provider were unavailable for interview. Attempted telephone interview with Resident #1's wound care center provider on 06/30/22 at 12:38pm was unsuccessful.	C 249		
C 266	10A NCAC 13G .0904 (c-3) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve appropriately substituted meal items of equal nutritional value during the lunch meal service on 06/29/22. The findings are: Review of the diet list posted on the refrigerator on 06/29/22 at 9:57am revealed 3 residents were listed as regular diets and 3 residents were listed as diabetic diets. Review of the lunch menu for Wednesday (06/29/22) for the regular diet menu and the diabetic diet menu revealed: -The lunch meal to be served for both diets included: ½ cup of chicken salad; 2 slices of whole wheat bread, 1 cup of fresh vegetable sticks, and 1 fresh orange. -Coffee, tea, and water were to be offered at all meals.	C 266		

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C 266	Continued From page 19 -All breakfast and dinner meals were served with 8 ounces of 2% milk. Observation of the lunch meal service on 06/29/22 from 11:58am - 12:18pm revealed: -The residents were served 1.5 to 2 cups of macaroni and cheese with bite sized pieces of fried chicken mixed in the macaroni and cheese instead of chicken salad. -The residents were not served bread or vegetable sticks. -There were no substitutions made for the bread or vegetable sticks. -The residents were not served fresh oranges. -The residents were served 8 to 10 ounces of 1 can of lite mixed fruit and 1 can of fruit cocktail blended and mixed in orange juice in the blender for the beverage with the lunch meal. Interview with a resident on 06/29/22 at 12:10pm revealed: -She was not sure what kind of beverage had been served. -She did not recall having it before. -She was not sure what was on the menu and what was supposed to be served. Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 4:45pm revealed: -She made macaroni and cheese and mixed some cut up pieces of fried chicken instead of chicken salad. -She did not answer when asked if macaroni and cheese was an appropriate substitution for chicken salad. -She did not serve wheat bread because she was saving it for the supper meal. -They usually got new groceries on the first day of the month so she would get more wheat bread then.	C 266		

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-She did not serve vegetable sticks because she did not know what that was.
-She did not answer when asked why she did not substitute with another vegetable.
-She blended the canned fruit with orange juice instead of serving oranges otherwise she did not think the residents would eat the fruit.
-She documented on the substitution list posted on the refrigerator.

Review of the facility's substitution list posted on the refrigerator on 06/29/22 at 4:50pm revealed:
-There was a statement at the top of the page: any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents.
-There were columns for: date, time, food item to be served, what food was served, and reason.
-On 06/29/22, food item to be served was documented as chicken salad, wheat bread, veggies, and oranges.
-On 06/29/22, food served was documented as macaroni and cheese, chicken wings, and fruit smoothies.
-On 06/29/22, the reason for the substitutions was not documented.

Interview with the Administrator/Registered Nurse (RN) on 06/29/22 at 5:20pm revealed:
-The SIC should have served wheat bread with the lunch meal.
-More groceries would be brought to the facility this evening because it was near the first of the month, so it was time to replenish.

Telephone interview with the Administrator/RN on 06/30/22 at 3:07pm revealed:
-She usually bought groceries based on the menu so there should not be a need for substitutions

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C 266	Continued From page 21 too often. -The bulk of the groceries were bought once a month and they replenished twice a month as needed. -If substitutions were used, it should be a comparable food item of equal nutritional value.	C 266		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure snacks were consistently offered or made available to all residents three times daily. The findings are: Observation of a closet in the hallway on 06/29/22 at 10:15am revealed: -The closet door was locked and had to be unlocked by the Supervisor-in-Charge (SIC). -There were 5 shelves in the closet with snacks and beverages such as crackers, cookies, granola bars, bottles water, and canned sodas. -The residents' names were labeled on the shelves with different supplies of snacks. Interview with the SIC on 06/29/22 at 10:15am revealed the closet contained the residents'	C 272		

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C 272	Continued From page 22 personal snack items. Review of the facility's Snack Menu posted on the refrigerator 06/29/22 at 10:52am revealed: -There was a morning, afternoon, and evening snack listed for each day of the week. -Snacks for Wednesday (06/29/22) included a morning snack - 1 slice of angel food cake; afternoon snack - ½ cup of unsalted pretzels; and evening snack - ½ cup of unsweetened applesauce and 3 vanilla wafers. -Snacks for Thursday (06/30/22) included a morning snack - 1 granola bar; afternoon snack - 2 cups of unsalted popcorn; and evening snack - 8 ounce fruit smoothie. -There were no beverages listed for snacks. Observation of the food supply on 06/29/22 at 4:24pm revealed: -There were snack items such as crackers, cookies, popcorn, canned fruit, and brownie mix. -There was no angel food cake, pretzels, or vanilla wafers. Interview with a resident on 06/29/22 at 10:26am revealed: -She had to buy her own snacks and staff kept them locked in a closet. -She could get her snacks if she asked staff to unlock the closet. Interview with a second resident on 06/29/22 at 10:38am revealed: -He had not had snacks "in a while" (could not specify timeframe). -He had written a list of snacks he wanted to get at the store. -He "missed" getting snacks. -He had not received any snacks today.	C 272		

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C 272	Continued From page 23 Interview with a third resident on 06/29/22 at 10:55am revealed: -The facility staff gave them cookies once a day. -Otherwise, residents had to buy their own snacks. -She had not received any snacks today. Interview with a fourth resident on 06/29/22 at 11:10am revealed: -She received a snack once a day around 2:00pm. -Her family member brought snacks for her to eat at other times. Observation during the survey on 06/29/22 from 9:00am - 5:30pm revealed: -No morning snack was offered or served to the residents. -At 2:05pm, the SIC gave a resident some honey buns and chips to pass out to the residents but no beverage was offered. -At 2:07pm and 2:11pm, two residents were observed drinking sodas from their personal supply of snack items. Interview with the SIC on 06/29/22 at 4:45pm revealed: -The residents usually did morning snacks on their own. -The residents usually received 1 facility snack after lunch and 1 after dinner. -She did not have pretzels to serve for the afternoon snack today so she used chips instead. -She gave no explanation for residents providing their own morning snack. Telephone interview with the Administrator/Registered Nurse (RN) on 06/29/22 at 3:15pm revealed: -Snacks were supposed to be served by the SIC	C 272		

