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D 000	Initial Comments The Adult Care Licesenure Section and the Rockingham County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 08/23/22 through 08/25/22. The complaints were initiated by the Rockingham County Department of Social Services on 08/11/22 and 08/17/22.	D 000		
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 3 sampled staff (Staff A, Administrator and Staff C) 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 and for assistance with ambulation and transferring. The findings are: 1. Review of Staff A's, personal care aide	D 161		

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(PCA)/cook, personnel record revealed:
-Staff A was hired on 08/02/22.
-There was no documentation Staff A had a completed a LHPS competency validation.

Observation of Staff A on 08/23/22 at 5:11pm revealed Staff A physically assisted a resident to the dining hall from his room and physically assisted him to sit in a chair in the dining hall.

Interview with Staff A, personal care aide (PCA)/cook on 08/25/22 at 11:12am revealed:
-She assisted Resident #1 with ambulation to and from the dining hall and with transfers in and out of his seat in the dining hall.
-Staff always assisted Resident #1 with ambulation due to his blindness.
-She had not been checked off by a Registered Nurse (RN) for LHPS tasks including ambulation and transferring at the facility.

Interview with a resident on 08/25/22 at 11:28am revealed:
-He was blind and ambulated with a cane.
-Sometimes he needed assistance with ambulation and transfers and sometimes he did not.
-Staff A assisted him with ambulating from and to his room for meals and with helping him find his seat in the dining hall.
-Staff had assisted him with ambulation since he was admitted to the facility in 2020.

Telephone interview with the facility's contracted RN on 08/25/22 at 12:50am revealed:
-She was not aware Staff A had been hired at the facility on 08/02/22.
-She had not been contacted prior to 08/23/22 to complete the LHPS competency validation for Staff A.

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D 161	Continued From page 2 Interview with the Owner on 08/24/22 at 10:34am revealed Staff A was a PCA and assisted residents with personal care, ambulation, and transfers. Interview with the Administrator on 08/25/22 at 1:45pm revealed: -She was responsible for ensuring all staff had required trainings, competencies and for maintaining personnel records. -Staff A assisted a resident with ambulation and provided assistance to residents -Staff A did not have her LHPS competency validation completed, but she knew it should have been completed prior to Staff A assisting residents with LHPS tasks. Refer to interview with the Owner on 08/25/22 at 11:42am. Refer to telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50am. 2. Review of the Administrator's personnel record revealed: -Staff B was hired on 11/01/20. -There was no documentation Staff A had a completed a LHPS competency validation. Telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50am revealed she had not been contacted prior to 08/23/22 to complete the LHPS competency validation for the Administrator. Interview with the Administrator on 08/25/22 at 1:45pm revealed: -She was responsible for ensuring all staff had	D 161		

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required trainings, competencies and for maintaining personnel records.
-She completed the LHPS competency validation at a different facility, and she thought it could transfer from facility to facility.
-She had not completed the LHPS competency validation at this facility.
-She occasionally administered medications to residents including insulin injections, checked fingerstick blood sugars (FSBS), and had occasionally assisted a resident with ambulation, but it had been a while.

Refer to interview with the Owner on 08/25/22 at 11:42am.

Refer to telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50am.

3. Review of Staff C's, Supervisor personnel record revealed:
-Staff C was hired on 11/01/20.
-There was no documentation Staff C had a completed a LHPS competency validation.

Review of a resident's electronic medication administration record (eMAR) for 08/01/22 through 08/23/22 revealed Staff C checked FSBSs 55 times and administered insulin 55 times between 08/01/22 and 08/23/22.

Observation of Staff C on 08/25/22 at 8:49am revealed Staff C checked a resident's FSBS and administered insulin.

Interview with Staff C on 08/25/22 at 8:50am revealed he administered medication to residents including insulin injections and checking FSBS.

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D 161	Continued From page 4 Telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50am revealed she had not been contacted prior to 08/23/22 to complete the LHPS competency validation for Staff C. Interview with the Administrator on 08/25/22 at 1:45pm revealed: -She was responsible for ensuring all staff had required trainings, competencies and for maintaining personnel records. -Staff C completed the LHPS competency validation at a different facility, and she thought it could transfer from facility to facility. -Staff C had not completed the LHPS competency validation at this facility. -Staff C administered medications to residents including insulin injections, checked fingerstick blood sugars (FSBS), and assisted a resident with ambulation. Refer to interview with the Owner on 08/25/22 at 11:42am. Refer to telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50am. _____ Interview with the Owner on 08/25/22 at 11:42am revealed: -She knew medication clinical skills checklists were specific to each facility. -She knew the LHPS competency validation should have been completed at the facility prior to staff providing LHPS tasks. -She was working on getting the nurse to come to the facility to complete the LHPS competency validations for staff, but she had not had time to get it completed yet.	D 161		

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D 161	Continued From page 5 Telephone interview with the facility's contracted RN on 08/25/22 at 12:50am revealed: -She completed LHPS competency validations for staff at the facility. -The Administrator usually called her when she had staff who needed a LHPS competency validation. -Once the LHPS competency validation was completed, she left it at the facility to be filed in the staff's personnel record.	D 161		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the 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, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#3) had completed tuberculosis (TB) testing upon admission. The findings are: Review of Resident #3's current FL-2 dated 08/09/22 diagnoses included blindness due to cataracts, chronic kidney disease stage III, muscle weakness, metabolic encephalopathy,	D 234		

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D 234	Continued From page 6 and elevated liver function tests. Review of Resident #3's Resident Register revealed an admission date of 06/20/20. Review of Resident #3's tuberculosis (TB) skin testing revealed: -There was documentation of a TB skin test was placed on 06/18/22 and read as negative on 06/20/20. -There was no documentation of a second TB skin test. Interview with Resident #3 on 03/23/22 at 6:15pm revealed he could not remember having any TB skin test placed or read at the facility. Interview with the Administrator on 08/25/22 at 1:45pm revealed: -She was responsible for ensuring residents had a 2 TB skin tests completed. -New residents received their first TB skin test prior to admission and received the second TB skin test after admission. -Resident #2 was admitted in 2022 under a different facility ownership. -Resident #2's second TB skin test had not been completed under the current facility ownership, and she did not know Resident #2's second TB skin test had not been completed.	D 234		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on	D 238		

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D 238	Continued From page 7 the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure a resident's FL2 included complete information and was clarified by the primary care provider (PCP) for 1 of 3 sampled residents (Residents #1) who had no medication frequency and missing medication orders on the current FL2. The findings are: Review of Resident #1's current FL2 dated 08/09/22 revealed: -Diagnoses included diabetes mellitus II, congestive heart failure, seizure disorder, Parkinson's disease, gastroesophageal reflux disease vitamin B deficiency, hypertension, and stroke like episodes. -There was a medication order for aripiprazole 2mg (used to treat depression) with no frequency. -There was a medication order for atorvastatin 80mg (used to treat cholesterol) with no frequency. -There was a medication order for aspirin 325mg (used to prevent blood clots) with no frequency. -There was a medication order for benztropine 1mg (used to treat tremors) with no frequency. -There was a medication order for	D 238		

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carbidopa/levodopa 25-100mg (used to treat tremors) with no frequency.
-There was a medication order for carvedilol 25mg (used to treat hypertension) with no frequency.
-There was a medication order for clopidogrel 75mg (used to prevent blood clots) with no frequency.
-There was a medication order for furosemide 20mg (used to treat hypertension) with no frequency.
-There was a medication order for gabapentin 300mg (used to treat seizures) with no frequency.
-There was a medication order for isosorbide mononitrate 60mg (used to treat heart disease) with no frequency.
-There was a medication order for lacosamide 50mg (used to treat seizures) with no frequency.
-There was a medication order for lantus injection 100/mL (used to treat diabetes) with no frequency.
-There were no other medication orders listed on the FL2.

