Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041072	A. BUILDING: ____ B. WING ____	R-C **08/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON OAKS	**3004 DEXTER AVENUE GREENSBORO, NC 27407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation from 08/17/22 through 08/19/22.	D 000		
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, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#3) who had a diagnosis of Alzheimer's dementia, was constantly disoriented and a history of falls. The findings are: Review of the facility's falls policy dated August-2021 revealed: -The community will evaluate fall risk on admission and readmission and document the intervention according to the care needs and physician orders. -On admission or readmission, the resident is evaluated by management for fall risk. -The resident is evaluated at each fall, and appropriate reports are completed with documentation of each new intervention. -The fall risk admission evaluation - management	D 270		

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completes on the day of admission or the day of return from a hospital admission (not an emergency room/ER visit).
-When a fall/fall related accident/incident occurred, a fall related accident/incident report should be completed by the Resident Care Coordinator (RCC) or designee in the electronic Medication Administration Record (eMAR) at which time the facility's 72-hour fall management process will be added in the eMAR.
-Within 24-48 hours of each fall a manager will complete the post fall care plan evaluation for interventions.
-A new intervention must be added for each additional fall.
-The Resident Care Coordinator (RCC) or designee will add the fall risk banner to the face sheet in the eMAR.
-The RCC or designee will add the fall risk emblem to the door name plate.
-The RCC or designee will add intervention(s) to the orders in the eMAR.

Review of Resident #3's progress notes, accident/incident reports and eMARs from 03/31/22 through 08/18/22 revealed:
-There were no documented interventions (fall mat/mattress, body/chair alarm, halo, etc.) in place to keep the resident safe from falling.
-There was no documentation of increased or continued supervision and/or monitoring to keep Resident #3 safe from falls.
-There was no documentation of a post fall care plan as specified in the facility's policy.
-There was no documentation of fall risk emblem on the door name plate. There was no documentation of any other interventions added to the eMAR system to show continued supervision was implemented for Resident #3.

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Review of Resident #3's current FL2 dated 01/10/22 revealed:
-Diagnoses included Alzheimer's dementia, type 2 diabetes mellitus, hypertension, and seizures.
-Resident #3 was constantly disoriented.
-The level of care was Special Care Unit (SCU).
-The resident was ambulatory.

Review of Resident #3's SCU profile and care plan dated 06/09/22 and 06/21/22 revealed:
-Resident #3's cognitive impairments were severe memory loss, paces, walked, rocked, swings, hums, claps, pats or rubs.
-There were no preventive measures in place for safety (such as interventions for falls, restraint's, behaviors, etc.).

Review of Resident #3's care plan dated 02/08/22 revealed:
-Resident #3 was independent with eating and ambulation.
-Resident #3 required limited assistance with transferring.
-Resident #3 required extensive assistance with bathing, dressing and grooming.

Review of Resident #3's updated care plan dated 08/09/22 revealed:
-Resident #3 was constantly disoriented.
-Resident #3 had a significant change; the resident currently used a wheelchair for mobility around the facility with staff assistance.
-Resident #3 was pleasantly confused and was non-verbal.
-Resident #3 required extensive assistance with ambulation and transferring.
-Resident #3 was required total assistance with toileting, bathing, dressing and grooming.

Review of a hospice communication note dated

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08/09/22 revealed:
-Resident #3 had Alzheimer's dementia with behavioral disturbance.
-Resident #3 had 6 falls within the past six months that resulted in a fracture to the left wrist, nasal fracture and lacerations to the head.

Observation of Resident #3 for three days revealed:
-On 08/17/22 from 8:45am through 4:30pm Resident #3 was sitting in a high back wheelchair with foot rest.
-The resident was placed in the activity room with other residents.
-The resident talked to herself and made gestures and movements with her arms and legs but did not attempt to get up from the wheelchair.
-On 08/18/22 from 8:30am through 4:30pm Resident #3 was sitting in same position in the activity room. The resident left the activity room to eat meals and twice for incontinent care.
-On 08/19/22 from 11:00am through 5:00pm Resident #3 was sitting in the same position as observed on the two previous days.
-There was no body/chair alarm observed to alert staff when Resident #3 was attempting to get up from the chair.

Observation of Resident #3 room on 08/18/22 at 3:40pm revealed:
-Resident #3's bed was a hospital.
-The headboard of Resident #3's bed was placed against the wall.
-The foundation of the hospital bed was a mattress on a spring.
-The mattress/spring was greater than 12 inches from the floor.
-The left side of the bed was pushed against the window and part of the wall.
-The right side of the bed had a bedside table

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D 270	Continued From page 4 adjacent to the headboard that was less than one-half foot from the bed. -There was no observed fall mat/mattress, halo, bed/chair body alarm or other interventions to keep Resident #3 safe from falling. a. Review of Resident #3's progress notes revealed: -On 03/31/22 at 10:22am, Resident #3 had a fall. -No injuries were documented. -There was documentation Resident #3 was checked once per shift from 04/01/22 through 04/03/22. -There was no documentation of increased supervision or monitoring in place for Resident #3 after 04/03/22. Review of Resident #3's accident/incident report dated 03/31/22 at 3:31pm revealed: -Resident #3 was in the activity room and tripped over another resident's cane. -There were no injuries documented. -Resident #3's vital signs would be obtained every shift for three days. -The resident would be monitored for 72-hours, per shift for bruising, change in mental status/condition, pain, or other injuries related to fall; there was a note for staff to document any changes or no changes. -The monitoring for bruising and mental status change was to be completed from 04/01/22 through 04/04/22. Review of Resident #3's April 2022 eMAR revealed: -The resident's vital signs were checked every shift from 04/01/22 at 11:00pm through 04/03/22 at 11:00pm. - There was no documentation of increased supervision and/or monitoring after the 72-hour	D 270		

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monitoring ended on 04/04/22.

Telephone interview with Resident #3's guardian on 08/18/22 at 3:58pm revealed:
-Within the past two months Resident #3 started falling more frequently.
-She had no documentation that Resident #3 sustained a fall on or around the date of 03/31/22.
-Nothing had been discussed with her regarding increased supervision for Resident #3.

Attempted telephone interview with the personal care aide (PCA) that reported the incident on 03/31/22, on 08/18/22 at 3:18pm was unsuccessful.

Attempted telephone interview with the medication aide (MA) that completed the report on 03/31/22, on 08/18/22 at 3:19pm was unsuccessful.

Refer to interview with a medication aide (MA) on 08/19/22 at 2:25pm.

Refer to interview with the Resident Care Coordinator (RCC) on 08/18/22 at 12:33pm.

Refer to interview with the Administrator on 08/19/22 at 1:43pm.

b. Review of Resident #3's progress notes revealed:
-On 04/28/22 at 3:15pm, Resident #3 was found on the floor.
-There was documentation Resident #3 was checked once per shift from 04/29/22 through 05/02/22.
-There was no documentation of increased supervision or monitoring in place for Resident #3 after 05/02/22.