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C 272	Continued From page 24 3 times a day: between breakfast and lunch; between lunch and supper; and right before bedtime medications were administered. -The facility had snacks to serve to the residents. Observation during the survey on 06/30/22 from 9:00am - 3:30pm revealed: -At 10:06am, the SIC gave a resident the key to the locked closet in the hallway. -The resident returned with orange nabs and granola bars for herself and another resident. -The other resident also had a soda from her personal snack items. -The SIC did not offer or serve snacks to the other residents. Interview with the SIC on 06/30/22 at 2:57pm revealed she had no explanation for not serving snacks 3 times a day to all residents.	C 272		
C 280	10A NCAC 13G .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve water to residents during the lunch and supper meals on 06/29/22. The findings are:	C 280		

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C 280	Continued From page 25 Review of the facility's Cycle Four Regular Diet Menu and Diabetic Diet Menu posted on the refrigerator revealed: -There were 3 meals (breakfast, lunch, and dinner) listed for each day of the week. -Coffee, tea, and water were to be offered at all meals. Observation of the lunch meal on 06/29/22 from 11:58am - 12:18pm revealed: -Five of the 6 residents ate the lunch meal and the sixth resident chose not to eat lunch. -Water was not served or offered to any of the residents during the lunch meal. Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 4:45pm revealed: -The refrigerator had an automatic ice and water dispenser. -The residents could get water from the refrigerator dispenser if they wanted water. Telephone interview with the Administrator/Registered Nurse (RN) on 06/29/22 at 3:15pm revealed: -She was not aware the SIC was not serving or offering water to the residents at meal times. -Water should be served to all residents at every meal each day. -The SIC knew she was supposed to serve water at every meal. Observation of the breakfast meal on 06/30/22 from 9:02am - 9:30am revealed: -Four residents ate breakfast in the dining room. -Water was not served or offered to any of the residents. Interview with a resident on 06/30/22 at 10:57am revealed:	C 280		

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C 280	Continued From page 26 -The residents were served water "occasionally" with a meal. -She would drink water if it was served or offered with her meals. Interview with a second resident on 06/30/22 at 11:02am revealed: -Water was not served or offered with meals every day. -He was not sure how often water was served with meals. -If water was served or offered, he would drink it. Interview with a third resident on 06/30/22 at 11:11am revealed: -She was served water "once in a while" with a meal. -She could not recall the last time she was served water with a meal. -She would drink water if it was offered or served to her. Interview with a fourth resident on 06/30/22 at 11:19am revealed: -Water was sometimes served with the meals at the facility. -She loved water and would drink it if water was served or offered. Telephone interview with the Administrator/RN on 06/30/22 at 3:07pm revealed: -She did not know why the SIC did not serve or offer water during the breakfast meal on 06/30/22. -She had reminded the SIC to serve or offer water at all meals on 06/29/22.	C 280		
C 288	10A NCAC 13G .0905(a) Activities Program	C 288		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 288	Continued From page 27 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Review of the activities calendar posted on the wall in the dining room / kitchen area on 06/29/22 revealed an activities calendar dated June 2022. Review of the June 2022 activities calendar for 06/29/22 revealed: -There was a devotional activity scheduled from 8:00am - 9:00am. -There was a reading activity scheduled from 10:00am - 11:00am. -There was a walking activity scheduled from 2:00pm - 3:00pm. Observations of the facility on 06/29/22 from 09:00am to 5:30pm revealed: -No activities were offered to the residents that day. -Staff on duty had not conducted or offered to facilitate the devotional activity, the reading activity, or the walking activity. Interviews with a resident on 06/29/22 at 10:22am and 10:55am revealed: -There was nothing to do at the facility and she got bored. -There were no group activities and nothing was	C 288		

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done together except watch television.
-She would like to play cards or board games.
-There had been no activities today, including no devotional activity.

Interview with a second resident on 06/29/22 at 10:38am revealed:
-He did not know of any activities being done at the facility.
-He usually took a walk in the neighborhood on his own every morning at 10:00am.

Observation of the facility on 06/29/22 at 1:02pm revealed:
-The SIC was sitting on a sofa in the living room doing a word search activity book.
-There were 3 residents sitting on the other sofa, 2 residents watching television and the other resident sleeping.
-The other 3 residents were in their rooms.
-The SIC did not offer to do any group activities with the residents.

Review of the June 2022 activities calendar for 06/30/22 revealed:
-There was a devotional activity scheduled from 8:00am - 9:00am.
-There was a game activity scheduled from 10:00am - 11:00am.
-There was a music activity scheduled from 2:00pm - 3:00pm.

Observations of the facility on 06/30/22 from 09:00am to 3:30pm revealed:
-No activities were offered to the residents that day.
-Staff on duty had not conducted or offered to facilitate the devotional activity, the game activity, or the music activity.

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C 288	Continued From page 29 Interview with a resident on 06/30/22 at 11:02am revealed no activities had been done at the facility today to his knowledge. Interview with a second resident on 06/30/22 at 2:53pm revealed: -There had not been any activities at the facility today or yesterday. -She sometimes cried because she was bored and had nothing to do. -She would like to play bingo and other games and have church devotions. -They had board games at the facility but they never played games as a group activity. Interview with the SIC on 06/30/22 at 2:57pm revealed she had not done activities with the residents because the residents did not usually want to do activities. Telephone interview with the Administrator/Registered Nurse (RN) on 06/29/22 at 3:15pm revealed: -The SIC was responsible for doing the activities listed on the activities calendar. -She was not aware activities were not being done with the residents.	C 288		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or	C 315		

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C 315	Continued From page 30 (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (#2) for medications used to treat and prevent constipation. The findings are: Review of Resident #2's current FL-2 dated 01/25/22 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, hyperlipidemia, hypercholesterolemia, schizoaffective disorder, and bipolar disorder. -There was an order for Colace 100mg 1 softgel capsule at bedtime. (Colace is a stool softener used to treat and prevent constipation.) -There was an order for Senna Plus 8.6-50mg take 1 tablet at bedtime. (Senna Plus contains two medications, a stimulant laxative, and Colace, a stool softener. Senna Plus is used to treat and prevent constipation.) Review of Resident #2's physician's order dated 02/22/22 revealed: -There was an order for Colace 100mg take 1 tablet at bedtime as needed (prn) for constipation. -There was no order to indicate if the resident was to continue receiving a scheduled dose of Colace. Review of Resident #2's April 2022 medication	C 315		

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administration record (MAR) revealed:
-There was an entry for Senna Plus 8.6-50mg take 1 tablet at bedtime scheduled for 8:00pm.
-Senna Plus was documented as administered at bedtime from 04/01/22 - 04/30/22.
-There was an entry for Colace 100mg 1 capsule at bedtime prn for constipation.
-No prn Colace was documented as administered in April 2022.
-There was no entry for a scheduled dose of Colace to be administered.