Review of Resident #1's physician's orders revealed:
-There were no physician's orders updated after the current FL2 dated 08/09/22.
-There were no orders which verified missing mediations or the frequency of the medications ordered on the current FL2 dated 08/09/22.

Review of Resident #1's electronic medication administration record (eMAR) for August 2022 revealed:
-There was an entry for ammonium lactate 12% spread topically liberally to both legs twice daily scheduled for administration at 8:00am and 8:00pm.

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-There was an entry for aripiprazole 2mg 1 tablet daily, give with 5mg= 7mg, scheduled for administration at 8:00am.
-There was an entry for aripiprazole 5mg 1 tablet daily, give with 2mg= 7mg, scheduled for administration at 8:00am.
-There was an entry for aspirin 325mg 1 tablet daily scheduled for administration at 8:00am.
-There was an entry for atorvastatin 80mg 1 tablet daily scheduled for administration at 8:00pm.
-There was an entry for benztropine 1mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was an entry for carbidopa/levodopa 25-100mg 1 tablet twice daily scheduled for administration at 8:00am and 12:00pm.
-There was an entry for carvedilol 25mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was an entry to check and record vitals monthly scheduled for 8:00am.
-There was an entry to check blood pressure and pulse every 12 hours scheduled for 8:00am and 8:00pm.
-There was an entry for clopidogrel 75mg 1 tablet daily scheduled for administration at 8:00am.
-There was an entry for furosemide 20mg 1 and ½ tablet (30mg) daily scheduled for administration at 8:00am.
-There was an entry to check and record temperature daily scheduled for 8:00am.
-There was an entry for gabapentin 300mg 1 capsule three times daily at 8:00am, 12:00pm, and 8:00pm.
-There was an entry for isosorbide mononitrate 1 tablet daily in the morning scheduled for administration at 8:00am.
-There was an entry for lacosamide 50mg 2 tablets twice daily scheduled for administration at

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8:00am and 8:00pm.
-There was an entry for lantus injection 100/mL inject 30 units twice daily scheduled for administration at 8:00am and 8:00pm.
-There was an entry for losartan/hydrochlorothiazide 100-25mg 1 tablet every 12 hours scheduled for administration at 8:00am and 8:00pm.
-There was an entry for melatonin 5mg 1 tablet daily at bedtime scheduled for administration at 5:00pm.
-There was an entry for metformin 1000mg 1 tablet twice daily with meals scheduled for administration at 8:00am and 8:00pm.
-There was an entry for novolog injection flexpen inject 10 units 3 times daily with meals; hold if FSBS was less than 150 or if Resident did not eat scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was an entry for omeprazole 20mg 1 capsule daily scheduled for administration at 8:00am.
-There was an entry for pimozide 1mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was an entry for sertraline 50mg 1 and 1/s tablets (75mg) daily in the morning scheduled for administration at 8:00am.
-There was an entry for tamsulosin 0.4mg 1 capsule daily scheduled for administration at 8:00pm.
-There was an entry for acetaminophen 500mg 1 tablet every 6 hours as needed for fever up to 101, minor discomfort, or headache; do not exceed 4 tablets in 24 hours scheduled for administration as needed.
-There was an entry for albuterol 108 (90 base) mcg/act inhale 1 puff every 4 hours as needed scheduled for administration as needed.
-There was an entry for anti-diarrhea 2mg 1 tablet

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with each loose stool up to 8 doses in 24 hours as needed for diarrhea; if condition persists more than 24 hours, contact physician scheduled for administration as needed.
-There was an entry for calcium carbonate chews 500mg 1 tablet three times daily as needed scheduled for administration as needed.
-There was an entry for geri-lanta 200-200-20/5mL take 30mL up to 4 times daily as needed; do not exceed 4 doses in 24 hours scheduled for administration as needed.
-There was an entry for hydrocortisone/aloe cream 0.5% spread topically to affected areas as needed scheduled for administration as needed.
-There was an entry for milk of magnesia 400/5mL take 30mL twice daily as needed; if no relief contact physician scheduled for administration as needed.
-There was an entry for siltussin syrup 100/5mL 2 teaspoonfuls (10mL) every 6 hours as needed; do no exceed 4 doses in 24 hours scheduled for administration as needed.

Telephone interview with the facility contracted pharmacy on 08/24/22 at 3:19pm revealed:
-The pharmacy did not receive a copy of Resident #1's FL2 dated 08/09/22.
-The pharmacy was providing medication based on the signed physician's orders dated 01/11/22 and any other medications orders that were sent over electronically by Resident #1's primary care providers (PCP).
-The current list of Resident #1's medication orders were reflected on Resident #8's current eMAR for August 2022.

Interview with the Owner on 08/24/22 at 10:07am revealed:
-She had not reviewed Resident #1's FL2 and did not know that the FL2 was incomplete.

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-The Supervisors were responsible for reviewing FL2 after the physicians signed to ensure there were no updates and that the orders on the FL2 matched the eMARs.

Interview with the Supervisor on 08/24/22 at 10:12am revealed:
-He did not notice the FL2 did not have the complete list of Resident #1's medications until he completed his care plan on 08/21/22.
-He did not know to follow up with Resident #1's PCP regarding the incomplete FL2 because he was still learning the process, but he did let the Administrator know.

Second interview with the Supervisor on 08/25/22 at 8:49am revealed:
-A previous medication aide (MA) completed Resident #1's current FL2.
-The MA was responsible for reviewing the FL2 after his primary care provider (PCP) signed it.
-He nor any other staff looked at the FL2 after Resident #1's PCP signed it until he looked at it on 08/21/22.
-Currently, he and the Owner were responsible for reviewing FL2s signed by residents' PCPs.

Interview with Resident #1's primary care provider (PCP) on 08/25/22 at 11:49am revealed:
-The facility completed the residents' FL2s and usually attached a list of medications from the pharmacy to the FL2.
-He did not notice Resident #1's FL2 did not have all of his medications listed and did not list directions for the medications that were listed.
-He expected the facility staff to review the FL2s and to contact him if there were any missing medications or directions were missing for any of the medications.
-Staff did not contact him regarding incomplete

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D 238	Continued From page 13 medication orders or missing medication orders. -He did not have immediate access to Resident #1's medications, but the pharmacy had the correct list of medications for Resident #1. -He tried to escribe all medications orders, so the orders went directly to the pharmacy. Interview with the Administrator on 08/25/22 at 1:45pm revealed: -She was responsible for ensuring FL2 were completed, signed by the physician, were accurate, and matched the residents' eMARs. -The Supervisor completed Resident #1's FL2 dated 08/09/22. -She had not reviewed Resident #1's FL2 dated 08/09/22, and she did not know there were incomplete and missing medication orders on the FL2.	D 238		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure health care referral and follow up for 2 of 5 sampled resident (#1 and #2) for a resident who had a pacemaker and a physician's orders for a neurology and cardiology consultation, and had several hospital visits (#1); and a resident who had physician's orders for continuous oxygen and did not have portable oxygen, and had an emergency room	D 273		

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visit due to shortness of breath (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 08/09/22 revealed:
-Diagnoses included diabetes mellitus II, congestive heart failure, seizure disorder, Parkinson's disease and hypertension.
-Resident #1 was semi-ambulatory and intermittently disoriented.
-There was documentation Resident #1 had been diagnosed with recurrent stroke like episodes.

Review of Resident #1's local hospital emergency department (ED) After Visit Summary dated 03/17/22 revealed:
-Resident #1 was seen for weakness and diagnoses included generalized weakness and heart failure.
-Resident #1 declined blood work, diagnostic testing, and observation.