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Review of Resident #3's accident/incident report dated 04/28/22 revealed:
-Resident #3 was in her room.
-Resident #3's roommate informed the MA that Resident #3 was on the floor.
-Staff observed Resident #3 sitting on her bottom.
-There were no injuries were documented.
-Resident #3's vital signs would be checked once per shift for three days.
-Resident #3 would be monitored for 72-hours post fall for bruising, change in mental status/condition, pain, or other injuries related to the fall; and staff was to document any change or no changes.
-The monitoring was from 04/29/22 through 05/02/22.
-There was no documentation of increased supervision and/or monitoring after the 72-hour monitoring for vitals and post fall bruises and mental status changes that ended on 05/02/22.

Review of Resident #3's physician's visit summary reports dated 04/25/22 and 04/28/22 revealed:
-Staff reported Resident #3 was having pain in her left hip.
-Staff reported if the resident had a fall it was unwitnessed.
-Staff reported on 04/28/22 Resident #3 had a fall in her room that was witnessed by the resident's roommate.

Telephone interview with Resident #3's guardian on 08/18/22 at 3:58pm revealed:
-On 04/28/22, facility staff called and told her that Resident #3's roommate reported Resident #3 was walking to the door and fell.
-The resident's roommate got facility staff to help Resident #3.

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D 270	Continued From page 7 -She was told Resident #3 did not have any injuries and would not be going to the hospital. -This was not Resident #3's first time falling. -The resident's falls had increased within the last year and started happening more frequently within the past two months. -Resident #3 had at least four falls within the last two months July and August 2022, two of the falls resulted in fractures, staples, stitches and lacerations. Based on observation, record review and interview it was determined that Resident #3's roommate was not interviewable. Attempted telephone interview with the staff that assisted Resident #3 on 04/28/22, on 08/19/22 at 3:58pm was unsuccessful. Refer to interview with a MA on 08/19/22 at 2:25pm. Refer to interview with the RCC on 08/18/22 at 12:33pm. Refer to interview with the Administrator on 08/19/22 at 1:43pm. c. Telephone interview with Resident #3's guardian on 08/19/22 at 3:31pm revealed: -She received a voice mail message on her answering machine from a facility staff on 06/28/22 (time unknown). -The staff stated Resident #3 stood up to walk and fell to the floor, ending up on her bottom. -The staff concluded there were no visible injuries and the resident was not sent out to the hospital. -She did not call the facility back to clarify if the fall was a witnessed or unwitnessed fall.	D 270		

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Interview with a medication aide (MA) on 08/19/22 at 11:58am revealed:
-She had worked at the facility since June 2022.
-She had observed that Resident #3 had "a lot of falls."
-She was unable to recall exact dates of Resident #3's falls.
-Staff were required to document each fall on a progress note and complete a fall accident/incident report.
-The resident was placed on the facility's 72-hour monitoring program.
-If a fall was not documented, that did not mean the fall did not happen.
-Sometimes residents had unwitnessed falls.

Interview with the Administrator on 08/19/22 at 3:55pm revealed:
-She did not have an accident/incident report dated 06/28/22.
-Staff were required to complete an accident/incident report even if there were no visible injuries.
-Without documentation she was unable to validate Resident #3 had a fall.
-After the fall on 07/19/22, staff were to monitor Resident #3 by visibly laying eyes on the resident every 30 minutes.

Refer to interview with a MA on 08/19/22 at 2:25pm.

Refer to interview with the RCC on 08/18/22 at 12:33pm.

Refer to interview with the Administrator on 08/19/22 at 4:13pm.

d. Review of Resident #3's progress notes revealed:

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-On 07/19/22 at 9:44am Resident #3 had a fall and was sent to the hospital.
-There was documentation Resident #3 was checked once per shift from 07/21/22 through 07/23/22.
-There was no documentation of increased supervision or monitoring interventions in place for Resident #3 after 07/23/22.

Review of Resident #3's accident/incident report dated 07/19/22 revealed:
-Resident #3 was found in the hallway by the medication aide (MA).
-The resident was laying on the floor.
-The resident exhibited/complained of pain.
-The resident had a head laceration.
-Resident #3 was put on 72-hour monitoring with vital signs checked every shift from 07/19/22 through 07/22/22.

Review of a emergency department (ED) discharge summary report dated 07/19/22 revealed:
-Resident #3 was nonverbal, unable to follow commands or provide information due to advanced Alzheimer's dementia.
-Resident #3 had a large scalp laceration about 5 centimeters (cm) on the vertex (crown towards back of the head) of the scalp with slight gaping.
-Resident #3 had multiple lacerations of the forehead including a gaping 3 and ½ inch laceration over the left brow.
-Resident #3 had extensive bruising developing around the base of the nose and the upper lip.
-Resident #3 had a small puncture laceration on the chin.
-Discharge diagnoses included a traumatic head injury with multiple lacerations, a nondisplaced fracture of the right nasal bone; minimally displaced fracture of the superior bony nasal

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septum, and hemorrhage present in the left sinus.
-Resident #3 received staples to her head and sutures to her face.

Telephone interview with Resident #3's guardian on 08/18/22 at 3:58pm revealed:
-On 07/19/22, she received a telephone call from a staff at the facility, that Resident #3 was found on the floor.
-The resident was bleeding from the head and was going to the hospital.
-The hospital diagnosed Resident #3 with facial fractures and lacerations.
-The resident had to have staples and stitches to close the lacerations.
-Within the last two months, Resident #3 had been falling more frequently.
-No one at the facility discussed with her alternatives to keep the resident safe from falling.
-The facility did not discuss with her increased monitoring of Resident #3.
-She was aware Resident #3 had dementia.
-The resident loved to walk and continually walked around the SCU.
-The resident needed more supervision because she was always trying to move.

Interview with the MA that assessed Resident #3 on 07/19/22 on 08/19/22 at 11:30am revealed:
-On 07/19/22, Resident #3 had an unwitnessed fall.
-The maintenance director was walking in the hallway and found the resident on the floor.
-The maintenance director told her the resident was on the floor.
-She observed Resident #3 was bleeding from her head.
-She did not touch Resident #3 but called emergency responders.
-When Resident #3 returned from the hospital

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she had staples, but she was not sure if the resident had fractures.
-Resident #3 was put on 72-hour "watch" for monitoring.
-During the 72-hour monitoring she kept Resident #3 close to the medication room, so she could see the resident and keep a close eye on the resident.
-There was a board in the medication room with the names of the residents that were on increased supervision.
-Resident #3's name was put on the board.
-Supervision was increased to every 30 minutes for Resident #3 after the first fall in July 2022.
-Additionally, Resident #3 was kept in the activity room all day for staff to keep an eye on the resident.
-Resident #3 had dementia and loved to walk.
-The resident used to walk non-stop around the building.
-When Resident #3 walked she had falls because the resident walked on her tip toes and was unbalanced causing her to fall.

Refer to interview with a MA on 08/19/22 at 2:25pm.

Refer to interview with the RCC on 08/18/22 at 12:33pm.