Review of Resident #2's May 2022 MAR revealed:
-There was an entry for Senna Plus 8.6-50mg take 1 tablet at bedtime scheduled for 8:00pm.
-Senna Plus was documented as administered at bedtime from 05/01/22 - 05/31/22.
-There was an entry for Colace 100mg 1 capsule at bedtime prn for constipation.
-The prn Colace was documented as administered on 05/05/22, 05/09/22, and 05/13/22.
-There was no entry for a scheduled dose of Colace to be administered.

Review of Resident #2's June 2022 MAR revealed:
-There was an entry for Senna Plus 8.6-50mg take 1 tablet at bedtime scheduled for 8:00pm.
-Documentation for the administration of Senna Plus was blank for all of June 2022 with no reason for the omissions.
-There was an entry for Colace 100mg 1 capsule at bedtime prn for constipation.
-No prn Colace was documented as administered in June 2022.
-There was no entry for a scheduled dose of Colace to be administered.

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C 315	Continued From page 32 Observation of Resident #2's medications on hand on 06/29/22 at 2:30pm revealed: -There was a supply of Senna Plus tablets dispensed on 04/01/22 with 25 of 31 tablets remaining. -There was a supply of Senna Plus tablets dispensed on 06/01/22 with 30 of 30 tablets remaining. -There was no Colace available for administration. Telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 06/30/22 at 11:46am revealed: -The pharmacy had an order on file dated 02/22/22 for Colace 100mg take 1 capsule at bedtime prn for constipation. -No Colace had been requested by the facility and none had been dispensed by the pharmacy. -There was an order dated 02/03/22 for Senna Plus take 1 tablet at bedtime. -There was a 30-day supply of Senna Plus dispensed on 03/01/22, 04/01/22, 05/01/22, and 06/01/22. -There was no order for Senna Plus to be administered prn. Interview with Resident #2 on 06/30/22 at 10:57am revealed: -She had never refused any medications. -She did not currently receive any tablets or gel capsules for constipation. -She was not currently having any problems with constipation or diarrhea. Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 2:30pm revealed: -She thought Colace and Senna Plus were the same medication. -She did not administer Senna Plus to Resident	C 315		

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C 315	Continued From page 33 #2 in June 2022 because she thought it was prn and it caused the resident to have diarrhea. -She did not know if there was an order to change Senna Plus from scheduled to prn. -She had not contacted the primary care provider (PCP) to clarify the medication orders. -She had no explanation for not clarifying the medication orders. Telephone interview with the Office Manager at Resident #2's PCP office on 06/30/22 at 11:58am revealed: -Someone at the facility contacted the PCP's office today to clarify the Colace and Senna Plus orders. -The resident did not need to take both the Senna Plus and the Colace. -The PCP was going to discontinue the Colace and change the Senna Plus to as needed (prn). -No one had contacted the PCP's office to clarify the orders prior to today, 06/30/22. Telephone interview with the Administrator/Registered Nurse (RN) on 06/30/22 at 11:31am revealed: -She thought there was a prn order for Resident #2's Colace because the resident wanted it to be prn. -She was not aware Resident #2 was not receiving scheduled Senna Plus. -The SIC should have clarified the medication orders. -She usually checked the medication orders with the MARs quarterly. -She last checked the medication orders and the MARs in March 2022. -She was supposed to check the medication orders and MARs this month, June 2022, but she had not done it yet.	C 315		

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C 330	Continued From page 34	C 330		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#1) sampled for record review including errors with medications for high blood pressure and Vitamin D deficiency. The findings are: Review of Resident #1's current FL-2 dated 03/29/22 revealed: -Diagnoses included gait instability, frequent falls, history of stroke associated with blood clotting tendency, venous insufficiency, insomnia, essential hypertension, and hypothyroidism. -There was an order for Amlodipine 5mg 1 tablet nightly. (Amlodipine lowers blood pressure.) -There was an order for Vitamin D3 1,000 units take 1 tablet nightly. (Vitamin D3 is used to treat Vitamin D deficiency.) Observation of the dining room on 06/29/22 from 9:10am - 10:52am revealed: -There was a small plastic bowl with a green lid and 3 tablets inside the cup.	C 330		

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C 330	Continued From page 35 -The cup was labeled with Resident #1's first name and "am". -The medications in Resident #1's labeled cup included one Amlodipine 5mg tablet and one Vitamin D3 1,000 units tablet. -At 10:46am, Resident #1 came to the dining room to eat breakfast. -At 10:52am, Resident #1 took her medication including Amlodipine and Vitamin D3 that were scheduled to be administered at 8:00pm. Interview with Resident #1 on 06/29/22 at 10:26am revealed: -She usually received her medications in the mornings at breakfast. -She was not sure which medications she received. Review of Resident #1's April 2022 medication administration record (MAR) revealed: -There was an entry for Amlodipine 5mg take 1 tablet at bedtime scheduled for 8:00pm. -Amlodipine was documented as administered daily at 8:00pm from 04/01/22 - 04/30/22 except the initials were circled from 04/12/22 - 04/18/22. -There was an entry for Vitamin D3 1,000 units take 1 tablet at bedtime scheduled for 8:00pm. -Vitamin D3 was documented as administered daily at 8:00pm from 04/01/22 - 04/30/22 except the initials were circled from 04/13/22 - 04/17/22. Review of Resident #1's May 2022 MAR revealed: -There was an entry for Amlodipine 5mg take 1 tablet at bedtime scheduled for 8:00pm. -Amlodipine was documented as administered daily at 8:00pm from 05/01/22 - 05/31/22. -There was an entry for Vitamin D3 1,000 units take 1 tablet at bedtime scheduled for 8:00pm. -Vitamin D3 was documented as administered	C 330		

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C 330	Continued From page 36 daily at 8:00pm from 05/01/22 - 05/31/22. Review of Resident #1's June 2022 MAR revealed: -There was an entry for Amlodipine 5mg take 1 tablet at bedtime scheduled for 8:00pm. -Amlodipine was documented as administered daily at 8:00pm from 06/01/22 - 06/28/22. -There was an entry for Vitamin D3 1,000 units take 1 tablet at bedtime scheduled for 8:00pm. -Vitamin D3 was documented as administered daily at 8:00pm from 06/01/22 - 06/28/22. Observation of Resident #1's medications on hand on 06/29/22 at 2:30pm revealed: -There was a supply of Amlodipine 5mg tablets dispensed on 06/01/22 with 2 of 30 tablets remaining. -Instructions on the Amlodipine label was to take 1 tablet at bedtime. -There was a supply of Vitamin D3 1,000 units tablets dispensed on 06/01/22 with 1 of 30 tablets remaining. -Instructions on the Vitamin D3 label was to take 1 tablet at bedtime. Interview with the Supervisor-in-Charge (SIC) on 06/30/22 at 2:20pm revealed: -She administered Resident #1's Amlodipine and Vitamin D3 at 8:00am because she thought the resident was receiving too many medications at bedtime. -The resident was receiving Amlodipine and Vitamin D3 in the morning prior to admission because that was how those medications were packaged in the supplies the resident brought with her upon admission. Telephone interview with the Administrator / Registered Nurse (RN) on 06/30/22 at 3:07pm	C 330		

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C 330	Continued From page 37 revealed: -Resident #1's Amlodipine and Vitamin D3 should be administered at the scheduled time of 8:00am. -If the resident did not want to take those medications at 8:00pm when scheduled, the SIC should have contacted the primary care provider (PCP) to get the time of administration changed. -If she had known the SIC was administering the Amlodipine and Vitamin D3 at the wrong time, she would have contacted the PCP herself.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident	C 335		

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and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 3 of 3 sampled residents (#1, #4, #5) during the morning of 06/29/22.