Review of Resident #1's primary care provider's (PCP) progress note dated 03/29/22 revealed:
-There was an order for Resident #1 to have a consultation with a neurologist for evaluation and to establish care related to his seizure disorder and Parkinson's disease.
-There was an order for Resident #1 to have a consultation with a cardiologist for evaluation and to establish care related to his diagnoses of a pacemaker and congestive heart failure.

Review of Resident #1's local hospital ED After Visit Summary dated 05/16/22 revealed:
-Resident #1 visited the ED due to a transient ischemic attack (TIA) (a brief stroke-like attack) and was diagnosed with a stroke-like episode.
-There were instructions to contact a neurologist

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D 273	Continued From page 15 in 2 days (around 05/18/22). Review of Resident #1's local hospital ED After Visit Summary dated 05/17/22 revealed: -Resident #1 visited the ED for medical screening and was diagnosed with generalized weakness. -Resident #1 had difficulty walking. -He was seen on 05/16/22 for similar problems and dizziness. Review of Resident #1's local hospital ED After Visit Summary dated 05/22/22 revealed Resident #1 visited the ED due dizziness, fall, and dehydration. Review of Resident #1's local hospital ED After Visit Summary dated 07/17/22 revealed Resident #1 visited the ED and was diagnosed syncope (a temporary loss of consciousness usually related to insufficient blood flow to the brain). Review of Resident #1's local hospital ED After Visit Summary dated 07/18/22 revealed: -Resident #1 visited the ED due to loss of consciousness and his diagnoses included syncope and collapse. -The ED could not provide a specific reason for Resident #1's episodes of passing out. -It was possible that he was having an issue where his heartbeat and blood pressure were not being adequately regulated and sometimes, for no particular reason, his blood pressure dropped cause him to pass out. -It was possible there was an underlying neurological issue and the ED provider strongly recommended that Resident #1 follow up with a neurologist as previously recommended and referred. -Resident #1 could benefit from follow-up with cardiology, either with an established provider or	D 273		

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one referred by his PCP.

Review of Resident #1's physician's orders dated 07/22/22 revealed:
-The PCP noted Resident #1's post hospital ED visit report.
-There was an order to follow up with a cardiologist and a neurologist.

Review of Resident #1's PCP's Progress Note dated 08/23/22 revealed:
-The PCP received a message with a request for a neurology and cardiology consultation.
-There was an initial order for consultation for neurology and cardiology for Resident #1 on 03/29/22 during his new patient visit.
-A review of Resident #1's transfer documents and medical records indicated Resident #1 had an extensive cardiac and neurological past medical history.
-Resident #1 had a self-reported pacemaker and CHF with exacerbation requiring a hospital visit.
-Resident #1 reported a history of multiple seizures and staff reported Resident #1 had multiple episodes where he appeared to "not be conscious."
-The PCP initially ordered a consultation with neurology and cardiology because collaborative care between the two specialists appeared crucial to establish care.
-Since the initial order for a neurology and cardiology consultation on 03/29/22, Resident #1 had several ED visits.
-The facility had not followed through, under unclear circumstances, with making appointments with a neurologist or a cardiologist.
-Symptoms were controlled during the PCP's last visit (date not indicated), however collaboration between a neurologist and cardiologist would be of benefit to Resident #1 and would reduce the

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frequency of hospital visits.
-There was an order for a neurology consultation due to diagnoses of seizure, cerebrovascular disease with repeated TIAs.
-There was an order for a cardiology consultation due to diagnoses of congestive heart disease, cardiomyopathy, and presence of a pacemaker with repeated near syncope episodes.

Review of Resident #1's record revealed there was no documentation Resident #1 had been seen by a neurologist or a cardiologist.

Interview with Resident #1 on 08/23/22 at 10:01am revealed:
-He was in a wheelchair because he had been getting dizzy and passing out.
-He went to the hospital ED 2 to 3 times a few weeks ago.

Interview with Resident #1 on 08/25/22 at 11:37am revealed:
-He had congestive heart failure and had a pacemaker for about 2 years.
-He had 7 heart attacks, 3 stints, and 4 bypass surgeries.
-He had chest pain a few weeks ago.
-He had not seen a cardiologist or had his pacemaker checked since he had been at the facility.
-He had several episodes of feeling weak and passing out.
-He was told by the hospital he needed to see a cardiologist and a neurologist.
-No one from the facility scheduled for him to see a cardiologist or a neurologist.

Interview with the Supervisor on 08/25/22 at 8:47am revealed:
-Resident #1 had several hospital visits due to

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passing out, but he did not know Resident #1 had orders for a cardiology and a neurology consultation.
-A previous medication aide (MA) was responsible for following up with orders, but now the Owner was responsible.

Interview with the Owner on 08/24/22 at 10:07am revealed:
-She did not know about the order dated 03/29/22 for a cardiology and neurology consultation, the hospital's recommendation for Resident #1 to have a consultation with cardiology and neurology, or the order dated 07/22/22 for a cardiology and neurology consultation.
-A MA, who no longer worked at the facility, had been responsible for reviewing physician's orders and hospital reports and following up with any orders and recommendations.
-She took for granted that there had been follow up with physician's orders and recommendations.
-She started calling around about a week ago and left a message with a neurologist, but she had not heard anything back or had time to follow up.
-She spoke to a representative from a cardiologist office yesterday, 08/23/22, and she was told she needed an order for cardiology with the reason why cardiology services were needed.
-She contacted Resident #1's PCP and he told her to look in the resident's on-line medical record to retrieve the order for cardiology and neurology from the local hospital.
-Resident #1's PCP had written a new order for cardiology and neurology dated 08/23/22; now she could schedule Resident #1 for a cardiology and neurology consultation.

Telephone interview with Resident #1's PCP on 08/24/22 at 11:45am revealed:
-He had not seen a consultation report for either

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cardiology or neurology.
-He expected the facility to follow up with orders for a cardiology and neurology consultation when he first provided the orders on 03/29/22 and after he provided orders for cardiology and neurology on 07/18/22.
-Resident #1's hospital visits for syncope could have been prevented had his condition been managed by a neurologist.
-He did not know if seeing a cardiologist could have prevented Resident #1's hospital visits, but Resident #1 did complain of chest pain at times and had a diagnosis of congestive heart failure.
-Resident #1's referral to cardiology was in part based on him having a pacemaker.
-Pacemaker maintenance was determined by the pacemaker manufacturer, but he would recommend that Resident #1's pacemaker be checked at least annually.
-Most likely a cardiology may have recommended pacemaker checks more often depending on Resident #1's symptoms of chest pain and/or other cardiac issues.

Interview with the Administrator on 08/25/22 at 1:45pm revealed:
-She was aware of Resident #1's multiple hospital visits due weakness and syncope.
-She did not know about the physician's order dated 03/29/22 and 07/18/22 for Resident #1 to have a neurology and cardiology consultation.
-She was responsible for reviewing physician's orders, physician's progress notes, and hospital after visit summaries for orders and recommendations and for following up on them.
-She and the owner had been working on getting an updated order for a cardiology and neurology consultation from Resident #1's PCP, but it took him a long time to respond.
-She knew Resident #1 had a pacemaker and

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she thought of asking for a referral prior to 07/18/22 to get the pacemaker checked, but it slipped her mind.

2. Review of Resident #2's current FL2 dated 08/09/22 revealed:
-Diagnoses included asthma and chest wall pain.
-There was an order for continuous oxygen at 2 liters (L)/minute.

Review of Resident #3's electronic medication administration record (eMAR) for June, July, and 08/01/22 through 08/23/22 revealed:
-There was an entry for oxygen 2L continuously scheduled for administration from 12:00am to 7:00am, 7:00am to 3:00pm, and from 3:00pm to 11:00pm.
-Oxygen 2L was documented as administered from 06/01/22 through 06/30/22.
-Oxygen 2L was documented as administered from 07/01/22 through 07/31/22.
-Oxygen 2L was documented as administered from 08/01/22 through 08/23/22.