Refer to interview with the Administrator on 08/19/22 at 4:13pm.

e. Review of Resident #3's progress notes revealed:
-On 07/27/22 at 2:50pm, Resident #3 was sent to the hospital due to a fall.
-There was documentation Resident #3 was checked once per shift from 07/28/22 through 07/30/22.

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-There was no documentation of increased supervision or monitoring in place for Resident #3 after 07/30/22.

Review of Resident #3's accident/incident report dated 07/27/22 revealed:
-At 2:30pm Resident #3 was in the hallway.
-Resident #3 fell to the floor and hit the middle of the back of her head.
-A laceration was observed.
-The resident complained of pain related to the fall.
-The resident was sent to the hospital.
-Resident #3 vital signs were to be checked for three days, per shift and documented by the MA.
-There was documentation Resident #3 was put on a 72-hour monitoring program.
-Staff were to monitor the resident for post fall bruising, change in mental status/condition, pain, or other injuries related to fall.

Review of Resident #3's ED discharge summary report dated 07/27/22 revealed:
-Resident #3 was in the emergency room due to having a fall at the facility.
-Resident #3 was diagnosed with lacerations of the scalp and closed left wrist fracture.

Telephone interview with Resident #3's guardian on 08/18/22 at 3:58pm revealed:
-On 07/27/22, she was informed that Resident #3 had a fall and was sent to the hospital.
-On 07/27/22, Resident #3 fell and fractured her left wrist.
-Recently, around 08/02/22 or 08/03/22, she had a meeting with the facility to discuss Resident #3's decline in health.
-The facility's Primary Care Provider (PCP) recommended hospice for Resident #3.
-She thought the facility's plan for hospice was to

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keep the resident from falling.
-She was told that hospice would intervene in the care of the resident.
-She thought that hospice was going to be at the facility everyday to assist Resident #3 and stay with the resident for several hours to prevent the resident from falling.
-The facility had not discussed with her other health alternatives to keeping Resident #3 safe from falls like a fall mattress or chair/bed alarms.

Interview with the medication aide (MA) that found Resident #3 on 08/19/22 at 11:30am revealed:
-On 07/27/22, she was in the activity room administering medications.
-Resident #3 was in the hallway when she heard Resident #3 hit the floor.
-When she got to Resident #3, she observed the resident's wrist was bent down and hanging like it was not attached.
-She knew something was wrong and she called 911.
-It was the facility's policy after a resident had a fall, the resident was put a monitoring program for 72-hours.
-Within that 72-hours the resident's vital signs were checked every shift.
-The resident was monitored for post fall injuries and behaviors.
-Within the last week 30 minute checks were implemented for Resident #3
-Residents on 30 minute checks were monitored continually past the 72-hours post fall monitoring.
-After a recent fall Resident #3 was given a wheelchair, and the resident continually tried to get out of the wheelchair.
-There was no system for monitoring residents more frequently than every 30 minutes.
-There was no system to document a resident

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D 270	Continued From page 14 was checked every 30 minutes. -During the first shift and part of the second shift, residents on increased supervision were kept in the activity room so staff could keep an eye on them. -She had observed that Resident #3 had declined significantly, and now had to be in a wheelchair due to her wrist fracture obtained last month. -Most of Resident #3's falls happened because the resident still thought she could walk, and she frequently tried to get up out of her wheelchair. -Before Resident #3 hit her head last month, she continually walked around the building. Interview with a personal care aide (PCA) on 08/19/22 at 2:03pm revealed: -She was aware Resident #3 had a history of falls. -As a fall precaution Resident #3 was kept in the activity room all day during her shift, the first shift. -There were staff assigned to be in the activity room and to monitor Resident #3 and other residents. -Staff switched off every hour to monitor residents in the activity room, which included Resident #3. -Resident #3 was unable to walk and stand without assistance, and continually made attempts to get up and walk. -Resident #3 needed constant supervision to keep her from getting up out of her chair. Interview with a second shift PCA on 08/19/22 at 4:21pm revealed: -She had worked at the facility for two months and had not observed Resident #3 having a fall. -She knew Resident #3 had a history of falls. -She observed Resident #3 had many occasions trying to get up out of her wheelchair. -When observed the resident getting up, she talked the resident into sitting back down.	D 270		

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-When she arrived to work at 3:00pm, Resident #3 was in the activity room with other residents.
-Staff kept an eye on Resident #3 in the activity room.
-Resident #3 was put to bed a few hours after the dinner meal.
-Resident #3 was checked every 2 hours for incontinence care.
-She observed Resident #3 every 30 minutes for 72 hours after her last fall on 07/27/22.
-It was the facility's policy after a fall to monitor the resident for every 30 minutes.
-Documentation by the PCAs related to the 30 minute check was not required.

Refer to interview with a MA on 08/19/22 at 2:25pm.

Refer to interview with the RCC on 08/18/22 at 12:33pm.

Refer to interview with the Administrator on 08/19/22 at 4:13pm.

f. Review of Resident #3's progress notes revealed on 08/15/22 at 11:36pm, Resident #3 had a fall. No injuries were documented.

Review of Resident #3's accident/incident report dated 08/15/22 at 11:24am revealed:
-On 08/15/22 at 11:36pm, Resident #3 was found in her room on the floor.
-The resident was laying on the floor beside her bed.
-No injuries were documented, and the resident did not express pain related to the fall.

Telephone interview with Resident #3's guardian on 08/19/22 at 3:31pm revealed:
-On 08/16/22, a medication aide (MA) called and

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told her Resident #3 was found in her room on the floor.
-The MA said no injuries were observed and she was not sending the resident to the hospital.
-Resident #3 needed to be on a fall prevention program.
-She expected the facility to monitor Resident #3 as close as possible to keep the resident safe from falls.
-She was led to believe by the facility that hospice staff would be in the facility more frequently to monitor Resident #3; not 24/7 monitoring but much more frequently than a couple days a week and one hour per each visit.
-Resident #3 had dementia and needed continuous monitoring.
-Nothing had been discussed with the facility regarding increased supervision or monitoring or preventative measures to keep the resident from falling.

Telephone interview with the MA that found Resident #3 on the floor on 08/15/22, on 08/19/22 at 2:06pm revealed:
-She worked third shift from 11:00pm to 7:00am at the facility.
-She was coming to work on 08/15/22, it was a little after 11:00pm.
-On 08/15/22 at 11:30pm, she was doing her rounds and walked past Resident #3's room.
-She observed the resident was laying on the floor by her bed.
-She was told by staff on the second shift that Resident #3 was in the bed.
-She believed the resident was trying to get up out of the bed and fell to the floor.
-She did not observe or see any injuries on the resident.
-She did a falls report and left the report for the Resident Care Coordinator (RCC) and the

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Administrator.
-There was a falls list in the medication room.
-Residents on the falls list were to be checked every 30 minutes.
-Resident #3 was on the falls list and should have been checked every 30 minutes.
-There was no system in place to document Resident #3 was checked every 30 minutes.
-Her and some other staff were doing 30 minute checks on their own because Resident #3 had a bad fall last month and broke her wrist.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 08/18/22 at 12:16pm revealed:
-The resident had Alzheimer's disease and had a loss of balance causing her to fall.
-She ordered hospice because the resident's falls would continue and happen more frequently.
-The hospice was not for supervision but for failure to thrive.
-It was the facility's responsibility to determine the frequency of supervision for Resident #3.