The findings are:

Observation of the dining room on 06/29/22 at 9:10am revealed:
-There were 3 breakfast meals prepared and sitting on the dining room table.
-There were medications prepared in plastic cups or containers sitting beside the plates.
-There were no residents at the dining room table.
-The first place setting on the left had a clear plastic cup with 4 tablets, 1 gel capsule and a bottle of Fluticasone 50mcg nasal spray beside it. (Fluticasone is used to treat nasal allergy symptoms.)
-The cup was not covered or protected from contamination or spillage.
-The cup was labeled with Resident #4's first name and "8am".
-The names and strengths of the medications were not labeled on the cup.
-The medications in Resident 4's labeled cup

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C 335	Continued From page 39 included Clopidogrel 75mg, Docusate Sodium 100mg, Metformin 1,000mg, Citalopram 20mg, and Multivitamin. (Clopidogrel is a blood thinner used to prevent heart attack and stroke. Docusate Sodium is a stool softener. Metformin is used to lower blood sugar. Citalopram is an antidepressant. Multivitamin is a vitamin supplement.) -The second place setting had a small plastic bowl with a green lid and 3 tablets inside the cup. -The cup was labeled with Resident #1's first name and "am". -The specific time of administration and the names and strengths of the medications were not labeled on the cup. -The medications in Resident #1's labeled cup included Levothyroxine 25mcg, Amlodipine 5mg, and Vitamin D3 1,000 units. (Levothyroxine is for hypothyroidism. Amlodipine lowers blood pressure. Vitamin D3 is for Vitamin D deficiency.) -The third place setting had a small plastic bowl with an orange lid with 3 tablets and 1 capsule inside the cup and a bottle of Fluticasone 50mcg nasal spray beside it. -The cup was labeled with Resident #5's first name. -The time of administration and the names and strengths of the medications were not labeled on the cup. -The medications in Resident #5's labeled cup included Escitalopram 10mg, Lisinopril 10mg, Loratadine 10mg, and Vitamin D3 5,000 units. (Escitalopram is an antidepressant. Lisinopril lowers blood pressure. Loratadine is for seasonal allergies. Vitamin D3 is for Vitamin D deficiency.) -There was a plastic basket sitting countertop next to the dining room table with 3 other small bowls with lids with the other 3 residents' first names and the bowls were empty.	C 335		

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C 335	Continued From page 40 Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 9:12am revealed: -She had prepared all 6 of the residents' morning medications at 6:00am. -Three of the residents had already taken their medications when they ate breakfast. Observation of Resident #5 on 06/29/22 from 9:16am - 9:30am revealed: -The resident came to the dining room table and started eating at 9:16am. -The resident used 1 spray of Flonase in each nostril at 9:18am. -The resident took her oral medications in the cup labeled with her name at 9:30am. Interview with Resident #5 on 06/30/22 at 9:56am revealed: -She usually received 3 or 4 medications in the mornings and her nasal spray. -She could not remember if her medications were usually prepared and left on the dining room table. Observation of Resident #4 on 06/29/22 at 9:47am revealed: -The resident came to the dining room table to eat breakfast. -The resident took her medications and started eating at 9:16am. Interview with Resident #4 on 06/29/22 at 10:55am revealed her morning medications were always already prepared and in a cup with her name beside her breakfast plate. Observation of Resident #1 on 06/29/22 at 10:52am revealed the resident poured the medications from the cup labeled with her name into her hand and took the medications.	C 335		

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C 335	Continued From page 41 Interview with Resident #1 on 06/29/22 at 10:26am revealed: -She usually received her medications in the mornings at breakfast. -The medications were put in a cup and sat beside her breakfast plate. Interview with a fourth resident on 06/29/22 at 10:38am revealed his morning medications were usually already prepared in a cup with his name beside his plate on the dining room table. Interview with a fifth resident on 06/29/22 at 11:10am revealed her morning medications were usually already prepared and in a container on the dining room table when she went to breakfast. A second interview with the SIC on 06/29/22 at 2:55pm revealed: -She usually prepared all of the residents' medications at one time. -She put the residents' medications in cups with their names on them. -She was not aware of the rules about preparing medications in advance. -She did not know she needed to write the names and strengths of the medications prepared on the cups or the time of administration. Telephone interview with the Administrator / Registered Nurse (RN) on 06/29/22 at 3:15pm revealed: -The SIC was supposed to prepare and administered medications to the residents one resident at a time. -The SIC was not supposed to "prepour" any medications. -There was a basket with containers labeled with the residents' names but the SIC was supposed	C 335		

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C 335	Continued From page 42 to use those to prepare and administer 1 resident's medications before going to the next resident. -She was not aware the SIC was preparing medications for all residents at the same time and leaving them on the dining room table in the mornings. -The SIC had all required medication training and the SIC knew she was not supposed to "prepour" medications.	C 335		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide observed residents taking their medications for 2 of 3 sampled residents (#1, #5) on 06/29/22. The findings are: Observation of the dining room on 06/29/22 at 9:10am revealed: -There were 3 breakfast meals prepared and sitting on the dining room table. -There were medications prepared in plastic cups	C 341		

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or containers labeled with the residents' first names sitting beside the plates.
-Resident #4's clear plastic cup had 4 tablets and 1 gel capsule and a bottle of Fluticasone 50mcg nasal spray beside it. (Fluticasone is used to treat nasal allergy symptoms.)
-The medications in Resident 4's labeled cup included Clopidogrel 75mg, Docusate Sodium 100mg, Metformin 1,000mg, Citalopram 20mg, and Multivitamin. (Clopidogrel is a blood thinner used to prevent heart attack and stroke. Docusate Sodium is a stool softener. Metformin is used to lower blood sugar. Citalopram is an antidepressant. Multivitamin is a vitamin supplement.)
-Resident #1's medications in the small plastic bowl included Levothyroxine 25mcg, Amlodipine 5mg, and Vitamin D3 1,000 units. (Levothyroxine is for hypothyroidism. Amlodipine lowers blood pressure. Vitamin D3 is for Vitamin D deficiency.)
-Resident #5's small plastic bowl had 3 tablets and 1 capsule inside the cup and a bottle of Fluticasone 50mcg nasal spray beside it.
-The medications in Resident #5's labeled cup included Escitalopram 10mg, Lisinopril 10mg, Loratadine 10mg, and Vitamin D3 5,000 units. (Escitalopram is an antidepressant. Lisinopril lowers blood pressure. Loratadine is for seasonal allergies. Vitamin D3 is for Vitamin D deficiency.)

