STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GALES ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

(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 a follow-up survey from 07/26/22 to 07/28/22.	{D 000}		
{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: FOLLOW-UP TO A TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Non-compliance continues. Based on observation, record reviews and interviews, the facility failed to ensure health care referral and follow up to meet the healthcare needs for 2 of 5 sampled residents (#2 and #5) who had orders for a referral to the pain clinic, compression stockings and a missed appointment at the wound clinic (#2) and refusals for fingerstick blood sugar (FSBS) checks and insulin (#5). 1. Review of Resident #2's current FL2 dated 04/11/22 revealed diagnoses included type 2 diabetes and neuropathy. a. Review of Resident #2's physician order dated 05/17/22 revealed there was a referral order to the pain clinic. Review of Resident #2's record on 07/26/22 at 3:00pm revealed there were no appointment notes from the pain clinic.	{D 273}		

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{D 273}	Continued From page 1 Interview with the Administrator on 07/27/22 at 11:50am revealed: -On 05/17/22 when the referral was written for Resident #2 to be evaluated at the pain clinic, she would have been the person responsible for ensuring the pain clinic appointment was scheduled. -There was another referral order written on the same order form for Resident #2 on 05/17/22 and that referral was completed, so she thought she must have overlooked the referral to the pain clinic. -Resident #2 had not been scheduled or seen at the pain clinic since the referral was written on 05/17/22. Telephone interview with Resident #2's former primary care provider's (PCP) supervisor physician on 07/27/22 at 3:00pm revealed: -Resident #2 had a chronic illness follow-up appointment with her former PCP on 05/17/22. -Resident #2 had requested either a prescription for pain medication or the referral to the pain clinic, so the former PCP wrote the referral order. -He was unable to see any additional notes regarding the reason or diagnosis for the referral. -He expected the facility to follow through with any referral orders written by the PCP. Interview with Resident #2 on 07/27/22 at 3:20pm revealed: -Her former PCP had referred her to the pain clinic due to ongoing pain in her lower legs. -Her pain level was usually an 8 out of 10 on the pain scale but sometimes a little more or a little less. -Her pain levels had not changed much in severity since the referral to the pain clinic was made.	{D 273}		

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{D 273}	Continued From page 2 -She thought she would be more active if her pain was better controlled. -She had not been evaluated at the pain clinic yet but would still like to have an appointment with them. Telephone interview with a medication aide (MA) on 07/28/22 at 10:05am revealed: -Resident #2 sometimes complained about pain in her legs. -Resident #2 had pain medication ordered to be administered three times daily, but she had missed doses in the last couple of months due to the medication not being available. -Resident #2 had never mentioned a referral to the pain clinic to her. Telephone interview with Resident #2's current PCP on 07/28/22 at 1:45pm revealed: -She had just started seeing residents at the facility a week prior. -She was not aware of Resident #2 needing to see the pain clinic and had not received a new referral request from the facility. Attempted telephone interview with Resident #2's former PCP on 07/27/22 at 10:15am was unsuccessful. b. Review of Resident #2's After Visit Summary (AVS) dated 07/07/22 revealed: -She had completed an appointment at the wound care center on 07/07/22. -Resident #2 was being treated for wounds on both legs. -There was an order for the facility to help Resident #2 obtain compression stockings, and once obtained to bring them with to her next appointment. -There was a handwritten note on the AVS that	{D 273}		

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{D 273}	Continued From page 3 said faxed 07/07/22 with a medication aide's (MA) name. Observation of Resident #2 on 07/26/22 at 4:10pm revealed: -She was laying on her bed with her feet up. -She was not wearing compression stockings. -Her left lower leg had a bandage wrapped around it midway between her ankle and knee. -Her right leg was wrapped in a dressing with a gauze fishnet stocking pulled over it. -There was slight swelling noted to her visible left leg, unable to determine if swelling was present to the right leg. Telephone interview with a representative from the wound clinic on 07/27/22 at 1:20pm revealed: -The compression stockings were ordered for Resident #2 to help treat the swelling in her legs. -Wearing the compression stockings would reduce swelling, prevent new wounds from developing and also promote wound healing. -Resident #2 could have a delay in wound healing for not following the timeline of treatment suggested by the wound care nurse which could result in an increase in pain to her legs. -Resident #2 had a follow-up appointment with a nurse at their clinic on 07/22/22. -Resident #2 told the nurse on 07/22/22 that the facility had ordered compression stockings for her but she was not given a pair to bring with her to her appointment that day. -The wound nurse thought Resident #2's legs were healing and that one of her legs would be ready to start wearing a compression stocking on, so they planned on applying it at her appointment with them that afternoon 07/27/22. Interview with Resident #2 on 07/27/22 at 3:20pm revealed she had not been given a pair of	{D 273}		

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compression stockings to bring with her to her appointment at the wound clinic that day.

Interview with the Administrator on 07/27/22 at 3:30pm revealed:
-Resident #2's compression stocking order had been faxed to the pharmacy on 07/07/22 but if she did not have them, they must not have been delivered yet.
-After the MA faxed the compression stocking order to the pharmacy, she would have been responsible for placing a copy of the order in the "follow-up" folder so that someone, either the Resident Care Director (RCD) or another MA, could follow up with the pharmacy if they did not get dispensed.

Telephone interview with a representative from the facility's contracted pharmacy on 07/27/22 at 4:20pm revealed:
-They had received the faxed AVS which contained the order for Resident #2's compression stockings on 07/07/22.
-Since the order was written on an AVS instead of a separate order form, the pharmacy technician who reviewed the fax filed the AVS under Resident #2's patient profile without realizing there was an order for compression stockings on it.
-They had not received a call from the facility to follow up on the compression stockings for Resident #2, which they would expect if the prescription was sent to them but never delivered to the facility.

Telephone interview with a MA on 07/28/22 at 1:30pm revealed:
-She had been the MA working when Resident #2 returned from her wound care appointment on 07/07/22.

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{D 273}	Continued From page 5 -She faxed the order for compression stockings to the pharmacy, signed and dated the order, then made a copy of the order. -She slid a copy of the order under the Administrator's door so that she could follow-up on it and placed the original order in Resident #2's record. -She thought it was the Administrator's responsibility to follow up on orders since they did not have a RCD working at that time. -She did not know that Resident #2 still had not received compression stockings. c. Review of Resident #2's wound clinic After Visit Summary (AVS) dated 07/07/22 revealed a request for a follow-up appointment in 1 week. Telephone interview with a representative from the wound clinic on 07/27/22 at 1:20pm revealed: -Resident #2 had a follow-up appointment with a nurse at their clinic on 07/22/22, and was seen before that on 07/07/22. -Resident #2 was scheduled for a follow-up appointment at their clinic that day, 07/27/22, at 3:30pm. -The wound nurse thought Resident #2's legs were healing and that one of her legs would be ready to start wearing a compression stocking on, so they planned on applying it at her appointment with them that afternoon 07/27/22. Interview with Resident #2 on 07/27/22 at 3:20pm revealed: -She had not been given a pair of compression stockings to bring with her to her appointment at the wound clinic that day. -Her appointment was scheduled for 3:30pm on 07/27/22 so she figured since nobody had come to her room to bring her to her appointment, it had either gotten cancelled or forgotten.	{D 273}		

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{D 273}	Continued From page 6 Interview with the Administrator on 07/27/22 at 3:30pm revealed: -She was not aware Resident #2 was supposed to have an appointment at the wound clinic today (07/27/22). -The transportation staff was not working today (07/27/22) because he told her there were no appointments scheduled. -She thought the wound care clinic must have given the follow-up appointment information to Resident #2 instead of the transportation staff, and Resident #2 forgot to let them know she had an appointment scheduled that she would need transportation to. -When a resident went to an appointment outside of the facility, whichever MA was working when the resident returned was responsible for obtaining the appointment information for follow-up. 2. Review of Resident #5's current FL2 dated 04/11/22 revealed diagnoses included diabetes mellitus type II, congestive heart failure and obesity. a. Review of Resident #5's signed physician's orders dated 05/03/22 revealed an order to check and record finger stick blood sugar (FSBS) 3 times a day before meals. Review of Resident #5's laboratory values dated 06/0722 revealed a hemoglobin A1C (used to measure blood sugar levels over an extended period of time) value of 7.1. (The Center for Disease Control and Prevention considers a hemoglobin A1C value of 5.7% normal and a goal of 7.0% for diabetes control). Review of Resident #5's June 2022 electronic	{D 273}		

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medication administration record (eMAR) revealed:
-There was an entry to check and record FSBS 3 times a day before meals scheduled at 8:00am, 12:00pm, and 7:59pm.
-There were 9 of 43 opportunities from 06/14/22 through 06/30/22 when FSBS values were documented as refused.
-There was documentation Resident #5 was out of the facility and FSBS was not obtained 5 times from 06/14/22 through 06/30/22.
-In June 2022 Resident #5's FSBS ranged between 88 and 181 from 06/14/22 through 06/30/22.

Review of Resident #5's eMAR notes (electronic progress notes) and documentation for faxes to the primary care provider (PCP) revealed there was no documentation Resident #5's PCP had been notified in June 2022 regarding the resident refusing scheduled FSBS.

Review of Resident #5's July 2022 eMAR revealed:
-There was an entry to check and record FSBS 3 times a day, before meals scheduled daily at 8:00am, 12:00pm and 4:30pm.
-There were 12 of 46 opportunities from 07/01/22 through 07/25/22 when FSBS values were documented as refused.
-There was documentation Resident #5 was out of the facility and FSBS were not obtained 29 times from 07/01/22 through 07/25/22.
-In July 2022 Resident #5's FSBS ranged between 86 and 157 from 07/01/22 through 07/25/22.