Refer to interview with a MA on 08/19/22 at 2:25pm.

Refer to interview with the RCC on 08/18/22 at 12:33pm.

Refer to interview with the Administrator on 08/19/22 at 4:13pm.

____
Interview with a MA on 08/19/22 at 2:25pm revealed:
-She was aware Resident #3 had falls.
-The falls were unwitnessed and happened when the resident got up from her wheelchair and ended up on the floor.
-The first time Resident #3 fell that she was

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aware of was when the resident was in the hallway, and she fell and hit her head.
-When staff ran down the hallway to where the resident was, she could see the blood was coming from the resident's head.
-The resident had hit her head on the side of an object near the door.
-After the first fall the resident was still ambulatory and able to walk around.
-Resident #3 also fell to floor a second time and hit her head, causing it to bleed.
-The majority of Resident #3's falls happened when she got up from her wheelchair.
-Each one of the falls Resident #3 was found on the floor.
-The resident got up from her wheelchair and fell to the floor.
-After Resident #3 fractured her wrist in July 2022, the supervision for Resident #3 was to keep the resident in the activity room so staff could see her when she tried to get up from the wheelchair.
-If the resident was in the activity room staff were able to observe the resident all day.

Interview with the RCC on 08/18/22 at 12:33pm revealed:
-She was aware Resident #3 had falls.
-On 08/09/22, she updated Resident #3's care plan to show the resident had a significant change in health care status from ambulatory to non-ambulatory using a wheelchair.
-The resident was now on hospice and had a wheelchair.
-She did not decide or identify which residents were to be checked on more frequently, that was done by the Administrator.
-If a resident had a fall, the resident was put on 72-hour post fall monitoring.
-Resident #3 was in the activity room most of the

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D 270	Continued From page 19 day so staff were able to keep an eye on the resident. -There was no fall mat/mattress, halo or alarms (bed/chair) because those had to come from hospice. -Prior to hospice intervention these type of interventions had not been discussed because obtaining these items were the guardian's responsibility. Interview with the Administrator on 08/19/22 at 4:13pm revealed: -She was aware Resident #3 had falls. -It was the responsibility of the guardian to provide the resident with chair/bed alarms and fall mat/mattress. -Obtaining these items had not been discussed with Resident #3's guardian. -Resident #3's PCP recommended hospice because the resident's Alzheimer's dementia was worsening, and the resident was having more falls. -Hospice was not going to monitor the resident to prevent falls, but they were monitoring due weakness caused by decline in health; and the resident walked on the tipped toes which caused the resident to fall. -She was unaware Resident #3's guardian thought hospice was going to monitor the resident more frequently for falls. -Since July 2022, staff were supposed to check on Resident #3 every 30 minutes and every 2 hours for incontinent care. -The resident was supposed to be in the activity room all day for staff to monitor her. -When Resident #3 was in her room, the resident's bed was supposed to be in the lowest position and the resident was supposed to be checked every 30-minutes when in bed. -The 30 minute checks were not documented.	D 270		

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D 270	Continued From page 20 __________________ The facility failed to provide supervision for Resident #3 who had a diagnosis of Alzheimer's dementia, walked and wandered throughout the facility and had unwitnessed falls resulting in nasal fractures, broken wrist, lacerations to the head and face that required staples and stitches. The facility's failure resulted in serious injuries to the resident and constitutes a Type A1 Violation. ___________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/19/22 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2022	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 residents (#6 and #7) observed during the medication pass including errors with an anticoagulant medication (#6) and a diuretic (#7); and for 2 of 5 sampled residents (#2 and #4) for record review including	D 358		

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errors with a laxative medication (#2 and #4).

The findings are:

1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 8:00am medication pass on 08/18/22.

a. Review of Resident #6's current FL2 dated 08/02/22 revealed:
-Diagnoses included vascular dementia, hypertension and type 2 diabetes.
-There was an order for clopidogrel (a blood thinning medication) 75mg once daily.

Observation of the medication pass for Resident #6 on 08/18/22 revealed:
-At 8:06am, Resident #6 was listed on the electronic Medication Administration Record (eMAR) as being due for clopidogrel 75mg.
-The medication aide (MA) prepared Resident #6's medications which were packaged in a multi-dose package from the pharmacy.
-While pouring the medications from the multi-dose package into the plastic medication cup, Resident #6's clopidogrel 75mg tablet fell on to the top of the medication cart and then fell onto the floor.
-The MA picked up the tablet and set it in a paper cup with the top pinched together and folded over to dispose of after administering the rest of Resident #6's medications.
-The MA asked another MA to come to the medication cart and asked the other MA what she was supposed to do regarding Resident #6's clopidogrel dose.
-The other MA advised the MA doing medication pass to dispose of the tablet that dropped on the floor, document the dose as not administered on

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the eMAR, then notify the primary care provider (PCP).
-The MA who was doing the medication pass documented Resident #6's clopidogrel as not administered and added a note that the pill had dropped to the floor and she would follow up with the PCP.
-The MA administered the remaining medication in the plastic medication cup to Resident #6 and disposed of the dropped clopidogrel tablet.

Interview with the MA on 08/18/22 at 8:10am revealed:
-She knew she was not supposed to administer a pill once it had been on the floor and that it needed to be disposed of, and she knew she was not supposed take a pill from the next day's multi-dose pack.
-She was not told during her new employee MA training what the process was if a medication fell of the floor.
-She was not told who to notify if a pill dropped on the floor, how she was supposed to document it or how the resident was supposed to get their missed dose of medication.

Review of Resident #6's August 2022 eMAR revealed:
-There was an entry for clopidogrel 75mg daily scheduled at 8:00am.
-There was documentation clopidogrel was not administered on 08/18/22; the documented reason was that pill dropped on the floor, was discarded, and will follow up with the PCP regarding the pill not being administered.

Review of the facility's Medication Administration policy on 08/18/22 at 1:20pm revealed there was no written policy or procedure for medications that had been dropped on the floor.

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D 358	Continued From page 23 Interview with a second MA on 08/18/22 at 8:47am revealed: -If a pill dropped on the floor, the MAs were supposed to dispose of it and check the overstock medication supply to see if the pill could be replaced from the single-dose packs remaining from the previous pharmacy. -If the medication was not available in the overstock supply, the MA needed to document the medication as not administered on the eMAR. -The MA also needed to call the PCP, and then the pharmacy to have a replacement sent if the PCP wanted the dose administered and it was okay to administer it late once it arrived from the pharmacy. Interview with a third MA on 08/18/22 at 4:05pm revealed: -If a pill was dropped on the floor during medication pass, the MA was supposed to check the overstock medications which were single-dose packs left over from the previous pharmacy. -The dropped medication was supposed to be documented as not administered on the eMAR and disposed of. -The MA was responsible for notifying the PCP of the missed dose and documenting the notification along with any new orders received. Interview with the facility's nurse on 08/18/22 at 9:15am revealed: -The facility had been receiving their medications in multi-dose packs for the last two years. -The MAs were told that if a pill dropped on the floor they needed to dispose of the pill and document in a progress note that the medication was dropped, then call the PCP. -If the PCP did want the dropped dose	D 358		

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administered that day, the MA would be responsible for calling the pharmacy and requesting the medication be delivered as soon as possible.

