STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	R 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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 on 08/03/22 to 08/05/22 with an exit conference via telephone on 08/05/22.	{D 000}		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff D) had a test for tuberculosis (TB) upon hire. The findings are: Review of Staff D's, personal care aide (PCA)/medication aide (MA), personnel record revealed: -Staff D's hire date was 06/28/22. -There was no documentation of a completed TB skin test. Observation on 08/04/22 from 3:00pm to 4:08pm revealed: -Staff D was the MA on duty on second shift. -Staff D was observed passing medications to residents at the facility.	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 131	Continued From page 1 Attempted interview with Staff D on 08/05/22 at 2:56pm was unsuccessful. Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed: -Staff D worked at the facility as a MA and as a PCA. -Staff D worked with the residents assisting with meals, baths/showers, transportation and with ambulation care. -She was not aware Staff D had not completed a TB skin test. -When staff were hired, they were required to have a TB skin test. -She had not had a chance to review Staff D's personnel record to ensure TB skin test was completed. -The previous Business Office Manager (BOM) left full-time and started part-time sometime in June 2022. -The corporate accountant started to help at the facility completing staff records at the end of June 2022 or the beginning of July 2022. -She thought Staff D's TB skin test was missed due to the turnover in staff in the business office. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -She was basically helping the facility out because the previous BOM became part-time in June 2022. -She started trying to get staff records together 2 weeks ago. -She did not realize Staff D did not have a TB skin test. Telephone interview with the previous BOM on 08/05/22 at 3:09pm revealed: -She left the facility as the full-time BOM in May	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 131	Continued From page 2 2022. -The paperwork initially went to the corporate office and then came to her at the business office. -When Staff D was hired, she no longer worked as the BOM and was not sure why there was no TB skin test for Staff D.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 4 of 6 sampled staff (Staff A, B, D and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1. Review of Staff A's, personal care aide (PCA)/medication aide (MA) personnel record revealed: -Staff A was hired on 04/20/22. -There was documentation that a HCPR was obtained on 08/03/22. There were not findings. -There was no documentation that an HCPR check was done on or prior to the date of hire.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 137	Continued From page 3	D 137		

Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff A had worked at the facility as a PCA and as a MA for over one month, maybe almost two months.
-When Staff A was hired the Business Office Manager (BOM) was responsible for making sure a HCPR status check was completed.
-She did not know who was responsible for completing the HCPR when there was no full-time BOM.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-She was not aware Staff A's HCPR status check was completed 2 days ago and not prior to hire.
-She was aware that all employees were required to have a HCPR status check completed prior to starting work.
-Staff A's HCPR should have been checked upon hire.

Refer to telephone interview with the previous Business Office Manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

2. Review of Staff B's personal care aide (PCA)/medication aide (MA) personnel record revealed:
-Staff B was hired on 06/14/22.

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D 137	Continued From page 4	D 137		

-There was documentation that a HCPR check was completed on 08/03/22. There was no findings noted.
-There was no documentation that a HCPR check was done on or prior to the date of hire.

Telephone interview with Staff B on 08/05/22 at 2:41pm revealed:
-She was a MA and sometimes she worked as a PCA.
-She started working at the facility in June 2022 (unable to recall the exact date).
-When she started working at the facility, the only thing she was asked to provide was previous MA training.
-No one told or informed her that a HCPR check would be completed.
-She was aware from previous employers that a HCPR check was required, but she was not informed by the facility that they were going to complete a HCPR check on her.

Telephone interview with the Resident Care Coordinator (RCC on 08/05/22 at 1:23pm revealed:
-Staff B had worked at the facility as a MA and as a PCA for almost two months.
-Someone in the business office was responsible for ensuring Staff B had a HCPR check completed.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-She was not aware Staff B's HCPR check was not completed until 08/03/22.
-She had not reviewed Staff B's personnel record to ensure the required documents and HCPR status checks were obtained.
-The business office currently did not have a full-time BOM and she thought that contributed to

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D 137	Continued From page 5	D 137		

not completing an HCPR check for Staff B.

Refer to telephone interview with the previous Business Office Manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

3. Review of Staff D's personal care aide (PCA)/medication aide (MA) personnel record revealed:
-Staff D was hired on 06/14/22.
-There was no documentation that a HCPR check was completed on or prior to the date of hire or thereafter.

Attempted telephone interview with Staff D on 08/05/22 at 2:56pm was unsuccessful.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff D had worked at the facility as a MA and as a PCA for a little over one month, maybe a month and a half.
-The business office was responsible for ensuring Staff D's HCPR check was completed upon hire.
-The business office had been without a full-time BOM for about two months or more.
-She was not aware who would be responsible for obtaining HCPR check because there was no BOM.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-She was not aware a HCPR status check had

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D 137	Continued From page 6	D 137		

not been completed on Staff D since her date of hire.
-The BOM was responsible for making sure a HCPR check was completed on Staff D.
-She had not reviewed Staff D's personnel record to ensure the required documents and status checks were obtained.

Refer to telephone interview with the previous Business Office Manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

4. Review of Staff E's medication aide (MA), personnel record revealed:
-Staff E was hired on 07/26/22.
-There was no HCPR check completed upon hire available for review in Staff E's personnel record.

Telephone interview with Staff E on 08/05/22 at 10:15am revealed:
-She started working at the facility as a MA through a staffing agency in June 2022.
-She was offered a full-time position of Special Care Unit Coordinator (SCUC) on 07/26/22 and started her role as SCUC on 08/01/22.
-She did not know if the facility had completed a HCPR check or who would have been responsible to keep personnel records.

Telephone interview with the SCUC on 08/05/22 at 1:23pm revealed:
-Staff E was the SCUC.
-Staff E officially became the SCUC on 08/01/22, but had previously worked with the facility through

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D 137	Continued From page 7 an agency as a MA. -When Staff E was hired, someone in the business office should have completed a HCPR check. Refer to interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the previous BOM on 08/05/22 at 3:09pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. _____ Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed: -She was aware that all employees were required to have a HCPR check completed prior to starting work. -She was not aware that a HCPR check was not completed on Staff A, B, D or E. -The Business Office Manager (BOM) was responsible for completing HCPR checks on new hires. -The business office currently did not have a full-time BOM and she thought that contributed to not completing an HCPR check for Staff A, B, D, or E. Telephone interview with the previous BOM on 08/05/22 at 3:09pm revealed: -She left the facility as the BOM at the end of May 2022. -She continued to work in the business office part-time. -Working part-time, she was not responsible for completing HCPR checks for new hires. -When she was the BOM she did not complete HCPR checks; the corporate office was responsible for completing the paperwork.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 137	Continued From page 8 -The corporate office emailed her completed HCPR verification, she printed them, and put then in the personnel records. -The paperwork for personnel records went through several different "hands" and sometimes never made it to her. -She was unable to say specifically, if the HCPR checks were completed but if there was not documentation, then they were not completed. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -She was the accountant for the corporate office. -Two weeks ago, she started helping in the business office. -She had planned to put together personnel records with paperwork that was required by the "state," but had not completed that process. -The HCPR check should be completed by the business office. -She had completed HCPR checks on 08/03/22 for some employees but not for all employees. _____ The facility failed to ensure 4 of 6 sampled staff (Staff A, B, D, and E) had a HCPR check completed prior to hire. This failure resulted in the facility not knowing if staff had substantiated findings on the HCPR which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on August 5, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2022.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 139	Continued From page 9	D 139		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to ensure 2 of 6 sampled staff (Staff A and Staff D) had a criminal background check completed upon hire. The findings are: 1. Review of Staff A's personal care aide (PCA) personnel record revealed: -Staff was hired on 04/20/22. -There was documentation that a criminal background check was obtained on 08/04/22 with no findings. -There was no documentation that a criminal background check was completed upon or before hire. Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful. Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed: -Staff A had worked at the facility as a PCA and as a MA for over one month, maybe almost two months. -When new hires came to the facility for an interview, the receptionist gave them paperwork to complete.	D 139		

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D 139	Continued From page 10	D 139		

-The paperwork included a form to sign for the criminal background check to be completed.
-The Business Office Manager (BOM) was responsible for making sure criminal background checks were completed and in the personnel record.
-The business office had been without a full-time BOM for almost three months.
-She did not know who was responsible for completing criminal background checks when there was no BOM.

Refer to telephone interview with the previous Business Office Manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

2. Review of Staff D's medication aide (MA) personnel record revealed:
-Staff D was hired on 06/14/22.
-There was no documentation that a criminal background check was completed upon hire, before hire or thereafter.

Attempted telephone interview with Staff D on 08/05/22 at 2:56pm was unsuccessful.

Telephone interview with the RCC on 08/05/22 at 1:23pm revealed:
-Staff D had worked at the facility as a MA and as a PCA for a little over one month, maybe a month and a half.
-When Staff D came for an interview, the receptionist should have given her paperwork to complete that included signing for a criminal

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D 139	Continued From page 11	D 139		

background check to be completed.
-The BOM was responsible for ensuring criminal background checks had been completed.
-The business office had been without a full-time BOM for about two months or more.

Refer to telephone interview with the previous Business Office Manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

_____

Telephone interview with the previous BOM on 08/05/22 at 3:09pm revealed:
-She left the facility as the BOM at the end of May 2022.
-She continued to work in the business office part-time.
-Working part-time, she was not responsible for completing criminal background checks.
-When she was the BOM she did not complete criminal background checks.
-The corporate office was responsible for completing the required paperwork for new hires.
-The corporate office sometimes emailed her the results of completed criminal background checks.
-The paperwork for personnel records went through several different "hands" and sometimes never made it to her.
-She was unable to say specifically why the criminal background checks were not completed.

Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed:
-She was the accountant for the corporate office.
-Two weeks ago, she started working at the

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D 139	Continued From page 12	D 139		

facility in the business office to help out.
-She had not completed criminal background checks for all employees and she was not aware which employees did not have a criminal background check.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-She was aware all employees should have a criminal background check upon hire.
-She did not why Staff A's criminal background check was completed yesterday and not upon hire.
-The business office was responsible for completing criminal background checks on new hires.
-The business office currently did not have a full-time BOM and she thought that contributed to not completing a criminal background check on Staff A.
-She was responsible for making sure paperwork was completed, but she had not reviewed Staff A's personnel record to ensure the required documents and criminal background checks were obtained.

_____
The facility failed to ensure 2 of 6 sampled staff (Staff A and Staff D) had a criminal background check completed upon hire. This failure resulted in the facility not knowing if staff had criminal history which was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation.

_____
The facility provided a plan of protection in accordance with G.S. 131D-34 on August 5, 2022 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 139	Continued From page 13 20, 2022.	D 139		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 6 sampled staff (Staff B, Staff D and Staff E) were competency validated for Licensed Health Professional Support (LHPS) tasks by return demonstration including obtaining fingerstick blood sugar checks and insulin injections prior to performing these tasks on diabetic residents. The findings are: 1. Review of Staff B's personal care aide (PCA)/medication aide (MA) personnel record revealed: -Staff B was hired on 06/14/22. -There was no documentation of completion of a LHPS competency validation. Review of a resident's electronic medication	D 161		

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	HAL034098	A. BUILDING: _____ B. WING _____	R 08/05/2022

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SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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administration record (eMAR) for August 2022 revealed Staff B documented obtaining fingerstick blood sugar checks for 3 opportunities in August 2022.

Telephone interview with Staff B on 08/05/22 at 2:41pm revealed:
-She was a MA and sometimes she worked as a PCA.
-She was checked-off for LHPS tasks at her previous employment but not at this facility.
-The facility nurse had verbally told her that she was going to provide LHPS training but had not completed the training.
-She worked third shift and she usually checked FSBS at 6:00am in the morning, but she did not administer insulin.
-Since her employment at the facility, she had not received training related to LHPS tasks.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff B worked at the facility as a MA and as a PCA for a little over one month, maybe a month and a half.
-There was a nurse who worked at the facility was part-time.
-She was not aware of the training provided by the facility's nurse.
-She was not sure if Staff B had been checked-off for LHPS tasks and competency validation.
-When a MA was hired, the only training she provided was for the MA to shadow another MA for one to two weeks before being on the medication cart by herself.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-She was not aware Staff B had not completed

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D 161	Continued From page 15	D 161		

the LHPS competency validation.
-The facility nurse was responsible for ensuring LHPS competency validations were completed.
-She had not reviewed Staff B's personnel record to ensure the required training was completed including LHPS competency validations.

Refer to interview with the facility's nurse on 08/04/22 at 5:35pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

2. Review of Staff D's personal care aide (PCA)/medication aide (MA) record revealed:
-She was hired on 06/14/22.
-There was no documentation a LHPS competency validation had been completed for Staff D.

Observation of Staff D on 08/04/22 at 4:30pm revealed Staff D obtained a FSBS on a resident and administered insulin.

Review of three diabetic residents' electronic medication administration records (eMARs) revealed Staff D documented she checked FSBS and administered insulin 28 opportunities from 06/01/22 through 06/30/22; 57 opportunities from 07/06/22 through 07/31/22; and 12 opportunities from 08/01/22 through 08/04/22.

Attempted telephone interview with Staff D on 08/05/22 at 2:56pm was unsuccessful.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff D worked at the facility as a MA and as a PCA for a little over one month, maybe a month

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and a half.
-The facility had a nurse, but she was not in the facility often.
-When a MA was hired, the training she provided consisted of placing the MA on the medication cart to shadow another MA for one to two weeks; after that the MA worked on her own on the medication cart.
-She was not aware of the training provided by the facility nurse.
-She was not aware if Staff D had been checked-off for LHPS tasks and completed the competency validation.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-She was not aware Staff D had not completed the LHPS competency validation since she was hired at the facility.
-The facility nurse recently started and worked part-time providing trainings.
-The nurse was responsible for ensuring LHPS competency validations were completed.
-She had observed the nurse providing trainings, but not sure if the training included LHPS competency validations.
-She had not reviewed Staff D's personnel record to ensure the required training and LHPS competency validation was completed.