Observation of Resident #2's bedroom on 08/23/22 at 9:47am revealed:
-Resident #2 was laying in bed with his nasal cannula in place using oxygen.
-There was an oxygen concentrator, but there was not a portable oxygen tank available for Resident #3 in his room.

Observation of Resident #2's bedroom on 08/24/22 at 10:00am revealed:
-He was using oxygen in his bedroom.
-Resident #2's oxygen concentrator was set between 2L and 3L.

Observations of Resident #2 at various times on 08/24/22 revealed:

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-Resident #2 ambulated independently through the halls without having oxygen on.
-Resident #2 was in the dining hall between 12:00pm and 12:18pm and he did not have his oxygen on.
-Resident #2 was in the dining hall between 5:10pm and 5:30pm and he did not have his oxygen on.

Interview with Resident #2 on 08/23/22 at 9:35am revealed:
-Sometimes he had a hard time breathing when he ambulated to the dining hall.
-He liked to sit outside on the porch, but when he went outside, he could not stay out long because he could not catch his breath.

Second interview with Resident #2 on 08/23/22 at 11:40am revealed:
-He never had a portable oxygen tank available for him at the facility.
-He had trouble breathing when he was not using the oxygen concentrator.
-He took his nasal cannula off when he went to the dining hall for meals and when he went to the bathroom.
-Staff had not discussed with him having a portable oxygen tank to use when he was not in his room.

Telephone interview with Resident #2's primary care provider (PCP) on 08/24/22 at 9:20am revealed:
-Resident #3 was prescribed oxygen.
-The facility had not requested an order for a portable oxygen tank for Resident #2.

Telephone Interview with a pharmacy technician with the facility's contracted pharmacy on 08/24/22 at 9:09am revealed there was an order

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D 273	Continued From page 22 for Resident to have 2L oxygen continuously. Interview with the Supervisor on 08/24/22 at 11:40am revealed: -Resident #2 used oxygen only when he was in his room. -Staff had not requested an order for a portable oxygen tank for the Resident #2. -He had not noticed Resident #2 having shortness of breath when he did not have oxygen outside of his room. Interview with Resident #2's guardian on 08/24/22 at 2:39PM revealed: -The guardian was aware Resident #2 used oxygen. -She did not know if Resident #2 had portable oxygen at the facility -The facility staff had not discussed requesting portable oxygen tank for Resident #2. Interview with Resident #2 on 08/25/22 at 9:31am revealed: -He did not see a specialist for his diagnosis of asthma or difficulty breathing. -He experienced difficulty with breathing this morning with his oxygen on. Observation on 08/25/22 at 10:55am revealed: -Resident #2 was sitting in a chair in the dining room with short, labored breaths and sweating. -Resident #2 did not have any oxygen present with him in the dining room. -The Supervisor called 911 for Resident #2. Interview with Resident #2 on 08/25/22 at 10:57am revealed: -He was dizzy and having trouble breathing. -He wanted to go to the hospital to be evaluated.	D 273		

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D 273	Continued From page 23 Observation on 08/25/22 at 11:05am revealed -Emergency Medical Service (EMS) arrived to assess Resident #2. -Resident #2's heart rate was low during the assessment by EMS. -Resident #2 was taken to hospital for evaluation. Interview with the Administrator on 08/25/22 at 1:45pm revealed: -She was responsible for reviewing the residents' FL2s. -She knew Resident #2 had orders for continuous oxygen. -She knew Resident #2 took his oxygen off to go to the dining room for meals and to go to the bathroom. -She had not requested an order for a portable oxygen tank for resident. -She had not noticed Resident #2 to have difficulty with breathing when he was out of his room without oxygen. _____ The facility failed to follow up on acute health care needs and coordinated referrals for 2 of 5 sampled residents (#1, and #2) including a resident who had a history of congestive heart failure and had a pacemaker, who had orders for a consultation with a neurologist and a cardiologist which were not completed and had 5 hospital emergency room visits for stroke-like episodes, generalized weakness, dizziness, fall, dehydration, and syncope (#1); and a resident who had a history of asthma, orders for continuous oxygen, and did not have a portable oxygen tank which resulted in the resident having episodes of shortness of breath while away from his oxygen concentrator and was transported to the emergency room for evaluation (#2). This failure resulted in substantial risk of serious physical harm and neglect to the residents and	D 273		

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D 273	Continued From page 24 constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/24/22. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2022.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure orders were implemented for 1 of 5 sampled residents (#3) related to orders for labs. The findings are: Review of Resident #3's current FL2 dated 08/09/22 revealed: -Diagnoses included blindness due to cataracts, chronic kidney disease stage III, muscle weakness, metabolic encephalopathy, and elevated liver function tests. -There was an order for Depakote (mood stabilizer) 500mg 1 tablet every evening.	D 276		

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a. Review of Resident #3's Psychiatry Progress Note dated 02/17/22 revealed:
-Resident #3 had a diagnosis of post-traumatic stress disorder.
-He was taking Depakote for mood stabilization
-There was an order to obtain valproic acid (VPA) (an anticonvulsant also used to treat mental health disorders) level in 2 weeks and every 3 months while on Depakote therapy.

Review of Resident #3's record revealed there were no lab results for Resident #3 after 02/17/22.

Interview with Resident #3 on 08/25/22 at 11:28am revealed he did not remember having lab work completed in February 2022.

Interview with the Supervisor on 08/24/22 at 3:11pm revealed:
-He did not know about any ordered labs, including an order to check Resident #2's VPA level, and he did not know if any labs had been completed for Resident #3.
-The owner was responsible for ensuring labs were completed as ordered.

Interview with the facility's contracted lab on 08/24/22 at 3:55pm revealed:
-The lab had not received any orders to check Resident #3's VPA levels.
-The lab had not received the order dated 02/17/22 to check Resident #2's VPA in 2 weeks and every 3 months.

Interview with Resident #3's mental health provider (MHP) on 08/24/22 at 4:22pm revealed:
-VPA labs were ordered to measure valproic acid levels for Resident #3 because he was on

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Depakote.
-It was important to have Resident #3's VPA labs completed every 3 months to ensure he did not become toxic.
-She did not know Resident #3's VPA labs had not been completed and she would have expected the facility to contact their contracted lab to have them completed as ordered.

Interview with the Owner on 08/25/22 at 5:46pm revealed:
-Labs ordered on 02/17/22 were not completed for Resident #3.
-She had relied on a former medication aide (MA) to follow up with lab orders and he did not contact the facility's contracted lab to have the lab completed.

Interview with the Administrator on 08/25/2 at 1:45pm revealed:
-She depended on a former MA to review physician's orders and to complete follow up.
-She did not know Resident #3 had a physician's order dated 02/17/22 for labs to check VPA levels in 2 weeks and every 3 months.
-She did not know labs had not been completed for Resident #3 after his physician's order dated 02/07/22.

b. Review of Resident #3's physician's orders dated 06/06/22 revealed an order for lab as follows: valproic acid (VPA) (an anticonvulsant also used to treat mental health disorders), comprehensive metabolic panel (CMP) (measures substances in your blood that provide information about your body's chemical balance and metabolism), and complete blood count (CBC) (measurement of red and white blood cells) with platelets.

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Review of Resident #3's record revealed there were no lab results for Resident #3 after 06/06/22.

Interview with Resident #3 on 08/25/22 at 11:28am revealed he did not remember having lab work completed in June 2022.

Interview the Supervisor on 08/24/22 at 3:11pm revealed:
-He did not know about any ordered labs, including an order to check Resident #3's VPA, CMP, and CBC with platelets, and he did not know if any labs had been completed for Resident #3.
-The owner was responsible for ensuring labs were completed as ordered.

