STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL042005	A. BUILDING: _____ B. WING _____	R-C 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REST HOME	1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on June 21, 2022 to June 24, 2022 with an exit conference via telephone on June 24, 2022. The complaint investigation was initiated by the Halifax County Department of Social Services on June 3, 2022.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 9 exit doors accessible to residents' use were equipped with a sounding device that activated for the safety of 2 sampled residents (#6, #7) who were documented as disoriented (#6, #7) and with wandering behaviors (#7). The findings are:	D 067		

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D 067	Continued From page 1	D 067		

Observations of the facility's main entrance door on 06/21/22 at 8:00am, 06/21/22 at 4:30pm, 06/22/22 at 7:30 am, 06/22/22 at 5:45pm, and 06/23/22 at 5:45pm revealed the door was unlocked and did not alarm when opened.

Intermittent observations of the smoking door (which led to an unfenced open field behind the facility) on 06/21/22 from 9:10am to 12:00pm revealed:
-The door was unlocked and did not have a sounding alarm when opened.
-Residents freely entered and exited through the smoking door to smoke and socialize.

1. Review of Resident #7's current FL-2 dated 06/23/22 revealed:
-Diagnoses included asthma, bronchiectesis, chronic airway obstruction, diabetes mellitus, and heart disease.
-She was ambulatory, constantly disoriented, and had wandering behaviors.

Interview with a personal care aide (PCA) on 06/21/22 at 9:05am revealed Resident #7 had confusion and wandering behaviors but had never exhibited exit seeking behaviors or eloped.

Based on observations, interviews, and record reviews it was determined that Resident #7 was not interviewable.

Refer to interview with a personal care aide on 06/22/22 at 10:20am.

Refer to interview with the Director of Operations on 06/22/22 at 10:30am.

Refer to interview with the Administrator on 06/23/22 at 2:00pm.

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D 067	Continued From page 2 Refer to interview with the facility's contracted primary care provider (PCP) on 06/23/22 at 10:46am. 2. Review of Resident #6's current FL-2 dated 03/25/22 revealed: -Diagnoses included advanced dementia with suicidal ideation. -She was ambulatory and constantly disoriented. Observation of Resident #6 on 06/21/22 at 8:16am revealed she was ambulating in the hall independently without staff supervision. Interview with a personal care aide (PCA) on 06/21/22 at 8:20am revealed Resident #6 had wandering behaviors but had never eloped. Interview with a second PCA on 06/21/22 at 9:05am revealed Residents #6 had confusion and wandering behaviors but had never exhibited exit seeking behaviors or eloped. Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable. Refer to interview with a personal care aide on 06/22/22 at 10:20am. Refer to interview with the Director of Operations on 06/22/22 at 10:30am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with the facility's contracted primary care provider (PCP) on 06/23/22 at 10:46am.	D 067		

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D 067	Continued From page 3 Interview with a personal care aide (PCA) 06/22/22 at 10:20am revealed: -PCAs would ensure residents were all present at least once per shift but they did not document it. -The front entrance door and smoking door remained unlocked without an alarm during the day. -She thought third shift staff members would lock and alarm both doors, but she was unsure what time. -There were a couple of residents with wandering behaviors, but they had never shown exit seeking behaviors or eloped. Interview with the Director of Operations (DO) on 06/22/22 at 10:30am revealed: -There were several residents who were disoriented and had wandering behaviors in the facility, but they did not have exit seeking behaviors and had never eloped. -Staff were responsible to perform supervision/safety checks every 2 hours and should ensure all residents were present at that time. -There was no documentation of supervision/safety checks, but it was a known process for all staff. -The main entrance door and the smoking door were frequently used throughout the day and remained unlocked without a sounding alarm during daytime hours so that staff, visitors, and residents could freely enter and exit through them. -They were able to alarm the doors during the day but did not realize they needed to. -The staff on third shift were responsible to lock and turn on the sounding alarm for both doors at 9:00pm per the facility policy.	D 067		

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D 067	Continued From page 4 Interview with the Administrator on 06/23/22 at 2:00pm revealed: -He was not aware of the rule to have doors with sounding alarms at all times if there were residents who had disorientation or wandering behaviors. -He and the DO should have been aware of the rule and ensured the facility was in compliance to have doors with sounding alarms as expected. -The facility had never had a resident wander outside of the building but sounding alarms were an extra measure of safety for disoriented and wandering residents. Interview with the facility's contracted primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected the facilty to maintain compliance in having sounding alarms on doors at all times for resident safety. -He expected facility staff to monitor who was coming in and out of the facility to ensure residents did not wander off. -Confused and disoriented residents who had wandering behaviors could wander into highways and roads, get hit by a vehicle, get lost, fall and become injured, and miss care that they required for their basic and health care needs.	D 067		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;	D 137		

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D 137	Continued From page 5 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 5 sampled staff (Staff A, B, C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1. Review of Staff A's record revealed: -She was hired on 11/01/21 as a personal care aide (PCA) and began working as a medication aide (MA) on 02/16/22. -There was no documentation of that a Health Care Personnel Registry status check was done on or prior to the date of hire or thereafter. Refer to interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:58pm. Refer to interview with the Director of Operations (DO) on 06/22/22 at 4:50pm. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with the PCP for several residents at the facility on 06/23/22 at 10:46am. 2. Review of Staff B's record revealed: -She was hired on 06/15/22 as a medication aide (MA). -There was no documentation of that a Health Care Personnel Registry status check was done on or prior to the date of hire or thereafter. Refer to interview with the Resident Care	D 137		

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D 137	Continued From page 6 Coordinator (RCC) on 06/22/22 at 3:58pm. Refer to interview with the Director of Operations (DO) on 06/22/22 at 4:50pm. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with the PCP for several residents at the facility on 06/23/22 at 10:46am. 3. Review of Staff C's record revealed: -She was hired on 07/30/18 as a MA. -There was no documentation of that a Health Care Personnel Registry status check was done on or prior to the date of hire or thereafter. Refer to interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:58pm. Refer to interview with the Director of Operations (DO) on 06/22/22 at 4:50pm. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with the PCP for several residents at the facility on 06/23/22 at 10:46am. _____ Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:58pm revealed: -A Health Care Personnel Registry (HCPR) status check should have been done on staff on day of hire. -There was no system in place to audit employee records. Interview with the Director of Operations (DO) on 06/22/22 at 4:50pm revealed she was unaware that a HCPR status needed to be done for	D 137		

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D 137	Continued From page 7 personal care aides (PCA) but a HCPR should have been done on all medication aides upon hire. Interview with the Administrator on 06/23/22 at 2:00pm revealed: -The RCC and DO were responsible for hiring new staff. -The DO was responsible for making sure the HCPR status had been checked. -A HCPR status should be done on staff prior to them starting work at the facility. -Not checking HCPR status prior to staff starting work at the facility could jeopardize the well-being of the residents. Interview with the primary care provider (PCP) for several residents at the facility on 06/23/22 at 10:46am revealed: -Residents who lived in a facility were at increased risk for abuse due to cognitive decline and were not always able to advocate for themselves. -HCPR checks should have been done for all staff in healthcare to protect the residents in their care. Refer to Tag D 338, 10A NCAC 13F .0909 Resident Rights _____ The facility failed to ensure 3 of 5 sampled staff (Staff A, B, C) had a HCPR check completed prior to hire. This failure resulted in the facility not knowing if staff had substantiated findings on the HCPR which was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on June 23, 2022	D 137		

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D 137	Continued From page 8 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 8, 2022.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to ensure 2 of 5 sampled staff (Staff A, Staff B) had a criminal background check completed upon hire. The findings are: 1. Review of Staff A's record revealed: -She was hired on 11/01/21 as a personal care aide (PCA) and began working as a medication aide (MA) on 02/16/22. -There was no documentation that a criminal background check was completed upon or before hire, or thereafter. Refer to interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:58pm. Refer to interview with the Director of Operations (DO) on 06/22/22 at 4:50pm. Refer to interview with the Administrator on	D 139		

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D 139	Continued From page 9 06/23/22 at 2:00pm. Refer to interview with the primary care provider (PCP) for several residents at the facility on 06/23/22 at 10:46am. 2. Review of Staff B's record revealed: -She was hired on 06/15/22 as a medication aide (MA). -There was no documentation that a criminal background check was completed upon or before hire. Refer to interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:58pm. Refer to interview with the Director of Operations (DO) on 06/22/22 at 4:50pm. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with the primary care provider (PCP) for several residents at the facility on 06/23/22 at 10:46am. _____ Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:58pm revealed: -A criminal background check should have been done on staff on day of hire. -There was no system in place to audit employee records. Interview with the Director of Operations (DO) on 06/22/22 at 4:50pm revealed: -A criminal background check was to be completed on staff when they were hired. -Staff were not permitted to begin working at the facility without having a criminal background check.	D 139		

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D 139	Continued From page 10 -She was not sure why a criminal background check was not performed for Staff A and B; it must have been overlooked. Interview with the Administrator on 06/23/22 at 2:00pm revealed: -The RCC and DO were responsible for hiring new staff. -The DO was responsible for making sure the criminal background checks were completed. -A criminal background check should be done on staff prior to them starting work at the facility. -Not checking a criminal background status prior to staff starting work at the facility could jeopardize the well-being of the residents. Interview with the primary care provider (PCP) for several residents at the facility on 06/23/22 at 10:46am revealed: -Residents who lived in a facility were at increased risk for abuse. -Criminal background checks checks should be done for all staff in healthcare to protect the residents in their care. Refer to Tag D 338 10A NCAC 13F .0909 Resident Rights _____ The facility failed to ensure 2 of 5 sampled staff (Staff A and Staff B) had a criminal background check completed prior to hire. This failure resulted in the facility not knowing if staff had criminal history which was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on June 23, 2022 for this violation.	D 139		

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D 139	Continued From page 11 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 8, 2022.	D 139		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3	D 164		

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medication aides (B) sampled who obtained finger stick blood sugars and administered insulin but did not receive training on the care of diabetic residents in accordance with the rule prior to administering insulin to residents.

The findings are:

Review of Staff B's personnel record revealed:
-Staff B was hired on 06/15/22 as a medication aide (MA).
-There was no documentation of diabetic care training on file.

Review of a resident's June 2022 electronic medication administration record (eMAR) with a diagnosis of diabetes revealed:
-There was an entry for Novolog (short-acting insulin) 40 units twice daily with meals at 8:00am and 5:00pm.
-Staff B documented administration of the Novolog to the resident on 06/21/22.

Interview with Staff B on 06/24/22 at 3:27pm revealed:
-The lead MA had spent three days with her upon hire supervising her medication passes and training her.
-When she worked on 06/21/22, it was her fourth day and she passed medications to all residents, including residents diagnosed with diabetes who required insulin independently.
-The lead MA had intermittently checked on her to ensure she was doing okay, but she did not supervise her medication passes that day.
-She administered insulin on 06/21/22 without supervision.
-She was still in training at the facility and had not yet received formal training in the care of diabetic residents and insulin from the facility.

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D 164	Continued From page 13 Interview with the lead MA on 06/22/22 at 3:47pm revealed: -Staff B passed medications independently on 06/21/22 while she worked in the office. -She did not realized that Staff B required diabetic care training and did not supervise her pass diabetic medications to residents who required them because she thought Staff B was off training status. -She was not aware she needed to continue to supervise Staff B until her diabetic care training had been completed. Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed: -She did not realize Staff B had been administering insulin medications independently without supervision from the lead MA. -The lead MA should have supervised Staff B administer insulin until Staff B's diabetic care training had been completed. Interview with the Administrator on 06/23/22 at 2:00pm revealed: -It was the Resident Care Coordinator's (RCC) and the DO's responsibility to ensure all required training was completed and kept on file in staff records. -It was the responsibility of the RCC or DO to contact the pharmacy and the nurse to provide training to MAs as required. -He expected MAs to be supervised and trained properly prior to passing medications to residents independently. -It was important for MAs to have proper training medication administration training to ensure they were capable of passing medications to residents safely.	D 164		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 164	Continued From page 14 Interview with the facility's contracted primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected the facility to provide proper training to the MAs passing medication to residents. -Proper training was imperative to ensure resident safety and accuracy in medication administration. -Without proper training, MAs would not know how to accurately follow orders, what side effects or adverse reactions to medications to look for, or what to report to him as needed.	D 164		
D 243	10A NCAC 13F .0704(a)(1) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Infomation on Home and Resident Register (a) An adult care home administrator or administrator-in-charge shall furnish and review with the resident or responsible person information on the home upon admission and when changes are made to that information. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the home. The information shall include the following: (1) the resident contract to which the following applies: (A) the contract shall specify rates for resident services and accommodations, including the cost of different levels of service, if applicable, and any other charges or fees; (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet pursuant to G.S. 131D-2(a1)(4); (C) the contract shall be signed and dated by the	D 243		

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administrator or administrator-in-charge and the resident or responsible person, a copy given to the resident or responsible person and a copy kept in the resident's record;
(D) the resident or responsible person shall be notified as soon as any change is known, but not less than 30 days before the change for rate changes initiated by the facility, of any changes in the contract and be provided an amended contract or an amendment to the contract for review and signature;
(E) gratuities in addition to the established rates shall not be accepted; and
(F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients is established by the North Carolina Social Services Commission and the North Carolina General Assembly.
Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room or a private or semi-private room in a special care unit.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to notify a resident (#6) of a rate change or provide an amended contract for review or signature.

The findings are:

Review of Resident #6's current FL-2 dated 03/25/22 revealed:
-Diagnoses included advanced dementia with suicidal ideation.
-She was constantly disoriented.

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Review of Resident #6's Resident Register revealed she was admitted to the facility 04/04/22.

Review of the facility admissions policy revealed:
-The established rate of $4300.00 monthly would be paid one month in advance.
-The admission policy was signed by Resident #6 and the Resident Care Coordinator (RCC) on 04/04/22.

Review of Resident #6's contract/facility disclosure revealed:
-Resident #6's admission rate was $4300.00 monthly.
-There was a handwritten notation which stated, "prorated $3870".
-It was signed by Resident #6 and the RCC on 04/04/22.

Review of paperwork provided by the facility revealed a receipt dated 04/12/22 stating Resident #6 paid $98,900.00 for room and board.

Review of Resident #6's record revealed there was no new contract stating that Resident #6 would no longer be paying $4300.00 monthly but would pre-pay $98,900.00 for 23 months of room and board.

Interview with Resident #6's family member on 06/23/22 at 11:26am revealed:
-She knew that Resident #6's room and board at the facility was $4,300.00 per month, but she did not know that the facility had taken money out of the resident's account to pre-pay for 23 months of room and board.
-She thought the facility was taking $4,300.00 out of Resident #6's account each month to pay for her room and board.