Telephone interview with a representative from the facility's contracted pharmacy on 08/18/22 at 9:45am revealed:
-Since they dispensed medications in multi-dose packages, the facility would need to call them to request a replacement for any medication that was dropped on the floor.
-If a medication needed to be delivered that same day, they were able to arrange the delivery through a back-up pharmacy that was close in location to the facility.

Telephone interview with Resident #6's PCP on 08/18/22 at 12:30pm revealed:
-Resident #6 was taking clopidogrel for diagnoses of peripheral vascular disease and coronary artery disease.
-She had received a text from the MA this morning stating that Resident #6's clopidogrel had been dropped on the floor so he missed that dose.
-She was not concerned about Resident #6 having adverse effects for missing one dose of clopidogrel and had not given the MA any additional orders for replacing the missed dose.

Interview with the Resident Care Coordinator (RCC) on 08/18/22 at 4:10pm revealed:
-The MAs were taught that if a pill fell on the floor, they were supposed to dispose of it, document it as not administered, and call the PCP.
-If the PCP wanted the missed dose to be administered that day, the MA was responsible for arranging the delivery of the medication that same day.

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-The MAs were supposed to document in a progress note every time they contacted the PCP and if new orders were received from the PCP.
-Once the PCP and pharmacy were notified, the MA was supposed to come and let her know what happened to cause the pill to drop.
-The MA who did the medication pass that morning, 08/18/22, did let her know about Resident #6's dropped clopidogrel.

Interview with the Administrator on 08/19/22 at 3:15pm revealed:
-If a MA dropped a pill on the floor during medication pass, they were responsible for calling the PCP and documenting the notification and if any orders were received.
-If new orders were received for the missed medication to be administered that day, the MA was responsible for arranging the delivery of the medication from the pharmacy.
-The pill that dropped on the floor needed to be disposed of.
-The MAs were taught to never open another day's multi-dose package to take a pill out.
-The MAs were supposed to notify the lead supervisor or the RCC if a pill was dropped on the floor and disposed of.
-If a replacement pill was needed the pharmacy was able to deliver it within an hour or two of the MA calling to request it.
-She expected all medications to be administered as ordered and that the MAs would be cautious as they poured the pills from the multi-dose packages into the medication cups so that errors did not occur.

b. Review of Resident #7's current FL2 dated 02/07/22 revealed:
-Diagnoses included dementia, shortness of breath, weakness, and diastolic heart failure.

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-There was an order for torsemide (a diuretic medication used to decrease fluid retention or swelling) 20mg tablets, take four tablets (80mg total) once daily.

Observation of the medication pass for Resident #7 on 08/18/22 revealed:
-At 8:15am, Resident #7 was listed on the electronic Medication Administration Record (eMAR) as being due for torsemide 80mg.
-The medication aide (MA) prepared Resident #7's medications which were packaged in a multi-dose package from the pharmacy.
-While pouring the medications from the multi-dose package into the plastic medication cup, one of Resident #7's torsemide 20mg tablets fell onto the floor.
-The MA picked up the tablet and set it aside to dispose of after administering the rest of Resident #7's medications.
-The MA administered the remaining medication in the plastic medication cup to Resident #7 and disposed of the dropped torsemide tablet.

Interview with the MA on 08/18/22 at 8:10am revealed:
-She knew she was not supposed to administer a pill once it had been on the floor and that it needed to be disposed of, and she knew she was not supposed take a pill from the next day's multi-dose pack.
-She was not told during her new employee MA training what the process was if a medication fell of the floor.
-She was not told who to notify if a pill dropped on the floor, how she was supposed to document it or how the resident was supposed to get their missed dose of medication.

Review of Resident #7's August 2022 eMAR

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revealed:
-There was an entry for torsemide 20mg, take four tablets (80mg total) daily, scheduled at 8:00am.
-There was documentation torsemide was administered.

Review of the facility's Medication Administration policy on 08/18/22 at 1:20pm revealed there was no written policy or procedure for medications that had been dropped on the floor.

Interview with a second MA on 08/18/22 at 8:47am revealed:
-If a pill dropped on the floor, the MAs were supposed to dispose of it and check the overstock medication supply to see if the pill could be replaced from the single-dose packs remaining from the previous pharmacy.
-If the medication was not available in the overstock supply, the MA needed to document the medication as not administered on the eMAR.
-The MA also needed to call the primary care provider (PCP), and then the pharmacy to have a replacement sent if the PCP wanted the dose administered and it was okay to administer it late once it arrived from the pharmacy.

Interview with a third MA on 08/18/22 at 4:05pm revealed:
-If a pill was dropped on the floor during medication pass, the MA was supposed to check the overstock medications which were single-dose packs left over from the previous pharmacy.
-The dropped medication was supposed to be documented as not administered on the eMAR and disposed of.
-The MA was responsible for notifying the PCP of the missed dose and documenting the notification

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along with any new orders received.

Interview with the facility's nurse on 08/18/22 at 9:15am revealed:
-The facility had been receiving their medications in multi-dose packs for the last two years.
-The MAs were told that if a pill dropped on the floor they needed to dispose of the pill and document in a progress note that the medication was dropped, then call the PCP.
-If the PCP did want the dropped dose administered that day, the MA would be responsible for calling the pharmacy and requesting the medication be delivered as soon as possible.

Telephone interview with a representative from the facility's contracted pharmacy on 08/18/22 at 9:45am revealed:
-Since they dispensed medications in multi-dose packages, the facility would need to call them to request a replacement for any medication that was dropped on the floor.
-If a medication needed to be delivered that same day, they were able to arrange the delivery through a back-up pharmacy that was close in location to the facility.

Telephone interview with Resident #6's PCP on 08/18/22 at 12:30pm revealed:
-Resident #7 was taking torsemide for diagnoses of lymphedema and swelling to her legs.
-She had received a text from the MA this morning stating that one of Resident #7's torsemide tablets had been dropped on the floor so she received 60mg instead of 80mg.
-She was not concerned about Resident #7 having adverse effects for receiving a decreased dose of torsemide that morning if she resumed her ordered 80mg dose the next day.

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-She had not given any new orders to the MA regarding Resident #7.

Interview with the Resident Care Coordinator (RCC) on 08/18/22 at 4:10pm revealed:
-The MAs were taught that if a pill fell on the floor, they were supposed to dispose of it, document it as not administered, and call the PCP.
-If the PCP wanted the missed dose to be administered that day, the MA was responsible for arranging the delivery of the medication that same day.
-The MAs were supposed to document in a progress note every time they contacted the PCP and if new orders were received from the PCP.
-Once the PCP and pharmacy were notified, the MA was supposed to come and let her know what happened to cause the pill to drop.
-The MA who did the medication pass that morning, 08/18/22, did let her know about Resident #7's dropped dose of torsemide.

