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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 10/18/22 through 10/20/22.	{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 A2 Violation Based on observations, record reviews and interviews the facility failed to ensure supervision was provided for 2 of 5 sampled residents (Residents #1 and #3) who had a history of falls including a resident who fell four times in two weeks and received sutures due to lacerations (#1) and a resident who fell 5 times in 6 weeks resulting in skin tears (#3). The findings are: Review of the facility's falls policy last revised October 2018 revealed: -Documentation of a fall should be completed. -Complete the change in condition from and the change of condition care plan form. -complete falls investigation worksheet and if applicable, complete the incident investigation from and state reportable form the investigation report should include the cause of the fall if known, interventions that were in place (such as toileting program).	{D 270}		

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{D 270}	Continued From page 1 -The event will be reflected on the 24-hour summary and on-going monitoring documented for 72 hours or until resolved. -Initiate the falls star program; initiate the nursing to therapy referral form and plan of care will be revised as indicated. -Fall risk data collection form in point click care shall be used to review new admissions for the potential for falls. -If a resident score above a 10 in fall risk data collection, the resident shall be placed on the falling star program. -The resident's care plan shall reflect that he/she is at higher risk for falls and identifies approaches that are to be taken. -A distinction will be made to alert care providers to observe safety precautions by placing a star on the resident's name place outside his/her door. -An additional star shaped tag will be secured to adaptive devices(s) used by the resident when outside of his/her room, alerting all disciplines to observe safety precautions. -Safety precautions include frequent monitoring of the resident; implementing the fall management program; bowel/bladder program (staying with the resident while on the toilet) and monitor or additional contributing factors. -The facility's falls management program included: a fall risk evaluation form; universal fall precautions (level 1) indicating on the personal service plan (PSP); (level 2 and 3) additional interventions for consideration related to the resident's individual medical condition, functional status, environmental factors and safety awareness and completion of a post fall evaluation form for falls that occur. 1. Review of Resident #1's current FL2 dated 08/24/22 revealed: -Diagnoses included dementia, major depressive	{D 270}		

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{D 270}	Continued From page 2	{D 270}		

disorder, hypothyroidism, osteoarthritis.

Review of Resident #1's care plan dated 09/21/22 revealed:
-The resident required supervision with eating, ambulation and transfers.
-The resident required hands on physical assistance with toileting, bathing, dressing and grooming.

Review of Resident #1's falls risk evaluation completed on 09/14/22 revealed:
-Resident #1's level of fall risk was Level 3, meaning "yes" indicators for risk of falls.
-Levels 2 and 3 required additional interventions for consideration related to the resident's individual medical condition, functional status, environmental factors, safety awareness and completion of a post-fall evaluation for falls that occur.

Observation of Resident #1's room on 10/18/22, 10/19/22 and 10/20/22 from 9:00am through 4:00pm revealed there was no leaf or other indications on the door the resident was a fall risk or was part of the falling star program.

a. Review of Resident #1's progress note dated 10/01/22 revealed:
-Resident #1 had a fall.
-While doing rounds around 2:00am, Resident #1 was found lying on her back on the floor.
-The resident had blood coming from her head.
-The resident was sent to the hospital.

Review of Resident #1's charting notes dated 10/01/22 revealed Resident #1 returned from the hospital with 2 stitches.

Review of Resident #1's incident reports revealed

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{D 270}	Continued From page 3 there was no incident report related to the fall that happened on 10/01/22 on the third shift and caused the resident to be sent to the hospital as required by facility's falls policy. Review of Resident #1's post-fall evaluations revealed there was no post-fall evaluation completed for fall that happened at 2:00am as required by the facility's policy. Review of Resident #1's hospital report dated 10/01/22 revealed: -Resident #1's cause for the visit was related to a fall. -The resident sustained an injury to back of the head resulting from a fall with lacerations and hematoma. -Resident #1 received sutures and was discharged back to the facility. Review of Resident #1's charting notes, progress notes, incident reports, and post-fall evaluations revealed there was no documentation of 72-hour monitoring, frequent monitoring implemented, there was no documentation Resident #1 was placed on the falling star program, and there was no documentation Resident #1 was placed on the facility's falls management program as required by the facility's falls policy. Interview with a medication aide (MA) on 10/20/22 at 8:51am revealed: -She worked the first shift on 10/01/22, she was made aware that Resident #1 had a fall on third shift. -She was unable to recall who third shift staff person was that found Resident #1 on the floor and sent the resident to the hospital. -The staff person that found Resident #1 should have completed an incident report.	{D 270}		