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D 243	Continued From page 17 -She expected to be informed by the facility that they had Resident #6 pre-pay that far in advance. -If she had been made aware by the facility that they wanted Resident #6 to pre-pay for 23 months of room and board she would not have consented to it. Interview with the RCC on 06/22/22 at 3:16pm revealed: -She, the Director of Operations (DO), and Resident #6 went to the resident's bank and closed her account. -The bank representative issued a cashiers' check to the facility in the amount of $98,900.00 to pay for 2 years of room and board for Resident #6. Interview with the DO on 06/24/22 at 9:20 am revealed: -On 04/12/22 she, the RCC, and Resident #6 went to the resident's bank and closed her account. -The bank representative issued a check to the facility in the amount of $98,900.00 for Resident #6's room and board for 23 months. -The decision that Resident #6 would pre-pay for 23 months of room and board was made by the bank representative. -Sometimes a contract was signed when residents pre-paid for room and board depending on whether the pre-payment was done before the resident was admitted to the facility or after the resident was admitted to the facility. Interview with the Administrator on 06/24/22 at 10:39am revealed if a resident was pre-paying room and board for months in advance, he expected a new contract to be completed and signed by the resident.	D 243		

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D 243	Continued From page 18 Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable.	D 243		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) for 2 of 5 sampled residents (#1, #3) including a resident with traumatic brain injury that displayed frequent aggressive behaviors (#3) and for a resident with multiple finger stick blood sugars (FSBS) that were equal to or less than 80 as per ordered parameters (#1). The findings are: Review of the facility's medication policy revealed: -Medications and treatments will be administered in accordance with the prescribing practitioner's orders. -Staff who have demonstrated competency according to state rules may prepare and administer medications and perform treatments. -In the event of medication errors or adverse reactions, the staff will notify a physician or appropriate health professional and their supervisor, obtain further orders, and document in the resident's record.	D 273		

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D 273	Continued From page 19 1. Review of Resident #3's current FL-2 dated 02/05/22 revealed: -Diagnosis included right sided weakness, traumatic brain injury with loss of consciousness, spastic hemiplegia of right side as a late effect of cerebral vascular accident, motor vehicle accident sequela and expressive aphasia. -There was no documentation of orientation status. Review of Resident #3's current care plan dated 09/03/21 revealed: -There was no documentation of physical or verbal aggression. -There was no documentation of disruptive behavior. -He was oriented and was able to communicate through gestures. -He required an assistive device for ambulation. -He required glasses for limited vision. Review of Resident #3's progress note dated 04/04/22 at 6:15pm revealed: -He had a lighter and began fighting staff when she took it away from him. -There was no documentation Resident #3's PCP was notified of the incident. Review of Resident #3's progress note dated 05/29/22 at 6:10pm revealed: -He swung at a staff member when she tried to take cigarette's away from him. -There was no documentation Resident #3's PCP was notified of the incident. Review of Resident #3's progress note dated 05/30/22 at 6:20pm revealed: -He was entering the building from the back porch and tried to roll over a staff member's feet	D 273		

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and she moved his wheelchair to avoid being run over.
-He hit the staff member in her stomach and a second staff member intervened, wheeling him to his room.
-There was no documentation Resident #3's PCP was notified of the incident.

Interview with Resident #3 on 06/21/22 at 9:30am revealed he hit a staff about 2 weeks prior.

Interview with a personal care aide (PCA) on 09/21/22 at 2:22pm revealed:
-She remembered a time when Resident #3 punched a medication aide (MA) in the stomach.
-She did not report the incident to anyone because the MA was responsible for making notifications.

Interview with a medication aide (MA) on 06/22/22 at 10:25am revealed:
-Resident #3 was physically aggressive with staff when he did not get his way.
-Resident #3 kicked her in her stomach when she told him he could not smoke with a nicotine replacement patch on but was unable to recall the date.
-She tried to roll him inside and he grabbed her by her wrist and would not let go.
-A second staff member intervened to get Resident #3 to let go of her wrist.
-She wrote a progress note about episodes of aggression and reported the incidents to the Director of Operations (DO) and the Resident Care Coordinator (RCC) but she did not notify the PCP.

Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:15pm revealed:
-A staff member reported to her that Resident #3

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hit her in the stomach and grabbed her arm and a second MA had to intervene before Resident #3 would let her arm go.
-Resident #3 would try to hit staff when he did not like what they said and this occurred least monthly.
-She did not know if Resident #3's primary care provider (PCP) was aware of the aggressive behaviors.
-She had notified Resident #3's PCP to report behaviors in the past but had not recently.
-She could not give the date of last notification to the PCP.

Interview with the DO on 06/22/22 at 4:20pm revealed:
-The RCC was responsible for notifying Resident #3's PCP if there was injury.
-She did not expect the PCP to be notified each time Resident #3 was aggressive.
-She had not notified Resident #3's PCP of the behaviors but she thought he was aware.

Interview with the Regional Director on 06/22/22 at 5:33pm revealed she expected the RCC and the DO to notify the PCP when residents display aggressive behaviors.

Telephone interview Resident #3's primary care provider (PCP) on 06/23/22 at 10:46am revealed:
-He was unsure of Resident #3's history of aggression.
-He had received a call from the facility in January 2022 and medication was increased at that time but there had been no contact from the facility since that time.
-He expected to be notified of episodes of aggression when they occurred so he could manage Resident #3's symptoms and behaviors.
-If he was notified of on-going aggression, he

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D 273	Continued From page 22 would have ordered a PRN medication or changed medications. Telephone interview with Resident #3's responsible person on 06/23/22 at 11:40am revealed: -Resident #3 had a history of being aggressive and was unable to be managed in her home. -She expected the facility to notify his PCP when he displayed aggressive behaviors so the PCP could decide if something was wrong and could do something about it. 2. Review of Resident #1's current FL-2 dated 12/21/21 revealed diagnoses included insulin dependent diabetes mellitus, hypertension, chronic obstruction pulmonary disease, peripheral neuropathy, anxiety, and history of seizures. Review of Resident #1's physician orders dated 01/21/22 revealed there was an order for finger stick blood sugars (FSBS) three times daily (a normal FSBS is between 70-140). Review of Resident #1's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 04/01/22 - 04/30/22 and ranged from 39 - 319. -The resident's FSBS were documented as follows: on 04/04/22, 64 at 8:00pm; 04/06/22, 64 at 8:00pm; 04/08/22, 69 at 8:00pm; 04/14/22, 66 at 8:00pm; 04/17/22, 64 at 8:00pm; 04/18/22, 61	D 273		

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D 273	Continued From page 23 at 11:00am and 61 at 8:00pm; 04/19/22, 48 at 8:00pm; 04/20/22, 59 at 8:00pm; 04/21/22, 50 at 8:00pm; 04/22/22, 66 at 8:00pm; 04/24/22, 56 at 11:00am and 39 at 8:00pm; 04/25/22, 61 at 8:00pm; 04/26/22, 48 at 8:00pm. -There was no documentation that the resident's PCP was notified of the FSBS being below normal. Review of Resident #1's May 2022 eMAR revealed: -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 05/01/22 - 05/31/22 and ranged from 45 - 455. -The resident's FSBS were documented as follows: on 05/01/22, 65 at 8:00pm, 05/03/22, 54 at 11:00am; 05/04/22, 60 at 11:00am; 05/05/22, 66 at 8:00pm; 05/11/22, 65 at 8:00pm; 05/14/22, 57 at 11:00am; 05/18/22, 62 at 8:00pm; 05/19/22, 63 at 8:00pm; 05/21/22, 54 at 8:00pm; 05/26/22, 50 at 11:00am; 05/27/22, 45 at 8:00pm; 05/30/22, 68 at 8:00pm; 05/31/22, 54 at 8:00pm. -There was no documentation that the resident's PCP was notified of the FSBS being below normal. Review of Resident #1's June 2022 eMAR revealed: -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 06/01/22 - 06/21/22 and ranged from 51 - 452. -The resident's FSBS were documented as follows: on 06/03/22, 51 at 8:00pm; 06/06/22, 55 at 8:00pm; 06/07/22, 54 at 8:00pm; 06/09/22, 57 at 11:00am; and 06/16/22, 54 at 8:00pm. -There was no documentation that the resident's	D 273		

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D 273	Continued From page 24 PCP was notified of FSBS being below normal. Review of Resident #1's record revealed there was no documentation of PCP notification of FSBS being below normal. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -When Resident #1's FSBS was low, she would administer the resident her glucose tablets then recheck the resident's FSBS in 1-2 hours to ensure the FSBS came up. -She did not report low FSBS to Resident #1's PCP when it occurred, she did not know why. -FSBS that were low and remained untreated were unsafe for the resident and could cause further health issues and complications. Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed she expected the MAs to contact the Resident #1 PCP for further guidance in care and to notify him so he could assess the resident and possibly adjust her medications as needed then document it in the resident's record. Interview with the Administrator on 06/23/22 at 2:00pm revealed: -He expected the MAs to contact the Resident #1's primary care provider for any low FSBS to obtain further guidance for her care. -It was a risk to the resident to have untreated low FSBS that could lead to adverse health events or a diabetic coma. Interview with Resident #1's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He was not aware that the resident was having recurrent low FSBS. -Resident #1 had diabetes mellitus and was	D 273		

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D 273	Continued From page 25 dependent on insulin to help control and lower her blood sugars. -Having low FSBS that were left untreated could cause harm or even death to the resident. -Not being aware of numerous occasions when Resident #1 had FSBS below normal was concerning because he needed to assess the resident, provide further orders to care for the resident, adjust the resident's medications, and ensure the resident had follow up care to monitor the FSBS more closely. _____ The facility failed to provide notification to the primary care provider (PCP) for Resident #3 who had aggressive behaviors and to notify Resident #1's primary care provider (PCP) of finger stick blood sugars (FSBS) below normal. The facility's failure was detrimental to the health, safety, and well-being of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on June 23, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 8, 2022.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this	D 276		

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D 276	Continued From page 26 Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure orders were implemented for 2 of 5 sampled residents (#1, #5) including errors in the use of compression hose (#1) and a continuous positive pressure airway (CPAP) treatment (#5). The findings are : 1. Review of Resident #1's current FL-2 dated 12/21/21 revealed: -Diagnoses included insulin dependent diabetes mellitus, hypertension, chronic obstruction pulmonary disease, peripheral neuropathy, anxiety, history of seizures. -The resident was semi-ambulatory and required 2 liters of oxygen (2L O2) at all times. Review of Resident #1's current care plan dated 12/21/21 revealed the resident required limited assistance with dressing. Review of Resident #1's physician orders dated 01/21/22 revealed: -There was an order for compression hose to wear as directed. (Compression hose are used to improve blood flow and prevent blood clots.) -There was no order for the resident to self-administer the use of the compression hose. Review of Resident #1's current Licensed Health Professional Support (LHPS) review dated 04/19/22 revealed: -The resident was to wear compression hose to her bilateral lower extremities daily. -The compression hose were to be applied in the	D 276		

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morning and removed at bedtime.
-The resident was able to self-administer the use of the compression hose.

Review of Resident #1's April 2022 electronic medication administration record (eMAR) revealed the compression hose were documented as administered daily from 04/01/22 - 04/30/22.

Review of Resident #1's May 2022 eMAR revealed the compression hose were documented as administered daily from 05/01/22 - 05/31/22.

Review of Resident #1's June 2022 eMAR revealed the compression hose were documented as administered daily from 06/01/22 - 06/20/22.

Observation of Resident #1 on 06/21/22 at 8:17am revealed she was not wearing her compression hose.

Observation of Resident #1 on 06/23/22 at 11:08am revealed she was not wearing her compression hose.

Interview with Resident #1 on 06/23/22 at 11:08am revealed:
-She would put the compression hose on and take them off herself, but only wore them on the days her legs would swell.
-She did not wear the compression hose every day because she thought they were too tight.
-There was only one MA who would occasionally ask her if she put the compression hose on, the MAs did not offer to help or assist her in putting them on because she could do it herself.
-None of the other MAs would ask or look to see

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if she was wearing them.
-She was not sure if the MAs documented her use of the compression hose in her record.

Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed:
-Resident #1 was competent enough to put on and take off her compression hose independently.
-She expected the MAs to verify the resident was wearing her compression hose daily prior to documentation of administration.
-She expected the MAs to encourage the use of Resident #1's compression hose and to document the resident's use of the compression hose accurately.

Interview with Resident #1's primary care provider (PCP) on 06/23/22 at 10:46am revealed:
-He expected Resident #1 to wear her compression hose as ordered.
-He did not provide Resident #1 with a self-administer order because he expected the facility to ensure the compression hose were worn daily as ordered.
-The compression hose were ordered for the resident due to her peripheral edema.
-He expected the MAs to document the resident's refusals of the compression hose accurately.

Refer to interview with the RCC on 06/22/22 at 11:58am.

Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am.

Refer to interview with the Administrator on 06/23/22 at 2:00pm.

Refer to interview with a pharmacist from the

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facility's contracted pharmacy on 06/22/22 at 2:45pm.

2. Review of Resident #5's current FL-2 dated 02/26/22 revealed:
-Diagnoses included hypertension, anxiety, hypothyroidism, gastroesophageal reflux disease, hyperlipidemia, hyperglycemia, atrial fibrillation, diastolic heart failure, coronary artery disease, depressive disorder, and neuropathy.
-The resident was ambulatory with the use of a walker.
-There was an order to use a CPAP machine (used to treat sleep apnea) every night at bedtime and remove in the morning.

Review of Resident #5's previous physician orders dated 02/23/22 revealed there was an order for to use a CPAP every night at bedtime and remove in the morning.

Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for CPAP every night before bed and remove in the morning.
-The CPAP was documented as administered every night from 04/01/22 - 04/16/22, 04/22/22, and 04/26/22 - 04/30/22.
-The CPAP was documented as not administered on 04/18/22 - 04/21/22 and 04/23/22 - 04/25/22 due to the resident being unable to take the medication.