Refer to interview with the facility's nurse on 08/04/22 at 5:35pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

4. Review of Staff E's medication aide (MA) personnel record revealed:
-Staff E was hired on 07/26/22.
-There was no (Licensed Health Professional

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Support) LHPS competency validation available for review in Staff E's personnel record.

Review of three diabetic residents' electronic medication administration records (eMARs) revealed Staff E documented she checked FSBS and administered insulin 21 opportunities from 06/01/22 through 06/30/22; 39 opportunities from 07/06/22 through 07/31/22; and 6 opportunities from 08/01/22 through 08/04/22.

Telephone interview with Staff E on 08/05/22 at 10:15am revealed:
-She started working at the facility as a MA through a staffing agency in June 2022.
-She was offered a full-time position of Special Care Unit Coordinator (SCUC) on 07/26/22 and started her role as SCUC on 08/01/22.
-She had completed competency validation for LHPS tasks but could not remember when.
-The facility should have her LHPS competency validation in her staff record.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff E started working at the facility on 08/01/22 as the SCUC.
-As the SCUC, Staff E worked on the medication cart checking FSBS and administering insulin.
-Prior to 08/01/22 Staff E worked at the facility as agency staff and administered medications; including checking FSBS and insulin administration of diabetic residents.
-She was not sure if Staff E completed LHPS competency validation training.
-The facility's nurse was responsible for providing the LHPS competency validation training.

Telephone interview with the Administrator on

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D 161	Continued From page 18 08/05/22 at 1:33pm revealed: -She was not aware Staff E had not completed the LHPS competency validation prior to checking FSBS and insulin administration. -Staff E had been at the facility as agency staff, then on Monday, 08/01/22 Staff E started working as the SCUC. -The facility nurse was responsible for making sure LHPS competency validations were completed. -She had not reviewed Staff E's personnel record to ensure the required training and LHPS competency validation was completed. Refer to interview with the facility nurse on 08/04/22 at 5:35pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. _____ Interview with the facility's nurse on 08/04/22 at 5:35pm revealed: -She had worked at the facility part-time for a little over one month. -She was still new and was not sure of the trainings that were required. -She had completed LHPS competency validations with some employees but not everyone. -She was unable to say which employees she completed the LHPS competency validations with. -She had documentation for some staff who had completed the LHPS competency validations. -Some trainings were not documented because she ran out of the form and did not document the training was completed anywhere. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed:	D 161		

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D 161	Continued From page 19 -She had been at the facility helping the business out since July 2022. -Two weeks ago she started to work on personnel records. -The facility hired a nurse to provide the LHPS competency validation training. -The nurse had been trained on how to complete the forms and the trainings required. -If the nurse was not sure what to do or if she needed forms, she should have let her know.	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration.	D 164		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 3 of 6 sampled medication aides (Staff A, Staff D and Staff E) had completed training on the care of diabetic residents prior to obtaining fingerstick blood sugars and administering insulin.

The findings are:

1. Review of Staff A's personal care aide (PCA)/medication aide (MA) personnel record revealed:
-Staff A was hired on 04/20/22.
-There was no documentation on the training of the care of diabetic residents for Staff A.

Review of the June and July 2022 electronic medication administration record (eMAR) for an insulin dependent resident revealed:
-There was documentation Staff A administered insulin on 22 occasions from 06/01/22 through 06/30/22.
-There was documentation Staff A administered insulin on 43 occasions from 07/01/22 through 07/31/22.

Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff A had worked at the facility as a MA for over one month, maybe almost two months.
-When Staff A worked, she checked FSBS and

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administered insulin to diabetic residents.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-She was not aware Staff A did not complete training for the care of diabetic residents.
-The Business Office Manager (BOM) was responsible for making sure trainings were completed by the nurse.
-The nurse had worked at the facility part-time and she observed her doing trainings.
-She was not sure if the trainings included caring for diabetic residents.
-She had not reviewed Staff A's personnel record to ensure the required documents and trainings were obtained.

Refer to interview with the facility's nurse on 08/04/22 at 5:35pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

2. Review of Staff D's personal care aide (PCA)/medication aide (MA) record revealed:
-Staff D was hired on 06/14/22.
-There was no documentation Staff D completed care of diabetic resident training prior to the administration of insulin.

Observation of Staff D on 08/04/22 at 4:30pm revealed Staff D obtained a FSBS on a resident and administered insulin.

Review of three diabetic residents' June and July 2022 electronic medication administration records (eMARs) revealed:
-There was documentation Staff D administered insulin on 28 occasions from 06/01/22 through 06/30/22.

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-There was documentation Staff D administered insulin on 57 occasions from 07/06/22 through 07/31/22.
-There was documentation Staff D administered insulin on 12 occasions from 08/01/22 through 08/04/22.

Attempted telephone interview with Staff D on 08/05/22 at 2:56pm was unsuccessful.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff D had worked at the facility as a MA since June 2022.
-When Staff D worked, she administered insulin and checked FSBS diabetic residents.
-The only training she provided to Staff D prior to administration of insulin was shadowing another MA on the medication cart.
-The Business Office Manager (BOM) was responsible for making sure trainings were completed by the nurse.
-The nurse had worked at the for a little over one month but was only worked part-time.
-She was not sure if the nurse provided diabetic training to Staff D.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-She was not aware Staff D had not completed diabetic training prior to the administration of insulin.
-The facility nurse was supposed to provide training to staff but was unaware if diabetic training had been provided.
-The business office was responsible for making sure trainings were completed by the nurse.
-She had not reviewed Staff D's personnel record to ensure the required documents and trainings

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were obtained.

Refer to interview with the facility's nurse on 08/04/22 at 5:35pm.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

4. Review of Staff E's medication aide (MA), personnel record revealed:
-Staff E was hired on 07/26/22.
-There was no documentation Staff E had completed training on the care of diabetic residents available for review in her personnel record.

Review of three diabetic residents' electronic medication administration records (eMARs) revealed:
-There was documentation Staff E administered insulin on 21 occasions from 06/01/22 through 06/30/22.
-There was documentation Staff E administered insulin on 39 occasions from 07/06/22 through 07/31/22.
-There was documentation Staff E administered insulin on 6 occasions from 08/01/22 through 08/04/22.

Telephone interview with Staff E on 08/05/22 at 10:15am revealed:
-She started working at the facility as a MA through an agency in June 2022.
-She was offered a full-time position of Special Care Unit Coordinator (SCUC) on 07/26/22 and started her role as SCUC on 08/01/22.
-She had completed training on the care of diabetic residents but could not remember the exact date.
-The facility should have her training certificate on

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D 164	Continued From page 24 file. Refer to interview with the facility's nurse on 08/04/22 at 5:35pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. _____ Interview with the facility's nurse on 08/04/22 at 5:35pm revealed: -She had worked at the facility part-time for a little over one month. -She was still new and was not sure of the trainings that were required. -She had not provided diabetic training for the medication aides. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -She had been at the facility helping the business out since July 2022. -Two weeks ago she started working on personnel records but she had not identified documents and trainings that were missing. -The facility hired a nurse to provide the trainings. -The nurse should have provided diabetic care training. -The nurse had been trained on how to complete the forms and the trainings required. -If the nurse was not sure what to do or if she needed forms, she should have let her know.	D 164		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs,	{D 270}		

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{D 270}	Continued From page 25 care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews, observations, and interviews, the facility failed to provide supervision according to the facility's policy for 2 of 5 sampled residents (#4 and #5) related to a resident who had 2 falls within a week with 1 fall resulting in a blackened eye and a laceration (#5) and a resident who had a history of falls including a fall resulting in pain and a decrease in ambulation (#4). The findings are: Review of the facility's Fall Intervention Protocol dated January 2022 revealed: -Vital signs were to be obtained and the resident was to be observed for injuries; if a resident hit their head, was bleeding, or complained of pain, the resident was to be sent out to the local hospital emergency department for further evaluation. -The environment was to be assessed for hazards and hazards removed; the physician was to be notified and a plan of care completed with appropriate documentation. -The physician was to be notified for a review of medication and evaluation for repeat falls. -The resident was to be referred to home health for physical therapy evaluation for strengthening and balance training if the resident had a fall while ambulating. -If the resident had a fall from a wheelchair, the resident was to be referred to home health for physical therapy evaluation for balance training	{D 270}		

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and positioning.
-Staff was to check on the resident as often as needed to anticipate needs and act proactively to ensure safety.
-Staff was to complete 15-minute checks for 72 hours following a fall per policy.

1. Review of Resident #5's current FL2 dated 03/16/22 revealed:
-Diagnoses included major depressive disorder, arthritis, metabolic encephalopathy, cellulitis of left lower extremity, acute cystitis without hematuria, and hyperkalemia.
-Resident #5 was semi-ambulatory with a walker.

Review of Resident #5's care plan dated 03/16/22 revealed:
-Resident #5 used a walker to ambulate.
-There was no documentation regarding the level of assistance Resident #5 needed with ambulation.
-Staff assisted Resident #5 with transfers.
-There was no documentation regarding Resident #5's orientation.

a. Review of Resident #5's progress notes dated 07/23/22 at 9:59am and 2:47pm revealed:
-Resident #5 was found on the floor of her room.
-Resident #5 stated that she fell and that her back and leg was hurting badly.
-She requested to go to the hospital.
-She was transported by emergency medical services (EMS) to a local hospital.
-She returned from the hospital on 07/23/22.

Review of Resident #5's Incident/Accident Report dated 07/23/22 at 9:45am revealed:
-Resident #5 fell on first shift.
-She was found in her room and complained that her back and leg hurt.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 270}	Continued From page 27 Attempted interview with the medication aide (MA) who completed the progress note and the Incident/Accident Report dated 07/23/22 on 08/04/22 at 10:54am was unsuccessful. Review of Resident #5's Fall Checklist dated 07/23/22 revealed: -Resident #5 did not hit her head, but she complained of unusual pain (place of pain not documented). -There was no bleeding and no skin tears. -Resident #5 was transported to the local hospital by EMS. Review of Resident #5's 24 Hour Post Fall Checklist date 07/23/22 revealed: -The checklist was not completed. -There was documentation Resident #5 should have been assessed for complaints of pain and discomfort, changes in walking ability, outward rotation of the legs or arms, increased drowsiness, and reluctance to get out of bed at 8 hours, 16 hours, and 24 hours after her fall on 07/23/22. -Resident #5 should have been assessed on 07/23/22 at 5:45pm, on 07/24/22 at 1:45am, and on 07/24/22 at 9:45am. -There was a space to check off Resident #5 was assessed at 8 hours, 16 hours, and 24 hours after her fall on 07/23/22, but there was no documentation she had been assessed. Review of Resident #5's 15-minute Check Sheet dated 07/25/22 revealed: -There was documentation of 15 minute checks for Resident #5 from 7:00am to 11:00pm on 07/25/22. -There was no additional documentation of increased supervision after Resident #5's fall on	{D 270}		

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{D 270}	Continued From page 28 07/23/22. Interview with a personal care aide (PCA) on 08/04/22 at 11:38am revealed: -She was one of the PCAs who found Resident #5 on the floor in her room on 07/23/22. -Resident #5 did not have any injuries, but she was sent to the local hospital for evaluation. -Resident #5 returned to the facility on the same day that she fell. -She was not told to do anything differently for Resident #5 when she returned. -She was not sure if Resident #5 was placed on 15 minute checks after her fall on 07/23/22. Telephone interview with Resident #5's primary care provider (PCP) on 08/05/22 at 8:50am revealed: -She had not been notified Resident #5 had a fall on 07/23/22; however she did become aware of her fall when she visited her on 07/25/22. -When she saw Resident #5 on 07/25/22, she observed Resident #5 had right side weakness and her right leg did not move like she wanted it to, so she ordered physical therapy (PT) for Resident #5. -PT was also ordered due to her recent fall. Telephone interview with Resident #5's home health provider on 08/05/22 at 8:34am revealed: -Resident #5 was currently receiving OT and was admitted on 07/08/22 with a diagnosis of lymphedema. -The provider had not received an order for PT until 08/04/22. Based on record reviews and interviews, there was no documentation 15-minute checks were implemented for Resident #5 after her fall on 07/23/22; the 15 minute checks were not	{D 270}		

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{D 270}	Continued From page 29	{D 270}		

implemented until 48 hours from the fall.

Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/03/22 at 4:20pm.

Refer to interview with the Administrator on 08/04/22 at 2:08pm.

b. Review of Resident #5's progress note dated 07/30/22 at 9:00am revealed:
-Resident #5 had an unwitnessed fall in her room around 7:15am.
-The medication aide (MA) assessed Resident #5 and noticed she had a blackened left eye and a small cut above her left eye with a small amount of bleeding.
-There were no other apparent injuries.
-Resident #5 was transported via emergency medical services (EMS) to the local hospital emergency room (ER).
-Resident #5 returned from the ER on 07/30/22 with no new orders and was placed on 15-minute checks for 3 days.
-Staff was to continue to "monitor."