Interview with the Administrator on 08/19/22 at 3:15pm revealed:
-If a MA dropped a pill on the floor during medication pass, they were responsible for calling the PCP and documenting the notification and if any orders were received.
-If new orders were received for the missed medication to be administered that day, the MA was responsible for arranging the delivery of the medication from the pharmacy.
-The pill that dropped on the floor needed to be disposed of.
-The MAs were taught to never open another day's multi-dose package to take a pill out.
-The MAs were supposed to notify the lead supervisor or the RCC if a pill was dropped on the floor and disposed of.
-If a replacement pill was needed the pharmacy

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was able to deliver it within an hour or two of the MA calling to request it.
-She expected all medications to be administered as ordered and that the MAs would be cautious as they poured the pills from the multi-dose packages into the medication cups so that errors did not occur.

Review of the facility's cart audit/medications on hand policy revealed:
-The facility should ensure that residents' always have all current orders in the facility.
-The facility would develop a schedule so that all residents medication orders are check on a weekly basis by completing a cart audit.
-Staff will check to see that all medications are available using a copy of the physician's order.
-Staff will reorder as needed and the reorder will be placed in the order processing system for follow-up.
-Staff will check expirations date on medications and removed any expired medications and reorder as needed and place in the order processing system for follow-up.
-Staff will date/sign the physician orders once the cart audit was completed and leave to be reviewed by the RCC.

Review of the facility's medication services/pharmaceutical care services policy revealed:
-Each resident had the right to have the facility order medications through the pharmacy of their choice.
-If the pharmacy chosen by the resident did not meet the minimum quality standards, the facility's backup pharmacy.
-All medication that staff administer, handle, and store will be documented on the medication administration record (MAR) and in accordance

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with state regulations and the facility's pharmacy standard and procedure manuel.

2. Review of Resident #3's current FL2 dated 01/10/22 revealed:
-Diagnoses included Alzheimer's dementia, type 2 diabetes mellitus, hypertension and seizures.
-There was an order for lactulose 30 milliliter (ml)/20 grams (gm) once daily (used to treat constipation).

Review of Resident #3's Physician's order sheet dated 08/15/22 revealed there was an order for lactulose 30ml/20gm once daily.

Review of Resident #3's progress note dated 03/15/22 revealed a request was made for a handwritten script for lactulose.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 04/01/22 through 04/30/22.

Review of Resident #3's May 2022 eMAR revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 05/01/22 through 05/31/22.

Review of Resident #3's June 2022 eMAR revealed:

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-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 06/01/22 through 06/30/22.

Review of Resident #3's July 2022 eMAR revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 07/01/22 through 07/31/22.

Review of Resident #3's August 2022 eMAR revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 08/01/22 through 08/17/22.

Observation of Resident #3's medications on hand at the facility on 08/17/22 at 3:11pm revealed lactulose 30ml/20gm was not available for administration.

Telephone interview with the facility's contracted pharmacy on 08/18/22 at 9:33am revealed:
-Lactulose was not dispensed from their pharmacy.
-The pharmacy had an order for Resident #3's lactulose but had never dispensed the medication.
-The pharmacy profiled the medication, so it appeared on the eMARs.

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Telephone interview with the pharmacy that dispensed Resident #3's medications on 08/18/22 at 10:34am revealed:
-The pharmacy received an order for Resident #3's lactulose on 03/15/22.
-The pharmacy filled and dispensed a 30-day supply of lactulose on 03/15/22.
-If lactulose was administered as ordered, it should have required a refill on or around 04/15/22.
-Lactulose was not set to automatically refill.
-The facility had to call and request a refill of lactulose.
-Yesterday, 08/17/22, in the evening the facility requested a refill of lactulose.
-Prior to yesterday (08/17/22), no request had been made to refill lactulose; and the medication had not been refilled since 03/15/22.

Interview with a medication aide (MA) on 08/18/22 at 10:25am revealed:
-She thought another MA used the last little bit of lactulose that was left and gave it to Resident #3.
-The MA should have re-ordered the medication if it was out.
-Resident #3's medications came from the local retail pharmacy.
-She thought there was a problem with the pharmacy back ordering medications.
-If the medication was not in the building and the MA was unable to get the medication; the MA should let the Resident Care Coordinator (RCC) know the medication was not available.

Telephone interview with Resident #3's primary care provider (PCP) on 08/18/22 at 12:16pm revealed:
-She ordered Resident #3 lactulose because the resident had a history of severe constipation.
-Resident #3 should have been administered

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lactulose as ordered.
-Missing a few doses of lactulose was okay, but if the medication was not available, she should be notified.
-Resident #3 was non-verbal and could not tell if she was constipated.
-If the resident's stomach was extended or bulged that might be a sign the resident was constipated.

Interview with a MA that signed she administered Resident #3's lactulose on 08/19/22 at 11:55am revealed:
-She was sure that she administered Resident #3's lactulose.
-Resident #3's medications, including lactulose came a local retail pharmacy, which always back ordered medications.
-The pharmacy did not automatically refill Resident #3's medications.
-Someone at the facility had to contact the pharmacy and request a refill.
-If the pharmacy had back ordered the lactulose, then she was supposed to let the Resident Care Coordinator (RCC) know.
-She did medication cart audits weekly; when doing cart audits, she printed the physician's order sheet.
-She checked the physician's order sheet with the resident's medications on the medication cart.
-If a medication was identified not on the medication cart, then she contacted the pharmacy to inquire why the medication was not available.
-She was supposed to let the RCC and the Administrator know.
-The RCC would investigate to find out why the pharmacy had not dispensed the medication.
-She did not recall Resident #3's lactulose not being on the medication cart when she did a cart audit.

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Interview with a second MA that signed she administered Resident #3's lactulose on 08/19/22 at 2:25pm revealed:
-Resident #3 had a bottle of lactulose on the medication cart.
-She remembered administering lactulose to the resident this week and last week.
-She was unable to validate if the lactulose administered had Resident #3's name on the bottle.

Telephone interview with a third MA that signed she administered Resident #3's lactulose on 08/19/22 at 2:08pm revealed:
-She was sure that she administered Resident #3's lactulose recently.
-She was unable to recall if she identified Resident #3's name was on the bottle of lactulose or another resident's name.
-She recalled a previous MA, who no longer worked at the facility, did a cart audit and identified Resident #3's lactulose was not on the medication cart.
-She thought the MA called the pharmacy to get the lactulose.

Interview with the RCC on 08/18/22 at 12:33pm revealed:
-Medications should be reordered at least two weeks before the medication runs out.
-She did not know Resident #3 was out of lactulose.
-If the medication was not in the facility, the MA should have let her, and the PCP know.
-The MA should not have initialed the eMARs as if she administered the medication.
-The MAs were supposed to do weekly audits of the medication cart, that included checking the medications on hand for each resident.