Review of Resident #5's May 2022 eMAR revealed:
-There was an entry for CPAP every night before bed and remove in the morning.
-The CPAP was documented as administered every night from 05/01/22 - 05/09/22, 05/12/22 -

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D 276	Continued From page 30 05/16/22, 05/19/22 - 05/26/22, 05/28/22, and 05/31/22. -The CPAP was documented as not administered on 05/10/22 - 05/11/22, 05/17/22 - 05/18/22, 05/27/22 - 05/30/22 due to the resident being unable to take the medication. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for CPAP every night before bed and remove in the morning. -The CPAP was documented as administered every night from 06/01/22 - 06/05/22, 06/07/22, 06/10/22 - 06/13/22, and 06/17/22 - 06/20/22. -The CPAP was documented as not administered on 06/06/22, 06/08/22 - 06/09/22, 06/14/22 - 06/16/22 due to the resident being unable to take the medication. Observation of the medication cart and Resident #5's room on 06/23/22 at 9:48am revealed there was no CPAP machine available to the resident. Interview with Resident #5 on 06/23/22 at 9:55am revealed: -Her CPAP machine had been broken for some time, but she could not recall how long. -Someone at the facility took the machine and was supposed to have it fixed, but she could not recall who. -She had not been wearing her CPAP machine at night as ordered because it was broken. Interview with an MA on 06/23/22 at 9:55am revealed: -She was not aware Resident #5's CPAP was broken. -She did not work night shift and would not have known the machine was broken because she would not have administered it to the resident.	D 276		

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D 276	Continued From page 31 Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed: -She was not aware that Resident #5's CPAP machine was broken and unavailable. -She expected facility staff to report broken equipment to her so she could correct the issue. -The resident had to wear the CPAP at night because she had sleep apnea. -She expected MAs to administer the CPAP as ordered and document the administration accurately. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -The resident needed to wear the CPAP at night to treat sleep apnea, hypertension, and poor output. -He expected the resident's CPAP machine to be available and in working order. -He was not aware the CPAP machine was not being administered as ordered. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. _____ Interview with the RCC on 06/22/22 at 11:58am revealed: -MAs were expected to administer medications and treatments accurately to residents per the	D 276		

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D 276	Continued From page 32 order then document the administration of the medication and treatments accurately on the eMAR. -MAs were expected to perform medication cart audits once per month, but they were only expected to look for expired medications and that medications were in the correct drawers. -There was no process in place to perform audits that included comparing the resident's current orders to the eMAR, to the medications and treatments on hand. Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed if medications and treatments were not administered as ordered it could a decline in the resident's health status. Interview with the Administrator on 06/23/22 at 2:00pm revealed: -He expected MAs to administer medications and treatments accurately as ordered for resident safety per the five rights. -He expected medication and treatment administration to be documented accurately for proper evaluation and assessment. Interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm revealed when medications or treatments were not administered as ordered could be detrimental to the safety of the residents in which there could be drug to drug interactions and not receiving the proper treatment for the diagnoses the medication was prescribed for.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 296		

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D 296	Continued From page 33 (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diet menus were available for 2 of 2 sampled residents with therapeutic diets (#1, #4) with an order for a no added salt diet (#1 ,#4), and no concentrated sweets diet (#1). The findings are: Observation of the kitchen on 06/22/22 at 8:00am revealed: -There was no therapeutic diet menu posted. -There was a hand-written list of resident food preferences and general kitchen notes produced when the diet menu was requested of the Kitchen Manager. 1. Review of Resident #1's current FL-2 dated 12/21/21 revealed diagnoses included diabetes mellitus and hypertension. (Hypertension is high blood pressure.) Review of Resident #1's current diet order dated 04/25/22 revealed an order for no concentrated sweets and no added salt diet. Interview with Resident #1 on 06/21/22 at 8:17am revealed: -She was diagnosed with diabetes and the staff gave her insulin and checked her fingerstick blood sugar three times daily.	D 296		

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D 296	Continued From page 34 -She was not on a special diet. Refer to interview with the Kitchen Manager on 06/22/22 at 8:00am. Refer to interview with the Resident Care Coordinator on 06/22/22 at 3:15. Refer to interview with the Director of Operations on 06/22/22 at 4:20pm. Refer to interview with the Administrator on 06/23/22 at 1:59pm. 2. Review of Resident #4's current FL-2 dated 05/13/22 revealed: -Diagnoses included asthma and gastro-esophageal reflux disease (GERD). -Her ordered diet was no added salt. Refer to interview with the Kitchen Manager on 06/22/22 at 8:00am. Refer to interview with the Resident Care Coordinator on 06/22/22 at 3:15. Refer to interview with the Director of Operations on 06/22/22 at 4:20pm. Refer to interview with the Administrator on 06/23/22 at 1:59pm. _____ Interview with the Kitchen Manager (KM) on 06/22/22 at 8:00am revealed: -That was her first day working independently as the KM. -She was given the hand-written list of residents' preferences by the previous KM. -There was no separate therapeutic diet menu available for residents on a therapeutic diet.	D 296		

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D 296	Continued From page 35 -She was not aware there needed to a separate menu for residents that were ordered a special diet. -She did not know who was responsible for ensuring menus were available. -She did not use a lot of salt when cooking and preparing meals. -She did not think residents on no added salt diets were given salt packets when the meal was served. -Residents on a no concentrated sweets diet were given sugar-free jello or sugar-free pudding as a replacement when sweets were served at mealtimes. Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:15pm revealed: -The current KM was new to the role and was trained by the previous KM before she left. -She was not aware there should be a separate therapeutic diet menu available in the kitchen. -She thought Director of Operations (DO) was responsible for menus were available. Interview with the Director of Operations (DO) on 06/22/22 at 4:20pm revealed: -She checked to be sure the available menu was followed daily. -She was not aware a separate therapeutic diet menu should be available in the kitchen. -The responsibility shifted from her to the lead medication aide (MA) when roles changed at the end of 2021. -She had not informed the lead MA or the RCC the responsibility had moved to the lead MA. Interview with the Administrator on 06/23/22 at 1:59pm revealed all menus were paid for and provided by the home office and he expected the DO and the RCC to ensure they were available	D 296		

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D 296	Continued From page 36 and followed.	D 296		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure resident rights were maintained as related to misappropriation of resident funds (#6) and abuse and neglect of a resident (#3). The findings are: 1. Review of Resident #6's current FL-2 dated 03/25/22 revealed: -Diagnoses included advanced dementia with suicidal ideation. -She was constantly disoriented. Review of Resident #6's Resident Register revealed she was admitted to the facility 04/04/22. Review of Resident #6's hospital history and physical dated 03/23/22 revealed: -Resident #6 was admitted to the hospital with a diagnosis of dementia. -Resident #6's family member had her involuntarily committed to the hospital because she had thrown away her medication and had made statements that she was going to get a gun	D 338		

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and shoot herself or drive a car and crash it.
-Resident #6 was admitted to the hospital with the intention of placing her into a facility upon discharge.

Review of Resident #6's record revealed:
-There was a form signed by Resident #6's primary care provider (PCP) on 05/25/22 which stated that the resident had dementia and was unable to recall specific important events and was confused with dates and occurrences at her office visit on 05/02/22.
-Resident #6 was not capable of managing or directing the management of benefits in her own best interest and that the resident was not expected to be able to manage her funds in the future.

Telephone interview with Resident #6's family member on 06/22/22 at 1:17pm revealed:
-The bank sent a letter stating Resident #6's account had been closed.
-Resident #6 had around $160,000 in her bank account when it was closed.
-He was not sure how Resident #6's money was removed from her bank account because she was not capable of making decisions on her own and he did not approve to have the money removed from her account.
-He got a different story about what happened with Resident #6's money from the Resident Care Coordinator (RCC) and the Director of Operations (DO) at the facility every time he talked to them.
-The facility would not let him move Resident #6 to a different facility because they said the issue would be settled in court.
-He was Resident #6's Power of Attorney (POA) but the facility said the POA was not valid even though the hospital honored the POA.
-Resident #6 had bills and a house that needed to

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be maintained but he was unable to pay her bills or maintain her house because he did not have access to her money.
-There was a court date scheduled for 07/27/22 to settle the matter.

Telephone interview with a second family member of Resident #6 on 06/23/22 at 11:26am revealed:
-Resident #6 was living on her own before she was admitted to the hospital March 2022.
-Resident #6's other family member was bringing her meals and taking care of her while she was at home.
-There was a lot of contention between Resident #6 and the other family member for about a year prior to the resident being hospitalized.
-The contention was what led Resident #6 to be hospitalized and then placed into the facility.
-She had been contacted by the facility and knew they had closed Resident #6's bank account and put her money into a trust until guardianship could be established for the resident.
-She knew that Resident #6's room and board at the facility was $4300.00 per month but she did not know that the facility had taken money out of the resident's account to pre-paid for 23 months of room and board, which totaled $98,900.00.
-She thought the facility was taking $4300.00 out of Resident #6's account each month to pay for her room and board.
-She expected to be informed by the facility that they had Resident #6 pre-pay that far in advance.
-If she had been made aware by the facility that they wanted Resident #6 to pre-pay for 23 months of room and board she would not have consented to it.
-Resident #6 was in late stage dementia and she was unsure how much longer the resident would live.
-Resident #6 was incompetent to make her own

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financial decisions.
-She would be present for the court date on 07/27/22 because she was petitioning the court for guardianship of Resident #6.

Interview with the RCC on 06/22/22 at 3:16pm revealed:
-Resident #6 was admitted into the hospital March 2022 after she was found wandering in the woods.
-The case worker at the hospital contacted her and told her Resident #6 needed placement at the facility.
-After Resident #6 was admitted to the facility the RCC and the DO took Resident #6 to the bank and closed her bank account.
-The bank representative gave them a cashier's check for $98,900 to cover 2 years' worth of room and board for Resident #6.
-The money that was left over after receiving the cashier's check was placed into Resident #6's facility account.
-All residents at the facility had a facility account which contained their money.
-Resident #6 received $1345.00 a month in Social Security and she and the DO took her to the bank every month to remove that money from the resident's bank account and place it into the resident's facility account.
-Resident #6's family member got verbally abusive on the phone with facility staff and when he came on the property, they had to make him leave because of his behavior.
-The facility made Resident #6's family member aware they had removed a lump sum from the resident's account and that was when the family member started getting verbally abusive.
-The facility had a lawyer look at the POA documents provided by the family member and were told they were falsified.

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D 338	Continued From page 40 -There was a court date set for 07/27/22 and another family member was petitioning for guardianship of Resident #6. Interview with the DO on 06/24/22 at 9:20am revealed: -On 04/12/22 she, the RCC, and Resident #6 went to the resident's bank and withdrew all her money from her account. -The bank representative asked how much monthly room and board at the facility was for Resident #6 and the bank representative encouraged them to pre-pay 23 months of room and board for Resident #6. -The bank issued a cashier's check for $98,900.00 for Resident #6's room and board for 23 months. -The $98,900.00 was placed into the facility's operational account. -She did not remember if she made the Administrator aware of the account closure and transfer of funds before or after the bank transaction occurred. -The remainder of Resident #6's money was placed into Resident #6's facility account. -On 05/04/22, she, the RCC, and Resident #6 went to the resident's bank and withdrew the resident's Social Security money totaling $1340.00 from the resident's personal bank account and transferred it into Resident #6's facility account. -On 06/01/22, the RCC and Resident #6 went to the resident's bank and withdrew her Social Security check for $1340.00 from the resident's personal bank account and transferred it into Resident #6's facility account. -It was typical for some residents to pre-pay for room and board at the facility and the number of months they pre-paid varied depending on what the resident's families wanted to do.	D 338		

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D 338	Continued From page 41 Second telephone interview with the DO on 06/24/22 at 12:05pm revealed: -Two checks for Resident #6 were deposited on 04/12/22, one into Resident #6's facility account and one into the operational account. -A check for approximately $163,000.00 was deposited into Resident #6's facility account and a $98,900.00 check was deposited into the facility's operational account. -She later received a call from the bank representative that she had issued a check for the wrong amount and needed the $163,000.00 check returned. -The facility issued a refund to the bank in the amount of $163,000.00 and then the bank issued them another check for around $64,000.00. -The $64,00.00 was to be deposited into Resident #6's facility account. -She could not find a receipt where the $64,000.00 was deposited into the facility account. -The $64,000.00 should have been deposited into Resident #6's facility account on 04/14/22 but she did not deposit the $64,000.00 check into the bank because she was off work that day and she assumed the RCC had deposited the money into Resident #6's facility account. Interview with the Regional Director on 06/23/22 at 3:20pm revealed: -The facility withdrew the money from Resident #6's bank account because they were concerned about the resident's family member's motives related to her funds. -She called the local Department of Social Services (DSS) to make an adult protective services (APS) report on Resident #6 and was told to let the courts decide what needed to be done.	D 338		

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-Pre-paying room and board for 23 months was a random number of months that was picked by the facility.

Telephone interview with the Administrator on 06/23/22 at 2:00pm revealed:
-There was an issue with Resident #6's family member wanting her money.
-No one at the facility was aware that Resident #6 had such a large sum of money in her account until the bank contacted the facility and made them aware.
-The facility did not normally like to handle resident's money.
-The facility contacted the county DSS to get guidance on what they should do with Resident #6's money because they were concerned about her family member's motives related to her funds.
-Resident #6's money was in her facility account until completion of the pending court case.
-The facility should not have done a pre-payment for 23 months for room and board for Resident #6 because no one knew how long the resident might live.
-Normally the facility sent a monthly bill to residents and the residents paid for that month only.
-The plan was to give the remaining balance back to Resident #6 after the court case and a guardian was established for her estate.
-He thought all of Resident #6's money was in Resident #6's facility account.
-He now knew $98,900.00 of Resident #6's money was placed into the facility's operational account.
-He did not know why the pre-payment was taken out of Resident #6's account and put into the facility's operational account.
-There was a hand-written ledger card that was kept by the facility to show how much money

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remained in Resident #6's facility account as well as how much of the $98,900.00 was left in the facility's operational account.

Second telephone interview with the Administrator on 06/24/22 at 10:39am revealed:
-Resident #6 was not able to make good decisions and the facility withdrew the money from her account so her family member could not convince her to turn her money over to him.
-He knew that $98,900.00 of Resident #6's money was deposited into the facility's operational account, but he did to know how they came up with that number.
-Once the $98,900.00 was deposited into the facility's operational account that left a balance of $64,556.62 that was to be deposited into Resident #6's facility account.
-There was currently no record of the $64,556.62 being deposited into Resident #6's facility account.
-The Regional Director, the DO, and the RCC had access to resident's facility accounts.
-The $98,900.00 should not have been placed in the facility's operational account because the operational account should not be co-mingled with resident funds.
-He had never known of a resident at the facility pre-paying room and board 23 months in advance before.
-The entire $163,00.00 should have been deposited into Resident #6's facility account and monthly withdrawals should have been made for her room and board.

Third telephone interview with the Administrator on 06/24/22 at 2:51pm revealed:
-The RCC and DO were at the bank with Resident #6 when the bank issued a check for around $64,000.00.

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-He was told by the DO that the check that was issued was in a plain envelope and was placed on the DO's desk by the RCC and no one knew what happened to the check after that.
-The $64,000.00 check was never deposited into Resident #6's facility account.
-The facility was waiting for a call from the bank to see if the $64,000.00 check was ever cashed.
-If the check was never cashed, he would ask the bank to cancel that check and reissue a new one.
-If the check was cashed, he would call the Sheriff's Office to file a report.

Telephone interview with a county attorney on 06/23/22 at 3:28pm revealed:
-She was told by the facility that they were going to put Resident #6's money into an account until guardianship was established for the resident.
-She did not know that the facility had put $98,900.00 of Resident #6's money into the facility's operational account.
-She was petitioning the court to become the guardian of Resident #6's estate and if she was awarded guardianship, she would ask for a list of bills and would do an audit of the resident's money.

Telephone interview with Resident #6's PCP on 06/23/22 at 10:46am revealed:
-Resident #6 had a history of dementia and cognitive issues.
-He signed paperwork in May 2022 stating that Resident #6 was incapable of handling her own finances.
-The paperwork was provided to him by someone at the facility.
-He did not think it was wise to pre-pay for 23 months of care for Resident #6 because of her advanced age and her diagnosis.
-Any financial decisions that were being made for

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Resident #6 should be made by a Health Care POA and not by the facility because the facility stood to benefit from making financial decisions for Resident #6.
-He was aware that the facility was controlling Resident #6's finances but he was not aware of the situation with the resident's family member or that such a large sum of money was withdrawn from the resident's account.
-It was a conflict of interest that the facility had Resident #6 pay her room and board so far in advance.

Attempted telephone interview with the bank representative on 06/24/22 at 9:44am was unsuccessful.

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

2. Review of Resident #3's current FL-2 dated 02/05/22 revealed:
-Diagnosis included right sided weakness, traumatic brain injury with loss of consciousness, spastic hemiplegia of right side as a late effect of cerebral vascular accident, motor vehicle accident sequela and expressive aphasia.
-There was no documentation of orientation status.

Review of Resident #3's current care plan dated 09/03/21 revealed:
-There was no documentation of physical or verbal aggression.
-There was no documentation of disruptive behavior.
-He was oriented and was able to communicate through gestures.
-He required an assistive device for ambulation.