Review of Resident #5's Incident/Accident Report dated 07/30/22 at 7:15am revealed:
-Resident #5's legs gave out on her while walking in her room.
-Her fall impact was on the side of her face causing a blackened eye and small cut above her left eye.
-Resident #5 was transported to the local hospital ER.

Review of Resident #5's ER After Visit Summary dated 07/30/22 revealed:
-Resident #5 visited the ER with a diagnosis of a fall.
-Imaging tests were completed, but there was no

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documentation of significant findings.
-There was no documentation regarding bruising and cut above left eye.

Attempted telephone interview with the MA who completed the progress note and Incident Accident Report dated 07/30/22 on 08/04/22 at 10:57am was unsuccessful.

Review of Resident #5's Fall Checklist dated 07/30/22 revealed:
-Resident #5 hit her head and complained of unusual pain (place of pain not documented).
-There was bleeding and a skin tears (location not documented).
-Resident #5 was transported to the local hospital by EMS.

Review of Resident #5's 24 Hour Post Fall Checklist date 07/30/22 revealed:
-Resident #5 was assessed for complaints of pain and discomfort, changes in walking ability, outward rotation of the legs or arms, increased drowsiness, and reluctance to get out of bed at 8 hours, 16 hours, and 24 hours after her fall on 07/30/22.
-There was documentation Resident #5 was assessed on 07/30/22 at 3:15pm, on 07/30/22 at 11:15pm, and on 07/31/22 at 7:15am; there had been no changes in her condition.

Review of Resident #5's 15 minute Check Sheets revealed:
-There was documentation of 15 minute checks for Resident #5 on 07/30/22 from 12:00pm to 12:00am.
-There was documentation of 15 minute checks for Resident #5 on 07/31/22 from 7:00am to 12:00am.
-There was documentation of 15 minute checks

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for Resident #5 on 08/01/22 from 12:15am to 2:00pm.
-There was no documentation of 15 minute checks on 07/31/22 from 12:15am to 6:45am.

Observation of Resident #5 on 08/03/22 at 9:41am revealed:
-Resident #5 had a scabbed, 1 inch horizontal laceration above her left eye.
-Resident #5's left eyelid was purple and the skin below her left eye was purple.
-There was yellowish skin discoloration on her left cheek.

Interview with Resident #5 on 08/04/22 at 11:29am revealed:
-She fell and hit her head, had a black eye and a cut above her eye.
-She could not remember the details of the fall or when it happened, but it was much better.

Interview with the Administrator on 08/04/22 at 2:08pm revealed:
-After Resident #5's second fall on 07/30/22, she went to check on Resident #5.
-Staff were supposed to complete 15 minute checks after her fall.
-She did not know if there were any other interventions put in place other than 15-minute checks for 72 hours after a fall.

Telephone interview with Resident #5's primary care provider (PCP) on 08/05/22 at 8:50am revealed she had not been notified Resident #5 had a fall on 07/30/22.

Based on record reviews and interviews, there was no documentation 15-minute checks were implemented continuously for 72 hours for Resident #5 after her fall on 07/30/22.

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{D 270}	Continued From page 32 Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/03/22 at 4:20pm. Refer to interview with the Administrator on 08/04/22 at 2:08pm. 2. Review of Resident #4's current FL2 dated 05/25/22 revealed: -Diagnoses included dementia with psychosis, hypoglycemia, vitamin D deficiency, schizophrenia, and insomnia. -Resident #4 was semi-ambulatory with a walker. -Resident #4 was intermittently disoriented. Review of Resident #4's care plan dated 05/19/22 revealed: -Resident #4 used a walker to ambulate. -There was no documentation regarding the level of assistance Resident #4 needed with ambulation or with transfers. a. Review of Resident #4's progress notes dated 05/18/22 revealed: -Resident #4 fell at the start of second shift as he lost his balance and fell hitting his head on the door beside him. (There was no documentation where Resident #4 was or which door he hit his head on.) -Emergency medical services (EMS) transported Resident #4 to the local hospital emergency room (ER). Attempted telephone interview with the MA who completed the progress note dated 05/18/22 on 08/04/22 at 10:57am was unsuccessful. Review of Resident #4's Incident/Accident Reports, Falls Checklists, Post Falls Checklists revealed there was none available for Resident	{D 270}		

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{D 270}	Continued From page 33 #4's fall on 05/18/22. Interview with Resident #4's physical therapist on 08/04/22 at 11:08am revealed: -Resident #4 was receiving physical therapy (PT) due to falls prior to his fall on 08/04/22 and was making progress; physical therapists were working with Resident #4 on ambulation to maintain his strength. -Physical therapists were also working with Resident #4 to ensure he was able to transfer from his wheelchair to his bed by himself. -He did not know about Resident #4's fall on 05/18/22 and had not made any recommendations for interventions for fall prevention to the facility. Interview with Resident #4's primary care provider (PCP) on 08/01/22 at 3:27pm revealed: -She saw Resident #4 for the first time in July 2022. -She reviewed a note from the previous provider documenting there was a face to face visit on 05/25/22 due to falls. -The previous provider ordered a rollator walker due to Resident #4 having abnormal gait. -She would have expected the facility to contact a medical equipment provider to order the rollator once the order for the rollator was written. Based on record reviews and interviews there was no documentation 15-minute checks were implemented for Resident #4 after his fall on 05/18/22. Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/03/22 at 4:20pm. Refer to interview with the Administrator on 08/04/22 at 2:08pm.	{D 270}		

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{D 270}	Continued From page 34 b. Review of Resident #4's progress note dated 06/07/22 revealed: -Resident #4 had an unwitnessed fall in the Special Care Unit (SCU) courtyard and was found laying on his back with his two wheeled walker nearby. -Resident #4 stated he tripped over his feet. -He complained of left hip pain, but he denied hitting his head. -Resident #4 was sent to the local hospital emergency room (ER) via emergency medical services (EMS). -He returned to the facility on 06/07/22. Attempted interview with the staff who documented the progress note dated 06/07/22 on 08/04/22 at 10:37am was unsuccessful. Review of Resident #4's Incident/Accident Report dated 06/07/22 revealed: -Resident #4 had an unwitnessed fall in the SCU courtyard. -He was found laying on his back. -He stated he tripped over his feet and he complained of left hip pain. Review of Resident #4's Fall Checklists revealed there was no Falls Checklist for Resident #4 dated 06/07/22. Review of Resident #4's 24 Hour Post Fall Checklist dated 06/07/22 revealed: -Resident #4 was assessed for complaints of pain and discomfort, changes in walking ability, outward rotation of the legs or arms, increased drowsiness, and reluctance to get out of bed at 8 hours, 16 hours, and 24 hours after her fall on 06/07/22. -There was documentation Resident #4 was	{D 270}		

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assessed at 7:00pm, 3:00am, and 11:00am, but there was no date; there had been no changes in his condition.

Review of Resident #4's progress note dated 06/09/22 at 2:26pm revealed:
-Resident #4's physical therapist visited with him on 06/09/22 and reported to the medication aide (MA) that Resident #4 was complaining of left hip pain and was unable to stand.
-The MA contacted Resident #4's PCP who gave a verbal order for an x-ray, left hip series, due to pain in the left hip and inability to stand.

Review of Resident #4's progress note dated 06/09/22 at 2:59pm revealed Resident #4 had been in his room all day complaining of leg pain.

Review of Resident #4's progress note dated 06/09/22 at 4:32pm revealed:
-Resident #4 complained of left hip pain and the MA contacted the PCP's office to request an order for pain medication.
-The MA was informed that the PCP was waiting on x-ray results from the x-ray completed during the local hospital ER visit on 06/07/22.

Review of Resident #4's progress notes dated 06/10/22 revealed:
-At 12:47pm, there was documentation a standing order for acetaminophen (a medication used to treat pain) was administered to Resident #4 due to pain in his left hip.
-At 10:53pm, the MA notified Resident #4's PCP he was complaining of left hip pain from his fall on 06/07/22; an order was received to start Resident #4 on ibuprofen.

Review of Resident #4's progress note dated 06/11/22 at 8:11pm revealed he continued to

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{D 270}	Continued From page 36 complain of pain in his left hip. Review of Resident #4's progress notes dated 06/14/22 revealed: -At 1:55pm, Resident #4 complained of pain in his left knee and leg when standing and of not being able to stand. -At 3:10pm, Resident #4 was given acetaminophen for leg pain. Review of Resident #4's progress note dated 07/09/22 revealed: -Resident #4 asked if his PCP could write an order for him to have a wheelchair. -Resident #4 stated his legs did not work like they used to, and he really needed a wheelchair. Interview with the facility's contracted registered nurse (RN) on 08/03/22 at 4:35pm revealed: -She assessed Resident #4 after he fell in the courtyard on 06/07/22. -Resident #4 said that he hurt his hip and he was sent out to the local hospital. -Resident #4 stopped walking after his fall on 06/07/22 and began using a wheelchair. -Physical therapy was in place for Resident #4, but she did not know what other interventions were in place. Interview with Resident #4's physical therapist on 08/04/22 at 11:08am revealed: -Resident #4 was progressing with his physical therapy and was working on ambulation to maintain his strength. -Physical therapists were also working with Resident #4 to ensure he was able to transfer from his wheelchair to his bed by himself. -He did not know about Resident #4's fall on 06/07/22 and had not made any recommendations for interventions to the facility.	{D 270}		

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{D 270}	Continued From page 37 Interview with Resident #4's primary care provider (PCP) on 08/02/22 at 3:27pm revealed: -She saw Resident #4 for the first time in July 2022. -Resident #4 had an x-ray of his left hip on 06/10/22 due to complaints of pain after he fell on 06/07/22. -The x-ray resulted in the absence of any fractures. -She reviewed a note from the previous provider documenting there was a face to face visit with Resident #4 on 06/15/22. -On the 06/15/22 visit, Resident #4 continued to complain of hip pain and the previous provider ordered Resident #4 a wheelchair. -Facility staff advised the previous provider Resident #4 was tall and did not fit the chair he was using that did not belong to him. Based on record reviews and interviews, there was no documentation 15-minute checks were implemented for Resident #4 after his fall on 06/07/22. Refer to interview with the SCUC on 08/03/22 at 4:20pm. Refer to interview with the Administrator on 08/04/22 at 2:08pm. c. Review of Resident #4's progress note dated 08/01/22 at 8:50pm revealed: -Staff found Resident #4 in his room with his wheelchair tipped over with him still in it. -Resident #4 stated he was trying to get in his bed. Review of Resident #4's Incident/Accident Report dated 08/01/22 at 7:30pm revealed:	{D 270}		

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{D 270}	Continued From page 38 -Resident #4 was found in his room with his wheelchair tipped over. -Resident #4 complained his ankles, left hip, and right elbow hurt. -Resident #4 was sent to the emergency room (ER). Observation of Resident #4 on 08/03/22 at 9:38am and 11:35am revealed: -Resident #4 was seated in a wheelchair in the courtyard. -He had a bandage wrapped loosely around his right hand. -Resident #4 was propelling in the hallway in a wheelchair. -The wheelchair had a label attached to it and another resident's name was on the label. -The back of Resident #4's calves were 1 and 1/2 feet away from the front edge of the wheelchair seat and his legs were slightly above a parallel level to the floor. Interview with Resident #4 on 08/03/22 at 9:39am revealed: -He had a fall a few days ago and hurt his arm. -He was trying to transfer from the wheelchair to his bed when he fell. -He was sent out to the hospital emergency room, but he did not have any fractures. -He had had previous falls, but he did not remember when. Interview with the medication aide (MA) who documented Resident #4's incident/accident report dated 08/01/22 on 08/03/22 at 4:07pm revealed: -Resident #4 was found in his room with his wheelchair tipped over on its side and he was still in the wheelchair. -Resident #4 stated his feet felt swollen and that	{D 270}		

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his elbow and his hip hurt.
-Resident #4 was sent to the hospital emergency room for further evaluation.
-Resident #4 was placed on 15-minute checks when he returned from the hospital.
-Resident #4 was not on 15-minute checks prior to his fall on 08/01/22.
-She usually checked on residents every 30-minutes or every hour.
-She did not know of any interventions put in place for Resident #4 except for physical therapy.

Review of Resident #4's Fall Checklist dated 08/01/22 revealed:
-Resident #4 did not hit his head, but he complained of unusual pain (place of pain not documented).
-There was no bleeding and no skin tears.
-Resident #4 was transported to the local hospital by EMS.

Review of Resident #4's 24 Hour Post Fall Checklist dated 08/01/22 revealed:
-Resident #4 was assessed for complaints of pain and discomfort, changes in walking ability, outward rotation of the legs or arms, increased drowsiness, and reluctance to get out of bed at 8 hours, 16 hours, and 24 hours after his fall on 08/01/22.
-There was documentation Resident #5 was assessed on 08/02/22 at 3:30am, on 08/02/22 at 11:30am, and on 08/02/22 at 7:30am and there had been no changes in his condition.
-There was a space to check off Resident #4 was assessed at 8 hours, 16 hours, or 24 hours after his fall on 08/01/22, but there was no documentation he had been assessed.