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{D 270}	Continued From page 4 -Resident #1 had a lot of falls since she was admitted to the memory care unit. -She did not know the exact number of falls the resident had but it was "a lot." -No one had given instructions regarding increased supervision. -She knew Resident #1 had falls, so she checked the resident at least every hour. -When she checked on the resident, she identified the resident's location. -She thought the resident was falling because she was confused and unaware of her limitations. -She had noticed that Resident #1 often tried to assist her roommate because she thought her roommate needed help. -Sometimes Resident #1 fell going to the bathroom, due to her walker having three wheels and not being steady. -Resident #1 was confused and the walker was difficult for the resident to maneuver. Interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:24pm revealed: -She completed the progress note dated 10/01/22 regarding Resident #1's fall that happened at 2:00am. -She did not witness or observe the fall, it was reported to her by the staff that found the resident. -She was not aware the staff had not completed an incident report. -The incident report should be done by the person that identified the incident and given to the Health and Wellness Director (HWD). -The HWD completed the post-fall evaluation. -If a resident had a fall, the resident should be observed by the MA on each shift for 72 hours. -The MA should document they observed the resident and status of the resident during that observation (location, what resident was doing,	{D 270}		

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{D 270}	Continued From page 5	{D 270}		

etc.).
-Resident #1 should have been checked at least every 2 hours.
-When she was hired, she was told to check on the residents every 2 hours.
-The HWD had given instructions to check on Resident #1 frequently, but no explanation was given as to how frequent to check.

Interview with the HWD on 10/19/22 at 10:26am revealed:
-The facility did not have a falling star program.
-She was told by upper management that it was a violation of resident's rights to put symbols on the resident's door indicating the resident was a fall risk.
-The facility did not have a specific supervision policy related to falls.
-The facility did not have a falls protocol for Resident #1.
-After a fall, the resident's record was placed in the "hot box (special attention)."
-The resident's name was put on the board at the nurse's station.
-The only supervision system in place required the MA to check on the resident and document each shift for 72 hours after a fall.
-The MA completed the incident report and gave them to her.
-She completed the post-fall evaluations.
-She was aware Resident #1 had a fall on 10/01/22 at 2:00am and was sent to the hospital.
-As a result of the fall Resident #1 received stitches.
-She did not have a post-fall evaluation for Resident #1's fall that happened on 10/01/22 at 2:00am.
-She did not see an incident report for the fall that happened on 10/01/22 at 2:00am.
-She was unable to recall the staff that was on

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{D 270}	Continued From page 6	{D 270}		

duty and reported the incident.
-There was no system that required staff to check on the residents with a specific time frequency.
-The staff on the third shift were only required to check on the residents' every 4 to 6 hours.
-She had instructed staff to do frequent checks on Resident #1; maybe a week ago, but she did not give a specific to the frequency of the checks.

Telephone interview with Resident #1's PCP on 10/20/22 at 3:37pm revealed:
-She was aware Resident #1 had a few falls.
-There was a fall on 10/01/22, the resident was sent to the hospital and received stitches to her head.
-This was the first fall that she was made aware of, no instructions regarding increased supervision was given by her.

b. Review of Resident #1's progress note dated 10/01/22 revealed:
-At 1:15pm Resident #1 was found on the floor sitting on her buttocks.
-There were no apparent injuries.