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D 338	Continued From page 46 -He required glasses for limited vision. Interview with the Director of Operations (DO) on 06/21/22 at 9:44am revealed there were no residents with aggression or behaviors. Review of Resident #3's progress note dated 05/30/22 at 6:20pm revealed: -Resident #3 was entering the building from the back porch and tried to roll over a staff member's feet and she moved his wheelchair to avoid being run over. -He hit the staff member in her stomach and a second staff member intervened, wheeling him to his room. Interview with a resident on 06/21/22 at 8:48am revealed: -She witnessed Resident #3 outside smoking and Staff A tried to make him go back inside the building. -Resident #3 hit Staff A and then Staff A hit Resident #3 three times in the face, breaking his glasses. Interview with a second resident on 06/21/22 at 2:48pm revealed: -If she had a concern or complaint, she would tell the nursing staff, but she would not complain to the management because they would not do anything about it. -She witnessed Staff A hit Resident #3 about two weeks ago as they entered the dining room from the smoking area outside. -Staff A hit Resident #3 in the head three times leaving the resident with a bruised face and a black eye. -She was not sure if any other staff members witnessed the incident, but several other residents had witnessed the incident.	D 338		

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-She did not report the incident to anyone because Staff A should have reported the incident and management.
-She did not think reporting the incident would have been beneficial.
-She was concerned about saying too much about the assault against Resident #3 because if any staff got in trouble, she would be concerned about retaliation against herself or other residents for talking which could make life difficult for them.

Interview with a third resident on 06/21/22 at 3:20pm revealed:
-Some staff had "bad" attitudes toward residents and would talk down to them disrespectfully and aggressively.
-Resident #3, who was wheelchair bound, had a history of aggressive behavior and was not supposed to be smoking.
-About two weeks ago, she witnessed Staff A tell Resident #3 he was not allowed to smoke, and Resident #3 and Staff A had a fight.
-Resident #3 hit Staff A first, then Staff A hit him back giving him a black eye and breaking his glasses.
-She did not report this to anyone because she assumed the staff had already done so and thought the Administrator already knew about the incident.
-She did not want to say too much because she was worried the staff would retaliate against her if they were held accountable and found out she reported them.

Interview with a fourth resident on 06/21/22 at 2:48pm revealed:
-She witnessed Staff A hit Resident #3 about three weeks ago in the dining room.
-Resident #3 was not supposed to be smoking and Staff A tried to bring the resident inside.

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-Resident #3 was upset and the resident and Staff A began yelling at each other.
-Resident #3 hit Staff A first then she heard Staff A say, "Oh no, you're not going to hit me!".
-Staff A then hit Resident #3 three times in the head.
-Resident #3 was bruised in the face and his glasses were broken in the incident.
-She did not report the incident to anyone because it would not have done any good and would not be taken seriously.
-She was concerned staff would retaliate against the residents for talking about the issue by making them have to wait longer than they should for things they need or treat them disrespectfully.
-There were no other staff around when Resident #3 was hit.

Interview with a fifth resident on 06/21/22 at 3:20pm revealed:
-She saw Staff A hit Resident #3 three times in the head after he came in from smoking in the dining room.
-She heard the DO tell Resident #3's family member that Resident #3 had hit a staff member and Staff A hit him back and they would replace his glasses three or four days after the incident.
-Resident #3 had black and blue bruises on his face.
-She also heard the Activities Director (AD) say that it should not have gone that far.

Interview with the Activities Director (AD) on 06/22/22 at 11:12am revealed:
-She had heard from staff that Resident #3 had been physically aggressive but had never witnessed any aggression.
-She was attempting to locate Resident #3's missing eyeglasses when a resident reported to her the eyeglasses were broken during a fight

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between a staff member and Resident #3.
-She did not know when the altercation had occurred.
-She reported what the resident had told her to the DO immediately but she did not remember what the date was and the reporting was not documented.

Interview with Resident #3 on 06/21/22 at 9:30am revealed:
-He hit a staff about 2 weeks prior.
-The staff member then hit him in the right shoulder but did not hit him in the face.
-There was no other staff in the smoking area to witness the staff hitting him.
-He did not report the incident to anyone.

Observation of Resident #3 on 06/21/22 at 9:30am revealed there was no bruising or swelling observed on his face or shoulder area.

Telephone interview with Resident #3's responsible person on 06/23/22 at 11:40am revealed:
-Resident #3 never reported that he was ever hit by staff.
-She was told by another resident that he gave Resident #3 a cigarette and Resident #3 became aggressive when staff attempted to redirect him back into the building.
-The resident did not tell her Resident #3's glasses were broken by staff during that incident or that staff struck Resident #3 or was abusive in any way during the incident.

Interview with a personal care aide (PCA) on 06/21/22 at 2:22pm revealed:
-Resident #3 punched a medication aide (MA) in the stomach.
-She could not remember the date of the incident

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but thought it had occurred more than 2 weeks before when the MA went to redirect Resident #3 back inside to stop him from smoking.
-She was in the front portion of the facility when she heard Resident #3 calling the MA a derogatory name and she responded.
-The MA was wheeling him inside the building when she arrived.
-She saw Resident #3 trying to get the MA away from him.
-She did not witness the MA strike Resident #3 at any time.
-She did not witness what happened outside in the smoking area.

Interview with a second PCA on 06/21/22 at 3:19pm revealed:
-Resident #3 used to have glasses but they went missing a few weeks ago.
-She was not aware if they were broken or lost.
-She was not aware of any incident of aggression for Resident #3.

Interview with a medication aide (MA) on 06/22/22 at 10:25am revealed:
-Resident #3 has a nicotine replacement patch ordered.
-He kicked her in her stomach when she told him he could not smoke with the patch on.
-She tried to roll him inside and he grabbed her by her wrist and would not let go.
-A second staff member intervened to get Resident #3 to let go of her wrist.
-Resident #3's glasses fell off of his face when he was being aggressive and he rolled over them with his wheelchair.
-She reported the incident to the DO, the RCC and to the MA but she was unsure of the date of the event.
-She denied hitting or pushing Resident #3 at any

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D 338	Continued From page 51 time. Interview with the RCC on 06/22/22 at 3:15pm revealed: -A staff member reported to her that Resident #3 hit her in the stomach and grabbed her arm. -The staff member reported a second staff responded to the incident. -No allegation of staff hitting Resident #3 had been made to her until 06/21/22. -She and the DO would be responsible for investigating any allegations of abuse and notifications would be made to DSS, family, and the Health Care Personal Registry (HCPR) after the investigation was completed if found to be true. -There had been no HCPR report made regarding the allegation she became aware of on 06/21/22 because the investigation was not complete. -She was trained on conducting investigation when she became RCC in August or September 2021. Second interview with the DO on 06/21/22 at 3:30pm revealed: -Resident #3 hit a staff member and a second staff member intervened to release the staff member from his grasp. -She was not able to recall the date of the incident but thought it was two to three weeks prior. -She thought the incident occurred on the back porch where residents went to smoke. -Resident #3 wore glasses and an MA told her Resident #3 needed new glasses but did not say why he needed a new pair. -She did not ask the MA why he a new pair and she did not ask what happened to the pair he had.	D 338		

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D 338	Continued From page 52 -She was not told the glasses were broken during the incident with staff. Third interview with the DO on 06/22/22 at 4:20pm revealed: -She and the RCC were responsible for completing an investigation when an abuse allegation was reported. -She was not aware of any report of a staff member hitting Resident #3 prior to 06/21/22. -There had been no report made to the HCPR for the allegation reported to her on 06/21/22 at 3:30pm because the investigation was not complete, and she did not know if it was necessary. -She was responsible for making the notification to the HCPR. -She was trained by the previous manager how to conduct investigations and who to report to but had not conducted any investigation of an abuse allegation since taking the role. -She had not reached out to the Regional Director (RD) or the Administrator for guidance regarding the allegation of abuse. Interview with the RD on 06/21/22 at 1:41pm revealed: -She came to the facility once per month to assist and needed and round of residents to ensure the facility ran according to expectations and the residents were happy. -She had never heard any complaints or concerns that residents were in fear of retaliation from facility staff, but she had to sometimes "coax" concerns out of the residents because they were hesitant to tell her things. -Any allegations of abuse should have been reported to the Administrator. -The Administrator may not have shared any concerns regarding abuse with her unless there	D 338		

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was a question about how to handle the situation.
-She had not received report of allegation of abuse for Resident #3.
-The Director of Operations and the RCC would be responsible for investigating reports of abuse.

Second interview with the RD on 06/22/22 at 5:33pm revealed:
-The RCC and the DO were responsible for conducting investigations of allegations of abuse and notifying the Health Care Personnel Registry.
-The RCC and the DO were not aware the HCPR had to be notified within 24 hours of learning of an allegation of abuse whether or not the investigation was complete, substantiated or unsubstantiated.
-She did not instruct them to complete the HCPR notification since learning of the allegation on 06/21/22.

Telephone interview Resident #3's primary care provider (PCP) on 06/23/22 at 10:46am revealed:
-He was not aware of Resident #3 having episodes of aggression or an allegation of abuse.
-He had received a call from the facility in January 2022 and medication was increased at that time.
-He expected to be notified of episodes of aggression when they occurred so he could manage Resident #3's symptoms and behaviors.

Interview with the Administrator on 06/23/22 at 1:59pm revealed he was not aware of any allegation of abuse prior to 06/21/22.

The facility failed to protect a resident (#6), who had dementia and was unable to make her own financial decisions, from exploitation which resulted in the misappropriation of funds by making financial decisions for the resident to place $98,900 of the resident's money into the

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D 338	Continued From page 54 facility's operational account for the benefit of the facility without consent from the resident's family and not being able to account for $64,556.62 of the resident's money and failed to protect a resident (#3) from physical abuse by staff which resulted in bruises of the face and the resident's glasses being broken. The facility's failure resulted in exploitation and abuse and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/21/22 and an addendum on 06/24/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 24, 2022.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments 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 2 of 5 sampled residents (#1, #5) including errors in diabetic medications ordered in relation to finger stick blood sugar (FSBS) parameters (#1), a blood thinner, a nasal spray (used to treat seasonal	D 358		

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allergies), and acid reflux medications (used to treat acid reflux) (#5).

The findings are :

Review of the facility's medication policy revealed:
-Medications and treatments will be administered in accordance with the prescribing practitioner's orders.
-Staff who have demonstrated competency according to state rules may prepare and administer medications and perform treatments.
-In the event of errors or adverse reactions, the staff notify a physician or appropriate health professional, their supervisor, obtain further orders, and document in the resident's record.

1. Review of Resident #1's current FL-2 dated 12/21/21 revealed:
-Diagnoses included insulin dependent diabetes mellitus, hypertension, chronic obstruction pulmonary disease, peripheral neuropathy, anxiety, and history of seizures.
-The resident was semi-ambulatory and required 2 liters of oxygen (2L O2) at all times.

a. Review of Resident #1's physician orders dated 01/21/22 revealed:
-There was an order for FSBS three times daily.
-There was an order for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated. (Glucose tablets are used to increase FSBS when they are too low.)

Review of Resident #1's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS three times daily at

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D 358	Continued From page 56 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 04/01/22 - 04/30/22 and ranged from 39 - 319. -There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm. -The resident's FSBS less than or equal to 80 were documented as follows: on 04/04/22, 78 at 11:00am and 64 at 8:00pm; 04/06/22, 64 at 8:00pm; 04/07/22, 79 at 8:00pm; 04/08/22, 69 at 8:00pm; 04/13/22, 76 at 8:00pm; 04/14/22, 66 at 8:00pm; 04/17/22, 64 at 8:00pm; 04/18/22, 61 at 11:00am and 61 at 8:00pm; 04/19/22, 48 at 8:00pm; 04/20/22, 59 at 8:00pm; 04/21/22, 50 at 8:00pm; 04/22/22, 66 at 8:00pm; 04/23/22, 73 at 11:00am; 04/24/22, 56 at 11:00am and 39 at 8:00pm; 04/25/22, 61 at 8:00pm; 04/26/22, 48 at 8:00pm; 04/28/22, 68 at 11:00am; 04/30/22, 78 at 11:00am; and all other FSBS were documented as greater than 80. -The glucose tablets were documented as administered twice daily at 8:00am and 8:00pm from 04/01/22 - 04/18/22 and from 04/28/22 - 04/30/22 with no relevance to FSBS values. -The glucose tablets were documented as administered on 04/19/22 at 8:00pm, 04/23/22 at 12:32pm, and 04/24/22 at 11:11am for FSBS less than 80. -There were 4 of 21 opportunities in which the glucose tablets were administered per parameters for FSBS less than 80 but the FSBS were never rechecked. -There were 17 of 21 opportunities in which the glucose tablets were not administered in reference to ordered parameters in which the FSBS were less than or equal to 80 and the FSBS were never rechecked.	D 358		

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D 358	Continued From page 57 Review of Resident #1's May 2022 eMAR revealed: -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 05/01/22 - 05/31/22 and ranged from 45 - 455. -There was an entry for Novolog 40 units twice daily at 8:00am and 5:00pm. -The Novolog was documented as administered from 05/01/22 - 05/03/22 twice daily, 05/04/22 at 8:00am, 05/05/22 - 05/06/22 twice daily, 05/11/22 at 8:00pm, and 05/12/22 - 05/31/22 twice daily. -There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm. -The resident's FSBS were documented as follows: on 05/01/22, 65 at 8:00pm, 05/03/22, 54 at 11:00am and 76 at 8:00pm; ; 05/04/22, 60 at 11:00am; 05/05/22, 66 at 8:00pm; 05/11/22, 65 at 8:00pm; 05/13/22, 72 at 8:00pm; 05/14/22, 57 at 11:00am; 05/18/22, 62 at 8:00pm; 05/19/22, 63 at 8:00pm; 05/20/22, 72 at 8:00pm; 05/21/22, 54 at 8:00pm; 05/25/22, 70 at 11:00am; 05/26/22, 50 at 11:00am and 70 at 8:00pm; 05/27/22, 45 at 8:00pm; 05/28/22, 75 at 11:00am; 05/29/22, 74 at 8:00pm; 05/30/22, 68 at 8:00pm; 05/31/22, 54 at 8:00pm; all other FSBS were documented as greater than 80. -The glucose tablets were documented as administered twice daily from 05/01/22 - 05/31/22 regardless of FSBS values. -There were 4 of 21 opportunities in which the glucose tablets were administered per parameters for FSBS less than 80 but the FSBS were never rechecked. -There were 17 of 21 opportunities in which the	D 358		

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D 358	Continued From page 58 glucose tablets were not administered in reference to ordered parameters in which the FSBS were less than or equal to 80 and the FSBS were never rechecked. Review of Resident #1's June 2022 eMAR revealed: -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 06/01/22 - 06/21/22 and ranged from 51 - 452. -There was an entry for Novolog 40 units twice daily at 8:00am and 5:00pm. -The Novolog was documented as administered from 06/01/22 - 06/21/22 twice daily. -There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm. -The resident's FSBS were documented as follows: on 06/01/22, 79 at 11:00am, 06/03/22, 51 at 8:00pm; 06/04/22, 72 at 8:00pm; 06/06/22, 55 at 8:00pm; 06/07/22, 54 at 8:00pm; 06/09/22, 5763 at 11:00am and 76 at 8:00pm; 06/10/22, 80 at 8:00pm; 06/12/22, 72 at 8:00pm; 06/16/22, 54 at 8:00pm; 06/20/22, 72 at 11:00am; all other FSBS were documented as greater than 80. -The glucose tablets were documented as administered twice daily from 06/01/22 - 06/12/22, 06/14/22, 06/17/22 - 06/21/22, and on 06/13/22 at 8:00am, 06/15/22 at 8:00pm, and 06/16/22 at 8:00am, regardless of FSBS values. -There was no documentation that the resident's FSBS were rechecked every ten minutes for values less than 80. -There was no documentation that the glucose tablets were administered every ten minutes for FSBS that continued to be less than 80.	D 358		