Review of Resident #4's 15-minute Check Sheets revealed:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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 270}	Continued From page 40 -There was documentation of 15-minute checks for Resident #4 from 7:00am to 3:00pm and from 4:15pm to 4:30pm on 08/01/22. -There was documentation of 15-minute checks for Resident #4 from 7:00am to 11:45am 08/03/22. -There was no additional documentation of increased supervision after Resident #5's fall on 08/01/22. Interview with the Special Care Unit Coordinator (SCUC) on 08/04/22 at 12:23pm revealed: -Resident #4 fell on 08/01/22 and was sent out to the ER. -He came back to the facility on the same day and staff started documenting his vitals and any changes each shift for 24 hours. -Resident #4 was also started on 15-minute checks for 72 hours. Interview with Resident #4's physical therapist on 08/04/22 at 11:08am revealed: -Resident #4 was progressing with his physical therapy and was working on ambulation to maintain his strength. -Physical therapists were also working with Resident #4 to ensure he was able to transfer from his wheelchair to his bed by himself. -He did not know about Resident #4's fall on 08/01/22 and had not made any recommendations for interventions to the facility. Interview with Resident #4's primary care provider (PCP) on 08/03/22 at 3:27pm revealed: -She saw Resident #4 for the first time in July 2022. -At the time of her first visit with Resident #4, staff informed her Resident #4 had a history of falls. -Staff also informed her Resident #4 liked to be independent and refused help.	{D 270}		

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{D 270}	Continued From page 41 -She was not notified of Resident 4's fall on 08/01/22. -If she had been notified of Resident #4's fall on 08/01/22, she would have requested a urinalysis and reviewed his medication. Based on record reviews and interviews, there was no documentation 15-minute checks were implemented continuously for 72 hours for Resident #4 after his fall on 08/01/22. Refer to interview with the SCUC on 08/03/22 at 4:20pm. Refer to interview with the Administrator on 08/04/22 at 2:08pm. _____ Interview with the SCUC on 08/03/22 at 4:20pm revealed: -If a resident had an unwitnessed fall and there was visible bleeding, the resident was sent to the emergency room. -Once the resident returned to the facility, any paperwork would be forwarded to the SCUC and any new orders would be faxed to the pharmacy and it would be documented in the resident's progress notes. -Once the resident returned to the facility, the resident was placed on 15 minute checks for 3 days and assessed for changes once each shift for 24 hours. -She did not know of any interventions put in place for residents prior to starting her role as SCUC on 08/01/22, but in the future, if a resident continued to fall, the intervention would be to have the resident's level of care reassessed. Interview with the Administrator on 08/04/22 at 2:08pm revealed: -If a resident had fall, they were placed on 15	{D 270}		

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{D 270}	Continued From page 42 minute checks for 72 hours, the primary care provider (PCP) was notified, and vitals, change of condition, and skin changes were monitored each shift for 24 hours. -If a resident had repeat falls, staff would discuss with the resident's family, there would be a medication review, and possible medication modifications. -Any interventions in place after a resident's fall should have been documented in the resident's record and increased supervision (15-minute checks) should have been documented on the 15-minute check sheet. -Residents who were high fall risks were not routinely on 15 minute checks. -MAs were supposed to document the 15 minute checks and the SCUC was supposed to follow-up to ensure the 15 minute checks were being completed and documented. -She did occasional pop-ups in the SCU and found holes in documentation of the 15-minute checks. _____ The facility failed to provide adequate supervision for 2 of 5 sampled residents (#4 and #5) including Resident #4 who had 3 falls which resulted in pain in his left hip, right elbow, right hand, and a decrease in ambulation; and Resident #5 who had 2 falls within a week and suffered a blackened eye and a laceration above her eye. This failure was detrimental the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 08/04/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2022.	{D 270}		

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{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 CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation has not been abated. Based on observations, record reviews and interviews, the facility failed to ensure health care referral and follow up were completed for 3 of 5 sampled residents (#1, #4, and #5) who had orders for urinalyses and physical therapy (#1); orders for a rollator walker and a wheelchair, and a recommendation to obtain a referral to see a neurologist (#4); and an order for physical therapy (#5). The findings are: 1. Review of Resident #1's current FL2 dated 08/26/21 revealed: -Diagnoses included schizoaffective disorder, moderate intellectual disability, and type 2 diabetes. -She was incontinent of bladder and bowel. -She was constantly disoriented. a. Review of Resident #1's physician order dated 06/06/22 revealed: -There was an order for a urinalysis (UA), a urine specimen obtained to test for the presence of a urinary tract infection.	{D 273}		

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{D 273}	Continued From page 44 -There was a handwritten note on the bottom of the order form that the UA had been collected on 06/07/22. Review of Resident #1's record revealed there was no UA result from the specimen collected on 06/07/22. Review of Resident #1's Emergency Medical Services (EMS) transfer report dated 06/17/22 revealed she had been transferred to the Emergency Department (ED) due to altered mental status (AMS) with weakness. Review of Resident #1's ED After Visit Summary dated 06/17/22 revealed: -She was diagnosed with a urinary tract infection (UTI). -She had been prescribed Bactrim DS 800-160mg (an antibiotic used to treat various infections) take one tablet two times daily for 7 days. Review of Resident #1's Progress Notes revealed: -On 06/07/22, the facility's previous Special Care Unit Coordinator (SCUC) documented that Resident #1's UA had been collected and the lab was called to pick it up from the facility. -On 06/09/22, a medication aide (MA) documented that Resident #1 had been upset all day and not allowing staff to help her with her care and that she was yelling out. -On 06/11/22, the facility's Administrator documented that Resident #1 had been hollering and screaming since the start of the shift; she had to be removed from her room because her roommates were unable to sleep with her yelling. Once in a private room Resident #1 was refusing assistance from staff and hitting, cursing and	{D 273}		

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screaming at staff to go away and threatening to harm them.
-On 06/13/22, the previous SCUC documented that Resident #1 was yelling in the hallways.
-On 06/14/22, a MA documented that Resident #1 was showing aggressive behaviors towards staff and her roommates.
-On 06/15/22, a MA documented that Resident #1 was aggravated during shift change, was yelling in the hallway but was able to be redirected.
-On 06/17/22 at 9:37am, a MA documented that Resident #1 was screaming and acting out, hitting her legs and arms on her wheelchair and not allowing staff to help her; she was sent to the hospital due to her behaviors and to protect her along with the other residents.
-On 06/17/22 at 6:43pm, a MA documented that she received a call from a nurse at the hospital who reported Resident #1 would be discharged that day and that she was being treated for a "raging UTI." She had received fluids and an antibiotic through an intravenous catheter (IV).

Interview with the SCUC on 08/04/22 at 10:00am revealed:
-She had not been employed at the facility on 06/06/22, but started working as a medication aide (MA) at the facility through an agency shortly thereafter.
-She knew that Resident #1 was a difficult resident to collect urine specimens from due to her dementia and her behaviors.
-When the PCP ordered UAs for residents, the order first went to the SCUC, then the SCUC was responsible for notifying the MA that a UA needed to be collected.
-Urine specimens were collected by placing a collection device into the toilet.
-Once collected, urine specimens were placed in the designated refrigerator until the laboratory

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{D 273}	Continued From page 46	{D 273}		

staff came to pick them up.
-If the previous SCUC had documented that the specimen was collected and awaiting pick-up from the laboratory staff, she did not know why there was no result for the UA.

Telephone interview with a representative from the facility's contracted laboratory on 08/04/22 at 12:50pm revealed they had not received a call to collect a UA specimen for Resident #1 in June 2022, and they did not have any UA results for Resident #1.

Telephone interview with a representative from a second laboratory on 08/04/22 at 1:00pm revealed they had not received a call to collect a UA specimen for Resident #1 in June 2022, and they did not have any UA results for Resident #1.

Interview with the Administrator on 08/04/22 at 3:00pm revealed:
-She was not aware that Resident #1 never had a UA obtained when it was ordered in June 2022.
-When the primary care provider (PCP) wrote an order to collect a UA, the SCUC was responsible for telling the MA on duty to obtain the specimen by placing a collection hat into the resident's toilet.
-Once the UA was collected, the MA or SCUC would label the specimen, place it in the designated refrigerator, and call the laboratory to come and pick up the specimen.
-The SCUC was responsible for following up on UA orders and ensuring they were collected and received by the laboratory.
-Once a UA result was available, the medical records staff would print the result and place a copy in the PCP's folder for review.

Telephone interview with Resident #1's guardian

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{D 273}	Continued From page 47 on 08/04/22 at 5:30pm revealed: -Resident #1 started having behaviors in early June 2022 so she had suggested to the staff that they test her for a UTI. -She never received a phone call about the UA result; the next communication she had received from the facility was to let her know that Resident #1 had went to the ED and was diagnosed with a UTI. Telephone interview with Resident #1's PCP on 08/05/22 at 9:00am revealed: -On 06/06/22, there was a telephone encounter between Resident #1's previous PCP and the facility's staff. -The facility staff were reporting that Resident #1 was having an increase in behaviors for the past week, her urine had a strong odor, and they were requesting an order for a UA. -The previous PCP ordered a UA for Resident #1, but there was no result available to review from that order. -It was the PCP's expectation that if an order for a UA was given, the facility collect the UA, send the specimen to the lab for testing, and follow up on the result so that treatment could be started if indicated. Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable. b. Review of Resident #1's physician order dated 07/25/22 revealed there was an order to obtain urine and send for urinalysis (UA) to rule out urinary tract infection (UTI) secondary to delirium and agitation. Review of Resident #1's record revealed: -There was no UA result from the order written on	{D 273}		

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07/25/22.
-There was no documentation regarding the UA order written 07/25/22.

Interview with the Special Care Unit Coordinator (SCUC) on 08/04/22 at 10:00am revealed:
-She had not been the SCUC on 07/25/22 when Resident #1's UA order was written.
-She knew that Resident #1 was a difficult resident to collect urine specimens from due to her dementia and her behaviors.
-If the MA was not able to collect a UA from Resident #1 they were supposed to document that in the Progress Notes and notify the primary care provider (PCP).
-When the PCP ordered UAs for residents, the order first went to the SCUC, then the SCUC was responsible for notifying the MA that a UA needed to be collected.
-Urine specimens were collected by placing a collection device into the toilet.
-Once collected, urine specimens were placed in the designated refrigerator until the laboratory staff came to pick them up.

Telephone interview with a representative at the facility's contracted laboratory on 08/04/22 at 12:50pm revealed they had not received a call to collect a UA specimen for Resident #1 in July 2022, and they did not have any UA results for Resident #1.

Telephone interview with a second laboratory on 08/04/22 at 1:00pm revealed they had not received a call to collect a UA specimen for Resident #1 in July 2022, and they did not have any UA results for Resident #1.

Interview with the Administrator on 08/04/22 at 3:00pm revealed:

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{D 273}	Continued From page 49 -She was not aware that Resident #1 never had a UA obtained when it was ordered on 07/25/22. -When the PCP wrote an order to collect a UA, the SCUC was responsible for telling the MA on duty to obtain the specimen by placing a collection hat into the resident's toilet. -Once the UA was collected, the MA or SCUC would label the specimen, place it in the designated refrigerator, and call the laboratory to come and pick up the specimen. -The SCUC was responsible for following up on UA orders and ensuring they were collected and received by the laboratory. -Once a UA result was available, the medical records staff would print the result and place a copy in the PCP's folder for review. -If an MA was not able to collect a UA on Resident #1, they were responsible for documenting that information in the Progress Notes and notifying the PCP. Interview with a MA on 08/04/22 at 4:00pm revealed: -She remembered Resident #1 having an order for a UA at the end of July 2022, but thought it had been collected on the day shift prior to her coming in, so she did not collect another one. -She did not remember Resident #1 having any increase in symptoms or behaviors at the time the UA was ordered on 07/25/22, because Resident #1 often had behaviors due to her dementia. -If a UA was ordered on her shift or needed to be collected on her shift, the SCUC would tell her. -If she was responsible for collecting a UA for Resident #1, she would put the collection hat into her toilet and place the specimen into a specimen cup labeled for Resident #1. -She did not know what she would do with the specimen once collected, because she had never	{D 273}		

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collected a UA for a resident before.

Telephone interview with Resident #1's PCP on 08/05/22 at 9:00am revealed:
-She had ordered the UA for Resident #1 on 07/25/22 because she had been having increased agitation that day.
-She had never received a result from the UA she ordered for Resident #1.
-She had not received an update from the facility stating they were not able to collect the UA for Resident #1.
-It was her expectation that if an order for a UA was given, the facility collect the UA, send the specimen to the lab for testing, and follow up on the result so that treatment could be started if indicated.

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

c. Review of Resident #1's physician order dated 06/07/22 revealed there was an order for physical therapy (PT) evaluation and treatment secondary to decline in mobility and balance.

Review of Resident #1's record revealed there were no PT notes regarding the evaluation and treatment order from 06/07/22.

Telephone interview with the facility's contracted physical therapist on 08/04/22 at 11:15am revealed he had not received a referral to evaluate Resident #1 and had not been providing PT treatment for Resident #1.

Interview with the Special Care Unit Coordinator (SCUC) on 08/04/22 at 12:30pm revealed:
-She had just found that day, 08/04/22, the hard

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copy of the PT order for Resident #1 from 06/07/22 and saw that it had been faxed to the pharmacy rather than the PT office.
-Resident #1 was able to stand, pivot, and transfer, but needed assistance.
-Some days, Resident #1 was able to stand and transfer without difficulty, but some days she was unsteady, and it took a lot of coaching to get her to stand and pivot to complete the transfer.
-Resident #1 did not have a history of frequent falls; she did have a fall on 07/23/22 but it was witnessed, and Resident #1 had sat on the floor with staff present.
-The SCUC who had been employed on 06/07/22 would have been responsible for faxing the order to the PT office, then once faxed if the facility did not receive a phone call within 48-72 hours, the previous SCUC would have been responsible for calling the PT office to ensure they received the order.
-Once an order was faxed, the SCUC was responsible for waiting for the confirmation receipt, stapling it to the original order, and placing it in the 48-hour folder for follow-up.