Observation of Resident #4 on 06/29/22 at 9:47am revealed:
-The resident took her medications while the Supervisor-in-Charge (SIC) was in the kitchen with her back turned at the microwave.
-The SIC did not observe the resident take her morning medications.
-The resident handed the empty cup to the SIC when the SIC returned to the dining room table and started eating at 9:16am.

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C 341	Continued From page 44 Interview with Resident #4 on 06/29/22 at 10:55am revealed: -Her morning medications were always prepared and in a cup with her name beside her breakfast plate. -Staff did not observe the resident take her medications. -Another resident brought her medications to her room in the evenings. -The other resident brought the medication to her room alone and staff did not observe her take her evening medications. Observation of Resident #1 on 06/29/22 at 10:51am revealed: -The SIC pushed Resident #1's medication cup toward the resident at the dining room table. -The resident poured the medications into her hand. -The SIC walked away and did not observe the resident actually swallow the medications. -The resident took the medications at 10:52am. -The SIC returned to the dining room at 10:53am. Interview with Resident #1 on 06/29/22 at 10:26am revealed: -She usually received her medications in the mornings at breakfast. -The medications were put in a cup and sat beside her breakfast plate. -Staff did not watch her take her medications. Interview with a third resident on 06/29/22 at 11:10am revealed: -She thought the staff person saw her take the medications in the morning but she was not sure. -Another resident delivered her medications to her door at night. -The SIC was not with the resident when her night	C 341		

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medications were delivered and the SIC did not watch her take her night medications.

Interview with fourth resident on 06/30/22 at 11:11am revealed:
-She helped the live-in SIC with passing out the residents' medications at night.
-The SIC put the medication in cups and she took the medications to the residents by herself.
-The SIC did not go with her to deliver the medications and the SIC did not observe the residents take their night time medications.
-She started helping the SIC pass out the medications at night about a month ago.

Interview with the SIC on 06/29/22 at 2:55pm revealed:
-She usually watched the residents take their morning medications and night time medications
-At night time, she got residents to help her with the medications because it made the residents "more active".
-She usually went with the residents when the night medications were delivered.

Telephone interview with the Administrator / Registered Nurse (RN) on 06/29/22 at 3:15pm revealed:
-The SIC was supposed to observe the residents actually take their medications.
-She was not aware the SIC was not observing the residents take their medications.
-The SIC should not allow residents to take medications to any residents.
-This was not the facility's policy and should not be done.
-The SIC had all required medication training and the SIC knew she was supposed to observe the residents take their medications.

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C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, #2) including inaccurate documentation of medications for high blood pressure, heartburn, mild pain, and Vitamin D deficiency (#1) and medication used to treat and prevent constipation (#2). The findings are: 1. Review of Resident #1's current FL-2 dated	C 342		

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C 342	Continued From page 47 03/29/22 revealed diagnoses included gait instability, frequent falls, history of stroke associated with blood clotting tendency, venous insufficiency, slow transit constipation, essential hypertension, and hypothyroidism. a. Review of Resident #1's current FL-2 dated 03/29/22 revealed: -There was an order for Amlodipine 5mg 1 tablet nightly. (Amlodipine lowers blood pressure.) -There was an order for Vitamin D3 1,000 units take 1 tablet nightly. (Vitamin D3 is used to treat Vitamin D deficiency.) Review of Resident #1's April 2022 medication administration record (MAR) revealed: -There was an entry for Amlodipine 5mg take 1 tablet at bedtime scheduled for 8:00pm. -Amlodipine was documented as administered daily at 8:00pm from 04/01/22 - 04/30/22 except the initials were circled from 04/12/22 - 04/18/22. -There was no reason documented for the circled initials. There was an entry for Vitamin D3 1,000 units take 1 tablet at bedtime scheduled for 8:00pm. -Vitamin D3 was documented as administered daily at 8:00pm from 04/01/22 - 04/30/22 except the initials were circled from 04/13/22 - 04/17/22. -There was no reason documented for the circled initials. Review of Resident #1's May 2022 MAR revealed: -There was an entry for Amlodipine 5mg take 1 tablet at bedtime scheduled for 8:00pm. -Amlodipine was documented as administered daily at 8:00pm from 05/01/22 - 05/31/22. -There was an entry for Vitamin D3 1,000 units take 1 tablet at bedtime scheduled for 8:00pm. -Vitamin D3 was documented as administered	C 342		

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C 342	Continued From page 48 daily at 8:00pm from 05/01/22 - 05/31/22. Review of Resident #1's June 2022 MAR revealed: -There was an entry for Amlodipine 5mg take 1 tablet at bedtime scheduled for 8:00pm. -Amlodipine was documented as administered daily at 8:00pm from 06/01/22 - 06/28/22. -There was an entry for Vitamin D3 1,000 units take 1 tablet at bedtime scheduled for 8:00pm. -Vitamin D3 was documented as administered daily at 8:00pm from 06/01/22 - 06/28/22. Observation of Resident #1's medications on hand on 06/29/22 at 2:30pm revealed: -There was a supply of Amlodipine 5mg tablets dispensed on 06/01/22 with 2 of 30 tablets remaining. -Instructions on the Amlodipine label was to take 1 tablet at bedtime. -There was a supply of Vitamin D3 1,000 units tablets dispensed on 06/01/22 with 1 of 30 tablets remaining. -Instructions on the Vitamin D3 label was to take 1 tablet at bedtime. Interview with Resident #1 on 06/29/22 at 10:26am revealed: -She usually received her medications in the mornings at breakfast. -She did not know which medications she received. Interview with the Supervisor-in-Charge (SIC) on 06/30/22 at 2:20pm revealed: -She circled her initials for Resident #1's medication in April 2022 because the resident was on a leave of absence and took her medications with her. -She did not realize she needed to document the	C 342		

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reason for the circled initials on the MAR.
-She administered Resident #1's Amlodipine and Vitamin D3 at 8:00am because she thought the resident was receiving too many medications at bedtime.
-She had no explanation for documenting Amlodipine and Vitamin D3 were administered at 8:00pm when she actually administered them each day at 8:00am.