Interview with the facility's contracted lab on 08/24/22 at 3:55pm revealed:
-There was an order for lab work on 02/04/22 for CMP and CBC for Resident #3.
-There was an order for lab work on 03/09/22 for COVID-19 testing for Resident #3.
-The lab had not received the order dated 06/06/22 to check Resident #3's VPA, CMP, and CBC with platelets.

Interview with Resident #3's mental health provider (MHP) on 08/24/22 at 4:22pm revealed:
-VPA labs were ordered to measure valproic acid levels for Resident #2 because he was on Depakote.
-It was important to have Resident #2s VPA labs completed every 3 months to ensure he did not become toxic.
-CMP labs were ordered to measure Resident #3's liver enzymes due to Depakote use.
-CBC labs were ordered to measure platelets because the amounts could decrease with

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D 276	Continued From page 28 Depakote use. -She did not know Resident #3's VPA, CMP, and CBC with platelets labs had not been completed and she would have expected the facility to contact their contracted lab to have them completed as ordered. Interview with the Owner on 08/25/22 at 5:46pm revealed: -Labs ordered on 06/06/22 were not completed for Resident #3. -She had relied on a former MA to follow up with lab orders and he did not contact the facility's contracted lab to have the lab completed. Interview with the Administrator on 08/25/22 at 1:45pm revealed: -She depended on a former MA to review physician's orders and to complete follow up. -She did not know Resident #3 had a physician's order dated 06/06/22 for labs to check VPA levels, CMP, and CBC with platelets. -She did not know labs had not been completed for Resident #3 after his physician's order dated 06/06/22.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at	D 280		

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least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews, observations, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 1 of 3 sampled residents (#3) to include the identified task of ambulation with an assistive device and transferring.

The findings are:

Review of Resident #3's current FL2 dated 08/09/22 revealed:
-Diagnoses included blindness due to cataracts and muscle weakness.
-Resident #3 was semi-ambulatory.

Review of Resident #3's care plan dated 04/26/22 revealed:
-Resident #3 was ambulatory and used a cane.
-Resident #3 required extensive assistance with ambulation and limited assistance with transferring.

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D 280	Continued From page 30 Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 06/30/22 revealed: -There was documentation Resident #3 was alert and oriented. -Resident #3 was visually impaired and ambulated independently with the use of a cane. -There were no LHPS tasks at the time. Observation of Resident #3 at various times on 08/23/22 between 11:00am and 2:15pm. -At 11:17am, staff physically assisted Resident #3 with ambulating to the bathroom; Resident #3 was walking with a cane. -At 12:09pm, staff physically assisted Resident #3 with ambulating to the dining hall and physically assisted him to a seated position; Resident #3 was walking with a cane. -At 12:23pm, staff physically assisted Resident #3 with getting up from a seated position in the dining room and physically assisted him with ambulating to his bedroom; Resident #3 walked with a cane. -At 2:02pm, staff physically assisted Resident #3 with ambulating to the dining hall and physically assisted him to a seated position; Resident #3 walked with a cane. -At 2:05pm, staff physically assisted Resident #3 with getting up from a seated position in the dining room and physically assisted him with ambulating to his room. Interview with Resident #3 on 08/25/22 at 11:28am revealed: -He was blind and ambulated with a cane. -Sometimes he needed assistance with ambulation and transfers and sometimes he did not. -Staff assisted him with ambulating from and to	D 280		

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the dining room and from and to his room for meals.
-Staff helped him find his seat, helped him to sit down in his seat, and to get up from his seat in the dining room.
-He was able to sit down and get up from his bed independently.
-Staff had assisted him with ambulation since he was admitted to the facility in 2020.

Interview with the Supervisor on 08/25/22 at 8:49am revealed:
-Resident #3 needed assistance with ambulating back and forth to the dining room.
-Staff had assisted him since he was admitted to the facility.

Interview with the facility contracted Registered Nurse (RN) on 08/25/22 at 12:50am revealed:
-She completed the LHPS review for Resident #3 dated 06/30/22.
-Resident #3 did not have any known LHPS tasks.
-She thought Resident #3's care plan may be incorrect regarding his need for extensive assistance with ambulation.
-He may have needed extensive assistance with ambulation previously due to him being legally blind, but she had observed him independent with ambulation using his cane.
-Staff had not reported to her that they physically assisted him with ambulation or transfers, and she had not observed staff physically assisting Resident #3.

Interview with the Administrator on 08/25/22 at 1:45pm revealed:
-Staff assisted Resident #3 with ambulating to and from the dining room.
-Resident #3 usually ambulated to the bathroom

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D 280	Continued From page 32 (right across the hall from his room) by himself. -She did not know that no LHPS tasks were list for Resident #3 on his LHPS review. -She depended on a former medication aide (MA) to review the LHPS reviews to ensure all LHPS tasks were checked and to follow up with any recommendations; she was now responsible to review and follow up with residents' LHPS reviews. -The LHPS tasks for assistance with ambulation and transfers should have been checked off for Resident #3 on his LHPS evaluation.	D 280		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 3 of 3 sampled residents (#1, #2, and #3) with physician's orders for a no concentrated sweets (NCS) diet (#1) and a regular diet with chopped meats (#2, and #3). The findings are: 1. Review of Resident #1's current FL2 dated 08/09/22 revealed diagnoses included diabetes	D 296		

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mellitus II, seizure disorder, Parkinson's disease, hypertension, and recurrent stroke episodes.

Review of Resident #1's physician's diet order dated 03/31/22 revealed an order for a no concentrated sweets (NCS) diet.

Observation of the kitchen on 08/23/22 at 9:21am revealed:
-There was a white board on the wall that documented 2 residents were to be served a chopped diet.
-There were no residents listed to be served a NCS diet.
-There was documentation all other residents were to be served a regular diet.
-There was a stack of regular menus on a desk with dates corresponding to days in the year 2020.
-There were no therapeutic diet menus available for review.

Observation of the lunch meal service on 08/23/22 at between 5:10pm and 5:30pm revealed:
-Resident #1 was served a sliced turkey sandwich, broccoli and cheese soup, strawberries, sugar free drink mix, and water.
-It could not be determined if Resident #1 was served the correct therapeutic diet due to a NCS menu was not available for food service staff guidance.

Observation of the breakfast meal service on 08/24/22 between 8:15am and 8:45am revealed:
-Resident #1 was served a pancake with syrup, and 2 sausage links.
-It could not be determined if Resident #1 was served the correct diet due to a NCS menu was not available for food service staff guidance.

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D 296	Continued From page 34 Review of the syrup bottle label which was used for the breakfast meal service on 08/24/22 revealed: -The first two ingredients on the label were corn syrup and high fructose corn syrup. -There were 17 grams of added sugar accounting for 34% of the daily value per serving. Review of Resident #1's electronic Medication Administration Records (eMARs) for June, July, and August 2022 revealed: -Fingerstick blood sugars (FSBS) ranged from 91 to 290 in June 2022. -FSBS ranged from 93 to 339 in July 2022. -FSBS ranged form 77 to 261 between 08/01/22 and 08/23/22. Interview with the Supervisor on 08/23/22 at 9:05am revealed all residents were on a regular diet. Second interview with the Supervisor on 08/25/22 at 8:49am revealed: -The Administrator and the Owner were responsible for reviewing diet orders and ensuring the dietary staff knew which diet each resident was supposed to be served. -The Owner was responsible for ensuring the facility had therapeutic diet menus available for staff guidance. -He did not know Resident #1 had an order for a NCS diet. -He did not know there were no therapeutic diet menus available for a NCS diet. Interview with Resident #1 on 08/25/22 at 12:11pm revealed: -He was diabetic, but he did not know he was supposed to be on a NCS diet.	D 296		

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-He was served the same meals as the other residents.
-He had pancakes for the breakfast meal on 08/25/22 and was served regular syrup on his pancakes.
-He was not served any sugar free food items that he was aware of.