Interview with the Administrator on 08/04/22 at 3:00pm revealed:
-She was not aware that Resident #1 had a PT referral that had not been followed-up on.
-Resident #1 used to be able to walk but needed a lot of cues, and could benefit from PT.
-Resident #1 used a walker to assist in her transfers but preferred her wheelchair.
-Once the order for PT was written, it would have been given to the SCUC; the SCUC would have been responsible for faxing the order to the PT office then placing a copy in the 48-hour folder to ensure follow-up was completed.

Telephone interview with Resident #1's guardian

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{D 273}	Continued From page 52 on 08/04/22 at 5:30pm revealed: -She did not remember an order for PT being written for Resident #1 in June 2022. -Resident #1 had a decrease in her mobility but it seemed due to her cataracts making her hesitant to stand up because she could not see well. -She did not want Resident #1 just sitting in her wheelchair all day when she was physically capable of walking. -Resident #1 did not have falls, but needed help with strengthening and balance. -She would like Resident #1 to have PT treatment to assist with strengthening and balance. Telephone interview with Resident #1's PCP on 08/05/22 at 9:00am revealed: -Resident #1's previous PCP had written the order for PT evaluation and treatment. -She knew Resident #1 was disoriented a lot due to her dementia. -Resident #1 could stand and pivot but she was not able to walk. -Seeing PT would benefit Resident #1 because it would help strengthen her muscles which would make transferring easier. Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable. 2. Review of Resident #4's FL2 dated 05/25/22 revealed: -Diagnoses included dementia with psychosis, hypoglycemia, vitamin D deficiency, schizophrenia, and insomnia. -Resident #4 was semi-ambulatory and used a walker. a. Review of Resident #4's physician's order dated 05/25/22 revealed an order for a rollator	{D 273}		

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{D 273}	Continued From page 53 walker. Observations of the Special Care Unit (SCU) on 08/03/22 between 11:35am and 12:00pm revealed: -Resident #4 was propelling in the hallway in a wheelchair. -Resident #4 had a two wheeled walker in his room, but there was no rollator walker. Interview with Resident #4 on 08/03/22 at 11:56pm revealed: -He had a walker with 2 wheels, but he had never had a rollator walker. -He did not use the two wheeled walker as much now, but he did use it when he ambulated to the bathroom and when he participated in physical therapy. Interview with the facility's contracted registered nurse (RN) on 08/03/22 at 4:35pm revealed: -Resident #4 had a fall in the SCU courtyard on 06/07/22. -He had his two wheeled walker with him when he fell. -Resident #4 did not have a rollator walker and she did not know if the facility had ordered a rollator for him. Interview with a medication aide (MA) on 08/03/22 at 12:06pm revealed: -Resident #4 was a high fall risk with his last fall being on 08/01/22. -Resident #4 did not have an order for a rollator walker to her knowledge. -Staff currently assisted Resident #4 with showers and with toileting. Interview with the Special Care Unit Coordinator (SCUC) on 08/04/22 at 12:23pm revealed:	{D 273}		

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{D 273}	Continued From page 54 -She had worked in the role of SCUC since 08/01/22 -The SCUC was responsible for reviewing orders and for ordering medical equipment for residents. -She was not aware of any orders for a rollator walker for Resident #4. Interview with Resident #4's primary care provider (PCP) on 08/01/22 at 3:27pm revealed: -She saw Resident #4 for the first time in July 2022. -She reviewed a note from the previous provider documenting there was a face to face visit on 05/25/22 due to falls. -The previous provider ordered a rollator walker due to Resident #4 having abnormal gait. -She did not know the rollator had not been ordered for Resident #4. -She would have expected the facility to contact a durable medical equipment provider to order the rollator once the order for the rollator was written. Interview with the Administrator on 08/04/22 at 2:08pm revealed: -Rollators were not covered by insurance. -Resident #4's family should have been contacted to inform of the order for a rollator and requested to cover the cost of the rollator. -She did not know if Resident #4's family had been contacted regarding the order for the rollator. -The SCUC was responsible for contacting Resident #4's family. Attempted telephone interview with Resident #4's responsible party on 08/04/22 at 9:40am was unsuccessful. b. Review of Resident #4's physician's order dated 06/15/22 revealed an order for a	{D 273}		

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{D 273}	Continued From page 55 wheelchair appropriate for his weight. Review of Resident #4's progress note dated 07/09/22 revealed: -Resident #4 asked if his PCP could write an order for him to have a wheelchair. -Resident #4 stated his legs did not work like they used to and he really needed a wheelchair. Observations of the Special Care Unit (SCU) on 08/03/22 between 11:35am and 12:00pm revealed: -Resident #4 was propelling in the hallway in a wheelchair. -The wheelchair had a label attached to it and another resident's name was on the label. -The back of Resident #4's calves were 1.5 feet away from the front edge of the wheelchair seat and his legs were slightly above a parallel level to the floor. -There was not another wheelchair in his room. Interview with Resident #4 on 08/03/22 at 11:56pm revealed: -He never had a wheelchair of his own, but he had been using a wheelchair provided by the facility for about 3 months. -He requested a wheelchair about a month ago and was told the physician did not approve for him to get a wheelchair. -He was 6 feet tall. Interview with the facility's contracted registered nurse (RN) on 08/03/22 at 4:35pm revealed: -Resident #4 needed a wheelchair conducive to his height. -There should be about 2 inches between the front edge of the seat and the back of the legs. -There was more than 2 inches between the front edge of the seat and the back of Resident #4's	{D 273}		

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{D 273}	Continued From page 56	{D 273}		

legs in the wheelchair he was currently using.
-She did not know if the facility had ordered a new wheelchair for Resident #4.

Interview with Resident #4's physical therapist on 08/04/22 at 11:08am revealed he definitely recommended Resident #4 have a new wheelchair with a cushion.

Interview with a medication aide (MA) on 08/03/22 at 12:06pm revealed:
-Resident #4 was a high fall risk with his last fall being on 08/01/22.
-Resident #4 did not have an order for a wheelchair to her knowledge.
-After a fall in July 2022, Resident #4 began having more difficulty with ambulation and started using a wheelchair.
-The wheelchair was donated to the facility by the family of a resident who had passed away.
-The Special Care Unit Coordinator (SCUC) and the Administrator were responsible for following up with orders for medical equipment.

Interview with the SCUC on 08/04/22 at 12:23pm revealed:
-She had worked in the role of SCUC since 08/01/22
-The SCUC was responsible for reviewing orders and for ordering medical equipment for residents.
-She was not aware of any orders for a wheelchair for Resident #4.

Interview with Resident #4's primary care provider (PCP) on 08/01/22 at 3:27pm revealed:
-She saw Resident #4 for the first time in July 2022.
-Resident #4 had an x-ray of his left hip on 06/10/22 due to complaints of pain after he fell on 06/07/22.

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{D 273}	Continued From page 57 -The x-ray resulted in the absence of any fractures. -She reviewed a note from the previous provider documenting there was a face to face visit with Resident #4 on 06/15/22. -On the 06/15/22 visit, Resident #4 continued to complain of hip pain and the previous provider ordered Resident #4 a wheelchair; She did not know the facility had not ordered the rollator for Resident #4. -Facility staff advised Resident #4 was tall and did not fit the chair he was using that did not belong to him. -She would have expected the facility to contact a durable medical equipment (DME) provider to order a wheelchair for Resident #4 once the order was written. Interview with the Administrator on 08/04/22 at 2:08pm revealed: -The SCUC was responsible for contacting the DME provider to order the wheelchair for Resident #4. -She did not know if a wheelchair had been ordered for Resident #4. c. Review of Resident #4's physical therapy notes dated 05/05/22 revealed: -The physical therapist discussed with the medication aide (MA) and the Special Care Unit Coordinator (SCUC) to have Resident #4's primary care provider (PCP) to refer him to a neurologist to confirm or rule out Parkinson's disease. -Resident #4 presented with a shuffling gait pattern increasing his risk of falls. Interview with the business office manager (BOM) on 08/03/22 at 4:50pm revealed: -She was responsible for making appointments	{D 273}		

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{D 273}	Continued From page 58	{D 273}		

with outside providers and for scheduling transportation.
-All scheduled appointments were documented in the facility's appointment book.
-She had not seen a referral for Resident #4 to see a neurologist and did not have any scheduled appointments for him to see a neurologist.

Interview with the SCUC on 08/04/22 at 12:23pm revealed:
-The SCUC was responsible for reviewing therapist notes and following up with any orders or recommendations.
-She had worked in the role of SCUC since 08/01/22.
-She did not know about the recommendation from the physical therapist to obtain a referral from Resident #4's PCP to see a neurologist to confirm or rule out Parkinson's disease.
-The previous SCUC would have been responsible for following up with Resident #4's PCP and the physicial therapist.

Interview with a representative from Resident #4's home health provider on 08/04/22 at 11:08am revealed:
-He saw Resident #4 for physical therapy and made the recommendation on 05/05/22 for facility staff to obtain a referral from Resident #4's PCP to see a neurologist.
-At that time, Resident #4 was so weak that he could not transfer or walk.
-Resident #4 was back at baseline now, but he continued to have Parkinsonisms (a term used to describe the collection of signs and symptoms found in Parkinson's disease) including shuffling and decreased gait.
-A consult with a neurologist would determine whether Resident #4's symptoms were medication related or neurological.

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{D 273}	Continued From page 59 Interview with Resident #4's PCP on 08/03/22 at 3:27pm revealed: -She saw Resident #4 for the first time in July 2022. -There was no documentation from the provider's communication system that documented the facility contacted the previous provider for a referral for Resident #4 to see a neurologist. -She did not see an order from the previous provider for Resident #4 to see a neurologist. -The previous provider had been treating numbness in Resident #4's feet and the tingling sensation wass still present in his feet. -She expected the facility to reach out to the previous provider for an order for Resident #4 to see a neurologist since it was recommended by the physical therapist. Interview with the Administrator on 08/04/22 at 2:08pm revealed: -She did not know about the recommendation from Resident #4's physical therapist to get a referral from her PCP to see a neurologist. -The home health providers usually spoke to the SCUC after seeing residents to give updates. -She expected the SCUC to follow up with Resident #4's PCP and the BOM to obtain a referral for Resident #4 to see a neurologist and to schedule the appointment. 3. Review of Resident #5's current FL2 dated 03/16/22 revealed diagnoses included major depressive disorder, arthritis, metabolic encephalopathy, cellulitis of left lower extremity, acute cystitis without hematuria, and hyperkalemia. Review of Resident #5's physician's order dated 07/25/22 revealed:	{D 273}		

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{D 273}	Continued From page 60 -There was an order for a physical therapy (PT)/occupational therapy (OT) evaluation with ambulation/walker and to check her right lower extremity strength. -There was documentation the order was faxed on 07/27/22 at 2:00pm, but there was no documentation where the order was faxed to. Review of Resident #5's progress notes for July 2022 revealed there was no documentation of a PT/OT order dated 07/25/22 and no documentation the order was sent to a home health agency for evaluation of services. Review of the facility's home health notebook revealed no documentation of PT services for Resident #5. Interview with the Special Care Unit Coordinator (SCUC) on 08/03/22 at 4:20pm revealed: -Home health referrals were documented by the SCUC and forwarded to the business office to schedule services with the home health provider. -If there was an urgent need, the SCUC would schedule services with the home health provider. Interview with the SCUC on 08/04/22 at 12:29pm revealed: -The order for a PT/OT evaluation dated 07/25/22 was accidentally faxed to the pharmacy on 07/27/22. -She did not know if anyone followed up to see if the order for a PT/OT evaluation had been processed. Interview with a representative form Resident #4's home health provider on 08/05/22 at 8:34am revealed: -Resident #5 was currently receiving occupational therapy and received physical therapy from	{D 273}		

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{D 273}	Continued From page 61 02/11/22 through 04/08/22. -There had been no other orders received for PT services for Resident #5 until yesterday, 08/04/22. -The order received on 08/04/22 was for PT/OT and was dated 07/25/22. Interview with Resident #5's primary care provider (PCP) on 08/05/22 at 8:50am revealed: -She had not been notified Resident #5 had a fall on 07/23/22, however she did become aware of her fall when she visited her on 07/25/22. -When she saw Resident #5 on 07/25/22, she observed Resident #5 had right side weakness and her right leg did not move like she wanted it to, so she ordered physical therapy and occupational therapy for Resident #5. -She expected the facility to follow up with the referral for PT/OT as soon as possible. Interview with the Administrator on 08/04/22 at 2:08pm revealed: -The SCUC was responsible for following up with orders for physical therapy/occupational therapy. -The order for PT/OT should have been followed up on once received. _____ The facility failed to ensure health care referral and follow-up related to a resident, who had orders for two urinalysis tests due to changes in behavior that were not obtained resulting in the resident having an emergency room visit and a diagnosis of a urinary tract infection, and an order for physical therapy due to a decline in mobility and balance which had not been referred to the home health agency (#1); a resident who was a high fall risk, had abnormal gait, and an order for a rollator walker and a wheelchair but did not receive the walker or wheelchair resulting in a fall with hip pain, and a recommendation from the	{D 273}		

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{D 273}	Continued From page 62 physical therapist to see a neurologist to rule out or confirm Parkinson's disease due to the resident's shuffling gait pattern which increased his risk for falls and the referral was not obtained from his primary care provider (#4); and a resident, who had right side weakness and restricted movement in her left leg, and an order for physical therapy that was not referred to the home health agency. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a continuing Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/04/22 for this violation.	{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. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a magic cup was served as ordered for 1 of 1 sampled resident with orders for a nutritional supplement (Resident #5). The findings are:	D 310		