Telephone interview with the Administrator/Registered Nurse (RN) on 06/30/22 at 11:31am revealed:
-The SIC had received medication training and she knew how to document accurately on the MAR.
-The SIC knew she was supposed to document the reason for circled initials on the back of the MARs.
-She usually checked the MARs quarterly.
-She last checked the MARs in March 2022.
-She was supposed to check the MARs for accuracy this month, June 2022, but she had not done it yet.

A second telephone interview with the Administrator/RN on 06/30/22 at 3:07pm revealed:
-Resident #1's Amlodipine and Vitamin D3 should be administered at the scheduled time of 8:00pm.
-The SIC should not have documented the medications were administered at 8:00pm on the MAR if she administered them at 8:00am.
-The MAR documentation should be accurate.

b. Review of Resident #1's current FL-2 dated 03/29/22 revealed:
-There was an order for Tums chewable, chew 1 tablet daily as needed (prn) for heartburn. (Tums is an antacid used to treat heartburn.)

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C 342	Continued From page 50 -There was an order for Tylenol 500mg take 2 tablets every 8 hours prn for pain. (Tylenol is a mild pain reliever.) Review of Resident #1's April 2022 medication administration record (MAR) revealed: -There was an entry for Tylenol 500mg take 2 tablets every 8 hours prn for pain. -The prn Tylenol was documented as administered on 04/10/22, 04/11/22, 04/19/22, and 04/22/22. -The time of administration, reason of administration, and resulting effects for the prn Tylenol were not documented on either of the 4 occasions it was administered. Review of Resident #1's May 2022 MAR revealed: -There was an entry for Tums chewable, chew and swallow 1 tablet daily prn for heartburn. -The prn Tums was documented as administered on 05/01/22, 05/22/22, 05/25/22, 05/27/22, and 05/29/22. -The time of administration, reason of administration, and resulting effects for the prn Tums were not documented on either of the 5 occasions it was administered. Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 2:30pm revealed: -She initialed the front of the MAR when she administered a prn medication. -If she initialed in the block at the top of the entry for that day; she administered the medication in the morning. -If she initialed the block at the bottom of the entry for that day; she administered the medication in the evening or at night. -She did not document the time, reason, or effectiveness of the prn Tums and prn Tylenol	C 342		

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because she did not realize she needed to document that information.

Telephone interview with the Administrator / Registered Nurse (RN) on 06/30/22 at 11:31am revealed:
-The SIC had received medication training and she knew how to document accurately on the MAR.
-The SIC knew she was supposed to document the time of administration, reason, and effectiveness of prn medications on the back of the MARs.
-She usually checked the MARs quarterly.
-She last checked the MARs in March 2022.
-She was supposed to check the MARs for accuracy this month, June 2022, but she had not done it yet.

2. Review of Resident #2's current FL-2 dated 01/25/22 revealed diagnoses included diabetes mellitus type 2, hypertension, hyperlipidemia, hypercholesterolemia, schizoaffective disorder, and bipolar disorder.

a. Review of Resident #2's current FL-2 dated 01/25/22 revealed an order for Senna Plus 8.6-50mg take 1 tablet at bedtime. (Senna Plus is used to treat and prevent constipation.)

Review of Resident #2's June 2022 medication administration record (MAR) revealed:
-There was an entry for Senna Plus 8.6-50mg take 1 tablet at bedtime scheduled for 8:00pm.
-Documentation for the administration of Senna Plus was blank for all of June 2022 with no reason for the omissions.

Observation of Resident #2's medications on hand on 06/29/22 at 2:30pm revealed:

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C 342	Continued From page 52 -There was a supply of Senna Plus tablets dispensed on 04/01/22 with 25 of 31 tablets remaining. -There was a supply of Senna Plus tablets dispensed on 06/01/22 with 30 of 30 tablets remaining. Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 2:30pm revealed: -She did not administer Senna Plus to Resident #2 in June 2022 because she thought it was prn and it caused the resident to have diarrhea. -She had no explanation for not documenting the reason for the omissions on the MAR. Interview with Resident #2 on 06/30/22 at 10:57am revealed: -She did not currently receive any tablets for constipation. -She was not currently having any problems with constipation or diarrhea. Telephone interview with the Administrator / Registered Nurse (RN) on 06/30/22 at 11:31am revealed: -The SIC had received medication training and she knew how to document accurately on the MAR. -Reasons for omissions should be documented on the MAR. b. Review of Resident #2's current FL-2 dated 01/25/22 revealed an order for Colace 100mg 1 softgel capsule at bedtime. (Colace is a stool softener used to treat and prevent constipation.) Review of Resident #2's physician's order dated 02/22/22 revealed an order for Colace 100mg take 1 tablet at bedtime as needed (prn) for constipation.	C 342		

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C 342	Continued From page 53 Review of Resident #2's May 2022 medication administration record (MAR) revealed: -There was an entry for Colace 100mg 1 capsule at bedtime prn for constipation. -The prn Colace was documented as administered on 05/05/22, 05/09/22, and 05/13/22. -There was no prn documentation on those 3 occasions with the time of administration, the reason for administration, or the effectiveness of the medication. Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 2:30pm revealed: -She initialed the front of the MAR when she administered a prn medication. -If she initialed in the block at the top of the entry for that day; she administered the medication in the morning. -If she initialed the block at the bottom of the entry for that day; she administered the medication in the evening or at night. -She did not document the time, reason, or effectiveness of the prn Colace because she did not realize she needed to document that information. Telephone interview with the Administrator / Registered Nurse (RN) on 06/30/22 at 11:31am revealed: -The SIC had received medication training and she knew how to document accurately on the MAR. -The SIC knew she was supposed to document the time of administration, reason and effectiveness of prn medications on the back of the MARs. -She usually checked the MARs quarterly. -She last checked the MARs in March 2022.	C 342		

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C 342	Continued From page 54 -She was supposed to check the MARs for accuracy this month, June 2022, but she had not done it yet.	C 342		
C 449	10A NCAC 13G .1213 (e-2) Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting Of Accidents And Incidents The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the responsible person for 1 of 1 sampled resident (#1) within 48 hours of a fall resulting in arm pain, a leg wound, and multiple bruises on the resident's body. The findings are: Review of Resident #1's current FL-2 dated 03/29/22 revealed diagnoses included gait instability, frequent falls, history of stroke	C 449		

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associated with blood clotting tendency, venous insufficiency, rotator cuff syndrome of both shoulders, insomnia, essential hypertension and hypothyroidism.