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D 358	Continued From page 59 -There were 4 of 21 opportunities in which the glucose tablets were administered per parameters for FSBS less than 80 but the FSBS were never rechecked. -There were 17 of 21 opportunities in which the glucose tablets were not administered in reference to ordered parameters in which the FSBS were less than or equal to 80 and the FSBS were never rechecked. Review of Resident #1's record revealed there was no documentation that any of her FSBS were ever rechecked. Interview with Resident #1 on 06/21/22 at 8:17am revealed: -She was diagnosed with diabetes and the staff gave her insulin and checked her FSBS three times daily. -She was not on a special diet and did not know if she had low blood sugars. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -MAs were expected to administer medications accurately per parameters as ordered for resident safety. -Resident #1 was only supposed to be administered glucose tabs when her FSBS were less than 80 per parameters. -When Resident #1's FSBS was low, she would administer the resident her glucose tablets then recheck the resident's FSBS in 1-2 hours to ensure the FSBS came up. -She did not document the resident's FSBS recheck after having low FSBS, she did not know why. -If an MA had rechecked the FSBS it would have been documented on the eMAR or in the resident's progress notes.	D 358		

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D 358	Continued From page 60 -She did not report low FSBS to Resident #1's PCP when it occurred, she did not know why. -She was not sure why Resident #1's glucose tabs were not being administered per parameters as ordered but thought it might be due to a misunderstanding in the order or just missed reading the order. -FSBS that were low and remained untreated were unsafe for the resident and could cause further health issues and complications. Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 11:58am revealed: -She was not aware that Resident #1's glucose tabs were being given twice daily at 8:00am and 8:00pm instead of every 10 minutes as needed for FSBS less than 80 until greater than 100. -She expected the MAs to read the order carefully prior to medication administration to ensure safe administration of medication to residents as ordered. -She expected MAs to administer medications per ordered parameters and to notify the resident's PCP of any FSBS less than 80 for further guidance. -It was concerning that MAs were not following parameter orders for Resident #1 regarding low FSBS. -Low FSBS that were left untreated could cause the resident adverse health effects such as coma or death. Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed: -She was not aware that Resident #1's glucose tablets were being administered twice daily despite the FSBS parameter order. -She expected MAs to follow the administration order for Resident #1's accurately as written and recheck her FSBS every ten minutes to continue	D 358		

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giving the glucose tablets as ordered.
-It was a safety concern to learn that Resident #1's FSBS were going untreated because untreated low FSBS could lead to negative outcomes such as a hospitalization or diabetic coma.

Interview with the Administrator on 06/23/22 at 2:00pm revealed:
-He expected the MAs to administer Resident #1's glucose tablets accurately per parameters.
-He expected the MAs to contact the Resident #1's primary care provider for any low FSBS to obtain further guidance for her care.
-It was a risk to the resident to have untreated low FSBS that could lead to adverse health events or a diabetic coma.

Interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm revealed:
-Resident #1 should only be administered glucose tablets for FSBS that are 80 or below.
-The resident's FSBS should be rechecked every ten minutes when the FSBS were 80 or below and she should be given glucose tablets every 10 minutes until the FSBS were greater than 100.
-She expected the MAs to administer glucose tablets per the FSBS parameters as ordered.
-If Resident #1's FSBS remain less than 80 and untreated it could lead to adverse health issues to include a diabetic coma.

Interview with Resident #1's primary care provider (PCP) on 06/23/22 at 10:46am revealed:
-Resident #1 had diabetes mellitus and was dependent on insulin to help control and lower her blood sugars.
-Having low FSBS that were left untreated with the glucose tablets as ordered could cause harm

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or even death to the resident.
-He expected the MAs to administer the resident's glucose tablets accurately as ordered and to notify him of any FSBS less than 80 immediately after administering the glucose tablets to further address low FSBS.
-Not being aware of numerous occasions when Resident #1 had FSBS less than 80 was concerning because he needed to assess the resident, provide further orders to care for the resident, adjust the resident's medications, and ensure the resident had follow up care to monitor the FSBS more closely.

Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm.

Refer to interview with the RCC on 06/22/22 at 11:58am.

Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am.

Refer to interview with the Administrator on 06/23/22 at 2:00pm.

Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm.

Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am.

b. Review of Resident #1's physician orders dated 01/21/22 revealed:
-There was an order for FSBS three times daily.
-There was an order for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as

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D 358	Continued From page 63 clinically indicated. (Glucose tablets are used to increase FSBS when they are too low.) Review of Resident #1's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 04/01/22 - 04/30/22 and ranged from 39 - 319. -There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm. -The glucose tablets were documented as administered twice daily from 04/01/22 - 04/18/22 and from 04/28/22 - 04/30/22 regardless of FSBS values. -There were 44 out of 60 opportunities that the glucose tablets were administered to the resident, instead of being held due to not being required or needed, when her blood sugars were greater than 80 and within normal parameters. Review of Resident #1's May 2022 eMAR revealed: -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 05/01/22 - 05/31/22 and ranged from 45 - 455. -There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm. -The glucose tablets were documented as administered twice daily from 05/01/22 - 05/31/22	D 358		

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regardless of FSBS values.
-There were 48 out of 60 opportunities that the glucose tablets were administered to the resident, instead of being held due to not being required or needed, when her blood sugars were greater than 80 and within normal parameters.

Review of Resident #1's June 2022 eMAR revealed:
-There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm.
-The resident's FSBS were documented as obtained as ordered daily from 06/01/22 - 06/21/22 and ranged from 51 - 452.
-There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm.
-The glucose tablets were documented as administered twice daily from 06/01/22 - 06/12/22, 06/14/22, 06/17/22 - 06/21/22, and on 06/13/22 at 8:00am, 06/15/22 at 8:00pm, and 06/16/22 at 8:00am, regardless of FSBS values.
-There were 33 out of 41 opportunities that the glucose tablets were administered to the resident, instead of being held due to not being required or needed, when her blood sugars were greater than 80 and within normal parameters.

Interview with Resident #1 on 06/21/22 at 8:17am revealed:
-She was diagnosed with diabetes and the staff gave her insulin and checked her FSBS three times daily.
-She was not on a special diet.

Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed:
-MAs were expected to administer medications

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accurately per parameters as ordered for resident safety.
-Resident #1 was only supposed to be administered glucose tabs when her FSBS were less than 80 per parameters.
-She was not sure why Resident #1's glucose tabs were not being administered per parameters as ordered but thought it might be due to a misunderstanding in the order or just missed reading the order.

Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 11:58am revealed:
-She was not aware that Resident #1's glucose tabs were being given twice daily at 8:00am and 8:00pm instead of every 10 minutes as needed for FSBS less than 80 until greater than 100.
-She expected the MAs to read the order carefully prior to medication administration to ensure safe administration of medication to residents as ordered.
-She expected MAs to administer medications per ordered parameters and to notify the resident's PCP of any FSBS less than 80 for further guidance.
-It was concerning that MAs were not following parameter orders for Resident #1 regarding administration of the glucose tablets for FSBS.

Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed:
-She was not aware that Resident #1's glucose tablets were being administered twice daily despite the FSBS parameter order.
-She expected MAs to follow the administration order for Resident #1's glucose tablets accurately as written per parameters.

Interview with the Administrator on 06/23/22 at 2:00pm revealed he expected the MAs to

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administer Resident #1's glucose tablets accurately per parameters.

Interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm revealed:
-Resident #1 should only be administered glucose tablets for FSBS that are 80 or below.
-She expected the MAs to administer glucose tablets per the FSBS parameters as ordered.

Interview with Resident #1's primary care provider (PCP) on 06/23/22 at 10:46am revealed:
-Resident #1 had diabetes mellitus and was dependent on insulin to help control and lower her blood sugars.
-He expected the MAs to administer the resident's glucose tablets accurately as ordered per parameters.

Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm.

Refer to interview with the RCC on 06/22/22 at 11:58am.

Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am.

Refer to interview with the Administrator on 06/23/22 at 2:00pm.

Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm.

Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am.

c. Review of Resident #1's physician orders dated

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D 358	Continued From page 67 01/21/22 revealed there was an order for Humulin 70/30 (long acting insulin), inject 40 units twice daily at 11:00am and 7:00pm. Review of Resident #1's hospital discharge paperwork dated 02/07/22 revealed there was an order to discontinue to the Humulin and begin administering Novolog (short-acting insulin used to lower FSBS) 40 units twice daily with meals. Review of Resident #1's May 2022 eMAR revealed: -There was an entry for Novolog 40 units twice daily at 8:00am and 5:00pm. -The Novolog was documented as administered from 05/01/22 - 05/03/22 twice daily, 05/04/22 at 8:00am, 05/05/22 - 05/06/22 twice daily, 05/11/22 at 8:00pm, and 05/12/22 - 05/31/22 twice daily. -The Novolog was documented as not administered on 05/04/22 at 5:00pm, 05/07/22 at 8:00am and 5:00pm, 05/08/22 at 8:00am and 5:00pm, 05/09/22 at 8:00am and 5:00pm, 05/10/22 at 8:00am and 5:00pm, and 05/11/22 at 8:00am due to the patient being unable to take the medication awaiting a refill from the pharmacy. -There were 10 of 62 opportunities that the resident's Novolog was not administered as ordered because the medication was not on hand. Interview with Resident #1 on 06/21/22 at 8:17am revealed she was diagnosed with diabetes and the staff gave her insulin and checked her FSBS three times daily, but sometimes she ran out of insulin. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed MAs were expected to administer medications accurately	D 358		

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D 358	Continued From page 68 per parameters as ordered for resident safety. Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 11:58am revealed she expected MAs to administer insulin as ordered Interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm revealed: -Resident #1 should only be administered glucose tablets for FSBS that are 80 or below. -She expected the MAs to administer glucose tablets per the FSBS parameters as ordered. Interview with Resident #1's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -Resident #1 had diabetes mellitus and was dependent on insulin to help control and lower her blood sugars. -He expected the MAs to have on hand and administer the resident's insulin accurately as ordered. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider	D 358		

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D 358	Continued From page 69 (PCP) on 06/23/22 at 10:46am. 2. Review of Resident #5's current FL-2 dated 02/26/22 revealed: -Diagnoses included hypertension, anxiety, hypothyroidism, gastroesophageal reflux disease, hyperlipidemia, hyperglycemia, atrial fibrillation, diastolic heart failure, coronary artery disease, depressive disorder, and neuropathy. -The resident was ambulatory with the use of a walker. a. Review of Resident #5's current FL-2 dated 02/26/22 revealed there was an order for Aspirin 81mg (used as a low-dose blood thinner) once daily. Review of Resident #5's previous physician orders dated 02/23/22 revealed there was an order for Aspirin 325mg daily. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 325mg to be administered daily. -The Aspirin 325mg was documented as administered daily from 04/01/22 - 04/16/22, 04/19/22 - 04/24/22, and 04/26/22 - 04/30/22. -There was no entry for Aspirin 81mg to be administered daily. Review of Resident #5's May 2022 eMAR revealed: -There was an entry for Aspirin 325mg to be administered daily. -The Aspirin 325mg was documented as administered daily from 05/01/22 - 05/31/22. -There was no entry for Aspirin 81mg to be administered daily.	D 358		

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D 358	Continued From page 70 Review of Resident #5's June 2022 eMAR revealed: -There was an entry for Aspirin 325mg to be administered daily. -The Aspirin 325mg was documented as administered daily from 06/01/22 - 06/21/22. -There was no entry for Aspirin 81mg to be administered daily. Observation of Resident #5's medications on hand on 06/23/22 at 9:48am revealed: -There was a bottle of Aspirin 325mg available for administration. -There was no Aspirin 81mg available for administration. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders. -It was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that document. -If a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders. Interview with the RCC on 06/22/22 at 11:58am revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders.	D 358		

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D 358	Continued From page 71 -She was responsible to compare current orders to new orders for any changes as soon as new orders were received. -Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered accurately as ordered per the FL-2 dated 02/26/22. -He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately. -Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm.	D 358		

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D 358	Continued From page 72 Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am. b. Review of Resident #5's current FL-2 dated 02/26/22 revealed there was an order for fluticasone 50mcg (used for seasonal allergies), one spray in each nostril daily. Review of Resident #5's previous physician orders dated 02/23/22 revealed there was an order for fluticasone 50mcg, one spray in each nostril daily as needed. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone 50mcg one spray in each nostril daily as needed. -There was no entry for fluticasone 50mcg one spray in each nostril scheduled daily. -The fluticasone was not documented as administered. Review of Resident #5's May 2022 eMAR revealed: -There was an entry for fluticasone 50mcg one spray in each nostril daily as needed. -There was no entry for fluticasone 50mcg one spray in each nostril scheduled daily. -The fluticasone was not documented as administered. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for fluticasone 50mcg one spray in each nostril daily as needed. -There was no entry for fluticasone 50mcg one spray in each nostril scheduled daily. -The fluticasone was not documented as administered.	D 358		

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D 358	Continued From page 73 Observation of Resident #5's medications on hand on 06/23/22 at 9:48am revealed the fluticasone was available for administration as ordered. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders. -It was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that document. -If a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders. Interview with the RCC on 06/22/22 at 11:58am revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders. -She was responsible to compare current orders to new orders for any changes as soon as new orders were received. -Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered	D 358		

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accurately as ordered per the FL-2 dated 02/26/22.
-He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately.
-Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls.

Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm.

Refer to interview with the RCC on 06/22/22 at 11:58am.

Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am.

Refer to interview with the Administrator on 06/23/22 at 2:00pm.

Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm.

Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am.

c. Review of Resident #5's current FL-2 dated 02/26/22 revealed there was an order for ranitidine 300mg (used to treat acid reflux) every night before bed.

Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed there was not an entry for ranitidine

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D 358	Continued From page 75 300mg every night before bed. Review of Resident #5's May 2022 eMAR revealed there was not an entry for ranitidine 300mg every night before bed. Review of Resident #5's June 2022 eMAR revealed there was not an entry for ranitidine 300mg every night before bed. Observation of Resident #5's medication on hand on 06/23/223 at 9:48am revealed there was no ranitidine 300mg available for administration. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders. -It was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that document. -If a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders. Interview with the RCC on 06/22/22 at 11:58am revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders. -She was responsible to compare current orders to new orders for any changes as soon as new orders were received.	D 358		

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D 358	Continued From page 76 -Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered accurately as ordered per the FL-2 dated 02/26/22. -He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately. -Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am.	D 358		

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D 358	Continued From page 77 d. Review of Resident #5's previous physician orders dated 02/23/22 revealed an order for omeprazole 20mg (used to prevent acid reflux) daily. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for omeprazole 20mg daily. -The omeprazole 20mg was documented as administered daily from 04/01/22 - 04/16/22, 04/19/22 - 04/24/22, and 04/26/22 - 04/30/22. Review of Resident #5's May 2022 eMAR revealed: -There was an entry for omeprazole 20mg daily. -The omeprazole 20mg was documented as administered daily from 05/01/22 - 05/31/22. Review of Resident #5's June 2022 eMAR revealed: _-There was an entry for omeprazole 20mg daily. -The omeprazole 20mg was documented as administered daily from 06/01/22 - 06/21/22. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders. -It was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that document. -If a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders.	D 358		

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D 358	Continued From page 78 Interview with the RCC on 06/22/22 at 11:58am revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders. -She was responsible to compare current orders to new orders for any changes as soon an new orders were received. -Residents needed to be administered medications accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered accurately as ordered per the FL-2 dated 02/26/22. -He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately. -Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am.	D 358		

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D 358	Continued From page 79 Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am. _____ Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -New medication orders were to be faxed to the pharmacy by the MAs or the RCC as soon as possible. -The pharmacy entered the orders onto the resident's eMAR. -When the medications arrived at the facility, it was the MAs responsible to compare the original order to the eMAR to the medication on hand for accuracy prior to approved the order and administering the medication. -MAs were responsible to compare the medication on hand to the resident's task list and the eMAR for accuracy prior to administering the medication, then document the administration accurately on the MAR. -She would perform medication cart audits once monthly and documented them but was not sure where they were. -Medication cart audits included comparing an original order to the medications on hand and the resident's eMAR for accuracy. Interview with the RCC on 06/22/22 at 11:58am revealed: -She or an MA were responsible to fax new medication orders to the pharmacy as soon as possible after receiving the orders.	D 358		

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D 358	Continued From page 80 -The pharmacy would enter the new order into the resident's eMAR and she or an MA were responsible to review the order on the eMAR for accuracy before approving the order for use. -When medications arrived for the new medication order, it was the MA's responsibility to compare the original order with the medication on hand and the eMAR for accuracy. -There was no process in place to have a second person check the accuracy of the orders after her or the MA approved the order. -MAs were expected to administer medications accurately to residents per the order then document the administration of the medication accurately on the eMAR. -MAs were expected to perform medication cart audits once per month, but they were only expected to look for expired medications and that medications were in the correct drawers. -There was no process in place to perform audits that included comparing the resident's current orders to the eMAR, to the medications on hand. Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed: -MAs were expected to administer medications via the five rights of medication; right medication, dose, time, resident, and route. -She expected MAs to compare medications to the eMAR prior to administration for resident safety. -If orders were not faxed to the pharmacy, the orders would not be entered onto the eMAR, and MAs would not know how to administer medications accurately. -If medications were not administered as ordered it could a decline in the resident's health status. Interview with the Administrator on 06/23/22 at 2:00pm revealed:	D 358		

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D 358	Continued From page 81 -He expected resident medication orders to be reflected accurately on their eMAR. -He expected MAs to administer medications accurately as ordered for resident safety per the five rights. -He expected medication administration to be documented accurately for proper evaluation and assessment. Interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm revealed: -MAs were responsible to administer medications accurately as ordered. -MAs were expected to compare the medications being administered to the eMAR to ensure accuracy prior to administration. -When medications are not administered as ordered could be detrimental to the safety of the residents in which there could be drug to drug interactions and not receiving the proper treatment for the diagnoses the medication was prescribed for. Interview with the facility's contracted primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected the MAs at the facility to administer medications to residents accurately and safely. -He expected orders to be reflected accurately on resident eMARs. -He expected to be notified when errors or adverse side effects from medications occurred.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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D 367	Continued From page 82 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 2 of 5 sampled residents (#1, #5) including orders for compression hose (#1), and orders for a blood thinner, a nasal spray, acid reflux medications, and a CPAP treatment (#5). The findings are: Review of the facility's medication policy revealed: -Medications and treatments will be administered in accordance with the prescribing practitioner's orders. -Staff will document administration of medications on the eMAR after observing the resident take the medication. -The eMAR will be updated and changed when	D 367		

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D 367	Continued From page 83	D 367		

medication or treatment orders from the prescribing practitioner changes.

1. Review of Resident #1's current FL-2 dated 12/21/21 revealed:
-Diagnoses included insulin dependent diabetes mellitus, hypertension, chronic obstruction pulmonary disease, peripheral neuropathy, anxiety, history of seizures, and a history of illegal drug use.
-The resident was semi-ambulatory and required 2 liters of oxygen (2L O2) at all times.

Review of Resident #1's physician orders dated 01/21/22 revealed:
-There was an order for compression hose to wear as directed.
-There was no order for the resident to self-administer the use of the compression hose.

Review of Resident #1's April 2022 electronic medication administration record (eMAR) revealed the compression hose were documented as administered daily from 04/01/22 - 04/30/22.

Review of Resident #1's May 2022 eMAR revealed the compression hose were documented as administered daily from 05/01/22 - 05/31/22.

Review of Resident #1's June 2022 eMAR revealed the compression hose were documented as administered daily from 06/01/22 - 06/20/22.

Observation of Resident #1 on 06/21/22 at 8:17 she was not wearing her compression hose.

Observation of Resident #1 on 06/23/22 at

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D 367	Continued From page 84 11:08am revealed she was not wearing her compression hose. Interview with Resident #1 on 06/23/22 at 11:08am revealed: -She would put the compression hose on and take them off herself, but only wore them on the days her legs would swell. -She did not wear the compression hose every day because she thought they were too tight. -There was only one MA who would occasionally ask her if she put the compression hose on. -None of the other MAs would ask or look to see if she was wearing them. -She was not sure if the MAs documented her use of the compression hose in her record. Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed: -Resident #1 was competent enough to put on and take off her compression hose independently. -She expected the MAs to verify the resident was wearing her compression hose daily prior to documentation of administration. -She expected the MAs to encourage the use of Resident #1's compression hose and to document the resident's use of the compression hose accurately. Interview with Resident #1's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected Resident #1 to wear her compression hose as ordered. -He did not provide Resident #1 with a self-administer order because he expected the facility to ensure the compression hose were worn daily as ordered. -The compression hose were ordered for the resident due to her peripheral edema.	D 367		

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D 367	Continued From page 85 -He expected the MAs to document the resident's refusals of the compression hose accurately. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am. 2. Review of Resident #5's current FL-2 dated 02/26/22 revealed diagnoses included hypertension, anxiety, hypothyroidism, gastroesophageal reflux disease, hyperlipidemia, hyperglycemia, atrial fibrillation, diastolic heart failure, coronary artery disease, depressive disorder, and neuropathy. a. Review of Resident #5's current FL-2 dated 02/26/22 revealed there was an order for Aspirin 81mg (used as a low-dose blood thinner) once daily. Review of Resident #5's previous physician orders dated 02/23/22 revealed there was an order for Aspirin 325mg daily. Review of Resident #5's April 2022 electronic	D 367		

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medication administration record (eMAR) revealed:
-There was an entry for Aspirin 325mg to be administered daily.
-The Aspirin 325mg was documented as administered daily from 04/01/22 - 04/16/22, 04/19/22 - 04/24/22, and 04/26/22 - 04/30/22.
-There was no entry for Aspirin 81mg to be administered daily.

Review of Resident #5's May 2022 eMAR revealed:
-There was an entry for Aspirin 325mg to be administered daily.
-The Aspirin 325mg was documented as administered daily from 05/01/22 - 05/31/22.
-There was no entry for Aspirin 81mg to be administered daily.

Review of Resident #5's June 2022 eMAR revealed:
-There was an entry for Aspirin 325mg to be administered daily.
-The Aspirin 325mg was documented as administered daily from 06/01/22 - 06/21/22.
-There was no entry for Aspirin 81mg to be administered daily.

Observation of Resident #5's medications on hand on 06/23/22 at 9:48am revealed:
-There was a bottle of Aspirin 325mg available for administration.
-There was no Aspirin 81mg available for administration.

Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed:
-She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders.

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D 367	Continued From page 87 -It was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that document. -If a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders. Interview with the RCC on 06/22/22 at 11:58am revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders. -She was responsible to compare current orders to new orders for any changes. -Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered accurately as ordered per the FL-2 dated 02/26/22. -He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately. -Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls.	D 367		

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D 367	Continued From page 88 Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am. b. Review of Resident #5's currently FL-2 dated 02/26/22 revealed there was an order for fluticasone 50mcg (used for seasonal allergies), one spray in each nostril daily. Review of Resident #5's previous physician orders dated 02/23/22 revealed there was an order for fluticasone 50mcg, one spray in each nostril daily as needed. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone 50mcg one spray in each nostril daily as needed. -There was no entry for fluticasone 50mcg one spray in each nostril scheduled daily. -The fluticasone was not documented as administered.	D 367		

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D 367	Continued From page 89 Review of Resident #5's May 2022 eMAR revealed: -There was an entry for fluticasone 50mcg one spray in each nostril daily as needed. -There was no entry for fluticasone 50mcg one spray in each nostril scheduled daily. -The fluticasone was not documented as administered. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for fluticasone 50mcg one spray in each nostril daily as needed. -There was no entry for fluticasone 50mcg one spray in each nostril scheduled daily. -The fluticasone was not documented as administered. Observation of Resident #5's medications on hand on 06/23/22 at 9:48am revealed the fluticasone was available for administration as ordered. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders. -It was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that document. -If a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders. Interview with the RCC on 06/22/22 at 11:58am	D 367		

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D 367	Continued From page 90 revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders. -She was responsible to compare current orders to new orders for any changes. -Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered accurately as ordered per the FL-2 dated 02/26/22. -He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately. -Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm.	D 367		

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D 367	Continued From page 91 Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am. c. Review of Resident #5's current FL-2 dated 02/26/22 revealed there was an order for ranitidine 300mg (used to treat acid reflux) every night before bed. Review of Resident #5's previous physician orders dated 02/23/22 revealed there was no order for ranitidine 300mg every night before bed. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed there was not an entry for ranitidine 300mg every night before bed. Review of Resident #5's May 2022 eMAR revealed there was not an entry for ranitidine 300mg every night before bed. Review of Resident #5's June 2022 eMAR revealed there was not an entry for ranitidine 300mg every night before bed. Observation of Resident #5's medication on hand on 06/23/223 at 9:48am revealed there was no ranitidine 300mg available for administration. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders. -It was the RCC's responsibility to fax a resident's	D 367		

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D 367	Continued From page 92 updated FL-2 to the pharmacy because medication aides would not see that document. -If a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders. Interview with the RCC on 06/22/22 at 11:58am revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders. -She was responsible to compare current orders to new orders for any changes. -Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered accurately as ordered per the FL-2 dated 02/26/22. -He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately. -Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls.	D 367		

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D 367	Continued From page 93 Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am. d. Review of Resident #5's current FL-2 dated 02/26/22 revealed an order to use a CPAP machine (used to treat sleep apnea) every night at bedtime and remove in the morning. Review of Resident #5's previous physician orders dated 02/23/22 revealed there was an order for to use a CPAP every night at bedtime and remove in the morning. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for CPAP every night before bed and remove in the morning. -The CPAP was documented administered every night from 04/01/22 - 04/16/22, 04/22/22, and 04/26/22 - 04/30/22. -The CPAP was documented as not administered on 04/18/22 - 04/21/22 and 04/23/22 - 04/25/22 due to the resident being unable to take the	D 367		

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D 367	Continued From page 94 medication. Review of Resident #5's May 2022 eMAR revealed: -There was an entry for CPAP every night before bed and remove in the morning. -The CPAP was documented administered every night from 05/01/22 - 05/09/22, 005/12/22 - 05/16/22, 05/19/22 - 05/26/22, 05/28/22, and 05/31/22. -The CPAP was documented as not administered on 05/10/22 - 05/11/22, 05/17/22 - 05/18/22, 05/27/22 - 05/30/22 due to the resident being unable to take the medication. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for CPAP every night before bed and remove in the morning. -The CPAP was documented administered every night from 06/01/22 - 06/05/22, 06/07/22, 06/10/22 - 06/13/22, and 06/17/22 - 06/20/22. -The CPAP was documented as not administered on 06/06/22, 06/08/22 - 06/09/22, 06/14/22 - 06/16/22 due to the resident being unable to take the medication. Observation of Resident #5's medication on hand on 06/23/22 at 9:48am revealed there was no CPAP machine available to the resident. Interview with Resident #5 on 06/23/22 at 9:55am revealed: -Her CPAP machine had been broken for some time, but she could not recall how long. -Someone at the facility took the machine and was supposed to have it fixed, but she could not recall who. -She had not been wearing her CPAP machine at night as ordered because it was broken.	D 367		

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D 367	Continued From page 95 Interview with an MA on 06/23/22 at 9:55am revealed: -She was no aware Resident #5's CPAP was broken. -She did not work night shift and would not have known the machine was broken because she would not have administered it to the resident. Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed: -She was not aware that Resident #5's CPAP machine was broken and unavailable. -She expected facility staff to report broken equipment to her so she could correct the issue. -The resident had to wear the CPAP at night because she had sleep apnea. -She expected MAs to administer the CPAP as ordered and document the administration accurately. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -The resident needed to wear the CPAP at night to treat sleep apnea, hypertension, and poor output. -He expected the resident's CPAP machine to be available and in working order. -He was no aware the CPAP machine was not being administered as ordered. -He expected the MAs to administer and document the administration of the CPAP accurately. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am.	D 367		

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D 367	Continued From page 96 Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am. e. Review of Resident #5's previous physician orders dated 02/23/22 revealed an order for omeprazole 20mg daily. Review of Resident #5's current FL-2 02/26/22 revealed there was not an order for omeprazole 20mg daily. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for omeprazole 20mg daily. -The omeprazole 20mg was documented as administered daily from 04/01/22 - 04/16/22, 04/19/22 - 04/24/22, and 04/26/22 - 04/30/22. Review of Resident #5's May 2022 eMAR revealed: -There was an entry for omeprazole 20mg daily. -The omeprazole 20mg was documented as administered daily from 05/01/22 - 05/31/22. Review of Resident #5's June 2022 eMAR revealed: _-There was an entry for omeprazole 20mg daily. -The omeprazole 20mg was documented as administered daily from 06/01/22 - 06/21/22.	D 367		

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D 367	Continued From page 97 Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders. -It was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that document. -If a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders. Interview with the RCC on 06/22/22 at 11:58am revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders. -She was responsible to compare current orders to new orders for any changes. -Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered accurately as ordered per the FL-2 dated 02/26/22. -He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately.	D 367		

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D 367	Continued From page 98 -Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the RCC on 06/22/22 at 11:58am. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm. Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am. _____ Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -New medication orders were to be faxed to the pharmacy by the MAs or the RCC as soon as possible. -The pharmacy entered the orders onto the resident's eMAR. -When the medications arrived at the facility, it was the MAs responsible to compare the original order to the eMAR to the medication on hand for accuracy prior to approved the order and administering the medication. -MAs were responsible to compare the medication on hand to the resident's task list and	D 367		

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the eMAR for accuracy prior to administering the medication, then document the administration accurately on the MAR.
-She would perform medication cart audits once monthly and documented them but was not sure where they were.
-Medication cart audits included comparing an original order to the medications on hand and the resident's eMAR for accuracy.

Interview with the RCC on 06/22/22 at 11:58am revealed:
-She or an MA were responsible to fax new medication orders to the pharmacy as soon as possible after receiving the orders.
-The pharmacy would enter the new order into the resident's eMAR and she or an MA were responsible to review the order on the eMAR for accuracy before approving the order for use.
-When medications arrived for the new medication order, it was the MA's responsibility to compare the original order with the medication on hand and the eMAR for accuracy.
-There was no process in place to have a second person check the accuracy of the orders after her or the MA approved the order.
-MAs were expected to administer medications accurately to residents per the order then document the administration of the medication accurately on the eMAR.
-MAs were expected to perform medication cart audits once per month, but they were only expected to look for expired medications and that medications were in the correct drawers.
-There was no process in place to perform audits that included comparing the resident's current orders to the eMAR, to the medications on hand.

Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed:

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D 367	Continued From page 100 -She expected MAs to compare medications to the eMAR prior to administration for resident safety. -If orders were not faxed to the pharmacy, the orders would not be entered onto the eMAR, and MAs would not know how to administer medications accurately. -If medications were not administered as ordered it could cause a decline in the resident's health status. Interview with the Administrator on 06/23/22 at 2:00pm revealed: -He expected resident medication orders to be reflected accurately on their eMAR. -He expected medication administration to be documented accurately for proper evaluation and assessment. Interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm revealed: -MAs were responsible to administer medications accurately as ordered. -MAs were expected to compare the medications being administered to the eMAR to ensure accuracy prior to administration. -When medications are not administered as ordered could be detrimental to the safety of the residents in which there could be drug to drug interactions and not receiving the proper treatment for the diagnoses the medication was prescribed for. Interview with the facility's contracted primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected the MAs at the facility to administer medications to residents accurately and safely. -He expected orders to be reflected accurately on	D 367		

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D 367	Continued From page 101 resident eMARs. -He expected to be notified when errors or adverse side effects from medications occurred.	D 367		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to report allegations of physical abuse by Staff A and misappropriation of funds by Staff D and Staff E to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours for 2 of 2 sampled residents (#3, #6). The findings are: 1. Review of Resident #3's current FL-2 dated 02/05/22 revealed: -Diagnosis included right sided weakness, traumatic brain injury with loss of consciousness, spastic hemiplegia of right side as a late effect of cerebral vascular accident, motor vehicle accident sequela and expressive aphasia. -There was no documentation of orientation status. Review of Resident #3's current care plan dated 09/03/21 revealed: -There was no documentation of physical or	D 438		

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verbal aggression.
-There was no documentation of disruptive behavior.
-He was oriented and was able to communicate through gestures.
-He required an assistive device for ambulation.
-He required glasses for limited vision.

Interview with the Director of Operations (DO) on 06/21/22 at 9:44am revealed there were no residents with aggression or behaviors.

Review of Resident #3's progress note dated 04/04/22 at 6:15pm revealed he had a lighter and began fighting staff when she took it away from him.

Review of Resident #3's progress note dated 05/29/22 at 6:10pm revealed he swung at a staff member when she tried to take cigarettes away from him.

Review of Resident #3's progress note dated 05/30/22 at 6:20pm revealed:
-The progress note was signed by Staff A.
-Resident #3 was entering the building from the back porch and tried to roll over Staff A's feet and she moved his wheelchair to avoid being run over.
-Resident #3 hit the Staff A in her stomach and a second staff member intervened, wheeling him to his room.

Interview with a resident on 06/21/22 at 8:48am revealed:
-She witnessed Resident #3 outside smoking and Staff A tried to make him go back inside the building.
-Resident #3 hit Staff A and then Staff A hit Resident #3 three times in the face, breaking his

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D 438	Continued From page 103 glasses. Interview with a second resident on 06/21/22 at 2:48pm revealed: -She witnessed Staff A hit Resident #3 about two weeks ago as they entered the dining room from the smoking area outside. -Staff A hit Resident #3 in the head three times leaving the resident with a bruised face and a black eye. -She was not sure if any other staff members witnessed the incident, but several other residents had witnessed the incident. -She did not report the incident to anyone because Staff A should have reported the incident to management. -She did not think reporting the incident would have been beneficial. -She was concerned about saying too much about the assault against Resident #3 because if any staff got in trouble, she would be concerned about retaliation against herself or other residents for talking which could make life difficult for them. Interview with a third resident on 06/21/22 at 3:20pm revealed: -She saw Staff A hit Resident #3 three times in the head after he came into the dining room from smoking. -Resident #3 had black and blue bruises on his face after the incident. -She also heard the Activities Director (AD) say that it should not have gone that far. Interview with Resident #3 on 06/21/22 at 9:30am revealed: -He hit Staff A about 2 weeks prior. -Staff A then hit him in the right shoulder but did not hit him in the face. -There was no other staff in the smoking area to	D 438		

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witness the staff hitting him.
-He did not report the incident to anyone.

Observation of Resident #3 on 06/21/22 at 9:30am revealed there were no bruises on his face or right shoulder and he was not wearing glasses.

Interview with the Activities Director (AD) on 06/22/22 at 11:12am revealed:
-She had heard from staff that Resident #3 had been physically aggressive but had never witnessed any aggression.
-She was attempting to locate Resident #3's missing eyeglasses when another resident reported to her the eyeglasses were broken during a fight between a Staff A and Resident #3.
-She did not know when the altercation had occurred.
-She reported what the resident had told her to the Director of Operations (DO) immediately but she could not remember the date and the report was not documented.

Interview with a personal care aide (PCA) on 06/21/22 at 2:22pm revealed:
-Resident #3 punched Staff A in the stomach.
-She could not remember the date of the incident but thought it had occurred more than 2 weeks before when Staff A redirected Resident #3 back inside to stop him from smoking.
-She was in the front portion of the facility when she heard Resident #3 calling Staff A a derogatory name and she responded.
-Staff A was wheeling Resident #3 inside the building when she arrived.
-She saw Resident #3 trying to get Staff A away from him.
-She did not see Staff A strike Resident #3 at any time.

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D 438	Continued From page 105 -She did not witness what happened outside in the smoking area. Interview with Staff A on 06/22/22 at 10:25am revealed: -Resident #3 had a nicotine replacement patch ordered. -He kicked her in her stomach when she told him he could not smoke with the patch on. -She tried to roll him inside and he grabbed her by her wrist and would not let go. -A second staff member intervened to get Resident #3 to let go of her wrist. -She reported the incident to the Director of Operations, the Resident Care Coordinator but she was unsure of the date of the event. -She denied hitting or pushing Resident #3 at any time. Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:15pm revealed: -Staff A reported to her that Resident #3 hit her in the stomach and grabbed her arm. -Staff A reported a second staff responded to the incident. -No allegation of Staff A hitting Resident #3 had been made to her until 06/21/22. -She and the Director of Operations (DO) were responsible for investigating any allegations of abuse and notifications would be made to the Division of Social Services (DSS), the resident's family and the Health Care Personal Registry (HCPR) after the investigation was completed and if the allegation was found to be true. -There had been no HCPR report made regarding the allegation she became aware of on 06/21/22 because the investigation was not complete. -If there was not enough evidence, there was nothing to report.	D 438		

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D 438	Continued From page 106 -She was not aware notification to the HCPR was required within 24 hours of becoming aware of any abuse allegation. -She was not aware of the 24-Hour Report or the 5-day Report used to notify the Health Care Personnel Registry. -She was trained on conducting investigations when she became RCC in August or September 2021. Interview with the Director of Operations (DO) on 06/22/22 at 4:20pm revealed: -She and the RCC were responsible for completing an investigation when an abuse allegation was reported. -She was not aware of any report of Staff A hitting Resident #3 prior to 06/21/22. -She would notify the Health Care Personal Registry and the Regional Director (RD) only if there was enough evidence to show the allegation was true through the investigation process. -There had been no report made to the HCPR for the allegation of abuse reported to her on 06/21/22 at 3:30pm because the investigation was not complete, and she did not know if it there was anything to report. -She was trained by the previous manager how to conduct investigations and who to report to but had not had to conduct any investigation of abuse allegation since taking the role and had not reached out to the RD or the Administrator for guidance. Interview with the Regional Director (RD) on 06/22/22 at 5:33pm revealed: -The RCC and the DO were responsible for conducting investigations of allegations of abuse and notifying the Health Care Personnel Registry. -The RCC and the DO were not aware HCPR had	D 438		

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to be notified within 24 hours of learning of an allegation of abuse whether or not the investigation was complete, substantiated or unsubstantiated.
-She did not instruct them to complete the HCPR notification upon learning of the allegation on 06/21/22.

Interview with the Administrator on 06/23/22 at 1:59pm revealed:
-He was not aware of an allegation of abuse until 06/21/22.
-He was not aware the DO did not know allegations of abuse should be reported to the HCPR within 24-hours.
-He expected all allegations of abuse to be reported within 24-hours.

Review of a fax transmission report dated 06/22/22 at 6:53pm revealed a 24-Hour Initial Report was faxed at 6:52pm to notify the Health Care Personal Registry of a resident abuse allegation by Staff A and signed by the Director of Operations.

Telephone interview with the Health Care Personal Registry on 06/23/22 at 1:57pm revealed they received a report for an allegation of physical abuse on 06/22/22 at 6:58pm for Staff A.

2. Review of Resident #6's current FL-2 dated 03/25/22 revealed:
-Diagnoses included advanced dementia with suicidal ideation, diabetes, hypothyroidism, sick sinus syndrome.
-She was constantly disoriented.

Review of Resident #6's Resident Register revealed she was admitted to the facility

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D 438	Continued From page 108 04/04/22. Review of Resident #6's record revealed: -There was a form signed by Resident #6's primary care provider (PCP) on 05/25/22 which stated that the resident had dementia and was unable to recall specific important events and was confused with dates and occurrences at her office visit on 05/02/22. -Resident #6 was not capable of managing or directing the management of benefits in her own best interest and that the resident was not expected to be able to manage her funds in the future. Telephone interview with Resident #6's family member on 06/22/22 at 1:17pm revealed: -The bank sent a letter stating Resident #6's account had been closed. -Resident #6 had around $160,000 in her bank account when it was closed. -He was not sure how Resident #6's money was removed from her bank account because she was not capable of making decisions on her own and he did not approve to have the money removed from her account. Interview with Staff E on 06/22/22 at 3:16pm revealed: -After Resident #6 was admitted to the facility she and Staff D took Resident #6 to the bank and closed her bank account. -The bank representative gave them a cashier's check for $98,900 to cover 2 years' worth of room and board for Resident #6. -The money that was left over after receiving the cashier's check was placed into Resident #6's facility account. Telephone interview with Resident #6's primary	D 438		

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care provider (PCP) on 06/23/22 at 10:46am revealed:
-Resident #6 had a history of dementia and cognitive issues.
-He signed paperwork in May 2022 stating that Resident #6 was incapable of handling her own finances.
-Any financial decisions that were being made for Resident #6 should be made by a Health Care POA and not by the facility because the facility stood to benefit from making financial decisions for Resident #6.

Telephone interview with a second family member of Resident #6 on 06/23/22 at 11:26am revealed:
-Resident #6 was incompetent to make her own financial decisions.
-She was contacted by the facility and knew they had closed Resident #6's bank account and she thought they put Resident #6's money into a trust until guardianship could be established for the resident.
-She knew that Resident #6's room and board at the facility was $4300.00 per month but she did not know that the facility had taken money out of the resident's account to pre-pay for 23 months of room and board.
-She expected to be informed by the facility that they had Resident #6 pre-pay that far in advance.
-If she had been made aware by the facility that they wanted Resident #6 to pre-pay for 23 months of room and board she would not have consented to it.

Telephone interview with Staff D on 06/24/22 at 9:20am revealed:
-On 04/12/22 she, Staff E, and Resident #6 went to the resident's bank and withdrew all the resident's money from her account.
-The bank issued a cashier's check for

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$98,900.00 for Resident #6's room and board for 23 months.
-The $98,900.00 was placed into the facility's operational account.
-The remainder of Resident #6's money was placed into Resident #6's facility account.

Telephone interview with the Administrator on 06/24/22 at 10:39am revealed:
-Once the $98,900.00 of Resident #6's money was deposited into the facility's operational account that left a balance of $64,556.62 that was to be deposited into Resident #6's facility account.
-There was currently no record of the $64,556.62 being deposited into Resident #6's facility account.
-The Regional Director, staff D, and Staff E had access to resident's facility accounts.
-None of Resident #6's money should have been placed in the facility's operational account because the facility operational account should not be co-mingled with resident funds.
-All of Resident #6's money should have been deposited into Resident #6's facility account and monthly withdrawals should have been made for her room and board.
-The Regional Director was going to submit a Health Care Personnel Registry (HCPR) report regarding the misappropriation of Resident #6's funds.

Telephone interview with a HCPR representative on 06/24/22 at 1:58pm revealed there was no record of any HCPR reports being filed against anyone at the facility for misappropriation of funds.

Second telephone interview with Staff D on 06/24/22 at 2:35pm revealed the allegation of the

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D 438	Continued From page 111 misappropriation of Resident #6's funds had been reported to the HCPR by the Regional Director on 06/24/22. Telephone interview with the Regional Director on 06/24/22 at 2:40pm revealed a report about the allegations of misappropriation of Resident #6's funds was made to the HCPR on 06/24/22 at 1:59pm. Review of a fax transmission report provided by the facility revealed a 24-hour initial report was faxed to HCPR registry regarding Staff D's misappropriation of Resident #6's finances on 06/24/22 at 1:59pm. Second telephone interview with the Regional Director on 06/24/22 at 3:45pm revealed she had not faxed a 24-hour initial report to HCPR for Staff E's allegations of misappropriation of Resident #6's funds but she would do so. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Refer to Tag D 338 10A NCAC 13F .0909 Resident Rights _____ The facility failed to report allegations of physical abuse by a staff (Staff A) and misappropriation of personal funds (Staff D and Staff E) involving 2 of 2 sampled resident (#3, #6) within 24 hours. Staff A was alleged to have hit Resident #3 in the head and face after Resident #3 hit her in the stomach and Staff D and Staff E deposited $98,900 of a resident's personal funds into the facility's operating account and were not able to account for $64,556.62 of the resident's money which was not deposited into the resident's facility account.	D 438		

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D 438	Continued From page 112 The facility's failure to report an allegation of physical abuse to the HCPR by Staff A within 24 hours resulted in substantial risk that serious physical harm could occur. The facility's failure to report an allegation to HCPR within 24 hours resulted in Staff D and Staff E continuing to work in the facility and have access to resident's facility accounts which resulted in a substantial risk for exploitation. The facility's failure resulted in substantial risk for continued abuse, physical harm, exploitation and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/23/22 for this violation. THE CORRECTIVE DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 24, 2022.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Other Staff Qualifications, Health Care, and ACH Medication Aides: Training and Competency.	D912		

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D912	Continued From page 113 The findings are: 1. Based on interviews and record reviews, the facility failed to ensure 3 of 5 sampled staff (Staff A, B, C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. [Refer to Tag 0137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)]. 2. Based on record reviews and interviews the facility failed to ensure 2 of 5 sampled staff (Staff A, Staff B) had a criminal background check completed upon hire. [Refer to Tag 0139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) for 2 of 5 sampled residents (#1, #3) including a resident with traumatic brain injury that displayed frequent aggressive behaviors (#3) and for a resident with multiple finger stick blood sugars (FSBS) that were equal to or less than 80 as per ordered parameters (#1). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 4. Based on observations, interviews, and record reviews the facility failed to ensure 1 of 3 sampled staff (Staff B) who administered medications had completed the medication aide training, including the 5, 10, or 15 hour medication aide training course and the clinical skills checklist, and competency evaluation before administering medications. [Refer to Tag 0935 G.S. 131D-4.5(B)(b) ACH Medication Aides; Training and Competency (Type B Violation)].	D912		

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D914	Continued From page 114	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from mental and physical abuse, neglect, and exploitation related to Resident Rights, Health Care Personnel Registry, and Implementation. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure resident rights were maintained as related to misappropriation of resident funds (#6) and abuse and neglect of a resident (#3). [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 2. Based on record reviews and interviews, the facility failed to report allegations of physical abuse by Staff A and misappropriation of funds by Staff D and Staff E to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours for 2 of 2 sampled residents (#3, #6). [Refer to Tag 0438 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the Administrator failed to ensure the management, total operations, and	D914		