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D 310	Continued From page 63 Review of Resident #5's current FL2 dated 06/16/22 revealed: -Diagnoses included major depressive disorder, arthritis, metabolic encephalopathy, ulcer to left lower extremity, breakdown of the skin, and cellulitis of the left lower extremity. -There was an order for a magic cup on the lunch meal tray daily. Review of Resident #5's electronic Medication Administration Record (eMAR) for May 2022 revealed: -There was an entry for magic cup on the lunch meal tray daily and scheduled for 12:00pm. -There was documentation a magic cup was provided for 30 of 31 opportunities in May 2022. Review of Resident #5's eMAR for June 2022 revealed: -There was an entry for magic cup on the lunch meal tray daily and scheduled for 12:00pm. -There was documentation a magic cup was provided for 31 of 31 opportunities in June 2022. Review of Resident #5's eMAR for July 2022 revealed: -There was an entry for magic cup on the lunch meal tray daily and scheduled for 12:00pm. -There was documentation a magic cup was provided for 29 of 31 opportunities in July 2022. Review of Resident #5's eMAR for 08/01/22 through 08/04/22 revealed: -There was an entry for magic cup on the lunch meal tray daily and scheduled for 12:00pm. -There was documentation a magic cup was provided for 2 of 4 opportunities in between 08/01/22 and 08/04/22.	D 310		

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D 310	Continued From page 64 Observation of the lunch meal service in the Special Care Unit (SCU) on 08/04/22 between 12:00pm and 12:34pm revealed: Interview with Resident #5 on 08/04/22 at 12:34pm revealed: -She did not know if she was supposed to get a magic cup with her lunch meal daily. -She did not get a magic cup with her lunch meal today and had not been served a magic cup previously. Observation of the kitchen freezer on 08/04/22 at 1:43pm revealed: -There was a box of 4-ounce magic cups in a box in the freezer. -There were 48 magic cups in the box and 20 magic cups were remaining. Interview with a dietary aide on 08/04/22 at 1:44pm revealed: -The dietary staff was responsible for ordering magic cups for residents. -The dietary staff placed magic cups on the lunch meal trays for residents who had orders for magic cups with their meals or on the cart for residents who were supposed to have magic cups between meals. -The medication aides (MA) and personal care aides (PCA) did get the magic cups from the freezer for residents. -There was only 1 resident in the SCU who had orders for magic cups, and she received a magic cup with her breakfast and supper meal tray. -She did not know Resident #5 had an order for magic cups with her lunch meal tray. -No one let the dietary staff know Resident #5 was supposed to receive magic cups and magic cups had never been placed on Resident #5's meal tray.	D 310		

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-The Special Care Unit Coordinator (SCUC) was supposed to let the dietary staff know when a resident was to be served a magic cup.

Telephone interview with a MA on 08/05/22 at 10:09am revealed:
-She thought Resident #5's magic cup was on her lunch meal tray daily.
-If she documented Resident #5's magic cup was given and it wasn't on her lunch meal tray, then she went to the kitchen to get a magic cup for her.

Interview with the SCUC on 08/05/22 at 10:22am revealed:
-She knew Resident #5 had an order for a magic cup with her lunch meal tray daily.
-She worked at the facility in a different capacity prior to becoming SCUC on 08/01/22, and she had asked about magic cups for Resident #5.
-She was told by dietary staff that a nutritional supplement was a sufficient replacement for a magic cup when Resident #5 did not have a magic cup on her tray.
-She should have gotten clarification earlier, but she got clarification from the Administrator on yesterday, 08/04/22 that Resident #5 should have received magic cups instead of nutritional supplements on the lunch meal tray daily.
-The MAs must have assumed without checking to see that a magic cup was on the lunch meal tray when they documented the magic cup was given.
-It was the MAs responsibility to make sure the magic cup was on the lunch meal tray, document, and to follow up with the kitchen if the magic cup was not on the tray.

Telephone interview with the facility contracted pharmacy on 08/05/22 at 10:37am revealed:

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SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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 310	Continued From page 66 -There was an order for a magic cup on the lunch tray daily. -The facility was responsible for ordering the magic cups through their dietary supplier. -The pharmacy could supply the facility with magic cups for Resident #5 if the facility requested them to. Telephone interview with Resident #5's primary care provider (PCP) on 08/05/22 at 8:50am revealed: -Resident #5 had an order in place for 1 magic cup daily with the lunch meal tray prior to her becoming her PCP in July 2022. -She did not know why Resident #5 had orders for a magic cup daily. -She expected staff to serve Resident #5 a magic cup daily with her lunch meal as ordered. Interview with the Administrator on 08/04/22 at 2:08pm revealed: -She did not know Resident #5 was not being served a magic cup daily with her meal tray as ordered. -She previously informed MAs to inform the SCUC or her if a medication or order on the MAR was not in the facility. -She would have expected the MAs to follow up with kitchen to ask why Resident #4 was not receiving a magic cup on her lunch meal tray.	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:	{D 358}		

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{D 358}	Continued From page 67 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medication as ordered for 3 of 6 sampled residents (#1, #3 and #6) who had orders for an anti-anxiety medication (#1), a vitamin and mineral supplement (#6), and a stool softener (#3). The findings are: 1. Review of Resident #6's current FL2 dated 06/29/22 revealed: -Diagnoses included vascular dementia, muscle weakness, hyperlipidemia, and type 2 diabetes. -There was an order for Cerovite Senior (a multiple vitamin and mineral supplement), 1 tablet daily. Review of Resident #6's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Cerovite Senior tablets take 1 tablet once daily scheduled at 9:00am. -There was documentation that Cerovite Senior tablet was administered daily from 07/01/22 through 07/31/22. Review of Resident #6's August 2022 eMAR on 08/03/22 revealed: -There was an entry for Cerovite Senior tablets take 1 tablet once daily scheduled at 9:00am. -There was documentation that Cerovite Senior tablet was administered daily from 08/01/22 through 08/03/22.	{D 358}		

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{D 358}	Continued From page 68 Observation of the medication pass for Resident #6 on 08/03/22 at 9:00am revealed: -The medication aide (MA) prepared four oral medications for Resident #6 and Cerovite Senior was not included with the other oral medications. -The MA documented Cerovite Senior as administered at 9:00am on 08/03/22. Observation of Resident #6's medications on hand on 08/04/22 at 12:00pm revealed there was a medication card for Resident #6 dispensed on 08/03/22 with 29 of 30 tablets remaining of Cerovite Senior tablets. Interview with a MA on 08/03/22 at 9:20am revealed: -She had clicked the wrong button on the eMAR documenting it as administered when she meant to document it as not administered. -Resident #6's Cerovite Senior supplement was on order from pharmacy. -The eMAR system was currently "offline" so she was not able to check when the medication refill had been requested from the pharmacy. -She was planning to send another refill request that day. -The MAs were supposed to reorder medications when the quantity reached the last row on the medication card, usually when there were 8 tablets remaining. -The MAs could request medication refills by clicking a refill button the eMAR. Telephone interview with a representative from the facility's contracted pharmacy on 08/03/22 at 2:45pm revealed: -Resident #6's Cerovite Senior tablets had last been dispensed on 06/20/22 for 30 tablets which was a 30-day supply.	{D 358}		

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{D 358}	Continued From page 69 -The pharmacy had not received another refill request until earlier that day on 08/03/22. -If the Cerovite had been administered daily starting on 06/21/22, the 30-day supply would have run out on 07/20/22. Interview with the Special Care Coordinator (SCUC) on 08/04/22 at 10:00am revealed: -Resident #6 had not been on any extended stays outside of the facility from June 2022 through July 2022, so there would not have been an extra supply of Cerovite tablets on hand. -She did not know why the MAs had been documenting the Cerovite tablets as administered daily for the last 45 days since 06/20/22 when they only had a 30-day supply. -It was possible the MAs who had documented the Cerovite as administered to Resident #6 from 07/21/22 through 08/02/22 and had the medication on hand if the missed doses occurred prior to 07/20/22. Interview with the Administrator on 08/04/22 at 3:00pm revealed: -She was not been aware that Resident #6 had not been receiving her Cerovite Senior tablets. -The MAs were supposed to send a refill request to the pharmacy once the quantity of tablets reached the shaded area on the medication card, usually when it was down to 8 doses. -If the medication refill was not available by the time the medication was due to be administered, the MA was responsible for calling the pharmacy to request the refill as soon as possible, and letting the SCUC know so that she could follow-up on the refill request. -When Resident #6 would have run out of Cerovite Senior tablets the SCUC in charge was someone different from who currently held the position of SCUC.	{D 358}		

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{D 358}	Continued From page 70 -She did not know if the previous SCUC had been notified of Resident #6's Cerovite needing to be refilled. -If a medication was not available during a medication pass, the MAs were supposed to document the medication as not administered, which would show up on the eMAR as the MA's initials with a circle around them. Telephone interview with Resident #6's primary care provider (PCP) on 08/05/22 at 9:00am revealed: -She was not aware that Resident #6 had missed doses of Cerovite Senior supplement. -The multivitamin had been ordered for Resident #6 by her previous PCP, but there was no specific indication for use documented. -Multivitamin and mineral tablets were sometimes prescribed for elderly patients, especially with dementia, to ensure they were getting the nutrients they needed. Telephone interview with a MA on 08/05/22 at 10:15am revealed: -She had documented Resident #6's Cerovite as administered on 07/30/22 and 07/31/22. -She did not remember Resident #6 being out of Cerovite. -She would not have documented the medication as administered if it had not been available. Attempted telephone interview on 08/04/22 at 11:00am with a MA who documented Resident #6's Cerovite as administered on 08/01/22 and 08/02/22 was unsuccessful. Based on observation and record review it was determined that Resident #6 was not interviewable.	{D 358}		

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{D 358}	Continued From page 71 2. Review of Resident #1's current FL2 dated 08/26/21 revealed: -Diagnoses included schizoaffective disorder and moderate intellectual disability. -She was constantly disoriented. Review of Resident #1's physician order dated 12/08/22 revealed there was an order for lorazepam (a controlled drug used to treat anxiety) 0.5mg, take one half tablet (0.25mg total) twice daily as needed (PRN) for anxiety. Review of Resident #1's physician order dated 06/08/22 revealed there was an order to increase the lorazepam PRN dose from 0.25mg twice daily PRN, to 0.5mg twice daily PRN. Review of Resident #1's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lorazepam 0.5mg, take one half tablet (0.25mg) twice daily PRN. -There was documentation that lorazepam 0.25mg PRN was administered 15 times from 06/01/22 through 06/30/22. -There was an entry for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily PRN, with a start date of 06/08/22 and a discontinue date of 06/08/22 and no documented administrations. Review of Resident #1's June 2022 CSCS revealed: -The CSCS was for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily, and one half tablet (0.25mg) twice daily PRN. -There was documentation that lorazepam 0.25mg PRN was administered 19 times from 06/07/22 when the PRN dose had increased to 0.5mg twice daily PRN, through 06/30/22.	{D 358}		

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Review of Resident #1's July 2022 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take one half tablet (0.25mg) twice daily PRN.
-There was documentation lorazepam 0.25mg PRN was administered 8 times from 07/01/22 through 07/31/22.
-There was an entry for lorazepam 0.5mg, take one tablet (0.5mg) twice daily PRN.
-There was documentation lorazepam 0.5mg PRN was administered three times from 07/01/22 through 07/31/22.

Review of Resident #1's July 2022 CSCS revealed:
-The CSCS was for lorazepam 0.5mg, take two half tablets twice daily, and one half tablet twice daily PRN.
-There was documentation lorazepam 0.25mg PRN was administered 12 times from 07/01/22 through 07/31/22.

Observation of medication on hand for Resident #1 on 08/03/22 at 3:40pm revealed:
-There was one medication card for lorazepam 0.5mg tablets take one tablet twice daily as needed.
-There was a dispensed date of 07/27/22 and dispensed quantity of 30 tablets.
-There were 12 tablets out of 30 tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 08/03/22 at 2:45pm revealed:
-They received an order to increase Resident #1's PRN lorazepam from 0.25mg twice daily PRN to 0.5mg twice daily PRN on 06/08/22.
-The facility still had half tablets on hand from the previous lorazepam order and from Resident #1's

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scheduled doses of lorazepam 0.5mg that they were going to use up prior to getting a refill from the pharmacy for the increased PRN dose.
-They last dispensed lorazepam 0.5mg for Resident #1 on 07/27/22 for the order to administer 0.5mg twice daily PRN; they dispensed 30 tablets.

Telephone interview with Resident #1's psychiatric primary care provider (PCP) on 08/04/22 at 10:45am revealed:
-Resident #1 had been having an increase in her behaviors, such as crying out and yelling, in early June 2022 so she had adjusted a couple of her medications including the PRN lorazepam.
-On 06/08/22 she increased Resident #1's lorazepam PRN dose from 0.25mg twice daily PRN to 0.5mg twice daily PRN.
-She expected when she wrote a new order for lorazepam for Resident #1, the facility would ensure the previous order was discontinued so that the medication aides (MA) understood what the current dose was.
-There would be no adverse effects to Resident #1 for receiving 0.25mg of lorazepam PRN instead of 0.5mg of lorazepam PRN aside from her anxiety and agitation behaviors not being as well controlled under the smaller dose.