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-When doing medications cart audits the MA signed off on a form that all medications on the eMAR were observed as being available on the medication cart.
-If the MA tried to reorder the lactulose and was not able to get the medication; then the MA should have told her, and she would have followed-up with the resident's PCP to find out if the PCP wanted to discontinue, give another medication or put the medication on hold until the pharmacy was able to get the medication.

Interview with the Administrator on 08/19/22 at 3:07pm revealed:
-The MAs were required to do weekly audits of the medication cart compared to the eMAR.
-The MAs should have identified Resident #3's lactulose was not available.
-The MA should have contacted the pharmacy and reordered the medication and let the RCC know.
-The MA should not document on the eMAR that she administered a medication that was not in the facility.

Based on observations, record review, and interviews it was determined Resident #3 was not interviewable.

3. Review of Resident #4's current FL2 dated 02/07/22 revealed:
-Diagnoses included dementia, schizoaffective disorder, bipolar type with psychosis, cerebral infarctions and transient ischemic attack.
-There was an order for lactulose 10gm/15ml take 30ml twice daily (used to treat constipation).

Review of Resident #4's Physician's Order sheet dated 04/25/22 revealed there was an order for lactulose 10gm/15ml take 30ml twice daily.

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D 358	Continued From page 37 Review of Resident #4's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for lactulose 10gm/15ml take 30ml twice daily scheduled for administration at 8:00am and 6:00pm. -There was documentation lactulose 10gm/15ml was administered twice daily from 06/01/22 through 06/30/22. Review of Resident #4's July 2022 eMAR revealed: -There was an entry for lactulose 10gm/15ml take 30ml twice daily scheduled for administration at 8:00am and 6:00pm. -There was documentation lactulose 10gm/15ml was administered twice daily from 07/01/22 through 07/31/22. Review of Resident #4's August 2022 eMAR revealed: -There was an entry for lactulose 10gm/15ml take 30ml twice daily scheduled for administration at 8:00am and 6:00pm. -There was documentation lactulose 10gm/15ml was administered twice daily from 08/01/22 through 08/18/22. Observation of Resident #4's medications on hand on 08/18/22 at 11:22am revealed: -There was a bottle of lactulose 10gm/15ml; 450 mL was dispensed on 10/04/21. -There was an open date of 08/10/22 and the bottle was over three fourths full; the bottle was labeled one of one. -There was a second bottle of lactulose 10mg/15ml; 450 mL was dispensed on 02/27/22; the bottle was labeled one of two. -The second bottle was full and unopened.	D 358		

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D 358	Continued From page 38 -There were instructions on the label of the second bottle to refill the bottle after 03/12/22. Telephone interview with a representative from the facility's previously contracted pharmacy on 08/18/22 at 11:53am revealed: -Resident #4 had an order for lactulose 10gm/15ml take 30ml twice daily; the order had not changed in over a year. -The pharmacy had dispensed 946 mL of lactulose on 02/27/22, 03/12/22 and 03/25/2; a fifteen-day supply had been dispensed on each date. -The facility had to call and request a refill on the order because lactulose was not on cycle fill. Telephone interview a pharmacist from the facility's current contracted pharmacy on 08/18/22 at 12:01pm revealed: -The facility began to use the pharmacy in July 2022. -Resident #4's current order was for lactulose 10gm/15ml take 30ml twice daily. -The pharmacy dispensed a 15-day supply of Resident #4's lactulose on 07/04/22. -Resident #4's lactulose was not dispensed again after 07/04/22. -Lactulose was used to prevent constipation. -Lactulose was usually ordered because it was stronger than laxatives that could be purchased over the counter and could be used long term. -If lactulose was not administered as ordered for Resident #4, she could experience constipation. -They did not cycle fill lactulose so the facility would have to order a refill from the pharmacy. Interview with a medication aide (MA) on 08/18/22 at 11:25am revealed: -Resident #4 was ordered the lactulose for her gut and bowels to make her go to the bathroom.	D 358		

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-She used a medication cup to measure the 30ml dose and mixed into a beverage for Resident #4 to drink.
-Resident #4 did not refuse the lactulose and was always good about drinking it.
-Resident #4 had two big bottles of lactulose plus the one opened on 08/10/22 so she used the other two bottles first.
-It took a while to use the first two bottles before she could use the one opened on 08/10/22.
-The MAs used to order the lactulose when it was needed but hospice ordered it now and hospice ordered a lot at one time.
-The last time she had ordered the lactulose from the pharmacy was 07/04/22; she had also asked the pharmacy why it was not refilled before 07/04/22.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 08/18/22 at 12:32pm revealed:
-Resident #4 was ordered lactulose for severe constipation.
-Resident #4 would become constipated or risk having a bowel obstruction if she was not administered the lactulose as ordered.
-Resident #4 was under hospice care so she did not review her record anymore.

Interview with Resident #4's hospice nurse on 08/18/22 at 12:51pm revealed:
-Resident #4 was ordered lactulose for severe constipation after she became impacted and was sent to the hospital over a year ago.
-She would ask the MAs if there were any issues with Resident #4's medication administration and she was told Resident #4 took all her medication as ordered and did not refuse.
-She had never been notified Resident #4 refused to take her lactulose.

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D 358	Continued From page 40 -She did not request refills on medications for Resident #4 from the pharmacy; the facility was responsible for requesting refills for the lactulose from the pharmacy. -Resident #4 had been eating well; staff would have to monitor her for symptoms of constipation. -She had not observed any symptoms of constipation with Resident #4. -Outcomes of not administering Resident #4's lactulose could include nausea, vomiting, pain and decreased appetite. -She expected the order for Resident #4's lactulose to be followed as ordered. Interview with the Resident Care Coordinator (RCC) on 08/19/22 at 12:46pm revealed: -She did medication cart audits and spot checks on medications on the medication carts. -She checked dispense dates and amounts of medications to ensure medications other than tablets were being administered correctly; this included inhalers, ointments, creams and liquids. -She had not done a cart audit in about a month. -She was made aware of Resident #4's lactulose on 08/18/22; a MA told her about the extra amounts of lactulose. -One of two things had to happen for Resident #4 to have an excess of lactulose; the MA's were pouring lactulose from one bottle to the other or the resident's lactulose was not administered as ordered. -Medication ordered by a PCP was not an option and must be administered as ordered. Interview with the Administrator on 08/19/22 at 1:16pm revealed: -The MAs were responsible for conducting daily medication cart audits. -The MAs were to check orders, check the cart for expired medications and reorder medications	D 358		

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D 358	Continued From page 41 if needed. -The RCC was responsible for checking behind the MAs on the medication cart audits and holding them responsible for the medications. -She expected all medications to be refilled when needed and to be discarded 30 days after opening. -She could not answer to why Resident #4 had an excessive amount of lactulose on hand. Based on observations, record reviews and interviews it was determined Resident #4 was not interviewable.	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).	D 367		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 1 of 5 sampled residents (#3) including a medication used to prevent constipation for a resident diagnosed with Alzheimer's dementia.