Review of Resident #1's current assessment and care plan dated 04/04/22 revealed:
-The resident was ambulatory with aide or device (not specified) and had limited strength in her upper extremities.
-The resident was oriented and her memory was adequate.
-The resident required limited assistance by staff with eating, toileting, ambulation, grooming, and transferring.
-The resident required extensive assistance by staff with bathing and dressing.

Observation of Resident #1 on 06/29/22 at 10:17am revealed:
-The resident was standing in her room wearing a shirt and an adult incontinence brief.
-The resident's right hip had a dark purple bruise about the size of a grapefruit.
-The resident's right upper outer leg had a dark purple bruise about the size of an orange.
-The resident had dark purple and black bruising and swelling around her right eye, down her right cheek, and on her right forehead.
-There was a large reddish, purple bruise on the outer edge of her right elbow.
-There were two large bandaids applied to the left outer side of the lower left leg.

Interview with Resident #1 on 06/29/22 at 10:26am revealed:
-She fell on the floor on Saturday (06/25/22) while she was trying to grab a cup from her nightstand.
-She did not go to the hospital and she did not remember if she was asked by staff if she wanted

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to go to the hospital.
-After she fell on 06/25/22, the wound on her left leg started bleeding again.
-The SIC put bandaids on her leg when they started bleeding.

Observation of Resident #1 on 06/29/22 from 10:46am - 10:52am revealed:
-The resident ambulated with a rolling walker independently to the dining room table.
-She grimaced multiple times when she was moving her arms to self-transfer from a standing position to a sitting position in the dining room chair.
-The resident grimaced again when she repositioned herself in the dining room chair.

Interview with Resident #1 on 06/29/22 at 10:52am revealed she was grimacing because her right arm hurt when she moved from her fall on 06/25/22.

Review of Resident #1's progress notes for June 2022 revealed:
-There was no documentation of the resident falling.
-There was no documentation of the resident's bruises on her hip, leg, elbow or face.
-There was no documentation of when the current bandaids were applied to the resident's lower left leg or the reason the bandaids were applied.
-There was no documentation that the resident's family/power of attorney (POA) was notified of the fall with injuries.

Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 2:55pm revealed:
-Resident #1 fell from her bed 4 days ago (06/25/22) in the morning.

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C 449	Continued From page 57 -She heard "a thump" and went to the resident's room and the resident was on the floor. -She helped the resident get up. -She would normally send a resident to the hospital when they hit their head but the resident said "no". -The resident had complained of arm pain since she was admitted so she did not associate it with the fall. -She reported the fall to the Administrator. -She did not document the fall. -She gave no explanation when asked why she did not document the fall. -She just noticed the bruise on the resident's face yesterday (06/28/22). -She had not noticed the bruising on the resident's hip, leg or elbow. Telephone interview with the Administrator / Registered Nurse (RN) on 06/29/22 at 3:15pm revealed: -The SIC reported Resident #1 had a fall recently (she thought last week) and the resident said she did not want to go to the hospital. -The SIC did not report any bruising from the fall to her. A second interview with the SIC on 06/30/22 at 2:37pm revealed: -When Resident #1 fell on 06/25/22, she reported it to the Administrator. -She did not report the fall to the resident's POA because the Administrator was supposed to contact the POA. A second telephone interview with the Administrator/RN on 06/30/22 at 3:07pm revealed: -The SIC was responsible for notifying the family when a resident fell.	C 449		

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C 449	Continued From page 58 -The SIC knew she was supposed to call the family when a resident fell. -She "assumed" the SIC had notified Resident #1's family of the fall on 06/25/22. -The SIC reported the resident was "okay" after the fall. -She spoke with Resident #1's POA about the fall today, 06/30/22, but she thought the POA already knew about the fall and knew the details of the fall. -The SIC should have reported the fall to the POA when the fall occurred. Telephone interview with Resident #1's POA on 06/30/22 at 12:44pm revealed: -The Administrator called her today, 06/30/22, and reported the resident fell over the weekend and hit her leg, where she had a previous wound. -The Administrator reported the resident had a bump on her head and did not want to go to the hospital. -The Administrator reported she was going to have home health come and evaluate the resident's leg wound. -The Administrator did not report any bruising from the fall. -She was the resident's POA and would like to have known at the time the fall occurred so she could have given her input on whether the resident should have been seen at the hospital for her injuries. -No one from the facility notified her of the fall or any injuries prior to today, 06/30/22.	C 449		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM	C 612		

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C 612	Continued From page 59 (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to protect residents from infection during the global coronavirus (COVID-19) pandemic as related to the screening of staff and visitors and staff not wearing face masks while on duty. The findings are: Review of the Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for healthcare personnel (HCP) during the coronavirus disease 2019 (COVID-19) pandemic dated 02/02/22 revealed: -Facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who has any one of the following three criteria so that they can be managed: a positive viral test for COVID-19,	C 612		

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C 612	Continued From page 60 symptoms of COVID-19, or close contact with someone with COVID-19 infection. -The options could include (but were not limited to): individual screening upon arrival to the facility or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. -Source control measures were to be implemented for HCP. -Source control referred to the use of a well-fitting face mask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. -Fully vaccinated HCP should wear source control (face mask) when they were in areas of the facility where they could encounter residents. -The face mask should cover the nose and mouth. Review of the North Caroline Department of Health and Human Services (NC DHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22 revealed: -Facilities should continue to screen all who enter for visitation. Individuals describing new onset of mild symptoms should be excluded from visitation, as even mild symptoms may be a sign of COVID-19 infection. -Visitors should wear face coverings or masks when around other residents or healthcare personnel, regardless of vaccination status. Review of a fax sent to all adult care home (ACH) and family care home (FCH) providers on 02/14/22 at 10:45am revealed ACHs and FCHs are required to adhere to the guidance dated 02/10/22 in accordance with N.C. G.S. 131D-4.4A and rules 10A NCAC 13F .1801/.1802 (ACH) and 10A NCAC 13G .1701/.1702 (FCH).	C 612		

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C 612	Continued From page 61 Review of the facility's current license for 2022 revealed the capacity was 6 residents. Interview with the live-in Supervisor-in-Charge (SIC) on 06/29/22 at 9:18am revealed the current census was 6 residents. Review of the facility's undated "COVID-19 Checks" Policy revealed: -Check temperature. -Use hand sanitizer stationed at the front door. -Ask if visitor was experiencing any cough, shortness of breath, fever, loss of smell or taste within the last 3 days. -Ask if visitor had any contact with someone who was sick with COVID-19 or was COVID-19 positive within the last 14 days. -Ask if visitor had traveled to a state with high positive COVID-19 cases within the last 14 days. -Please wear masks inside the facility at all times during visit (mandatory). -COVID-19 checks would be done before entering the facility. -Please do not visit if you were feeling sick. Review of the facility's Infection Prevention and Control Program Manual dated 10/23/20 revealed: -All staff would report any signs of illness (fever, cough, difficulty breathing, muscle or body aches, sore throat, new loss of taste or smell). -All staff would be screened for fever and respiratory symptoms at the start of each shift. -Staff's temperature would be taken and the absence of shortness of breath, new or change in cough, and sore throat would be documented. -All visitors would enter through the front door only. -All visitors would be screened for the presence	C 612		