Interview with the Special Care Unit Coordinator (SCUC) on 08/04/22 at 11:45am revealed:
-The previous SCUC who was working at the time of Resident #1's lorazepam PRN dose change was responsible for ensuring the current lorazepam dose was entered on the eMAR and the previous dose was discontinued.
-The pharmacy was able to add or remove medication orders from the eMAR but the facility needed to approve the changes, which did not happen.

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{D 358}	Continued From page 74 -The SCUC was responsible for completing eMAR audits which would include checking the eMAR for accurate orders compared to the physician orders in the resident record. -She had just started her role as SCUC within the last week, so she had not yet completed any eMAR audits. -She did not know when the previous SCUC had last completed an audit of Resident #1's eMAR. -The MAs were supposed to check every medication three times before administering it and should have reported to her that there were double entries for lorazepam on Resident #1's eMAR so that she could remove the incorrect entry. Interview with the Administrator on 08/04/22 at 3:00pm revealed: -She was not aware that Resident #1 had two entries on her eMAR for PRN lorazepam and that the MAs had been administering the 0.25mg dose instead of the 0.5mg dose in June and July 2022. -The SCUC was responsible for checking the eMARs for accuracy, but the SCUC who would have completed the last eMAR audit no longer worked there. -Once the MA administered lorazepam to Resident #1 and saw that there were two entries on the eMAR to document under, the MA should have reported it to the SCUC so that the incorrect dose entry could be removed. Interview with a MA on 08/04/22 at 4:00pm revealed: -She had documented administration of lorazepam 0.25mg PRN to Resident #1 three times in July 2022. -There were no entries on the eMAR to administer lorazepam 0.5mg PRN for Resident #1 so she administered the dose that was	{D 358}		

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ordered in the eMAR.
-She started administering 0.5mg of lorazepam PRN at the end of July 2022 once that order entry was added to the eMAR because she assumed the dose had increased due to Resident #1's behaviors.

Based on observations and record review, it was determined that Resident #1 was not interviewable.
3. Review Resident #3's current FL2 dated 03/09/22 revealed diagnoses included diabetes mellitus type II, osteoarthritis, hyperlipidemia, tardive dyskinesia, unsteady gait and depression.

Review of Resident #3's medication orders revealed there was an order dated 05/17/22 for senexon-S 50-8.6mg Monday, Wednesday and Friday at bedtime (used to treat constipation).

Review of Resident #3's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for senexon-S 8.6mg scheduled on Monday, Wednesday and Friday at 8:00pm.
-There was documentation senexon-S 50-8.6mg was administered every Monday, Wednesday and Friday at 8:00pm from 07/01/22 through 07/31/22.

Review of Resident #3's August 2022 eMAR revealed:
-There was an entry for senexon-S 8.6mg scheduled on Monday, Wednesday and Friday at 8:00pm.
-There was documentation senexon-S 50-8.6mg was administered every Monday, 08/01/22 at 8:00pm and Wednesday, 08/03/22 at 8:00pm.

Observation of Resident #3's medications on

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hand at the facility on 08/04/22 at 2:58pm revealed senexon-S 8.6mg was not available for administration.

Telephone interview with a pharmacist from the facility's contract pharmacy on 08/04/22 at 9:40am revealed:
-There was an order for senexon-S 8.6mg Monday, Wednesday and Friday.
-On 06/28/22, the pharmacy dispensed 12 tablets of senexon-S 8.6mg.
-Because Senexon-S was to be administered on Monday, Wednesday and Friday; the 12 tablets of senexon-S should have lasted the resident until 07/25/22, with the last administration being on Monday 07/25/22.
-Senexon-S was not automatically refilled, the facility had to call and request a refill.
-As of today's, date (08/04/22), no one at the facility had called to request a refill of Resident #3's senexon-S.

Interview with Resident #3 on 08/04/22 at 11:58am revealed:
-She did not know her medications.
-She did not know if senexon-S was administered.
-She had been a little nauseated lately, but she did not tell anyone because it was not bad.
-She had not experienced constipation or difficulty having a bowel movement.

Interview with the Resident Care Coordinator (RCC) on 08/04/22 at 12:06pm revealed:
-The facility medications were not automatically refilled.
-The medication aide (MA) who administered Resident #3's last dose of senexon-S should have reordered the medication using the eMAR system.

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{D 358}	Continued From page 77 -If the MA did not reorder the senexon-S, the MA working when the next time senexon-S was due should have reordered the medication. -The MA's were supposed checked the medication label with the eMAR before administering a medication to ensure the right medication and right dose was administered. -If the medication was available the MA was supposed to document on the eMAR the medication was administered. -If Resident #3's senexon-S was not administered the MA should not have documented the medication as administered on the eMAR. -The MA should have contacted the pharmacy to see why the medication was not in the building. -The MA should have also let her know the medication was not available. -The facility was doing weekly medication and eMAR audits to if identify medications were available. -The medication and eMAR audits had not been done within the past two weeks because the Administrator was in the process of updating the forms. Interview with the Administrator on 08/04/22 at 11:34am revealed: -The MA that administered the last senexon-S dose should have reordered the medication using the eMAR system. -If the system had went down when reordering the medication; when the system was back up the MA should have made a note and checked to see if the medication order went through. -The next time the medication was due for administration the MA should not have checked off that she administered the medication and it was not available. -The MA should have reported the medication was not available to the Administrator and RCC.	{D 358}		

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{D 358}	Continued From page 78 -When the MA attempted to administer the medication and it was not available, the MA should have reordered the medication. -There was no exceptional accuse why Resident #3's senexon-S was not administered for 4 administration dates and the MA signed the eMAR as if she administered the medication. -She expected medications to be available and to be administered as ordered. -The RCC was supposed to complete weekly medication cart audits and should have discovered senexon-S was not available. Interview with the MA that documented she administered Resident #3's last three doses of senexon-S on 08/04/22 at 10:15am revealed -On 07/25/22, She administered Resident #3's last dose of senexon-S. -She thought that she had reordered the medication using the eMAR system. -The system went down but she did not check to see if the order went through. -The eMAR system continually went down and sometimes did not reorder medications. -The next administration due date she documented that she administered the senexon-S, and was unable to explain why. -She thought that she called the pharmacy regarding the medication but was not sure. -She did not document that she called the pharmacy and she did not inform the Administrator and RCC the medication was not available. -She was unable to explain why she did not reorder the medication for the third time but documented she administered the medication. -She was aware the medication was not in the facility, and she aware that she should not signed the eMAR as if she administered the medication.	{D 358}		

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{D 358}	Continued From page 79 Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 08/04/22 at 12:26pm was unsuccessful.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to accurately document administration of medications on the electronic Medication Administration Record (eMAR) for 1 of 5 sampled residents (#1) who had an order for a scheduled anti-anxiety medication. The findings are:	D 367		

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D 367	Continued From page 80 Review of Resident #1's current FL2 dated 08/26/21 revealed: -Diagnoses included schizoaffective disorder and moderate intellectual disability. -She was constantly disoriented. Review of Resident #1's physician order dated 12/08/22 revealed there was an order for lorazepam 0.5mg, take two half tablets (0.5mg total) twice daily. Review of Resident #1's June 2022 eMAR revealed: -There was an entry for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily scheduled at 9:00am and 9:00pm. -There was documentation lorazepam 0.5mg was administered twice daily from 06/01/22 through 06/30/22 except for the 9:00pm dose on 06/17/22 with the documented reason being "out of the facility." Review of Resident #1's June 2022 Controlled Substance Count Sheet (CSCS) revealed: -The order was for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily and one half tablet (0.25mg) twice daily as needed (PRN). -There was documentation lorazepam 0.5mg was administered twice daily at 9:00am and 9:00pm from 06/01/22 through 06/30/22 except for the 9:00pm dose on 06/14/22 and 06/17/22. Review of Resident #1's July 2022 eMAR revealed: -There was an entry for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily scheduled at 9:00am and 9:00pm. -There was a second entry for lorazepam 0.5mg, take one full tablet (0.5mg) twice daily scheduled	D 367		

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at 8:00am and 8:00pm, with a start date of 07/26/22.
-There was documentation lorazepam 0.5mg was administered under both entries for the evening dose on 07/26/22, 07/27/22, 07/28/22, and 07/31/22.

Review of Resident #1's July 2022 CSCS revealed:
-The order was for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily and one half tablet (0.25mg) twice daily as needed.
-There was documentation that only one lorazepam 0.5mg dose was administered at 9:00pm on 07/26/22, 07/27/22, 07/28/22 and 07/31/22.

Review of Resident #1's August 2022 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily scheduled at 8:00am and 8:00pm.
-There was a second entry for lorazepam 0.5mg, take one full tablet (0.5mg) twice daily scheduled at 8:00am and 8:00pm.
-There was documentation lorazepam 0.5mg was administered under both entries for the 8:00pm dose on 08/01/22.

Review of Resident #1's August 2022 CSCS revealed there was documentation only one lorazepam 0.5mg dose was administered at 8:00pm on 08/01/22.

Observation of medication on hand for Resident #1 on 08/03/22 at 3:40pm revealed:
-There was one medication card for lorazepam 0.5mg tablets, take one tablet twice daily as needed.
-There was a dispensed date of 07/27/22 and

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dispensed quantity of 30 tablets.
-There were 12 tablets out of 30 tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 08/03/22 at 2:45pm revealed:
-They dispensed 180 one-half tablets of lorazepam 0.5mg for Resident #1 on 05/20/22 for an order to take two half tablets twice daily scheduled and one half tablet twice daily PRN.
-The MAs would have been using the same medication card to dispense both the scheduled doses and the PRN doses.
-They received an order to increase Resident #1's PRN lorazepam from 0.25mg twice daily PRN to 0.5mg twice daily PRN on 06/08/22.
-The facility still had half tablets available that they were going to use up prior to getting a refill from the pharmacy for the increased PRN dose.
-They last dispensed lorazepam 0.5mg for Resident #1 on 07/27/22 for the order to administer 0.5mg twice daily PRN; they dispensed 30 tablets.
-They had received a new refill request that day, 08/03/22, for Resident #1's lorazepam 0.5mg twice daily scheduled.

Telephone interview with Resident #1's mental health provider (MHP) on 08/04/22 at 10:45am revealed that she expected when she wrote a new order for lorazepam for Resident #1, the facility would ensure the previous order was discontinued so that the medication aides (MA) understood what the current dose was and could not erroneously document under the previous dose.

Interview with the Special Care Coordinator (SCUC) on 08/04/22 at 11:45am revealed:

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D 367	Continued From page 83 -The previous SCUC who was working at the time that Resident #1's second lorazepam entry was placed on the eMAR was responsible for ensuring the current lorazepam dose was entered on the eMAR and that there were no duplicate entries. -The pharmacy was able to add or remove medication orders from the eMAR but the facility needed to approve the changes. -The SCUC was responsible for completing eMAR audits which would include checking the eMAR for accurate orders compared to the physician orders in the resident record. -She had just started her role as SCUC within the last week, so she had not yet completed any eMAR audits. -She did not know when the previous SCUC had last completed an audit of Resident #1's eMAR. -The MAs were supposed to check every medication three times before administering it and should have reported to her that there were double entries for lorazepam on Resident #1's eMAR so that she could remove one of the entries. Interview with the Administrator on 08/04/22 at 3:00pm revealed: -She was not aware that Resident #1 had two entries on her eMAR for scheduled lorazepam. -The SCUC was responsible for checking the eMARs for accuracy, but the SCUC who would have completed the last eMAR audit no longer worked there. -Once the MA administered lorazepam 0.5mg to Resident #1 and saw that there were two entries on the eMAR to document under, the MA should have reported it to the SCUC so that the extra entry could be removed. Second interview with the SCUC on 08/04/22 at 3:50pm revealed:	D 367		

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D 367	Continued From page 84 -She had documented that she administered lorazepam 0.5mg to Resident #1 under both entries on the eMAR on 07/26/22 and 07/31/22. -She had not noticed there were two entries, she documented she administered one dose to Resident #1 and since the facility was having issues with their eMAR system she thought her documentation had not saved so she clicked the second entry and documented it again. -She did not administer two separate 0.5mg doses to Resident #1 on 07/26/22 or 07/31/22. Interview with a MA on 08/04/22 at 4:00pm revealed: -She had documented she administered lorazepam 0.5mg to Resident #1 under both entries on the eMAR for the 8:00pm dose on 07/27/22, 07/28/22, and 08/01/22. -She only administered one dose of lorazepam 0.5mg to Resident #1. -She would have noticed if she was administering a second dose erroneously because she would have seen her documentation on the CSCS. -She had not noticed there were two separate entries on the eMAR for Resident #1's scheduled lorazepam. Based on observations and record review, it was determined that Resident #1 was not interviewable.	D 367		
D 477	10A NCAC 13F .1409 Special Care Unit Orientation ANd Training 10A NCAC 13F .1409 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff	D 477		

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D 477	Continued From page 85 receive at least the following orientation and training: (1) Prior to establishing a special care unit for residents with a mental health disability, the administrator shall document receipt of at least 20 hours of training specific to the population by a qualified mental health professional, as defined in 10A NCAC 27G .0104(18), for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, direct care staff shall complete 20 hours of training specific to the population being served. (4) In addition to the training required in Rule .0501 of this Subchapter, direct care staff assigned to the unit shall complete at least 8 hours of continuing education annually that is specific to the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility had completed the six hours of orientation and training specific to the population served within the first week hire. The findings are: 1. Review of Staff A's personal care aide	D 477		

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(PCA)/medication aide (MA) personnel record revealed:
-Staff A's date of hire was 04/20/22.
- There was no documentation of special care unit (SCU) orientation in the first week of hire.

Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff A worked the SCU as needed.
-When Staff A was hired the business office manager (BOM) was still at the facility full-time.
-The business office was responsible to ensure Staff A completed SCU training.
-She was not sure who specifically provided the training but the BOM was responsible to make sure the training was done.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

2. Review of Staff B's personal care aide (PCA)/medication aide (MA) personnel record revealed:
-Staff B's date of hire was 06/14/22.
- There was no documentation of special care unit (SCU) orientation in the first week of hire.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm

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revealed:
-Staff B was crossed training to work in the assisted living and the SCU.
-Staff B mostly worked the third shift but she also assisted as needed with toileting, bathing, dressing, ambulation and transferring.
-She was not sure if SCU training had been provided for Staff B.
-The business office was responsible for ensuring all trainings were completed.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

3. Review of Staff D's personal care aide (PCA)/medication aide (MA) personnel record revealed:
-Staff D's date of hire was 06/14/22.
- There was no documentation of special care unit (SCU) orientation in the first week of hire.

Attempted telephone interview with Staff D on 08/05/22 at 2:56pm was unsuccessful.

Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:
-Staff D was crossed training to work in the assisted living and the SCU.
-Staff D had worked only in the SCU since she was hired at the facility.
-Staff D was responsible for medication administration, and assisted as needed with

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toileting, dressing, ambulation/transferring and feeding as needed.
-She was not sure if SCU training had been provided to Staff D.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.
4. Telephone interview with Staff E on 08/05/22 at 10:15am revealed:
-She started working at the facility as a MA through an agency in June 2022.
-She was offered a full-time position of Special Care Coordinator (SCUC) on 07/26/22 and started her role as SCUC on 08/01/22.
-She had completed SCU orientation prior to starting as SCUC on 08/01/22 but could not remember what day she had completed the training.
-The facility should have her training record on file.

Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm.

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

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Telephone interview with the corporate

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accountant on 08/05/22 at 3:00pm revealed:
-She was aware Special Care Unit (SCU) training was required within the first week of hire.
-In July 2022, she came to the facility to help the business office part-time.
-Two weeks ago, she started working on personnel records.
-She was not aware some employees had not received the required 6 hours of special care unit training.

Telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm revealed:
-The business office was responsible for making sure all trainings were completed.
-She left the business in May 2022 and she was not sure why some staff SCU training was not completed.
-She had observed the paperwork went through several hands and sometimes never made it to the business office.
-The SCU training was usually provided within the first week of orientation and should be in the personnel record.

Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed:
-The special care unit orientation and training was supposed to be completed during orientation, which was done the first week of hire.
-The business office was responsible for making sure all personnel records were complete.
-The previous BOM was responsible for making sure personnel records included the required trainings.
-The previous BOM left sometime in June 2022, but still helped the business office two to three days per week.
-She was not sure if the previous BOM would

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D 477	Continued From page 90 have still been responsible for making sure SCU orientation and training had been completed. -The corporate accountant started helping the business office out at the end of June 2022 or early July 2022. -She thought the required trainings and documents had not been completed due to the turnover in the business office.	D 477		
{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 observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to staff qualifications-North Carolina Health Care Personnel Registry and criminal background checks, personal care and supervision, health care and medication aide training and competency. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure 4 of 6 sampled staff (Staff A, B, D and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. [Refer to Tag 137, 10A NCAC 13F .0405(a)(5) Other Staff	{D912}		

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{D912}	Continued From page 91 Qualifications (Type B Violation)]. 2. Based on record reviews and interviews the facility failed to ensure 2 of 6 sampled staff (Staff A and Staff D) had a criminal background check completed upon hire. [Refer to Tag 139, 10A NCAC 13F .0405(a)(7) Other Staff Qualifications (Type B Violation)]. 3. Based on record reviews, observations, and interviews, the facility failed to provide supervision for 2 of 5 sampled residents (#4 and #5) related to a resident who had 2 falls within a week with 1 fall resulting in injuries (#5) and a resident who had a history of falls, sustained 3 falls with 1 fall resulting in pain and a decrease in ambulation (#4). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision(Type B Violation)]. 4. Based on observations, record reviews and interviews, the facility failed to ensure health care referral and follow up were completed for 3 of 5 sampled residents (#1, #4, and #5) who had orders for urinalyses and physical therapy (#1); orders for a rollator walker and a wheelchair, and a recommendation to obtain a referral to see a neurologist (#4); and an order for physical therapy (#5).[Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 5. Based on observations, interviews, and record reviews the facility failed to ensure 4 of 6 sampled staff (Staff A, Staff B, Staff D and Staff E) who administered medications had completed the medication aide training, including the 5, 10, or 15 hour medication aide training course, the medication clinical skills checklist, employee verification, and validation of successfully taking and passing the medication aide examination.	{D912}		

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	HAL034098	A. BUILDING: _____ B. WING _____	R 08/05/2022

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{D912}	Continued From page 92 [Refer to Tag 935, G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)].	{D912}		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration.	D935		

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D935	Continued From page 93 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure 4 of 6 sampled staff, who administered medications, had employee verification that they had worked as a medication aide during the previous 24 months (A, B, D and E); 1 of 6 sampled staff completed a medication clinical skills checklist prior to administering medications (B); and 3 of 6 sampled staff completed the 5, 10, or 15 hour medication aide training course (A, D and E). The findings are: 1. Review of Staff A's personal care aide (PCA)/medication aide (MA) personnel record revealed: -Staff A was hired on 04/20/22. -There was documentation Staff A had completed the medication clinical skills checklist on 04/15/22. -There was no documentation Staff A completed the 5, 10, or 15-hour medication aide training. -There was no documentation of an employee verification. -There was no documentation Staff A had taken or passed the medication aide examination.	D935		

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D935	Continued From page 94 Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful. Review of residents' June and July 2022 electronic medication administration records (eMARs) revealed: -There was documentation Staff A administered medications on 6 occasions from 06/01/22 through 06/30/22. -There was documentation Staff A administered medications on 7 occasions from 07/01/22 through 07/31/22. Refer to interview with the facility's nurse on 08/04/22 at 5:35pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm. Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm. 2. Review of Staff B's personal care aide/medication aide (PCA/MA) personnel record revealed: -Staff B was hired on 06/14/22. -There was documentation Staff B completed the 5, 10, or 15-hour medication aide training on 06/28/22. -There was no documentation Staff B completed the medication clinical skill checklist. -There was no documentation of an employee verification.	D935		

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D935	Continued From page 95 -There was no documentation Staff B had taken or passed the medication aide examination. Review of residents' July and August 2022 electronic medication administration records (eMARs) revealed: -There was documentation Staff B administered medications on 8 occasions from 07/01/22 through 07/31/22. -There was documentation Staff B administered medications on 3 occasions from 08/01/22 through 08/04/22. Telephone interview with Staff B on 08/05/22 at 2:41pm revealed: -She had worked at the facility since June 2022 (unable to recall the exact start date), but she thought she started working mid-June 2022. -When she worked, she mostly worked on the medication cart. -She administered medications to the residents. -She had her 15-hour medication aide training, but no other training had been provided since she began working at the facility. -The facility nurse verbally told her that she was going to provide additional training, but nothing had been provided. -She had taken and passed the medication aide examination prior to starting work at the facility. Refer to interview with the facility's nurse on 08/04/22 at 5:35pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm. Refer to telephone interview the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the corporate	D935		

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D935	Continued From page 96	D935		

accountant on 08/05/22 at 3:00pm.

Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm.

3. Review of Staff D's personal care aide/medication aide (PCA/MA) personnel record revealed:
-Staff D was hired on 06/14/22.
-There was documentation Staff D had completed the medication clinical skills checklist on 07/06/22.
-There was no documentation of employment verification for Staff D.
-There was no documentation of 5, 10 or 15-hour medication aide training and competency validation.
-There was no documentation Staff D had taken and passed the medication aide examination.

Review of residents July and August 2022 eMARs revealed:
-There was documentation Staff D administered medications on 13 occasions from 07/01/22 through 07/31/22.
-There was documentation Staff D administered medications on 4 occasions from 08/01/22 through 08/04/22.

Attempted telephone interview with Staff D on 08/05/22 at 2:56pm was unsuccessful.

Refer to interview with the facility's nurse on 08/04/22 at 5:35pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm.

Refer to telephone interview with the

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D935	Continued From page 97 Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm. 4. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E was hired on 07/26/22. -Staff E completed the Medication Administration Clinical Skills Validation Checklist on 07/28/22. -There was no documentation of completion of a 5, 10, or 15-hour MA training course or medication aide examination. -There was no documentation of employment verification for Staff E. Review of a resident's July and August 2022 electronic Medication Administration Records (eMARs) revealed: -From 07/01/22 through 07/31/22 Staff E documented the administration of medications on 15 days. -From 08/01/22 through 08/04/22 Staff E documented the administration of medications on 1 day. Telephone interview with Staff E on 08/05/22 at 10:15am revealed: -She started working at the facility as a MA through an agency in June 2022. -She was offered a full-time position of Special Care Unit Coordinator (SCUC) on 07/26/22 and started her role as SCUC on 08/01/22. -She had completed MA training and testing because she needed that for the agency she worked for prior to starting employment at the	D935		

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D935	Continued From page 98 facility, but she could not remember exactly when she had completed the training and her MA exam. -The facility should have her training record on file. Refer to interview with the facility's nurse on 08/04/22 at 5:35pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm. Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm. _____ Interview with the facility's nurse on 08/04/22 at 5:35pm revealed: -She had worked at the facility part-time for a little over one month. -She was still new and was not sure of the trainings that were required. -She had completed some medication clinical skills checklists but stopped when she ran out of the checklist forms. -She did not document the training and was not sure what staff had completed the training. -She had also provided 15-hour training for some MAs but not all the MAs. -She did not print the certificate for the 15-hour training, but she had the test results. -If the MA did not have a 15-hour training test result, then she had not provided the training. -To her knowledge she was not responsible for obtaining proof the MA had taken and passed the	D935		

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D935	Continued From page 99 medication aide examination. Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed: -When MAs were hired, the training provided consisted of starting them out on the first shift, working with another MA for training. -The nurse was supposed to check the MA off before they started training on the medication cart. -The MA was verbally asked to submit any previous medication aide training, including verification of taking and passing the medication aide examination. -The business office was responsible for ensuring MAs hired had certification as a medication aide. -The business office had been without a full-time business office manager (BOM) since late May 2022 or early June 2022. -She did not know who was responsible for obtaining required documents without a BOM. Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed: -The business office was responsible for making sure all personnel records were complete. -The previous BOM was responsible for making sure personnel records included the required trainings. -The previous BOM left sometime in June 2022, but still helped the business office two to three days per week. -The corporate accountant started helping the business office out at the end of June 2022 or early July 2022. -The facility's nurse was supposed to provide training to the MAs, but she had only worked at the facility for a little over one month. -She thought the required trainings and	D935		

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D935	Continued From page 100 documents had not been completed due to the turnover in the business office. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -The previous BOM left in June 2022 but continued to help the facility out part-time to get paperwork completed. -She started working at the facility in July 2022 trying to help with the paperwork. -Two weeks ago, she started working on personnel records. Telephone interview with the previous BOM on 08/05/22 at 3:09pm revealed: -She left the facility as the BOM at the end of May 2022. -The paperwork initially went to the corporate office, and then came to the business office. -When she was the BOM she noticed the paperwork went through several different hands, and sometimes never made it to her. -Obtaining the MA training was not her responsibility, but she had to make sure the paperwork was available in the record. _____ The facility failed to ensure four staff who worked as MAs and administered medications to residents had completed the medication aide training and competency evaluation before administering medications including the 5, 10, or 15 hour medication aide training course (A, D and E); the clinical skills checklist (B); and had proof of prior employment verification during the previous 24 months (A, B, D and E) resulting in possible medication errors. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____	D935		

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D935	Continued From page 101 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/05/22 for this violation. Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2022.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled	D992		

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D992	Continued From page 102 substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 2 of 6 sampled staff (Staff A and Staff E) prior to hire. The findings are: 1. Review of Staff A's, personal care aide (PCA)/medication aide (MA) personnel record revealed: -Staff A was hired on 04/20/22. -There was no documentation Staff A completed a drug screening. Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm. Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. 4. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E was hired on 07/26/22.	D992		

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D992	Continued From page 103 -There was no drug screen completed upon hire available for review in her personnel record. Telephone interview with Staff E on 08/05/22 at 10:15am revealed: -She started working at the facility as a MA through an agency in June 2022. -She was offered a full-time position of Special Care Coordinator (SCUC) on 07/26/22 and started her role as SCUC on 08/01/22. -She remembered completing a pre-employment drug screen between her hire date of 07/26/22 and her start date of 08/01/22 but could not remember the exact day. -The facility should the result of her drug test in her staff record but she did not know if it would have been filed yet since she was so new. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm. Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. _____ Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed: -When new hires came to the facility for an interview, the receptionist gave them paperwork to complete. -The new hires were given a form to complete that they had to take to a lab to have the drug screen completed. -The drug screens came back by email to the business office manager (BOM). Telephone interview with the Administrator on	D992		

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D992	Continued From page 104 08/05/22 at 1:33pm revealed: -The business office was responsible for ensuring drug screens were completed. -If an employee drug screen was not completed the BOM was responsible for checking to obtain the drug screen. -She thought the drug screen was missed due the turnover in the business office. -She had not checked personnel records to identify missing paperwork. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -She started helping the facility out in July 2022 but had not completed personnel records. -Two weeks ago, she started working on personnel records but was unaware of employees who had not completed drug screens.	D992		