Review of Resident #5's eMAR notes (electronic progress notes) and documentation for faxes to the PCP revealed there was no documentation

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{D 273}	Continued From page 8 Resident #5's PCP had been notified in July 2022 regarding the resident refusing scheduled FSBS. Review of the facility's Medication Order policy revealed if a resident consistently refused a medication, staff were to contact the physician and follow the physician's instructions/orders. Interview with Resident #5 on 07/27/22 at 12:38pm revealed: -There were orders for his FSBS to be checked 3 times a day. -His blood sugars had improved, and were much lower due to another insulin recently being added. -When he was in the facility, he sometimes refused FSBS because he felt that he did not need his FSBS checked. -He was not sure if his PCP was aware that he refused FSBS. Interview with a first shift medication aide (MA) on 07/27/22 at 1:38pm revealed: -Resident #5 often refused to have his FSBS checked or he was out of the facility. -When Resident #5 refused to have his FSBS refused, she documented the refusal on the eMAR. -The facility's protocol when a resident refused was to contact the resident's PCP after two refusals. -She was unable to recall if she had notified Resident #5's PCP regarding the refusal of FSBS. -If she notified Resident #5's PCP, she would have documented in the resident's record. Interview with a second shift MA on 07/27/22 at 3:53pm revealed: -Resident #5 often refused to have his FSBS checked, stating his blood sugars were good and he did not need insulin.	{D 273}		

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-She did not contact the resident's PCP when he refused to have his FSBS checked.
-She notified the third shift MA.

Interview with a third shift MA on 07/27/22 at 9:49am revealed:
-She checked Resident #5's FSBS in the morning.
-When Resident #5 refused to have his FSBS checked, she did not contact the PCP.
-She passed it on to the MA coming on the next shift.
-The MA coming on duty on the first shift should have contacted the resident's PCP.
-Resident #5 always refused his medications.

Interview with the Administrator on 07/27/22 at 1:11pm revealed:
-The facility's policy for refusing medications and treatments, like FSBS, was after three refusals in one day or in a week, the PCP should be notified.
-The MA should document in the resident's record when she notified the PCP regarding refusals.
-She was aware that Resident #5 often refused to have his FSBS checked.
-She did not have any documentation from the PCP or in the resident's record to verify the PCP was notified.
-In the past, the Resident Care Director (RCD) was responsible for auditing the eMARs weekly and checking for missing documentation or frequency of medication refusals.
-The new RCD just started working at the facility last week and had not started auditing the eMARs.

Telephone interview with Resident #5's former Nurse Practitioner (NP) physician supervisor on 07/27/22 at 3:28pm revealed:
-The facility should contact the resident's medical

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provider or follow-up with the NP or even the triage team to let them know the resident refused FSBS.
-The facility staff was able to fax or text message to the office 24 hours a day.
-He saw no documentation where the NP was made aware Resident #5 was refusing FSBS checks.
-Knowing the resident's FSBS was important for maintaining control of diabetes.
-If the resident refused FSBS checks, the outcome could be poor control of diabetes and inability to monitor medication therapy effectively.
-The effect of not properly controlling blood sugar was damage to the eyes, kidney and heart disease.

b. Review of Resident #5's signed physician's orders dated 05/03/22 revealed a medication order for lantus insulin (a long-acting insulin used to lower blood sugar) give 15 units subcutaneously (SQ) at bedtime.

Review of Resident #5's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lantus insulin give 15 units SQ at bedtime scheduled for administration at 10:00pm.
-There were 8 of 14 opportunities from 06/14/22 through 06/30/22 when lantus insulin was not documented as administered at 10:00pm due to the resident refusing the medication as follows:
-On 06/14/22, 06/19/22, 06/20/22, 06/22/22, 06/24/22, 06/25/22, 06/28/22, and 06/29/22 no lantus insulin was documented as administered, and resident refused was documented in the exceptions section of the eMAR.
-There was documentation Resident #5 was out of the facility twice and lantus was not

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administered from 06/14/22 through 06/30/22.
-Resident #5's FSBS ranged between 88 and 181 from 06/14/22 through 06/30/22.

Review of Resident #5's eMAR notes (electronic progress notes) and documentation for faxes to the primary care provider (PCP) revealed there was no documentation that Resident #5's PCP had been notified in June 2022 regarding the resident refusing lantus insulin.

Review of Resident #5's July 2022 eMAR revealed:
-There was an entry for lantus insulin give 15 units SQ at bedtime scheduled for administration at 10:00pm.
-There was documentation lantus was administered for 5 of 25 ordered doses between 07/01/22 through 07/25/22.
-There was documentation the resident was out of the facility and no lantus was administered from 07/01/22 through 07/25/22.
-There were 11 of 25 opportunities from 07/01/22 through 07/25/22 when lantus insulin was not documented as administered at 10:00pm due to the resident refusing the medication as follows:
-On 07/06/22, 07/08/22, 07/10/22, 07/11/22, 07/14/22, 07/16/22, 07/17/22, 07/18/22, 07/20/22, 07/21/22, and 07/24/22 no lantus insulin was documented as administered, and resident refused was documented in the exceptions section of the eMAR.
-Resident #5's FSBS ranged between 86 and 157 from 07/01/22 through 07/25/22.

Review of Resident #5's eMAR notes (electronic progress notes) and documentation for faxes to the PCP revealed there was no documentation that Resident #5's PCP had been notified in July 2022 regarding the resident refusing lantus

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insulin.

Interview with Resident #5 on 07/27/22 at 12:38pm revealed:
-When his FSBS was less than 200, he refused the lantus.
-He thought the PCP told him that he did not need insulin when his FSBS was under 200.
-If the MA tried to give him lantus he refused it.
-He had not seen the PCP that ordered the lantus since 05/03/22.
-He was not sure if the PCP was aware that he refused lantus.

Interview with a medication aide (MA) on 07/27/22 at 1:38pm revealed:
-Resident #5 did not have orders to hold lantus insulin when his FSBS was less than 200.
-The resident's PCP should have been notified by the MA that documented the refusal.
-The third shift MA had not made her aware Resident #5 refused lantus and she needed to notify the PCP.
-The MA was able to notify the PCP and was supposed to document in the resident's record the PCP's response.
-If there was no documentation, the PCP was not notified.

Interview with a second MA on 07/27/22 at 11:35am revealed:
-Resident #5 often refused insulin.
-She was aware that after two refusals of lantus insulin, she should notify Resident #5's PCP.
-When she notified the PCP, she was supposed to document in the resident's record that the PCP was notified of the resident's refusal.
-If there was no documentation, she was not sure the PCP was notified.
She was also supposed to notify the

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{D 273}	Continued From page 13 Administrator of the resident's refusal. -She had not notified the Administrator of Resident #5's refusal of lantus insulin. -The weekend that she worked and had planned to inform the Administrator of the resident's refusals, but there was a lot going on with other residents and she forgot to let the Administrator know. Interview with a third MA on 07/27/22 at 3:53pm revealed: -Resident #5 usually refused his lantus insulin. -The resident said he did not need lantus insulin because his blood sugars were good. -She did not notify the resident's PCP to inform the resident refused the insulin. -She told the first shift MA about the refusal. -The first shift MA was supposed to notify the resident's PCP because her shift ended. -She did not document when she told the first shift MA about the refusals. -The facility's policy was after two refusals, the PCP should be notified. Interview with a fourth MA on 07/27/22 at 9:49am revealed: -When Resident #5 refused lantus, she did not notify the PCP but she told the first shift MA about the refusal. -The first shift MA was supposed to contact the resident's PCP. -If the MA contacted the PCP, there should be documentation in the resident's record. -If a resident refused medication and/or treatments twice back-to-back, the PCP was supposed to be notified. -Resident #5 always refused his medications. -If the PCP was notified there should be documentation in the resident's record to show the PCP was notified.	{D 273}		

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{D 273}	Continued From page 14 Telephone interview with the Administrator on 07/28/22 at 1:55pm revealed: -The facility's policy was after three refusals of medication and treatments in one day or in a week, the PCP was supposed to be notified. -The MA should also let her and RCD know after three refusals. -The MA should document when (date and time) she notified the PCP and the PCP's response in the resident's record. -If the PCP did not respond, that should be documented also in the resident's record. -The MA that documented the refusal of Resident #5's lantus should have notified the resident's PCP and also made her aware of the refusal. Telephone interview with Resident #1's former Nurse Practitioner (NP) physician supervisor on 07/27/22 at 3:28pm revealed: -The facility should contact the resident's medical provider or follow-up with the NP or even the triage team to let them know the resident refused lantus. -The facility staff was able to contact the PCP's office by fax or text message to the office 24 hours a day. -He saw no documentation where the NP was made aware Resident #5 refused lantus. -If the resident's lantus was not administered as ordered, the outcome could not be favorable to control diabetes and obtain proper diabetic control of blood sugars. -The long-term effect of not properly controlling blood sugars was damage to the eyes, kidney and heart failure. Attempted telephone interview with Resident #1's previous NP on 07/27/22 at 10:15am was unsuccessful.	{D 273}		

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{D 273}	Continued From page 15 The facility failed to ensure referral and follow-up to meet the health care needs for 2 of 5 sampled residents (#2 and #5). Resident #2 who had a diagnosis of diabetes and history of wounds and pain in her lower legs was not provided with compression stockings, as ordered, to reduce swelling, promote wound healing, and prevent new wounds. The resident was not scheduled for an appointment with the pain clinic and missed a wound clinic appointment on 07/27/22. The facility's failure placed Resident #2 at risk for increased swelling and altered skin integrity and resulted in the resident's pain level rated as 8 out of 10 on the pain scale not being addressed. The facility failed to notify Resident #5's PCP of refusals of FSBS and long acting insulin over a 2 month time frame placing the resident at risk of uncontrolled diabetes and damage to the eyes, kidneys, and heart. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on August 5, 2022.	{D 273}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	{D 310}		

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{D 310}	Continued From page 16 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Non-compliance continues. Based on observations, record review and interviews, the facility failed to ensure therapeutic diets and nutritional supplements were served as ordered for 1 of 5 (Resident #1) with orders for a pureed diet with nectar thickened liquids and a nutritional supplement three times daily. The findings are: Review of Resident #1's current FL2 dated 04/11/22 revealed: -Diagnoses included dysphagia, gastrointestinal erosion, cognitive dysfunction, and severe thrombocytopenia. -There was an order for a pureed diet and nectar thickened liquids. Review of Resident #1's diet order dated 04/11/22 revealed an order for a pureed diet and nectar thickened liquids. Review of the diet list (no date listed) posted in the dining room revealed: -Resident #1 was to be served a regular pureed diet. -Nectar thickened liquids was not on the diet list. -Nutritional supplement or great (health) shake was not on the diet list. 1. Observation of the breakfast meal on 07/26/22 from 8:40 am to 9:05am revealed:	{D 310}		

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-Resident #1 was brought into the dining room.
-A personal care aide (PCA) provided feeding assistance to the resident.
-There was no health shake given to the resident for the duration of the meal.
-At 9:05am, Resident #1 was taken from the dining room and placed in the common TV room.
-At 9:55am, Resident #1 was observed in her room, lying in her bed.