The findings are:

Review of Resident #3's current FL2 dated 01/10/22 revealed:
-Diagnoses included Alzheimer's dementia, type 2 diabetes mellitus, hypertension and seizures.
-There was an order for lactulose 30 milliliter (ml)/20 grams (gm) once daily (used to treat constipation).

Review of Resident #3's Physician's Order sheet dated 08/15/22 revealed there was an order for lactulose 30ml/20gm once daily.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 04/01/22 through 04/30/22.

Review of Resident #3's May 2022 eMAR revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm

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was administered once daily from 05/01/22 through 05/31/22.

Review of Resident #3's June 2022 eMAR revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 06/01/22 through 06/30/22.

Review of Resident #3's July 2022 eMAR revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 07/01/22 through 07/31/22.

Review of Resident #3's August 2022 eMAR revealed:
-There was an entry for lactulose 30ml/20gm once daily scheduled for administration at 8:00am.
-There was documentation lactulose 30ml/20gm was administered once daily from 08/01/22 through 08/17/22.

Observation of Resident #3's medications on hand at the facility on 08/17/22 at 3:11pm revealed lactulose 30ml/20gm was not available for administration.

Telephone interview with the pharmacy that dispensed Resident #3's medications on 08/18/22 at 10:34am revealed:
-The pharmacy received an order for Resident #3's lactulose on 03/15/22.

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-The pharmacy filled and dispensed a 30-day supply of lactulose on 03/15/22.
-If the medication was administered as ordered, the medication should have required a refill on or around 04/15/22.
-The medication was not set to automatically refill.
-The facility had to call and request a refill of lactulose.
-Yesterday, 08/17/22, in the evening, the facility requested a refill of lactulose.
-Prior to yesterday (08/17/22), Resident #3's lactulose had not been refilled since 03/15/22.

Interview with a medication aide (MA) on 08/18/22 at 10:25am revealed:
-She thought another MA used the last little bit of lactulose that was left and gave it to Resident #3.
-The MA should have re-ordered the medication if it was out.
-Resident #3's medications came from the local retail pharmacy.
-She thought there was a problem with the pharmacy back ordering medications.
-If the medication was not in the building and the MA was unable to get the medication; the MA should let the Resident Care Coordinator (RCC) know the medication was not available.

Interview with a MA that signed she administered Resident #3's lactulose on 08/19/22 at 11:55am revealed:
-She was sure that she administered Resident #3's lactulose.
-If the medication was not available, she would not have signed the eMAR as if the medication was administered.
-When administering a medication; she was supposed to check the medication with the resident's eMAR prior to administering the

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medication.
-She was unable to explain why she initialed for a medication that was not in the facility.

Interview with a second MA that signed she administered Resident #3's lactulose on 08/19/22 at 2:25pm revealed:
-She remembered administering lactulose to the resident this week and last week.
-She was unable to validate if the lactulose administered had Resident #3's name on the bottle.
-The facility's policy was if a medication was not available, there should be documentation on the eMAR to reflect the medication was not in the facility.
-She had no reason why she initialed the eMAR as she administered lactulose and the medication was not available.

Telephone interview with a third MA that signed she administered Resident #3's lactulose on 08/19/22 at 2:08pm revealed:
-If Resident #3's lactulose was not in the facility, the eMAR should show the medication was not available and why.
-She could not explain why she initialed the eMAR as administering lactulose, when in actually the medication had not been dispensed from the pharmacy since 03/15/22.

Interview with the RCC on 08/18/22 at 12:33pm revealed:
-The MA should not have initialed the eMARs as if she administered lactulose, if the medication was not in the facility.

Interview with the Administrator on 08-19/22 at 3:07pm revealed:
-The MA should not document on the eMAR that

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D 367	Continued From page 46 she administered a medication that was not in the facility. Based on observations, record review, and interviews it was determined Resident #3 was not interviewable.	D 367		
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 of neglect and in compliance with federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observation, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#3) who had a diagnosis of Alzheimer's dementia, was constantly disoriented and a history of falls. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.	D935		

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D935	Continued From page 47 (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 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 observations, interviews, and record	D935		

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reviews the facility failed to ensure 1 of 3 sampled staff (C) who administered medications had validation of successfully taking and passing the written medication aide exam.

The findings are:

Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 01/03/22.
-Staff C had completed the 15-hour MA training course on 01/14/22.
-Staff C completed the medication administration clinical skills competency validation checklist on 01/20/22.
-There was no documentation of employment verification for Staff C.
-There was no documentation Staff C had taken or passed the written MA exam.

Review of a resident's June, July, and August 2022 electronic Medication Administration Records (eMAR) revealed:
-From 06/01/22 through 06/30/22, Staff C documented the administration of medications 8 days.
-From 07/01/22 through 07/31/22, Staff C documented the administration of medications 11 days.
-From 08/01/22 through 08/18/22, Staff C documented the administration of medications 14 days.

Interview with the facility's nurse on 08/18/22 at 1:30pm revealed:
-He did not keep track of personnel records, that was the responsibility of the Business Office Manager (BOM).
-His role was to complete the clinical skills competency validation checklist with MAs after

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they completed their 15-hour training.
-The MAs were responsible for scheduling their own written MA exams and bringing a copy of the result to the BOM to be placed in their personnel record.

Interview with the Administrator on 08/19/22 at 10:45am revealed:
-Staff C never took the written MA exam in North Carolina.
-The previous BOM would have been responsible for ensuring Staff C completed the written MA exam.
-Between the previous BOM leaving employment and the new BOM starting in March 2022, Staff C's written MA exam "fell through the cracks."
-There was no formal hand-off of information from the previous BOM to the new BOM since the previous BOM left unexpectedly.

Interview with the BOM on 08/19/22 at 12:20pm revealed:
-She had been the facility's BOM since 03/07/22, and the previous BOM had left one week prior.
-It was the responsibility of the BOM to ensure personnel records are current and complete.
-When she started as the BOM, most of the personnel records were already complete; she was under the impression she only needed to start keeping track of the personnel records for the employees who began employment after her.
-She had not audited any of the personnel records for the staff who were hired prior to March 2022.
-She did not have any prior experience with clinical examinations and testing processes, so she had not been aware of what testing was required or in what timeframe.
-The facility's nurse was not responsible for helping the staff schedule tests or making sure

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D935	Continued From page 50 the written MA exam was completed in the allotted timeframe, that was her responsibility. -She had not been aware that Staff C did not complete a written MA exam in North Carolina. Telephone interview with Staff C on 08/19/22 at 2:00pm revealed: -She started working at the facility in the beginning of January 2022, but did not start working on the medication cart until early February 2022. -The last shift she had worked was Tuesday night on 08/16/22. -She had taken the MA exam in another state in July 2021, but once she was hired at the facility, she completed the 15-hour training and clinical skills competency validation checklist. -She had not scheduled the written MA exam upon completing the MA clinical skills competency validation checklist because she did not know she needed to re-take the written MA exam in North Carolina. -The previous BOM had not advised her to schedule the written MA exam, and neither did the nurse who completed her clinical skills competency validation checklist.	D935		