Interview with the personal care aide (PCA)/cook on 08/25/22 at 9:26am revealed:
-She did not know Resident #1 had diet orders for NCS diet.
-She questioned whether residents who had diabetes had different diet orders and she was told that all residents were to be served a regular diet.
-There was no menu available for guidance to prepare meals for residents who had orders for a NCS diet.
-She served Resident #1 what she served other residents who were on a regular diet including regular syrup and jelly.
-She served residents canned fruit that was in lite syrup and sugar free drink mixes.

Interview with Resident #1's primary care provider (PCP) on 08/25/22 at 11:49am revealed:
-Resident #1 had an order for NCS diet to his diagnoses of diabetes.
-He did not know Resident #1 was not being served a NCS diet according to a NCS menu.
-He did not have his notes in front of him, but he believed Resident #1's last A1C reading was at his goal.
-He expected the facility to serve Resident #1 a NCS diet.

Interview with Resident #1's primary care provider (PCP) on 08/25/22 at 11:49am revealed:
-Resident #1 had an order for NCS diet due to his

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diagnoses of diabetes.
-He did not know Resident #1 was not being served a NCS diet according to a NCS therapeutic diet menu.
-He did not have his notes in front of him, but he thought Resident #1's last A1C reading was at his goal.
-He expected the facility to serve Resident #1 a NCS diet.

Interview with the Administrator on 08/25/22 at 1:45pm revealed:
-She knew Resident #1 had an order for a NCS diet.
-She knew there was no menu available in the facility for a NCS diet.
-She told staff to adjust his foods accordingly, but she realized staff would not know how to adjust his food without a menu.
-A menu should have been available for therapeutic diets, including NCS.

Refer to interview with the personal care aide (PCA)/cook on 08/23/22 at 9:20am.

Refer to second interview with the personal care aide (PCA)/cook on 08/25/22 at 9:16am revealed:

Refer to interview with the Supervisor on 08/25/22 at 8:49am.

Refer to interview with the Administrator on 08/025/22 at 1:45pm.

2. Review of Resident #2's current FL2 dated 08/09/22 revealed diagnoses included asthma, chest wall pain, stroke, anxiety syndrome, hypertension, coronary syndrome, and irritable bowel syndrome.

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D 296	Continued From page 37 Review of Resident #2's physician's diet order dated 10/13/21 revealed an order for a regular diet with chopped meats. Observation of the kitchen on 08/23/22 at 9:21am revealed: -There was a white board on the wall that listed Resident #2 was to be served a chopped diet. -There was a stack of regular menus on a desk with dates corresponding to days in the year 2020. -There were no therapeutic diet menus available for review. Observation of the lunch meal service on 08/23/22 at between 5:10pm and 5:30pm revealed: -Resident #2 was served a sliced turkey sandwich, broccoli and cheese soup, strawberries, sugar free drink mix, and water. -It could not be determined if Resident #2 was served the correct diet due to a NCS/NAS menu was not available for food service staff guidance. Observation of the breakfast meal service on 08/26/22 between 8:15am and 8:45am revealed: -Resident #2 was served a pancake with syrup, and 2 sausage links. -It could not be determined if Resident #2 was served the correct diet due to a NCS/NAS menu was not available for food service staff guidance. Interview with Resident #2 on 08/23/22 at 9:35am revealed he was not on a special diet. Interview with the personal care aide (PCA)/cook on 08/25/22 at 9:26am revealed: -She did not know Resident #2 had diet orders for a regular diet with chopped meats. -She served Resident #2 a sliced turkey	D 296		

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sandwich for the lunch meal on 08/23/22 and she did not have a therapeutic diet menu available for guidance in preparing Resident #2's turkey sandwich according to his diet order.
-She served Resident #2 whole sausage links for the breakfast meal on 08/24/22 and she did not have a therapeutic diet menu for guidance in preparing Resident #2 sausage links according to his diet order.
-Dinner meals were catered by a local restaurant and all residents received the same meals.
-She did not know Resident #2 was to be served a regular diet with chopped meats.
-There was no therapeutic diet menu available for a regular diet with chopped meats

Interview with Resident #2's primary care provider (PCP) on 08/25/22 at 11:49am revealed:
-Resident #2 had an order for a regular diet with chopped meats.
-He did not know staff was not serving Resident #2 chopped meats and did not have a therapeutic diet menu for guidance.
-He expected Resident #2 to be served according to his diet order and menu.
-Outcomes of not serving Resident #2 a regular diet with chopped meats as ordered could have resulted in aspiration.

Interview with the Administrator on 08/25/22 at 1:45pm revealed she did not know Resident #2 had orders for a regular diet with chopped meats.

Refer to interview with the personal care aide (PCA)/cook on 08/23/22 at 9:20am.

Refer to second interview with the personal care aide (PCA)/cook on 08/25/22 at 9:16am revealed:

Refer to interview with the Supervisor on 08/25/22

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D 296	Continued From page 39 at 8:49am. Refer to interview with the Administrator on 08/025/22 at 1:45pm. 3. Review of Resident #3's current FL2 dated 08/09/22 revealed diagnoses included blindness due to cataracts, chronic kidney disease stage III, muscle weakness, metabolic encephalopathy, and elevated liver function tests. Review of Resident #3's physician's diet order dated 09/29/21 revealed an order for a regular diet with chopped meats. Observation of the kitchen on 08/23/22 at 9:21am revealed: -There was a white board on the wall that listed Resident #3 was to be served a chopped diet. -There was a stack of regular menus on a desk with dates corresponding to days in the year 2020. -There were no therapeutic diet menus available for review. Observation of the lunch meal service on 08/23/22 at between 5:10pm and 5:30pm revealed: -Resident #2 was served a sliced turkey sandwich, broccoli and cheese soup, strawberries, sugar free drink mix, and water. -It could not be determined if Resident #2 was served the correct diet due to a regular diet with chopped meats menu was not available for food service staff guidance. Observation of the breakfast meal service on 08/26/22 between 8:15am and 8:45am revealed: -Resident #2 was served a pancake with syrup, and 2 sausage links.	D 296		

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-It could not be determined if Resident #2 was served the correct diet due to a regular diet with chopped meats menu was not available for food service staff guidance.

Interview with the Supervisor on 08/23/22 at 9:05am revealed all residents were on a regular diet.

Second interview with the Supervisor on 08/25/22 at 8:49am revealed:
-He knew Resident #3 had diet orders for a regular diet with chopped meats.
-He thought he had an order for chopped meats because it allowed him more independence being blind.

Interview with Resident #3 on 08/25/22 at 11:28am revealed:
-He had an order for chopped meats and received chopped meats when the meats needed to be chopped, for example, when steak was served.
-He was served whole sausage links for breakfast on 08/24/22, but he bit off bite sized pieces.
-He also had chicken on the bone this week, but he pulled the chicken off the bone with his fork.
-It was easier to pick up his meats with a fork or spoon when they were chopped due to his vision loss.
-He did not have any upper teeth, but he did not have any trouble with chewing or swallowing, and he had never gotten choked while eating.
-He was served regular meals catered from a local restaurant for dinner meals and the meats usually were not chopped.

Interview with the personal care aide (PCA)/cook on 08/25/22 at 9:26am revealed:
-She served Resident #3 a sliced turkey

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sandwich for the lunch meal on 08/23/22.
-She cut the sandwich into four pieces.
-She did not have a regular diet with chopped meats menu for guidance in preparing Resident #3's turkey sandwich according to his diet order.
-She served Resident #3 whole sausage links for the breakfast meal on 08/24/22.
-"I should have cut up the sausage links," but he usually just took a bite of the link and put it down.
-There was no regular diet with chopped meats therapeutic diet menu available.