Observation of the breakfast meal on 07/27/22 from 9:03am to 9:25am revealed:
-Resident #1 was brought to the dining room in high back wheelchair.
-The resident was provided feeding assistance by a PCA.
-There was no health shake provided to the resident.
-At 9:25am, Resident #1 was taken out of the dining room and taken to her room.

Review of Resident #1's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for "great" shakes scheduled for administration three times daily at 8:00am, 1:00pm and 6:00pm.
-There was documentation the great shakes were administered in the morning at 8:00am on 07/26/22 and 07/27/22.

Interview with a first shift medication aide (MA) on 07/27/22 at 4:00pm revealed:
-She documented on the eMAR that Resident #1 was administered the great shake at 8:00am on 07/26/22.
-The resident's great shake was supposed to be given with the meal.
-She did not give the resident the great shake.
-She did not observe Resident #1 consume the

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great shake.
-She asked the PCA if the resident was given the great shake or she observed the great shake on the table with the resident's food.
-After she observed the great shake on the table she documented on the eMAR the shake was administered.

Telephone interview with a second shift MA on 07/28/22 at 1:33pm revealed:
-On 07/27/22 at 8:00am, she did not observe Resident #1 consume her great shake.
-The kitchen staff were supposed to give the resident's great shake to the PCA who provided feeding assistance to Resident #1.
-The PCA was to give the great shake to the resident.
-There had been maybe once or twice when she observed the great shake was not available and the resident did not get the shake.
-She was unable to recall the exact date, but thought it was maybe last month when the great shake was not available.
-She did not tell anyone the great shake was not available and she did not document on the eMAR the shake was not available.
-On 07/27/22, she did not physically see Resident #1 consume the great shake and she did not observe the shake on the table with the resident's meal.
-She was unable to explain why she initialed the eMAR that the shake was administered.
-She did not know why the resident was ordered the great shake and she had not observed the resident had any weight loss.

Interview with a third shift MA on 07/27/22 at 4:40pm revealed:
-The staff in the kitchen was responsible for giving Resident #1 her great shake with every

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meal.
-She documented on the eMAR on 07/02/22, 07/16/22 and 07/17/22 at 6:00pm and on 07/03/22 at 8:00am and 1:00pm the great shake was administered.
-She documented the shake was administered because the kitchen staff put every resident's great shake on their food tray.
-She did not observe Resident #1 consuming the great shake.
-She assumed Resident #1 received the great shake every morning.

Interview with the PCA (who provided feeding assistance on 07/26/22) on 07/27/22 at 4:05pm revealed:
-Resident #1 was non-ambulatory and was totally dependent upon staff for all her care needs including feeding assistance.
-The resident was unable to consume food or beverages without staff assistance.
-The resident did not consume any food or beverages unless it was provided by the PCA.
-Resident #1 was sometimes given a great shake at meals but not at every meal.
-He provided feeding assistance to Resident #1 for the breakfast meal on 07/26/22.
-The resident was not administered a great shake during the morning meal.
-He mostly saw the resident with a great shake during the lunch meals.

Interview with the dietary aide (DA) on 07/27/22 at 9:23am revealed:
-He was responsible for preparing beverages for the meals.
-He made the juice and fruit drinks for the residents to have with their meals.
-The food service manager (FSM) prepared the food trays based on the diet cards.

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-If the diet card had a great shake listed, the FSM told him to put a great shake on the food tray.
-Resident #1's food tray was not prepared and put on the cart with the other residents' food trays because the resident's meal was prepared differently.
-He did not know Resident #1 was supposed to get a health shake with every meal.

Interview with the FSM on 07/27/22 at 9:40am revealed:
-Resident #1 was supposed to receive a great shake with every meal.
-She forgot to tell the DA to give Resident #1 a great shake with the breakfast meals yesterday and today.
-She just remembered the great shake was not given to Resident #1, but the resident was gone from the dining room, so she did not give the resident the shake.

Telephone interview with Resident #1's former NP supervisor physician on 07/27/22 at 3:28pm revealed:
-The previous NP was unavailable.
-If the NP ordered great shakes, then there was a concern for the resident potentially not getting enough nutrition from foods consumed.
-Not getting the great shake as ordered put the resident at risk for weight loss and other health issues.
-He did not see any notation related to the resident's weight in the PCP's record.

Telephone interview with the Administrator on 07/28/22 at 1:58pm revealed:
-Normally, the FSM was responsible for making sure the great shakes were given to the PCA feeding Resident #1.
-The PCA made sure the resident consumed the

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great shake.
-The MA was supposed to make sure the FSM gave the resident the great shake by verbally asking if the great shake was administered.
-Currently, there was no system in place to monitor meals and ensure Resident #1's great shake was provided.
-She was not sure if Resident #1 had weight loss.
-The resident's weight was not obtained because the facility did not have a scale that would accommodate the resident's wheelchair.

2. Review of the therapeutic diet menu for the lunch meal on 07/26/22 revealed a resident ordered a pureed diet was to be served: pureed beef roast, pureed potatoes, pureed carrots, pureed corn muffin and pureed cinnamon apple slices.

Observation of the lunch meal on 07/26/22 from 12:40pm to 1:25pm revealed:
-Resident #1 was brought to the dining room by the personal care aide (PCA).
-Resident #1 was sitting in a high back wheelchair.
-Resident #1 was unable to communicate verbally or feed herself.
-The PCA went to the kitchen door and was given a plate for Resident #1.
-The food on Resident #1's plate consisted of pureed carrots, pureed meat with gravy and mashed potatoes.
-The carrots and meat with gravy were pureed to the correct consistency.
-The mashed potatoes had visible potato skins, and chunks of firm potatoes.
-The PCA used the resident's fork to push away the potato skins from the rest of the potatoes.
-The PCA used the resident's fork and forcibly mashed the chunked potatoes before feeding the

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potatoes to the resident.
-The resident consumed the meal including the mashed potatoes without choking, coughing or gagging.

Interview with the PCA (providing feeding assistance) on 07/26/22 at 1:25pm revealed:
-Resident #1 had potato skins in her mashed potatoes.
-There were also large chunks of potatoes in the mashed potatoes.
-She did not feed the resident the potato skins.
-She used the fork to mash the large chunks of potatoes.
-The resident's food was sometimes not pureed completely and was sometimes too thin and runny or not completely pureed.

Interview with a second PCA on 07/27/22 at 4:09pm revealed:
-Sometimes Resident #1's food was not pureed correctly.
-The breakfast meal was usually too runny for him to even spoon feed the resident.
-The resident did not like when the food was thin and runny and refused to eat the food.
-He did not ask the kitchen staff for more food but took the resident out of the dining room.

Telephone interview with Resident #1's former Nurse Practitioner (NP) physician supervisor on 07/27/22 at 3:28pm revealed:
-He was the supervisor and head of Resident #1's PCP's practice.
-The PCP was not available.
-Looking at Resident #1's medical record, he saw the resident was ordered a pureed diet for diagnosis related to dysphagia.
-Based on the resident's medical condition, the resident had swallowing difficulties.

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{D 310}	Continued From page 23 -Not serving the meal at the consistency ordered put the resident at risk by inhibiting proper ingestion of foods and possible swallowing difficulties. -The expectation was diets should be served as ordered. Interview with the Food Service Manager (FSM) on 07/27/22 at 11:38am revealed: -She prepared the mashed potatoes for Resident #1's lunch meal today. -There were potato skins in the mashed potatoes. -There were chunks of potatoes in the mashed potatoes. -She usually made Resident #1 instant mashed potatoes, but she forgot today. Interview with the Administrator on 07/27/22 at 4:33pm revealed: -Resident #1 should be served pureed meals. -The FSM was aware Resident #1 was ordered a pureed diet. -She was sure the FSM had been trained how to puree meals. -There was no system in place for observing the meals to ensure diets were served as ordered. -She had no idea why the FSM would serve Resident #1 mashed potatoes with potato skins and chunks of potatoes. 3. Review of the instructions on the container of Resident #1's thickener on 07/27/22 at 9:13am revealed: -To obtain nectar consistency in 4 ounces of water, use three to four teaspoons of thickener. -To obtain nectar consistency in 4 ounces of apple juice, use three and one-half to four teaspoons of thickener. -To obtain nectar consistency in 4 ounces of orange juice, use three to three and one-half	{D 310}		

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teaspoons of thickener
-To obtain nectar consistency in nutritional supplement, use 4 to 4 and one-half teaspoons of thickener.

Observation of the measuring scoop used to prepare Resident #1's liquids on 07/27/22 at 9:14am revealed:
-There was a yellow scoop inside the container of thickener.
-The scoop was able to measure a teaspoon and a tablespoon.