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C 612	Continued From page 62 of fever and symptoms consistent with COVID-19. -Guidance for use of personal protective equipment (PPE) was indicated for Standard Precautions but was not specific to use of PPE during the COVID-19 pandemic. Review of the facility's Infection Prevention and Control Policy Manual dated January 2022 revealed: -It was the policy of the facility to adhere to the federal CDC and NC DHHS guidelines for infection control. -This was a general infection control policy and did not indicate specific guidance for the COVID-19 pandemic. Review of the facility's visitor's sign in notebook revealed: -Visitors including outside agency providers signed their names and dates on the notebook for visits to the facility. -Documentation of temperatures of visitors dated 08/07/21 - 04/27/22 ranged from 79.9 degrees Fahrenheit (F) - 90.4 degrees F with one temperature of 97.9. (Normal body temperature can range between 97 degrees F - 99 degrees F.) -There was no documentation of any temperatures being checked for 16 visitors from 05/03/22 - 06/28/22. -There was no documentation of any screening questions for COVID-19 for any visitors from 08/07/21 - 06/28/22. -There was no documentation the thermometer readings were inaccurate. Observation of entrance into the facility on 06/29/22 at 9:00am revealed: -There were no signs posted outside to instruct visitors to screen for COVID-19 or to wear masks.	C 612		

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C 612	Continued From page 63 -The live-in Supervisor-in-Charge (SIC) answered the door and she was not wearing a mask. -There was a table on the right upon entrance to the facility near the front door. -There was a bottle of hand sanitizer, gowns, gloves, a box of surgical face masks, and a spray can of disinfectant spray on the table. -There was a wall scan thermometer lying on top of the table. -The SIC did not offer to or instruct the surveyor to take temperature or screen with a questionnaire for COVID-19 symptoms. Interview with the SIC on 06/29/22 at 9:00am revealed when prompted, the SIC stated that visitors signed in and checked their temperatures. Observation on 06/29/22 at 9:05am revealed: -Surveyor used the facility's wall scan thermometer with temperature results of 78.1 degrees F, 99.6 degrees F, and 87.5 degrees F. -After signing the visitor's log notebook with date, time, name and temperature, the SIC did not offer or attempt to screen the surveyor for symptoms of COVID-19. -The SIC went into the staff room and came back out wearing a face mask. A second interview with the SIC on 06/29/22 at 9:09am revealed: -Visitors only checked their temperatures. -She did not use COVID-19 screening questions for the visitors. -She used to do COVID-19 screening questions for visitors when COVID-19 was "worse" about 5 to 6 months ago. -She was the live-in SIC and she did not check her temperature or screen herself for COVID-19 because she was usually at the facility 24 hours a day, 7 days a week.	C 612		

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C 612	Continued From page 64 -The wall scan thermometer was the only thermometer she had at the facility. -She did not think it was reading accurately but she did not know how to fix it. -She had not reported it to anyone. -She did not answer when asked what a normal body temperature should be. -She usually wore a face mask but she had no explanation for not wearing a face mask that morning. Interview with a resident on 06/29/22 at 10:38am revealed the live-in SIC wore a face mask most of the time but not all of the time. Interview with a second resident on 06/29/22 at 10:55am revealed the live-in SIC did not usually wear a face mask. Interview with a third resident on 06/29/22 at 11:10am revealed: -The live-in SIC used to wear a face mask but the SIC did not usually wear a face mask now. -She could not recall how long ago the SIC routinely wore a face mask. Telephone interview with the Administrator / Registered Nurse (RN) on 06/29/22 at 9:21am revealed: -Staff should always wear face masks in the facility. -The SIC was supposed to do a COVID-19 questionnaire for visitors. -She was not sure why the SIC was not doing the questionnaire. -There was a list of questions posted on the door of the staff room near the front entrance. -She was not aware the facility's thermometer was not reading accurately. -There should be extra thermometers at the	C 612		

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C 612	Continued From page 65 facility. -The SIC should have notified her that the thermometer was not reading accurately. -The facility staff was supposed to check their temperature and screen for COVID-19 daily. -She was last at the facility a couple of weeks ago to drop off supplies but she did not go inside the facility. -She usually checked the visitors' sign in log and staff log every 3 months and she last checked them about 3 months ago. -She did not recall noticing any issues with the logs when she last checked them. -She was due to check the logs again in July 2022. -They last had COVID-19 in the facility with one positive resident last year. -All staff and residents had been vaccinated with at least one booster vaccination. Observation of entrance into the facility on 06/30/22 at 9:00am revealed: -The live-in SIC handed the surveyor a new handheld no touch thermometer because she could not get the thermometer to scan. -Surveyor checked temperature with the new thermometer and the reading was 97.0 degrees F. -The SIC did not offer or instruct the surveyor to screen with the COVID-19 questionnaire posted on the wall and staff room door. Interview with the SIC on 06/30/22 at 9:10am revealed: -She did not have any forms with a COVID-19 questionnaire for visitors to fill out. -She had not noticed the questionnaire was posted on the wall near the entrance or the staff room door.	C 612		

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C 612	Continued From page 66 Telephone interview with the Administrator/RN on 06/30/22 at 11:31am revealed the live-in SIC should have screened the surveyor for COVID-19 symptoms and documented it that morning, 06/30/22. Telephone interview with a nurse at the local health department on 06/28/22 at 9:29am revealed: -There had been no reports of a COVID-19 outbreak at this facility. -He had not given any specific instructions to the facility regarding COVID-19. -The facility was responsible for following the CDC and NC DHHS guidelines. -All staff should be wearing face masks in the facility. -Visitors, staff, and residents should be screened according to the guidelines.	C 612		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 a resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care. The findings are:	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092153	A. BUILDING: _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANOR AT EDGEWATER	1038 STORMY LANE RALEIGH, NC 27610

(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
C 912	Continued From page 67 Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) for 1 of 3 sampled residents (#1) related to a fall resulting in arm pain and multiple bruises on the face, hip, leg, and elbow and notifying the PCP and wound care provider of redness, swelling, and open wounds with drainage on the resident's left leg. [Refer to Tag D246, 10A NCAC 13G .0902(b) Health Care (Type A2 Violation)].	C 912		