Interview with Resident #3's primary care provider (PCP) on 08/25/22 at 11:49am revealed:
-Resident #3 had an order for a regular diet with chopped meats.
-He did not know staff was not serving Resident #3 chopped meats and did not have a menu for guidance.
-He expected Resident #3 to be served meals according to his diet order and menu.

Interview with the Administrator on 08/25/22 at 1:45pm revealed:
-She did not know Resident #3 had an order for a regular diet with chopped meats.
-She did not know if Resident #3 was served meals according to his diet order.

Refer to interview with the personal care aide (PCA)/cook on 08/23/22 at 9:20am.

Refer to second interview with the personal care aide (PCA)/cook on 08/25/22 at 9:16am revealed:

Refer to interview with the Supervisor on 08/25/22 at 8:49am.

Refer to interview with the Administrator on

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D 296	Continued From page 42 08/025/22 at 1:45pm. _____ Interview with the personal care aide (PCA)/cook on 08/23/22 at 9:20am revealed: -All residents were on a regular diet. -She prepared breakfast and lunch and the dinner meals were catered by a local restaurant. -She used a stack of old menus to prepare meals for residents since all residents were on a regular diet -She had not seen any therapeutic diet menus. Second interview with the PCA/cook on 08/25/22 at 9:16am revealed: -She had been serving all residents a regular diet. -She had not been given a copy of any of the residents' diet orders. -She had a stack of regular menus, but they were not current; she flipped through the stack and picked out meals. -She remembered menus and items to be served because she had "been doing this for 30 years." -She just found one therapeutic diet spread sheet for one day in 2021, and she had never used it. -Dinner meals for all residents were catered by a local restaurant and each resident received the same meal. Interview with the Supervisor on 08/25/22 at 8:49am revealed: -The Administrator and the Owner were responsible for reviewing diet orders and ensuring the dietary staff knew which diet each resident was supposed to be served. -When diabetic residents were served a diabetic meal, they did not like it. -The Owner was responsible for ensuring the facility had therapeutic diet menus available for guidance. -He did not know there were no therapeutic diet	D 296		

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D 296	Continued From page 43 menus available for food service staff guidance. Interview with the Administrator on 08/025/22 at 1:45pm revealed: -The facility did not have any therapeutic diet menus available for guidance in preparing meals for residents. -She was currently working with a Registered Dietician from a local food provider to obtain regular and therapeutic diet menus. -She knew regular and therapeutic diet menus should have been prepared and available for guidance at least a week in advance, but she had been "behind on a lot of stuff." -The caterer for the dinner meals had been provided a menu for the regular diets, but did not have any menu as guidance for therapeutic diets. -She and the Owner had been ordering food items based off old regular diet menus.	D 296		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure 13 of 13	D 315		

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D 315	Continued From page 44 residents were offered activities designed to promote the residents' active involvement. The findings are: Review of the Activities Calendar posted in the main hallway on 08/23/22 at 9:55am revealed: -There was no Month documented on the calendar, but it was dated from the 1st through the 31st. -The calendar did not coincide with the dates for the current month of August 2022. -For the 1st through the 5th: current events, bible study, dance party, shopping, and movie/popcorn were scheduled with no beginning or end times. -For the 6th through the 12th: church, current events, dance party, bible study, spa day, shopping, and movie/popcorn were scheduled with no beginning or end times. -For the 13th through the 19th: church, current events, spa day, bible study, dance party, pizza party, and residents' birthday party were scheduled with no beginning or end times. -For the 20th through the 26th: church, dance party, current events, bible study, spa day, shopping, and movie/popcorn were scheduled with no beginning or end times. -For the 27th through the 31st: church, current events, spa day, bible study, and dance party were scheduled with no beginning or end times. Observations of the facility at various times on 08/23/22 between 9:00am and 6:00pm, on 08/24/22 between 8:00am and 5:30pm, on 08/25/22 between 8:15am and 3:45pm revealed: -No activities were offered to residents. -Residents sat in the family room and watched television. -Residents were in their rooms asleep or watching television.	D 315		

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D 315	Continued From page 45 -Residents were outside smoking. Interview with a resident on 08/23/22 at 9:32am revealed: -The facility did not offer any activities and the residents did not go on any outings. -He would like to do activities, but he had not talked to staff about it. -He did not know about an activities calendar. Interview with a second resident on 08/23/22 at 4:02pm revealed: -The facility did not offer any activities to residents. -He would participate in activities if offered. -There were no games at the facility that he was aware of. -He sat in his room most of the time and watched the news; he went outside on the porch once in a while. -He would like to be able to go to the store. Interview with a third resident on 08/23/22 at 4:16pm revealed: -He had been at the facility for about a week and there had been no activities offered. -He would at least like to play bingo. -He usually slept a lot, but he would participate in activities if offered. Interview with a fourth resident on 08/23/22 at 4:27pm revealed: -Activities were last offered at the facility about 7 months ago. -He would like to do coloring and drawing activities, play bingo or other board games, go to the movies, and go shopping. -Currently, he watched television and slept all day long.	D 315		

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Interview with a fifth resident on 08/23/22 at 4:34pm revealed:
-There were no activities or outings offered by the facility.
-The residents used to have nail painting, talks, visitors who played music, and visitors who conducted bible study, but all that stopped months ago.
-She would like to play bingo, have nail painting, and prayer meetings.
-Since there were no activities, she watched television and liked to wash clothes.

Interview with the Supervisor on 08/25/22 at 8:49am revealed:
-The staff stopped doing activities with residents and taking them out of the facility when the pandemic began.
-There was a wooden activity set the staff was going to begin implementing as an activity for residents, but they have not done that yet.
-He knew there should have been 14 hours of activities for residents weekly.
-The Owner was working on activities and planned on putting activities in place within a couple of weeks.
-Only 1 resident complained about not having activities.

Interview with the Owner on 08/25/22 at 3:00pm revealed:
-She was responsible for ensuring at least 14 hours of activities were carried out for residents each week.
-The facility was offering activities for resident prior May 2022 and used to take the residents on outings once a month, but they stopped due to COVID-19 and staff shortages.
-Now that the facility was fully staffed, they should be getting back on track with activities.

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D 315	Continued From page 47 Interview with the Administrator on 08/25/22 at 1:45pm revealed: -She and the Owner were responsible for creating the activities calendar and ensuring activities were carried out. -She knew there should have been at least 14 hours of activities provided for residents weekly. -There were currently no activities taking place in the facility. -It was hard to do activities because of other matters that had to be taken care of in the facility. -There were no activity supplies available in the facility, but she planned on buying some soon.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled resident (#5) was free from exploitation related to the use of the resident's insurance benefit healthy food card for purchases after the resident was discharged from the facilty. The findings are: Review of Resident #5's current FL2 dated 10/14/22 revealed diagnoses included anxiety disorder, intellectual disability, right hip repair, gastroesophageal reflux disease, and insomnia. Review of a list of discharged residents provided	D 338		

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by the Owner on 08/23/22 revealed Resident #5 was discharged from the facility on 06/18/22.

Interview with Resident #5's responsible party on 08/25/22 at 1:16pm revealed:
-She gave a 30-day discharge notice to the facility on 05/15/22 and Resident #5 was discharged from the facility on 06/18/22.
-When Resident #5 was discharged from the facility, he did not receive his insurance benefit healthy food card upon discharge.
-She contacted Resident #5's insurance company and found that his insurance benefit healthy food card was used by the facility 3 times after he was discharged from the facility on 06/18/22.
-Resident #5's insurance benefit healthy food card was used on 06/24/22 debiting $75.00 and then again on 07/03/22 and 07/05/22 for a total of $75.00 and with a total use of $150.00 from all three dates.