Observation of the breakfast meal on 07/26/22 from 8:40am to 9:05am revealed:
-Resident #1's beverages for the breakfast meal consisted of 8 ounces of orange juice and no other beverages.
-The orange juice was in a plastic container sealed with a metal lid.
-There was a 10-ounce glass on the table that had a dry white powdery substance in the glass. The actual amount of the powdered substance could not be determined.
-The PCA feeding Resident #1 opened the juice and poured it into the glass with the powdered substance.
-The PCA did not stir or mix the white powdery substance with the juice.
-The PCA swished the juice around in the glass several times and gave the juice to Resident #1 to drink.
-The upper top 4-ounces of the orange juice was thin and moved easily. The orange juice was not nectar consistency.
-The PCA put the cup of juice up to the resident's mouth.
-The juice dribbled from the resident's mouth and the resident made loud sopping and slurring sounds as the resident consumed the orange

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juice.
-The PCA gave the resident the orange juice three more times, then did not offer the orange juice anymore to the resident.
-The bottom 4-ounces of the orange juice was observed as being thick and jelled and had residue of the white powder. The orange juice was not nectar consistency.

Observation of the lunch meal on 07/26/22 at 1:25pm revealed:
-The resident had an unopened 4-ounce container of nutritional supplement, two glasses of liquids (water and apple juice) and one unopened 4-ounce container of apple juice.
-The beverages in the glasses were already thickened.
-The consistency of both beverages were thick enough for the spoon to stand up.
-The PCA feeding Resident #1 opened the 4-ounce container of apple juice and poured it into the already thickened juice.
-The juice was not nectar consistency and the PCA got more juice from the kitchen.
-The PCA feeding Resident #1 did not thicken the nutritional supplement.
-The resident consumed three drinks of the supplement and did not cough, choke or gag.

Interview with the PCA on 07/26/22 at 1:40pm revealed:
-Resident #1's beverages had never been as thick as they were today at the lunch meal, but they were usually much thinner.
-The resident's beverages should be thickened.
-She was not sure of the consistency ordered, but the beverages served today were too thick.
-Resident #1's nutritional supplement was never thickened but given straight from the container.

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{D 310}	Continued From page 26 Telephone interview with Resident #1's former NP physician supervisor on 07/27/22 at 3:28pm revealed: -He was the supervisor and head of Resident #1's PCP's practice. -The PCP was not unavailable. -Looking at Resident #1's medical record, he saw the resident was ordered nectar thickened liquids due to a diagnosis of dysphagia. -Not serving the diet at the consistency it was ordered put the resident at risk for aspiration. -He expected the facility to serve the resident's diet as ordered. Interview with the Food Service Manager (FSM) on 01/27/22 at 11:38am revealed: -The dietary aide was to prepare Resident #1's thickened liquids. -She did not observe the thickened liquids before they left the kitchen. -She had instructed the dietary aide to prepare the thickened liquids based on the instructions on the side of the thickened liquids container. -She was not aware nutritional supplements should be thickened because they were like milk. Interview with the dietary aide on 07/27/22 9:28am revealed: -He prepared Resident #1's thickened liquids. -He never thickened the nutritional supplements. -Yesterday (07/26/22), at the lunch meal he did not know how much thickener to put in the glass. -He guessed and put 3 of the large scoops of the powdered thickener in the glass. -He put thickener in the glass and gave the glass to the PCA feeding Resident #1. -He thought that he was supposed to put a few scoops of thickener into some water. -He was not sure if the amount of water was 4 ounces or 8 ounces.	{D 310}		

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{D 310}	Continued From page 27 -He judged how much thickener to use by the size of the glass. -He did not know that each beverage (i.e., water, orange juice, cranberry juice and milk) had a different amount of thickener to use. -He followed instructions on the container but was not sure which set of instructions were specific to nectar consistency. Interview with the Administrator on 07/27/22 at 4:33pm revealed: -Resident #1 should be served nectar thickened liquids at each meal. -The dietary aide was responsible for thickening the resident's beverages. -Sometimes she reminded the dietary aide to make Resident #1's beverage nectar consistency. -She was not present for each of Resident #1's meals. -Her expectation was that staff should read the back of the container of thickener and thicken the resident's beverages to the correct consistency. Attempted telephone interview with Resident #1's previous NP on 07/27/22 at 10:15am was unsuccessful. Attempted telephone interview with Resident #1's court appointed guardian on 07/28/22 at 2:39pm was unsuccessful. Based on record reviews, observations and interviews, it was determined Resident #1 was not interviewable. _____ The facility failed to ensure therapeutic diet orders were served as ordered for 1 of 5 sampled residents (#1), who had a diagnosis of dysphagia and an order for nutritional supplement, and a pureed diet with nectar thickened liquids, and was	{D 310}		

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{D 310}	Continued From page 28 observed drooling when her meals were not pureed and her beverages were not thickened, placing the resident at increased risk for aspiration of food or beverage and weight loss by not receiving nutritional supplement. This failure was detrimental to the health, safety, and welfare of the resident and constitutes an unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on August 5, 2022.	{D 310}		
{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: FOLLOW-UP TO CONTINUING TYPE A2 VIOLATION Based on these findings, the Previous Unabated Type A2 Violation has not been abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 2 residents (#7) observed during the medication pass including errors with an antidepressant medication; and for 4 of 6 sampled residents (#2, #4, #5, and #6) for	{D 358}		

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record review including errors with an antibiotic (#4); a pain medication and stool softener (#2); and a fast acting insulin (#5 and #6).

The findings are:

1. The medication error rate was 5.5% as evidenced by the observation of 2 errors out of 36 opportunities during the 8:00am medication pass on 07/27/22.

Review of Resident #7's current FL2 dated 04/11/22 revealed:
-Diagnoses included type 2 diabetes, peripheral vascular disease, and dementia.
-There was an order for sertraline (a medication used to treat depression) 25mg one tablet every morning with 50mg dose for a total of 75mg.
-There was an order for sertraline 50mg one tablet once daily.

Observation of the medication pass for Resident #7 on 07/27/22 revealed:
-At 8:00am, Resident #7 was listed on the electronic medication administration record (eMAR) as being due for sertraline 50mg and sertraline 25mg for a combined total of sertraline 75mg.
-The medication aide (MA) prepared and scanned Resident #7's medication into the eMAR.
-The MA prepared two sertraline 50mg tablets and two sertraline 25mg tablets for a combined total of sertraline 150mg that would have been administered to Resident #7.
-The MA was prompted at 8:33am to verify the sertraline dose.
-One of the 50mg and one of the 25mg sertraline tablets were discarded by the MA, after being prompted.

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{D 358}	Continued From page 30 -The MA administered medication to Resident #7 at 8:36am including 75mg of sertraline. Review of Resident #7's July 2022 eMAR from 07/01/22 to 07/27/22 revealed: -There was an entry for sertraline 50mg, take 1 tablet once daily with 25mg for a total of 75mg scheduled at 8:00am. -There was another entry for sertraline 25mg, take 1 tablet once daily with 50mg for a total of 75mg at 8:00am. -There was a discontinued order entry for sertraline 50mg, take 1 tablet once daily with 25mg for a total of 75mg at 8:00am. -There was another discontinued order entry for sertraline 25mg, take 1 tablet once daily with 50mg for a total of 75mg at 8:00am. -There was documentation that sertraline 50mg and sertraline 25mg were administered daily as ordered from 07/01/22 to 07/27/22. -There was documentation under the discontinued order entries that an additional sertraline 50mg dosage and sertraline 25mg dosage were administered from 07/01/22 to 07/05/22 and from 07/07/22 to 07/27/22. -The discontinued order entries for sertraline 50mg and sertraline 25mg were marked as "not available" on 07/06/22. Observation of the medications on hand for Resident #7 on 07/27/22 at 12:09pm revealed: -There were two sertraline 25mg tablet bubble pack medication cards dispensed on 07/08/22 and each had 9 of 30 tablets that remained. -There were two sertraline 50mg tablet bubble pack medication cards dispensed on 07/08/22 and each had 9 of 30 tablets that remained. Interview with the MA observed during the medication pass on 07/27/22 at 8:33am revealed:	{D 358}		

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{D 358}	Continued From page 31 -The computer system did not trigger a warning when the same medications were scanned twice. -The bubble pack medication cards of the same medications were normally held together by a rubber band to prevent the same medication from being administered twice. Second interview with the same MA on 07/27/22 at 12:12pm revealed: -When an order was discontinued, the MAs or the Administrator faxed them to the pharmacy. -The pharmacy normally removed old or discontinued orders from the eMAR. Interview with Resident #7 on 07/27/22 at 2:36pm revealed: -He thought that staff administered the correct amount of medication as far as he knew. -He was never groggy during the day after staff administered his sertraline. Interview with a second MA on 07/27/22 at 1:30pm revealed: -Her normal process for medication administration was to scan the medication, check the medication order, pop the pill into a medication cup, and administer the medication to the resident. -She had never noticed if a double dosage of sertraline was administered to Resident #7. -She thought she administered the correct amount of sertraline to Resident #7. Telephone interview with a representative from the facility's contracted pharmacy on 07/27/22 at 2:51pm revealed: -The current orders on file for sertraline for Resident #7 were sertraline 25mg tablet once daily and sertraline 50mg tablet once daily for a combined total dose of sertraline 75mg once	{D 358}		

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daily.
-A quantity of 30 sertraline 25mg tablets was dispensed on 06/01/22.
-A quantity of 30 sertraline 50mg tablets was dispensed on 06/01/22.
-The pharmacy mistakenly dispensed the sertraline 25mg and sertraline 50mg medication card bubble packs twice on the same day on 07/01/22 for a total of 60 sertraline 25mg tablets and 60 sertraline 50mg tablets.
-There were two different prescription numbers for the same medication that were filled by two different staff members at the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/27/22 at 3:21pm revealed:
-Potential side effects of a double dose of the ordered 75mg dose of sertraline included headaches, lethargic behavior, and nausea.
-A total of 150mg of sertraline daily was within the normal dosing range of the medication.
-A duplicate prescription was received by the pharmacy in late June 2022.
-The pharmacy received two separate prescriptions for Resident #7 with the same medication order, sertraline 75mg once daily.
-The previous sertraline order was not removed from the pharmacy's electronic system when the new prescription of sertraline was ordered and as a result twice the normal amount of sertraline was dispensed from the pharmacy in July 2022.