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D914	Continued From page 115 policies/procedures of the facility were implemented and maintained each residents' right to receive care and services and remain free from abuse and exploitation and to maintain substantial compliance with the rules and statutes governing adult care homes. [Refer to Tag 0980 G.S. 131D-25 Implementation (Type A1 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program	D935		

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D935	Continued From page 116 developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure 1 of 3 sampled staff (Staff B) who administered medications had completed the medication aide training, including the 5, 10, or 15 hour medication aide training course and the clinical skills checklist, and competency evaluation before administering medications. The findings are: Review of Staff B's, medication aide (MA) personnel record revealed: -Staff B was hired on 06/15/22. -There was documentation Staff B passed the written MA exam on 01/06/16. -There was no documentation she completed the 5,10 or 15-hour medication aide training. -There was no documentation Staff B completed a medication clinical skills competency validation. -There was no documentation of employee verification.	D935		

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D935	Continued From page 117 Intermittent observations on 06/21/22 at from 8:17am to 9:07am revealed Staff B was independently passing medications to residents without supervision. Review of a resident's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Buspirone 10mg (used for mood stabilization) every 12 hours. -Staff B documented administration of the Buspirone on 06/21/22 at 8:00am. -There was an entry for glucose tablets, take 2 for finger stick blood sugar (FSBS) less than or equal to 80, give every 10 minutes until FSBS is great than or equal to 100, twice daily or more often as indicated. (Used to increase FSBS that are too low.) -Staff B documented administration of the glucose tablets on 06/21/22 for a FSBS of 480 even though the medication should have been held due to the ordered parameters which resulted in a medication error. -There was an entry for Duloxetine 60mg (used as an antidepressant or to treat nerve pain) twice daily. -Staff B documented administration of the Duloxetine on 06/21/22 at 8:00am. -There was an entry for Hydroxyzine 25mg (used to treat anxiety) each morning. -Staff B documented administration of the Hydroxyzine on 06/21/22 at 8:00am. -There was an entry for Lactulose 10gram/15mL (used to treat constipation) solution every morning. -Staff B documented administration of the Lactulose on 06/21/22 at 8:00am. -There was an entry for Keppra 500mg (used as an anticonvulsant) twice daily. -Staff B documented administration of the Keppra	D935		

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D935	Continued From page 118 on 06/21/22 at 8:00am. -There was an entry for a Lidocaine 5% patch (used to treat pain) to be applied every morning. -Staff B documented administration of the Lidocaine 5% patch on 06/21/22 at 8:00am. -There was an entry for Metformin 1,000mg (used to regulate blood sugars) twice daily. -Staff B documented administration of the Metformin on 06/21/22 at 8:00am. -There was an entry for Mupirocin 2% ointment (used to treat infections) daily. -Staff B documented administration of the Mupirocin 2% on 06/21/22 at 8:00am. -There was an entry for Novolog (short-acting insulin used to lower blood sugars) 40 units twice daily with meals at 8:00am and 5:00pm. -Staff B documented administration of the Novolog to the resident on 06/21/22 at 8:00am. -There was an entry for Pantoprazole 40mg (used to prevent and treat acid reflux) daily. -Staff B documented administration of the Pantoprazole 40mg on 06/21/22 at 8:00am. -There was an entry for Actos 15mg (used to regulate blood sugars) daily. -Staff B documented administration of the Actos on 06/21/22 at 8:00am. -There was an entry for stool softener 100mg daily. -Staff B documented the administration of the stool softener on 06/21/22 at 8:00am. -There was an entry for Trelegy Ellipta inhaler, one puff every day for COPD. -Staff B documented the administration of the Trelegy Ellipta inhaler on 06/21/22 at 8:00am. Review of a second resident's June 2022 eMAR revealed: -There was an entry for Xanax (controlled medication to reduce anxiety) 0.5mg twice daily. -Staff B documented administration of the Xanax	D935		

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D935	Continued From page 119 on 06/21/22 at 8:00am. -There was an order for Amiodarone 200mg (used to regulate heart rhythms) once daily. -Staff B documented administration of the Amiodarone on 06/21/22 at 8:00am. -There was an entry for Norvasc 5mg (used to lower blood pressure) once daily. -Staff B documented administration of the Norvasc on 06/21/22 at 8:00am. -There was an entry for Aspirin 325mg (used as a blood thinner or to treat pain) once daily. -Staff B documented the administration of the Aspirin on 06/21/22 at 8:00am. -There was an entry for Gabapentin 100mg (used to treat nerve pain) three times daily. -Staff B documented the administration of the Gabapentin on 06/21/22 at 8:00am. -There was an entry for Imdur 30mg (used to treat chest pain, heart failure, or esophageal spasms) daily. -Staff B documented administration of the Imdur on 06/21/22 at 8:00am. -There was an entry for Levothyroxine 112mcg (used to regulate the hormones of the thyroid) daily. -Staff B documented the administration of the Levothyroxine on 06/21/22 at 8:00am. -There was an entry for Lisinopril 20mg (used to treat high blood pressure) daily. -Staff B documented the administration of the Lisinopril on 06/21/22 at 8:00am. -There was an entry for Nystatin cream 100,000 (used to treat yeast infections) apply three times daily. -Staff B documented administration of the Nystatin cream on 06/21/22 at 8:00am. -There was an entry for omega-3 fish oil (dietary supplement) three times daily. -Staff B documented administration of the omega-3 fish oil on 06/21/22 at 8:00am.	D935		

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D935	Continued From page 120 -There was an entry for Prilosec 20mg (used to prevent and treat acid reflux) daily. -Staff B documented administration of the Prilosec 20mg on 06/21/22 at 8:00am. -There was an entry for Oxybutynin 5mg (used to treat overactive bladder) twice daily. -Staff B documented the administration of the Oxybutynin on 06/21/22 at 8:00am. -There was an entry for Symbicort inhaler (used to treat asthma or COPD) twice daily. -Staff B documented administration of the Symbicort inhaler on 06/21/22 at 8:00am. -There was an entry for Vitamin D3 (dietary supplement) daily. -Staff B documented administration of the Vitamin D3 on 06/21/22 at 8:00am. Interview with Staff B on 06/24/22 at 3:27pm revealed: -The lead MA had spent three days with her upon hire supervising her medication passes and training her. -When she worked on 06/21/22, it was her fourth day and she passed medications to all residents. -The lead MA had intermittently checked on her to ensure she was doing okay, but she did not supervise her medication passes that day. Interview with the lead MA on 06/22/22 at 3:47pm revealed: -Staff B passed medications independently on 06/21/22 while she worked in the office. -She did not realized that Staff B required any further documentation of training and did not supervise her administering medications to residents because she thought Staff B was off training status. -She was not aware she needed to continue to supervise Staff B.	D935		

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D935	Continued From page 121 Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 3:58pm revealed: -Medication aides (MA) train with the lead MA for 40 hours. -New MAs were to shadow the lead MA until they were checked off on the medical clinical skills by the facility nurse. -Once the MA's clinical skills checklist was complete they were able to pass medications independently. -If a new employee had been a MA in the past at another facility, the facility did not ask for verification of their 5, 10, or 15-hour medication training. -The facility nurse asked newly hired MAs if they had passed medications before and if they had the nurse would complete their clinical skills checklist. -If the MA had not passed medications before the facility nurse would do a 15-hour training with that MA. -If the facility hired a MA sometimes they would call their former employer for verification of their MA status but sometimes MAs said they left their previous employment without notice and then the facility would not contact the former employer for verification because they did not realized they needed to. -She was unaware that the facility needed verification of a MA's 5, 10 or 15- hour medication training or a MA employment verification needed to be done upon hire. -There was no system in place to audit employee records. Interview with the Director of Operations (DO) on 06/22/22 at 4:50pm revealed: -She was unaware that MA verification or the 15 hour MA training needed to be done for all MAs upon hire.	D935		

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D935	Continued From page 122 -When a MA was hired by the facility, they shadowed another MA on the medication cart for 1 to 1 1/2 weeks. -When the newly hired MA shadowed another MA, the MA would watch the newly hired MA pass medications. -After the newly hired MA shadowed another MA the facility nurse should complete their medication clinical skills checklist. -If a newly hired MA passed medications prior to their hire, they were to request the MA employment verification or their 5, 10, or 15-hour medication training and their medication test. -If the newly hired MA could not provide verification, she should contact the facility nurse and the nurse would do the medication training and competency checklist with the MA. -Staff B did not have a certificate for the 5, 10, or 15-hour medication training or a MA employment verification. -Staff B should not be passing medications independently and she was unaware that she was doing so. -She expected Staff B to shadow the lead MA until she completed her medication training. -Staff B could make medication errors if she had not received medication training or deemed competent by the RN. Interview with the Administrator on 06/23/22 at 2:00pm revealed: -It was the Resident Care Coordinator's (RCC) and the DO's responsibility to ensure all required training was completed and kept on file in staff records. -It was the RCC's or DO's responsibility to ensure the pharmacy and the nurse provided training to MAs as required. -He expected MAs to be supervised and trained properly prior to passing medications to residents	D935		

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D935	Continued From page 123 independently. -It was important for MAs to have proper training medication administration training to ensure they are capable of passing medications to residents safely. Interview with the facility's contracted primary care provider (PCP) on 06/23/22 at 10:46am revealed: -He expected the facility to provide proper training to the MAs passing medication to residents. -Proper training was imperative to ensure resident safety and accuracy in medication administration. -Without proper training, MAs would not know how to accurately follow orders, what side effects or adverse reactions to medications to look for, or what to report to him as needed. _____ The facilty failed to ensure Staff B who functioned as a medication aide (MA) and administered medications to residents without supervision had completed the medication aide training and competency evaluation before administering medications including the 5, 10, or 15 hour medication aide training course and the clinical skills checklist. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/22/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 8, 2022.	D935		

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D980	Continued From page 124	D980		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the Administrator failed to ensure the management, total operations, and policies/procedures of the facility were implemented and maintained each residents' right to receive care and services and remain free from abuse and exploitation and to maintain substantial compliance with the rules and statutes governing adult care homes. The findings are: Interview with the Director of Operations on 06/23/22 at 10:31 revealed she performed the functions of the Administrator in Charge for the facility. Interview with the Regional Director (RD) on 06/22/22 at 5:33pm revealed: -The previous DO was responsible for training the current DO but she did not train her well. -The DO was new to the role and wasn't aware of some rules. Interview with the Administrator on 06/21/22 at 10:52am revealed: -He went to the facility monthly but it had been	D980		

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D980	Continued From page 125	D980		

about six weeks since his last visit.
-The DO and the Resident Care Coordinator (RCC) were in charge of the facility with the RD providing oversight.

Second interview with the Administrator on 06/23/22 at 1:59am revealed:
-The DO was the Administrator in Charge (AIC) of the facility and was trained by following the previous AIC.
-The DO's management training occurred over the course of 5 yrs as she assisted the previous AIC but he was not aware management training should be documented.
-He did not know the DO was not aware of many of the rules as he had expected.

Non-compliance was identified in the following rule areas:

1. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 9 exit doors accessible to residents' use were equipped with a sounding device that activated for the safety of 2 sampled residents (#6, #7) who were documented as disoriented (#6, #7) and with wandering behaviors (#7). [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Standard Deficiency)].

2. Based on interviews and record reviews, the facility failed to ensure 3 of 5 sampled staff (Staff A, B, C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. [Refer to Tag D137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)].

3. Based on record reviews and interviews the facility failed to ensure 2 of 5 sampled staff (Staff

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D980	Continued From page 126 A, Staff B) had a criminal background check completed upon hire. [Refer to Tag D139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violations)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 medication aides (B) sampled who obtained finger stick blood sugars and administered insulin but did not receive training on the care of diabetic residents in accordance with the rule prior to administering insulin to residents. [Refer to Tag D164 10A NCAC 13F .0505 Training on Care of Diabetic (Standard Deficiency)]. 5. Based on interviews and record reviews the facility failed to notify a resident (#6) of a rate change or provide an amended contract for review or signature. [Refer to Tag D243 10A NCAC 13F .0704(a)(1) Resident Contract (Standard Deficiency)]. 6. Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) for 2 of 5 sampled residents (#1, #3) including a resident with traumatic brain injury that displayed frequent aggressive behaviors (#3) and for a resident with multiple finger stick blood sugars (FSBS) that were equal to or less than 80 as per ordered parameters (#1). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 7. Based on observations, interviews, and record reviews, the facility failed to ensure orders were implemented for 2 of 5 sampled residents (#1, #5) including errors in the use of compression hose (#1) and a continuous positive pressure airway (CPAP) treatment (#5). [Refer to Tag 276 10A NCAC 13F .0902(c) 3-4 Health Care	D980		

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D980	Continued From page 127 (Standard Deficiency)]. 8. Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diet menus were available for 2 of 2 sampled residents with therapeutic diets (#1, #4) with an order for a no added salt diet (#1 ,#4), and no concentrated sweets diet (#1). [Refer to Tag D296 10A NCAC 13F .0904(c)(7) Nutrition and Food Service (Standard Deficiency)]. 9. Based on interviews and record reviews, the facility failed to ensure resident rights were maintained as related to misappropriation of resident funds (#6) and abuse and neglect of a resident (#3). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 10. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1, #5) including errors in diabetic medications ordered in relation to finger stick blood sugar (FSBS) parameters (#1), a blood thinner, a nasal spray (used to treat seasonal allergies), and acid reflux medications (used to treat acid reflux) (#5). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Standard Deficiency)]. 11. Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 2 of 5 sampled residents (#1, #5) including orders for compression hose (#1), and orders for a blood thinner, a nasal spray, acid reflux medications, and a CPAP treatment (#5). [Refer to Tag D367 10A NCAC 13F .1004(j) Medication Administration (Standard Deficiency)].	D980		

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D980	Continued From page 128 12. Based on record reviews and interviews, the facility failed to report allegations of physical abuse by Staff A and misappropriation of funds by Staff D and Staff E to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours for 2 of 2 sampled residents (#3, #6). [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personal Registry (Type A2 Violation)]. 13. Based on observations, interviews, and record reviews the facility failed to ensure 1 of 3 sampled staff (Staff B) who administered medications had completed the medication aide training, including the 5, 10, or 15 hour medication aide training course and the clinical skills checklist, and competency evaluation before administering medications. [Refer to Tag D935 G.S. 131D-4.5B(b) (Type B Violation)]. _____ The Administrator's failure to ensure policies and procedures were implemented to provide appropriate care and services maintained within substantial compliance resulted in Staff A, Staff B, and Staff C working in direct contact with residents without having a HCPR check completed, Staff A and Staff B working in direct contact with residents without having a criminal background check completed, a delay in care for Resident #3 who was frequently aggressive, failure of notification to the provider who had frequent low finger stick blood sugars outside of parameters that were left untreated with glucose tablets as ordered, not ensuring the rights of Resident #3's and Resident #6's were protected regarding abuse and exploitation, a delay in reporting allegations of physical abuse by Staff A and a delay in investigating and reporting allegations of exploitation by Staff E and Staff D. This failure resulted in of serious neglect and exploitation which constitutes a TYPE A1	D980		

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D980	Continued From page 129 violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 06/23/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 24, 2022 .	D980		