Review of an itemized report of Resident #5's insurance benefit healthy food card transactions revealed:
-There was a benefit deposit on the card of $75.00 on 06/01/22.
-On 06/24/22 at 4:04pm, there was a purchase made at a local store in the amount of $75.00
-There was a benefit deposit on the card of $75.00 on 07/01/22.
-On 07/03/02 at 12:15pm, there was a purchase made at a local store in the amount of $64.59.
-On 07/08/22 at 6:51pm, there was a purchase made at a local store in the amount of $10.41.
-Both purchases in July 2022 totaled $75.00.

Interview with the Owner on 08/25/22 at 10:42am revealed:
-She was at a local store and had all the residents' insurance benefit food cards and she

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accidentally used Resident #5's card by mistake.
-Resident #5 had already been discharged from the facility when she used the insurance benefit healthy food card, but it was a mistake.
-She usually took orders from residents and then went to the store to make purchases, but sometimes she did not pay attention to the cards being used.
-"It was a mistake."
-Resident #5's responsible party came by the facility on 07/31/22 to pick up the his insurance benefit healthy food card, but she was out of the facility at a funeral and had Resident #5's card with her.
-She did not know what time Resident #5's responsible party was coming by the facility to pick the card up.
-She sent $75.00 to Resident #5's responsible party by certified mail on 08/02/22, but it was returned to the facility due to the missing information in the address.
-After a conversation with the Resident #5's responsible party, the Administrator dropped a check for $75.00 off to her at home on 08/10/22.
-She did not know what to do about the other $75.00 that was owed to Resident #5 as the responsible party did not want any additional contact from the facility.

Interview with the Administrator on 08/25/22 at 10:39am revealed:
-She knew the Owner accidentally made purchases with Resident #5's insurance benefit healthy food card.
-She provided reimbursement of $75.00 to Resident #5's responsible party on 08/10/22.
-She did not realize there was an additional $75.00 charge on Resident #5's insurance benefit healthy food card until she was notified by a representative with the local county Department

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D 338	Continued From page 50 of Social Services. -She attempted to provide the reimbursement of the additional $75.00 to Resident #5's responsible party about a week after the first reimbursement, but the Resident #5's responsible party requested not have any further contact with the facility.	D 338		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free from mental and physical abuse, neglect, and exploitation and in compliance with relevant federal and state laws and rules and regulations related to Health Care. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure health care referral and follow up for 2 of 5 sampled resident (#1 and #2) for a resident who had a pacemaker and a physician's orders for a neurology and cardiology consultation, and had several hospital visits (#1); and a resident who had physician's orders for continuous oxygen and did not have portable oxygen, and had an emergency room visit due to shortness of breath (#2). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D914		

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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. 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	D935		

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by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure 2 of 2 sampled medication aides (the Administrator and C) had documentation of a completed medication administration clinical skills validation, had documentation of a total of 15 hour medication administration training course or had verification of previous employment before administering medication to residents.

The findings are:

1. Review of the Administrator's personnel record revealed:
-Staff B was hired on 11/01/20 as the Administrator.
-There was documentation a medication clinical skills checklist with completed for the Administrator on 07/17/19.
-FSBS and injections were not checked off for the Administrator on 07/19/19.
-There was no documentation of a completed medication administration clinical skills checklist completed for the Administrator since her hire date at the facility on 11/01/20.
-There was documentation a 10-hour medication training was completed on 07/17/19.
-There was no documentation a 5-hour medication training had been completed.

Interview with the Administrator on 08/25/22 at 1:45pm revealed:
-She was responsible for ensuring all staff had required trainings and for maintaining staff records.
-She thought she had the 5-hour medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079105	A. BUILDING: _____ B. WING _____	R 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S AGAPE ASSISTED LIVING	5767 HWY 135 STONEVILLE, NC 27048

(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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training completed by a facility contracted pharmacist at a different facility.
-She did not have a copy of the 5-hour certificate.
-She completed the medication administration clinical skills checklist at a different facility, and she thought it could transfer from facility to facility.
-She had not had the medication administration clinical skills checklist completed at this facility.
-She occasionally administered medications to residents including insulin injections, checked fingerstick blood sugars (FSBS), but it had been a while.

Telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50am revealed:
-She had not completed the medication administration clinical skills checklist or the 5-hour medication training for Staff B.
-She had not been contacted prior to 08/23/22 to complete a medication clinical skills checklist for Staff B.

Refer to interview with the Owner on 08/25/22 at 11:42am.

Refer to telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50pm.

2. Review of Staff C's, Supervisor, personnel record revealed:
-Staff C was hired on 11/01/20.
-There was documentation a medication administration clinical skills checklist with completed for Staff B on 07/17/19.
-FSBS and injections were not checked off for Staff B on 07/19/19.
-There was no documentation of a completed

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	HAL079105	A. BUILDING: _____ B. WING _____	R 08/25/2022

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medication administration clinical skills checklist completed for Staff B since his hire date at the facility on 11/01/20.
-There was documentation a 10-hour medication training was completed on 07/17/19.
-There was no documentation a 5-hour medication training had been completed.

Review of a resident's electronic medication administration record (eMAR) for June 2022, July 2022, and 08/01/22 through 08/24/22 revealed:
-Staff C checked documented administration of medication 8 days in June 2022.
-Staff C checked documented administration of medication 14 days in July 2022.
-Staff C checked documented administration of medication 20 days between 08/01/22 and 08/24/22.

Observation of Staff C on 08/25/22 between 8:38am and 8:48am revealed Staff C administered medications to residents.

Interview with Staff C on 08/25/22 at 8:50am revealed he administered medication to residents including insulin injections and checking FSBS.

Telephone interview with the facility contracted registered nurse (RN) on 08/25/22 at 12:50am revealed:
-She had not completed the medication clinical skills checklist or the 5-hour medication training for Staff C.
-She had not been contacted prior to 08/23/22 to complete a medication clinical skills checklist for Staff C.

Interview with the Administrator on 08/25/22 at 1:45pm revealed:
-She was responsible for ensuring all staff had

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required trainings and for maintaining staff records.
-She thought Staff C had the 5-hour medication training completed by a facility contracted pharmacist at a different facility.
-She did not know why the 5-hour certificate was not in Staff C's personnel record.
-Staff C completed the medication administration clinical skills checklist at a different facility, and she thought it could transfer from facility to facility.
-Staff C had not had the medication clinical skills checklist completed at this facility.
-Staff C administered medication to residents including insulin injections and checked fingerstick blood sugars (FSBS).

Refer to interview with the Owner on 08/25/22 at 11:42am.

Refer to telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50pm.

_____

Interview with the Owner on 08/25/22 at 11:42am revealed:
-She knew medication administration clinical skills checklists were specific to each facility.
-She knew medication administration clinical skills checklist should have been completed at the facility prior to MA and supervisors administering medication to the facility's residents.
-She was working on getting the nurse to come to the facility to complete the medication clinical skills checklist, but she had not had time to get it completed yet.
-She thought for sure staff had 5-hour medication training because the 10-hour medication training had been completed by a pharmacist from the

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D935	Continued From page 56 contracted pharmacy at a sister facility. -She did not know where the documentation of the 5-hour training was, but she would check with to see if she had sent a copy to a representative with the local county Department of Social Services. -She and the Administrator were responsible for ensuring staff had required trainings and competencies completed. Telephone interview with the facility's contracted Registered Nurse (RN) on 08/25/22 at 12:50pm revealed: -She completed the medication administration clinical skills checklist and all other medication training for staff at the facility. -The Administrator usually called her when she had staff who needed a medication clinical skills check off. -Once the medication administration clinical skills checklist or the 5-hour, 10-hour, or 15-hour medication training was completed, she signed the document/certificate and left it at the facility to be filed in the staff's record.	D935		