Interview with the Administrator on 07/27/22 at 3:06pm revealed:
-She expected MAs to read medication orders carefully and administer medications to the residents as they were prescribed by the provider.
-She was not aware that Resident #7 was administered 150mg of sertraline in July 2022.

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-She completed eMAR audits every day and cart audits twice per week.
-The MAs were responsible for ensuring that Resident #7's sertraline was administered as ordered.

Attempted telephone interview with Resident #7's mental health provider on 07/27/22 at 12:37pm unsuccessful.

2. Review of Resident #4's current FL2 dated 04/11/22 revealed diagnoses included encephalopathy and history of sepsis.

Review of Resident #4's After Visit Summary from the Emergency Department (ED) dated 07/21/22 revealed:
-Resident #4 had been evaluated for leg pain and diagnosed with cellulitis (a bacterial skin infection which, if not treated with an antibiotic, could spread to the lymph nodes or bloodstream and become life-threatening) of the lower extremity.
-While in the ED she was treated with a dose of antibiotic, then discharged with a prescription for clindamycin (an antibiotic used to treat various types of infections) 300mg, take one capsule three times daily for 7 days.

Review of Resident #4's prescription form dated 07/21/22 revealed:
-The prescription was for clindamycin 300, take one capsule three times daily.
-There was a dispensed quantity of 21 capsules with 0 refills.
-There was a handwritten note which stated "Faxed 07/22/22 at 1:47am."

Review of Resident #4's July 2022 electronic medication administration record (eMAR) revealed there was no entry for clindamycin

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{D 358}	Continued From page 34 300mg three times daily and no documentation of administration. Observation of medication on hand for Resident #4 on 07/27/22 at 11:00am revealed there was no clindamycin available for administraton. Observation of Resident #4 on 07/26/22 at 4:00pm revealed: -She was laying on her bed. -Her legs were swollen from the knee down to her toes. -Her legs from her shins to her ankles were reddened in color and had scattered scabbing and scratches. -There was no open skin, drainage, weeping or bleeding observed. Interview with Resident #4 on 07/27/22 at 9:25am revealed: -Her legs had been swollen for at least the last couple of months. -She had been to the Emergency Department (ED) to have her legs looked at and got a prescription for a medication but she did not know what the medication was. -She did not remember her primary care provider (PCP) coming to see her legs before or after her trip to the ED. -She took a diuretic medication to help reduce the swelling. -She had an order for compression stockings to help reduce the swelling, but she had not been wearing them for the last few days due to the sores on her legs. -Her legs hurt but she could not specify where. Interview with a medication aide (MA) on 07/27/22 at 10:00am revealed: -Resident #4 had not been wearing her	{D 358}		

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compression stockings since she went to the ED to have her legs evaluated on 07/21/22.
-Resident #4 had returned from the ED during night shift when she was working, so she faxed the order for clindamycin to the pharmacy and placed the order into the folder for the PCP to review.
-She had told the MA on the shift after her that the order had been faxed and to follow up with the pharmacy to make sure they had received the clindamycin order for Resident #4.

Telephone interview with a representative from the facility's contracted pharmacy on 07/27/22 at 10:30am revealed:
-They had not received a prescription fax from the facility for clindamycin for Resident #4.
-Clindamycin had not been dispensed for Resident #4.

Interview with a second MA on 07/27/22 at 11:10am revealed:
-She was familiar with Resident #4 and her medications.
-She did not remember Resident #4 having a new order for clindamycin or administering it.

Telephone interview with Resident #4's former PCP's supervisor physician on 07/27/22 at 3:00pm revealed:
-He did not see an order faxed to their office regarding Resident #4 starting an antibiotic.
-He would expect the facility to implement antibiotic orders the same day that they were received by the ED to prevent the infection from worsening or spreading.

Interview with the Administrator on 07/27/22 at 3:30pm revealed:
-She was aware of Resident #4's visit to the ED

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to have her legs evaluated.
-She was not aware that Resident #4 had not started the clindamycin that was prescribed.
-The MA who faxed the order to the pharmacy was responsible for placing a copy of the order in the "follow-up" folder.
-The Resident Care Director (RCD) reviewed the "follow-up" folder every morning Monday through Friday, and the MAs reviewed it every Saturday and Sunday to ensure orders were not missed.
-She expected the MAs to file orders in the appropriate place so that proper follow-up could be completed by either herself, the RCD or another MA.
-Follow-up would include checking that all of the medication orders in the "follow-up" folder had been dispensed by the pharmacy and added to the eMAR, and if they had not been received, to call the pharmacy and verify they received the faxed prescription order.

Interview with the RCD on 07/27/22 at 4:55pm revealed:
-She had been working as the RCD for the facility for the last week.
-New medication orders were supposed to be placed in her "follow-up" folder so that she could ensure they were carried out as ordered.
-The MA who faxed Resident #4's clindamycin order had placed the prescription form in the folder for the PCP to review, and since the PCP had not been to the facility since the prescription was written, nobody had noticed the pharmacy never sent the prescription.

Telephone interview with a third MA on 07/28/22 at 10:05am revealed:
-She had been working on 07/21/22 when Resident #4 when to the ED to have her legs evaluated.

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{D 358}	Continued From page 37 -She also worked the shift following Resident #4's return from the ED, and she did not remember the MA who faxed the clindamycin order to the pharmacy telling her that an order had been faxed and she needed to follow up. -When a resident returned to the facility from the ED with new medication orders, the MAs were supposed to fax the order to the PCP and the pharmacy. -Once the order was faxed to the PCP and pharmacy, the MA was responsible for signing, dating and initialing it, then make a copy of the order and give it to the Administrator or RCD to follow-up on, and place the original order form in the "follow-up" folder. -Follow-up would include checking that all of the medication orders in the "follow-up" folder had been dispensed by the pharmacy and added to the eMAR, and if they had not been received, to call the pharmacy and verify they received the faxed prescription order. Attempted telephone interview with Resident #2's former PCP on 07/27/22 at 10:15am was unsuccessful. 3. Review of Resident #2's current FL2 dated 04/11/22 revealed diagnoses included type 2 diabetes and neuropathy. a. Review of Resident #2's physician order dated 06/07/22 revealed there was an order to start hydrocodone 5mg-acetaminophen 325mg (Norco 5-325mg) tablet (a controlled medication used to treat moderate to severe pain), take one tablet every 8 hours. Review of Resident #2's June 2022 electronic medication administration record (eMAR) for 06/15/22 through 06/30/22 revealed:	{D 358}		

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{D 358}	Continued From page 38 -There was an entry for Norco 5-325mg take one tablet every 8 hours scheduled for 6:00am, 2:00pm and 10:00pm. -There was documentation that Norco 5-325mg was not administered at 2:00pm and 10:00pm on 06/18/22, or at 6:00am, 2:00pm and 10:00pm on 06/19/22. -Norco 5-325mg was not administered on 06/18/22 at 2:00pm with the documented reason being "out of facility." -Norco 5-325mg was not administered on 06/18/22 at 10:00pm with a documented reason of the medication was not available. -Norco 5-325mg was not administered on 06/19/22 at 6:00am, 2:00pm or 10:00pm with a documented reason of the medication was not available. Review of Resident #2's July 2022 eMAR for 07/01/22 through 07/26/22 revealed: -There was an entry for Norco 5-325mg take one tablet every 8 hours scheduled for 6:00am, 2:00pm and 10:00pm. -There was documentation that Norco 5-325mg was not administered on 07/10/22 at 2:00pm or 10:00pm, on 07/11/22 at 6:00am, 2:00pm or 10:00pm, on 07/12/22 at 6:00am, 2:00pm or 10:00pm, or 07/13/22 at 6:00am or 2:00pm. -Norco 5-325mg was not administered on 07/10/22 at 2:00pm and 10:00pm with a documented reason of the medication was not available. -Norco 5-325mg was not administered on 07/11/22 at 6:00am, 2:00pm and 10:00pm with a documented reason of the medication was not available. -Norco 5-325mg was not administered on 07/12/22 at 6:00am and 10:00pm with a documented reason of the medication was not available.	{D 358}		

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-Norco 5-325mg was not administered on 07/12/22 at 2:00pm with a documented reason being "out of facility."
-Norco 5-325mg was not administered on 07/13/22 at 2:00pm with a documented reason being "out of facility."
-Norco 5-325mg was not administered on 07/13/22 at 6:00am with a documented reason of the medication was not available.

Review of Resident #2's Nurse's Notes revealed:
-There were no notes dated June 2022 regarding Resident #2's missed doses of Norco 5-325mg.
-There was a note dated 07/10/22 that Resident #2 had run out of Norco 5-325mg in the transition of switching doctors and MA had contacted Resident #2's previous primary care provider (PCP) who was agreeable to writing a 30-day prescription of Norco 5-325mg for Resident #2.

Observation of the medications on hand for Resident #2 on 07/27/22 at 11:00am revealed:
-There was one medication card of Norco 5-325mg with a dispensed date of 07/14/22 with 20 remaining tablets out of a total of 30 tablets for that card.

Telephone interview with a representative from the facility's contracted pharmacy on 07/27/22 at 10:30am revealed:
-They had dispensed 90 tablets, a 30-day supply, of Norco 5-325mg for Resident #2 on 06/07/22.
-They had received a new refill order of Resident #2's Norco 5-325mg on 07/12/22 at 8:57pm and the refill was processed the following morning on 07/13/22.
-They had dispensed a quantity of 90 tablets on 07/13/22 which was a one-month supply.

Interview with a medication aide (MA) on

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{D 358}	Continued From page 40 07/27/22 at 11:10am revealed: -The Administrator kept the overstock medication cards for narcotics locked in her office, which is where card 3 of 3 of Resident #2's Norco 5-325mg was. -Card 1 of 3 for Resident #2's Norco 5-325mg tablets had been used up which was why they were currently using card 2 of 3. -When Resident #2 went without her Norco 5-325mg on 06/18/22 and 06/19/22, it was during a weekend. -Whichever MA worked Friday, 06/17/22, would have been responsible for checking the quantity of Resident #2's Norco 5-325mg remaining on the medication cart and getting the next full medication card from the Administrator's office so she would not run out over the weekend. -Resident #2's missed doses of Norco 5-325mg in July 2022 was because they had been switching PCPs for the facility and the refill had not been requested prior to the previous PCP leaving and the new PCP officially taking over care for Resident #2. Telephone interview with Resident #2's former PCP's supervisor physician on 07/27/22 at 3:00pm revealed: -Resident #2's former PCP had been prescribing her Norco 5-325mg, the diagnosis was not specified in the PCP's note. -The former PCP had last sent an electronic prescription for Norco 5-325mg on 07/12/22 but the representative was not able to see when the medication refill request had been received. -There would be no concern of withdrawal for Resident #2 missing doses of Norco 5-325mg since she had not been on the medication long-term. -Adverse effects for missing doses of Norco 5-325mg would include an increase in pain level.	{D 358}		

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{D 358}	Continued From page 41 Interview with Resident #2 on 07/27/22 at 3:20pm revealed: -Her pain was located in both of her legs from the knee down. -At baseline her pain level was an 8 out of 10 on the pain scale, but when she did not take Norco 5-325mg every 8 hours as ordered, her pain level rose to a 10 out of 10. -She thought she would be more active around the facility if her pain was better controlled. -She thought she remembered having an increase in her pain levels in both June and July 2022 when she was not administered Norco 5-325mg. Interview with the Administrator on 07/27/22 at 3:30pm revealed: -She had worked Friday, 06/17/22, helping the MAs on the medication cart but must have forgotten to check the quantity of Resident #2's Norco 5-325mg to ensure she had enough to last through the weekend. -She had not realized that Resident #2 ran out on Saturday afternoon, 06/18/22, and did not receive Norco 5-325mg again until Monday morning, 06/20/22. -She sent a text message to Resident #2's former PCP on Tuesday, 07/12/22, when she realized he had not sent a refill for Norco 5-325mg to the pharmacy. -The former PCP had texted her back apologizing for forgetting to send the refill and e-prescribed it that day. -The MAs were responsible for checking the overstock medication supply in her office when any medication was down to the last 8 tablets remaining. -If there were no overstock medication cards in her office, the MA was responsible for calling the	{D 358}		

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pharmacy to see if any refills remained on the medication order and could be sent to the facility.
-If no refills remained on the medication order, the MA was responsible for calling the PCP to request a new prescription be sent so the resident would not run out of medication.
-If the MA had to request a new prescription order from the PCP, they were also responsible for letting the Resident Care Director (RCD) know so that she could follow-up on the order request and ensure the medication arrived.
-The RCD was newly employed in the last week, but prior to the new RCD starting, the Administrator was completing weekly audits of the eMARs checking for missing documentation or frequent medication refusals.
-The MAs were responsible for doing medication cart audits weekly which included checking to see that if a medication quantity was running low, a refill request had been sent.
-Resident #2's Norco 5-325mg refill must have been missed during one of the MA's audits.

Interview with a MA on 07/27/22 at 4:50pm revealed:
-The MAs were supposed to reorder medication when the quantity of tablets remaining was down to 8.
-She mostly worked night shift but did work over into day shift sometimes.
-The day shift MAs were responsible for reordering medications when the pharmacy was open and staff were available at the PCP's office.

Interview with the RCD on 07/27/22 at 4:55pm revealed:
-She had been working as the RCD at the facility for the last week.
-Any MA could reorder medications on any shift by clicking the "Re-Order" button on the eMAR,

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including controlled substances if refills remained on the prescription.
-If there were no available refills left on a prescription, the MA was responsible for calling the PCP's office and requesting the refill, then letting her know so that she could follow up with the pharmacy.

Telephone interview with a second MA on 07/28/22 at 9:45am revealed:
-She had requested a refill of Resident #2's Norco 5-325mg from the PCP on 07/05/22 when there were around 15 doses remaining but she had not documented the request in the resident's record.
-She did not work the couple of days prior to Resident #2 running out of medication so she did not know if anyone had followed up on the refill request.
-She worked on 07/10/22 when Resident #2 was out of the Norco 5-325mg and contacted the PCP for a refill again and he told her he would send the prescription to the pharmacy.
-Resident #2 had not complained of pain to her on 07/10/22 during her shift.

Telephone interview with a third MA on 07/28/22 at 10:05am revealed:
-She had worked Friday, 07/08/22, prior to Resident #2 running out of Norco 5-325mg on Sunday, 07/10/22.
-She did not remember Resident #2 running low on Norco 5-325mg because she always checked every resident's medications on Fridays to ensure they had enough to last through the weekend.
-She thought either she had overlooked Resident #2's Norco 5-325mg or someone else had already requested the refill and that was why she had not sent another refill request.
-The process for refilling Resident #2's Norco

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{D 358}	Continued From page 44 5-325mg was to call the PCP when 15 doses remained. -Resident #2's prescription was written as follows: "Hydrocodone/Acetaminophen 5-325mg, take 1 tablet every 8 hours, contact PCP when doses remain equals 15" so all of the MAs knew when to reorder. Attempted telephone interview with Resident #2's former PCP on 07/27/22 at 10:15am was unsuccessful. b. Review of Resident #2's current FL2 dated 04/11/22 revealed there was an order for docusate sodium (a stool softener medication used to treat constipation) 100mg, take one capsule every 12 hours. Review of Resident #2's physician order dated 05/17/22 revealed there was an order for anti-diarrhea 2mg tablets, take two tablets as needed after each loose stool then one tablet after each subsequent loose stool (not to exceed 4 tablets per 24 hours). Review of Resident #2's physician order dated 05/17/22 revealed there was an order to discontinue docusate sodium (Colace) 100mg every 12 hours due to reported diarrhea. Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Colace 100mg, take one capsule every 12 hours scheduled at 8:00am and 8:00pm. -There was documentation that Colace was administered twice daily from 06/01/22 through 06/30/22 except for 06/04/22 at 8:00am and 8:00pm and 06/05/22 at 8:00am.	{D 358}		

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{D 358}	Continued From page 45 -There was an entry for anti-diarrhea 2mg tablets, take two tablets as needed after each loose stool then one tablet after each subsequent loose stool (not to exceed 4 tablets per 24 hours). -There was documentation the anti-diarrhea tablets were administered on 06/17/22, 06/25/22 and 06/28/22. Review of Resident #2's July 2022 eMAR revealed: -There was an entry for Colace 100mg, take one capsule every 12 hours scheduled at 8:00am and 8:00pm. -There was documentation that Colace was administered twice daily from 07/01/22 through 07/26/22. -There was an entry for anti-diarrhea 2mg tablets, take two tablets as needed after each loose stool then one tablet after each subsequent loose stool (not to exceed 4 tablets per 24 hours). -There was documentation the anti-diarrhea tablets were administered once on 07/01/22, 07/03/22, 07/06/22, twice on 07/10/22, once on 07/11/22, 07/12/22 and 07/21/22. Observation of medication on hand for Resident #2 on 07/27/22 at 11:00am revealed: -There were two medication cards for Colace 100mg capsules with dispensed dates of 07/08/22 and quantities of 30 capsules on each medication card. -One medication card had 9 capsules out of 30 remaining and the other medication card had 10 capsules out of 30 remaining. Telephone interview with the facility's contracted pharmacy on 07/27/22 at 10:30am revealed: -They had a current order for Colace 100mg, take one capsules every 12 hours on file for Resident #2.	{D 358}		

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-They last dispensed a one-month supply of Colace for Resident #2 on 07/08/22.
-They had not received an order to discontinue Colace.

Telephone interview with Resident #2's former primary care provider's (PCP) supervisor physician on 07/27/22 at 3:00pm revealed:
-On 05/17/22, Resident #2's former PCP saw her for a monthly routine visit and discontinued Colace at that time due to reports of diarrhea from Resident #2.
-He expected facility staff to follow medication orders as written and to discontinue any medication as requested by the PCP on the same day the order was written.
-Not discontinuing Colace when Resident #2 had reported having diarrhea could result in dehydration from ongoing loose stools.

Interview with Resident #2 on 07/27/22 at 3:20pm revealed:
-She had intermittent days where she had diarrhea and she had reported that to her PCP in May 2022.
-She took an anti-diarrhea medication three times in June 2022 and eight times in July 2022.
-She thought that if she was no longer taking Colace she would not need to also take the anti-diarrhea medication.
-She had not asked staff to stop giving her the Colace because she never knew which days she was going to have an issue with loose stools.

Interview with the Administrator on 07/27/22 at 3:30pm revealed:
-She was not aware that Resident #2 had an order from 05/17/22 to discontinue Colace and that she was still receiving it twice daily.
-She had been completing audits of the eMARs

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every week but had been looking for documentation errors and frequent medication refusals, so she had not noticed there was a discrepancy in Resident #2's orders versus her eMAR.
-The medication aides (MA) were responsible for following up on medication order changes.
-The order to discontinue Resident #2's Colace came to the facility via fax, so whichever MA took the fax from the fax machine was responsible for faxing the order to the pharmacy and placing the copy in the "follow-up" folder for her to verify the medication was removed from both the eMAR and the medication cart.
-The copy of the order was placed into the "to-be-filed" folder and was then placed into Resident #2's record, so the follow up was missed.

Attempted telephone interview with Resident #2's former PCP on 07/27/22 at 10:15am was unsuccessful.

4. Review of Resident #6's current FL2 dated 04/11/22 revealed diagnoses included type 2 diabetes, encephalopathy, and dementia.

Review of Resident #6's physician's order dated 05/06/22 revealed an order for Humulin R (used to treat elevated blood glucose) inject 10 units subcutaneously three times a day, hold for blood glucose less than 250.

Review of Resident #6's physician's order dated 06/14/22 revealed that there was an order to hold all "pm" (evening) dosages of insulin for 14 days.

Review of Resident #6's physician's order dated 06/30/22 revealed:
-There was an order for Humulin R inject 10 units

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subcutaneously twice a day, hold for blood glucose less than 250.
-The order for Humulin R three times a day was discontinued.

Review of Resident #6's June 2022 electronic medication administration record (eMAR) from 06/14/22 to 06/30/22 revealed:
-There was an entry for Humulin R injection U-100 inject 10 units subcutaneously three times daily (hold for blood glucose less than 250) scheduled for 8:00am, 2:00pm, and 8:00pm.
-On 06/14/22, Humulin R was administered but should have been held for a blood glucose result of 241.
-On 06/17/22, Humulin R was administered but should have been held for a blood glucose result of 167.
-On 06/22/22, Humulin R was not administered for a blood glucose result of 257.
-On 06/20/22, it was unable to be determined if Resident #6 should have received Humulin R because the blood glucose was not documented.
-On 06/29/22, Humulin R was administered but should have been held for a blood glucose result of 246.

Review of Resident #6's July 2022 eMAR from 07/01/22 to 07/27/22 revealed:
-There was an entry for Humulin R injection U-100 inject 10 units subcutaneously twice daily (hold for blood glucose less than 250) scheduled for 8:00am and 2:00pm.
-On 07/02/22, it was unable to be determined if Resident #6 should have received Humulin R because the blood glucose was not documented.
-On 07/04/22, it was unable to be determined if Resident #6 should have received Humulin R because the blood glucose was not documented.
-On 07/07/22, Humulin R was not administered

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for a blood glucose result of 250.
-On 07/09/22, Humulin R was administered but should have been held for a blood glucose result of 210.
-On 07/11/22, Humulin R was administered but should have been held for a blood glucose result of 209.
-On 07/21/22, Humulin R was documented as administered but should have been held for a blood glucose result of 189.
-On 07/22/22, Humulin R was documented as administered but should have been held for a blood glucose result of 193.

Interview with a medication aide (MA) on 07/27/22 at 1:31pm revealed:
-She was aware that Humulin R was to be held if Resident #6's blood glucose was below 250.
-There were two instances where she had accidentally documented administration of Humulin R for Resident #6 when it was held.
-The blood glucose values for Resident #6 were 189 on 07/21/22 and 193 on 07/22/22.

Attempted interview with a second MA on 07/27/22 at 12:12pm unsuccessful.

Telephone interview with Resident #6's former primary care provider's (PCP) supervisor physician on 07/27/22 at 3:16pm revealed:
-He was not aware that Humulin R was administered when it should have been held and held when it should have been administered for Resident #6.
-There was potential for hypoglycemia with any administration of insulin, but it would depend on the resident and how they responded to it.
-He would expect the facility to administer medications as ordered.

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{D 358}	Continued From page 50 Interview with the Administrator on 07/27/22 at 3:07pm revealed: -She was not aware that Humulin R was administered when it should have been held and held when it should have been administered for Resident #6. -She expected the MAs to administer medications as ordered. -The MAs were responsible for ensuring that residents received the correct amount of insulin. Based on observations, record reviews and interviews, it was determined that Resident #6 was not interviewable. 5. Review of Resident #5's current FL2 dated 04/11/22 revealed diagnoses included diabetes mellitus type II, congestive heart failure and obesity. Review of Resident #5's signed physician's orders dated 05/03/22 revealed: -There was an order to administer humalog (fast-acting insulin to lower blood sugar) 5 units for finger stick blood sugar (FSBS) greater than 200. -There was an order for FSBS three times daily with meals. Review of Resident #5's laboratory values dated 06/07/22 revealed a hemoglobin A1C (used to measure blood sugar levels over an extended period of time) value of 7.1. (The Center for Disease Control and Prevention considers a hemoglobin A1C value of 5.7% normal and a goal of 7.0% for diabetes control). Review of Resident #5's June 2022 electronic medication administration record (eMAR) from 06/14/22 through 06/30/22 revealed:	{D 358}		

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-There was an entry for humalog insulin 5 units for FSBS greater than 200.
-There was an entry for FSBS three times daily scheduled at 8:00am, 12:00pm and 4:30pm.
-There were 7 of 48 opportunities when no FSBS was documented at 4:30pm and it could not be determined if 5 units of humalog was required to help lower blood sugar from 06/14/22 through 06/30/22.
-There were 17 of 48 opportunities when humalog was documented as administered for FSBS that were less than 200 with examples as follows:
-On 06/14/22 at 4:30pm, FSBS was 103, humalog was documented as administered.
-On 06/21/22 at 4:30pm, FSBS was 109, humalog was documented was administered.
-On 06/22/22 at 12:00pm, FSBS was 108, humalog was documented as administered.
-On 06/24/22 at 8:00am, FSBS was 108, humalog was documented as administered.
-On 06/26/22 at 4:30pm, FSBS was 108, humalog was documented was administered.
-On 06/27/22 at 12:00pm, FSBS was 88, humalog was documented as administered.
-On 06/29/22 at 12:00pm, FSBS was 108, humalog was documented was administered.

Review of Resident #5's July 2022 eMAR from 07/01/22 through 07/25/22 revealed:
-There was an entry for humalog insulin 5 units for FSBS greater than 200.
-There was an entry for FSBS three times daily scheduled at 8:00am, 12:00pm and 4:30pm.
Review of Resident #5's July 2022 eMAR from 07/01/22 through 07/25/22 revealed:
-There were 6 of 46 opportunities when no FSBS was documented and it could not be determined if 5 units of humalog was required from 07/01/22 through 07/25/22.
-There were 22 of 75 opportunities when humalog

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was documented as administered for FSBS that were less than 200 with examples as follows:
-On 07/01/22 at 12:00pm, FSBS was 108, humalog was documented as administered.
-On 07/08/22 at 8:00am, FSBS was 118, humalog was documented was administered.
-On 07/09/22 at 4:30pm, FSBS was 126, humalog was documented as administered.
-On 07/12/22 at 8:00am, FSBS was 114, humalog was documented as administered.
-On 07/13/22 at 4:30pm, FSBS was 95, humalog was documented was administered.
-On 07/17/22 at 8:00am, FSBS was 120, humalog was documented was administered.
-On 07/26/22 at 8:00am, FSBS was 111, humalog was documented as administered.

Interview with Resident #5 on 07/27/22 at 12:38pm revealed:
-He was a diabetic and was administered three types of insulin.
-He was recently ordered trulicity (used to control blood sugar levels) which had lowered his blood sugar levels significantly.
-When his FSBS was greater than 200, he was supposed to be administered humalog insulin.
-If his FSBS was under 200, he was not supposed to get any insulin.
-His FSBS was supposed to be checked three times daily but was not because some days he was out of the facility and sometimes he refused FSBS checks.
-He was able to recall specific dates he refused FSBS or was out of the facility.
-The MA should know the dates.
-When staff checked his FSBS, he asked to see the results.
-If the FSBS was less than 200, he refused all insulin for the day.
-If the medication aide (MA) documented that she

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administered him insulin, then he was administered insulin.

Interview with a MA on 07/27/22 at 1:38pm revealed:
-She was unable to explain why some dates Resident #5 did not have FSBS documented on the eMAR.
-If the resident was out of the facility, she would note that on the eMAR.
-If the resident refused FSBS, her initials should be circled on the eMAR with corresponding documentation to show the FSBS was not checked and why.
-Resident #5 was not administered humalog when his FSBS was less than 200.
-She was unable to explain why she initialed the eMAR as administering humalog.

Interview with a second MA on 07/27/22 at 11:35am revealed:
-She did not administer humalog as it appeared on the eMAR.
-She was aware Resident #5 should not be administered insulin when his FSBS were less than 200.
-Resident #5 was aware when his FSBS was less than 200 and he would refuse insulin.
-She was unable to explain why there was documentation she administered insulin when the resident's FSBS was less than 200.

Telephone interview with a MA on 07/28/22 at 9:37am revealed:
-She was not aware that her initials on the eMAR were not circled when she did not administer humalog.
-She thought there was a "glitch" in the eMAR system, and the system shut down.
-When she turned the computer back on, her

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initials were not circled.
-The Administrator was the only staff that could correct the problem.
-She was supposed to let the Administrator know so she could change the system, but she got busy and forgot to tell the Administrator.

Interview with the Administrator on 07/27/22 at 1:11pm revealed:
-She expected Resident #5's FSBS to be obtained as ordered, and insulin administered as ordered.
-If the resident was out of the facility or refused FSBS and insulin, it should be documented on the eMAR.
-She was unable to explain why the MA did not document when FSBS were not obtained to show if humalog should or should not be administered.
-However, she was aware there was a problem with the eMAR system.
-She had talked with the pharmacy regarding correcting the problem.
-She was still waiting on the pharmacy to get the problem resolved.
-There was a way to go into the system and manually document the medication was not administered.
-The MAs should have documented to show they did not administer the humalog.
-The previous Resident Care Director (RCD) audited the eMARs weekly.
-She tried to keep up with auditing the eMAR weekly.

Telephone interview with Resident #5's former Nurse Practitioner (NP) physician supervisor on 07/27/22 at 3:28pm revealed:
-FSBS should be obtained as ordered and insulin administered as ordered.
-Following instructions for insulin administration

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{D 358}	Continued From page 55 was critical to controlling diabetes. -Giving humalog when it was not ordered put the resident at risk for hypoglycemia. -The medication should be administered as ordered. Attempted telephone interview with Resident #5's previous NP on 07/27/22 at 10:15am was unsuccessful. _____ The facility failed to ensure medications were administered as ordered for 1 of 2 residents observed during the medication pass and for 2 of 6 residents sampled for record review. Resident #4 was treated at the local Emergency Department (ED) on 07/21/22 for a diagnoses including cellulitis and ordered an antibiotic to treat the infection. The resident did not receive the antibiotic resulting in increased risk for spread and/or worsening infection; Resident #2 who had pain rated at 8 out of 10 on the pain scale and missed 5 doses of Norco 5-325mg (used to treat pain) from 06/18/22 through 06/19/22, and missed an additional 10 doses of Norco 5-325mg from 07/10/22 through 07/13/22 resulting in a pain level increased to 10 out of 10 on the pain scale and Colace administered when discontinued resulted in the resident needing an as needed anti-diarrhea medication; and errors with insulin resulting in residents at risk for hypoglycemia and possible death (#5 and #6). This failure placed residents at risk for substantial serious physical harm and neglect which constitutes a continuing unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/27/22 for this violation.	{D 358}		

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{D 612}	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) by staff. The findings are: Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the COVID-19 Pandemic dated 02/02/22 revealed:	{D 612}		

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{D 612}	Continued From page 57 -Source control measures were to be implemented for HCP. -Source control referred to the use of a well-fitting face mask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughing. -Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCP. -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/19/21 revealed: -Source control referred to the use of well-fitting face masks to cover a person's mouth and nose. -Cloth masks were not considered PPE and should not be worn by staff. Review of the facility's undated Standard Operating Procedures/Guidelines related to COVID-19 revealed in-service training should be provided to ensure all staff understand the CDC guidance including proper use of PPE including face masks. Observation of the facility on 07/26/22 at various times between 8:40am and 4:30pm revealed: -At 8:40am, residents were coming into the dining room for the second meal seating. -There was a total of 29 residents present for the second meal seating. -At 8:41am, two personal care aides (PCA) were present in the dining room. -The PCAs were helping residents with seating and placing food trays on the tables in front of the residents.	{D 612}		

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{D 612}	Continued From page 58 -Both PCAs were wearing cloth face masks with designer logos. -At 9:09am, the Food Service Manager (FSM) came from the kitchen and started talking to a resident about not carrying coffee out of the dining room. -The FSM had on a surgical face mask with strings that looped over both her ears. -The face mask covered the FSM's chin but her mouth and nose were not covered as she talked with the resident. -At 9:11am, residents were still present in the dining room. The FSM returned to the dining room to show the PCAs where the diet list was posted on the wall in the dining room. The FSM's face mask covered her chin only; her mouth and nose were uncovered. -At 9:14am, the FSM returned to the dining room with her face mask in the same position. The FSM opened a carton of milk for a resident and peeled a banana for a resident. -At 9:28am, the PCA was observed walking down the hallway on his cell phone with this nose and mouth uncovered. The PCA had on a surgical face mask with strings attached at each end. The strings were looped around each of the PCA's ear. The face mask covered the PCA's chin only. The PCA walked past several residents while on the phone with his nose and mouth uncovered. -At 9:30am, the housekeeper was observed cleaning a resident's room with the resident present in the room. The housekeeper had on a surgical face mask that had strings attached to each end of the mask. The strings of the face mask were looped over each of the housekeeper's ears. The face mask covered the housekeeper's chin leaving his nose and mouth uncovered. -At 11:30am, the FSM was observed standing in the middle of the dining room with residents	{D 612}		

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present and talking with residents and staff. The FSM had on a face mask that covered her chin only; her nose and mouth were uncovered.
-At 11:33am, the FSM was observed physically assisting a resident to the dining room. The FSM's face mask was on, but her nose and mouth were uncovered.
-At 12:35pm, the FSM was observed physically helping a resident out of the dining room by holding both the resident's hands. The FSM talked with the resident and instructed the resident regarding walking while she assisted the resident out of the dining room. The FSM had on a face mask that covered her chin only; her nose and mouth were uncovered.
-At 12:53pm, the FSM was again observed in the dining with residents being present with her face mask not covering her nose and mouth.

Observation of the facility on 07/27/22 at various times on 07/27/22 from 12:00pm to 2:30pm revealed:
-At 12:01pm, the housekeeper was observed in the hallway with residents present and his face mask below his nose and mouth, covering only his chin.
-At 2:30pm, a PCA was observed coming out of a resident's room without a face mask on.

Interview with a resident on 07/26/22 at 12:38pm revealed:
-Facility staff seldom wore face masks.
-The second shift staff were worse about wearing face masks and most times did not wear a face mask.
-When they (staff) wore face masks, some staff wore their own face mask with a design printed on the mask.
-She was concerned about staff not wearing face masks because they could bring COVID-19 to her

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and other residents.
-She had observed the Administrator telling staff to wear face masks, but they did not wear them.

Interview with a second resident on 07/26/22 at 12:40pm revealed:
-Sometimes staff did not wear a face mask.
-The FSM always had her face mask down past her nose and mouth. The face mask only covered her chin.

Interview with a third resident on 07/26/22 at 12:45pm revealed:
-Staff did not wear face masks all the time.
-She was unable to say how often staff were observed without face masks because she did not pay attention to them every day.

Interview with a fourth resident on 07/27/22 at 12:54pm revealed:
-Staff pulled their face mask down to talk to the residents and then pulled them back up when they were done talking.
-Sometimes staff walked down the hallway without their face mask on, then later they put them on.

Interview with the FSM on 07/26/22 at 12:04pm revealed:
-Sometimes she wore a face mask when in the dining room.
-If she had a face mask on, she usually pulled it down to talk with the residents because they could not hear her with the face mask pulled up.
-The Administrator had not provided training to her regarding wearing a face mask at all times.
-She had not received training about the proper way to wear PPE.

Interview with a PCA on 07/26/22 at 11:37am

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{D 612}	Continued From page 61 revealed: -Today (07/26/22) was her first day at the facility. -She was being trained by another PCA. -No one had told her that she should not wear personal face masks. -She was unaware that surgical face masks were required in the facility. -She had not received training related to wearing PPE. Interview with a second PCA on 07/26/22 at 11:50am revealed: -She had worked at the facility for two months and always wore a personal cloth face mask. -No one at the facility had said anything to her about not wearing her personal face mask. -She had not received any COVID-19 training since she started working at the facility. Interview with a third PCA on 07/26/22 at 3:19pm revealed: -He often worked the first and second shifts back-to-back. -When he worked, he honestly forgot to wear his face mask. -Today, he took his face mask off because he was on the phone. -Sometimes when working he got hot and oily, so he took the face mask off to wipe his face. -He sometimes forgot to put the face mask back on but when he saw other staff with their face mask on that prompted or reminded him to put his face mask on. -He had been told to wear surgical face masks, but staff were told to wear personal face masks if they were not comfortable with the surgical face masks. Interview with the housekeeper on 07/27/22 at 9:40am revealed:	{D 612}		

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{D 612}	Continued From page 62 -He usually put his face mask on as soon as he got in the facility. -When cleaning a resident's room, he took the face mask off his nose and mouth because when in the bathroom the chemicals and the face mask made it difficult to breathe. -There were no residents in the bathroom, so he thought it was okay to take the face mask off. -He usually remembered to put the face mask back on when in the hallway. -He had received COVID-19 training regarding proper use of PPE. -He was aware face masks should be worn to cover his nose and mouth. Interview with the Administrator on 07/26/22 at 12:00pm revealed: -She preferred wearing her own cloth mask which had a surgical mask inserted inside of it. -She changed out the surgical mask insert at least once daily. -She had told the staff they needed to either wear a surgical mask or a cloth mask with a surgical mask insert. -Staff were aware that they were expected to wear a surgical mask at all times while in patient-care areas, or areas of the facility where they might come into contact with residents. -Staff were trained to wear their mask under their chin and above their nose, with the mask pinched over the bridge of the nose. Second interview with the Administrator on 07/26/22 at 12:50pm revealed: -She had told staff to wear a face mask numerous times. -She even did impromptu trainings with staff regarding PPE by asking staff what was appropriate PPE and the proper way to wear PPE.	{D 612}		

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ST GALES ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D912}	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 health care and nutrition and food service. The findings are: 1. Based on observation, record reviews and interviews, the facility failed to ensure health care referral and follow up to meet the healthcare needs for 2 of 5 sampled residents (#2 and #5) who had orders for a referral to the pain clinic, compression stockings and a missed appointment at the wound clinic (#2) and refusals for fingerstick blood sugar (FSBS) checks and insulin (#5). [Refer to Tag D 0273, 10A NCAC 13F .0902(b) Health Care (Unabated Type B)]. 2. Based on observations, record review and interviews, the facility failed to ensure therapeutic diets and nutritional supplements were served as ordered for 1 of 5 (Resident #1) with orders for a pureed diet with nectar thickened liquids and a nutritional supplement three times daily. [Refer to Tag D 0310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Unabated Type B)].	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041023	A. BUILDING: _____ B. WING _____	R 07/28/2022

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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
{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 and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 2 residents (#7) observed during the medication pass including errors with an antidepressant medication; and for 4 of 6 sampled residents (#2, #4, #5, and #6) for record review including errors with an antibiotic (#4); a pain medication and stool softener (#2); and a fast acting insulin (#5 and #6). [Refer to Tag D 0358, 10A NCAC 13F .1004(a) Medication Administration (Continuing Unabated Type A2 Violation)].	{D914}		