Review of Resident #1's charting notes dated 10/01/22 at 3:02pm revealed:
-Resident #1 was found on the floor at 1:15pm.
-There were no apparent injuries, but pain medication was given.

Review of Resident #1's incident report dated 10/01/22 revealed:
-At 1:15pm Resident #1 had an unwitnessed fall.
-The resident was found in her room on the floor, sitting on her buttocks.
-Frequent monitoring implemented.
-There was no documentation frequent monitoring was implemented.

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{D 270}	Continued From page 7 Review of Resident #1's post-fall evaluation dated 10/01/22 revealed: -At 1:15pm Resident #1 was found sitting on the floor in her bedroom. -The resident said she was in pain all over and her pain was a level 7 on a numerical pain scale from 1 to 10. -The resident said she was trying to go to the bathroom. -Additional observations/notes/comments were will continue to monitor. -There was no documentation of a monitoring system in place for Resident #1. Review of Resident #1's charting notes, progress notes, incident reports, and post-fall evaluations revealed there was no documentation of 72-hour monitoring, frequent monitoring implemented, there was no documentation Resident #1 was placed on the falling star program, and there was no documentation Resident #1 was placed on the facility's falls management program as required by the facility's falls policy. Interview with the activity director on 10/19/22 at 3:33pm revealed: -On Saturday, 10/01/22, they were trying to keep Resident #1 was in bed because she had returned from the hospital due to a fall, that had happened earlier that morning. -It was around lunch time and she went to Resident #1's room. -The resident was lying on the floor near between her bed and bathroom door. -She reported the incident to the MA. -She had heard the HWD tell the MAs and PCAs to alternate keeping an eye on Resident #1. -She was not told to keep eye on Resident #1 but if a resident was a high fall risk everyone had to keep an eye on the resident. -There was no specific time given of how frequent	{D 270}		

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{D 270}	Continued From page 8 to keep an eye on the resident. Interview with the maintenance director on 10/19/22 at 3:30pm revealed: -He was working on Saturday, 10/01/22, and observed Resident #2 lying on the floor in her room near the bathroom door. -Resident #1 had a fall earlier that morning and hit her head on the corner of the nightstand that was near the bathroom door. -It appeared as if the resident fell trying to go to the bathroom. -There was still blood on the floor from the fall that had happened earlier in the day. -Resident #1 had another fall a few days after 10/01/22, (unable to recall the exact date) he did not know if the resident had injuries. Interview with the MA on 10/20/22 at 8:51am revealed: -On 10/01/22 Resident #1 was found by the Activity Director on the floor in her room. -She assessed the resident and did not observe any injuries. -Resident #1 had a "lot of falls." -She was unable to recall the exact number of falls the resident had but she thought it was "a lot." -No one had given instructions regarding increased supervision, -She decided on her own to check on the resident frequently, a least every hour. -She thought Resident #1 had falls because she was confused and tried to assist her roommate because she thought her roommate needed help. Telephone interview with Resident #1's PCP on 10/20/22 at 3:37pm revealed: -She was aware Resident #1 had a fall on 10/01/22, in the early morning.	{D 270}		

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-She was not made aware of another fall on 10/01/22.
-She wanted to be made aware of all Resident #1's falls.
-When a resident had falls, she recommended increased supervision by facility staff.
-This was usually not a written order but a recommendation.
-She also suggested more frequent visits to the bathroom to ensure the falls were not resulting from the resident attempting to take herself to the bathroom.
-It would be a good idea if staff had documentation to support increased supervision, but she did not suggest documentation.
-If the resident was rolling out of bed, she would have ordered a fall mat.

c. Review of Resident #1's progress not dated 10/11/22 revealed:
-Resident #1 was found on the floor by the PCA.
-There were no identified injuries.
-Will continue to monitor.
-There was no documentation or identified monitoring program.

Review of Resident #1's charting notes revealed there was no charting notes dated 10/11/22.

Review of Resident #1's incident reports revealed there was no incident report dated 10/11/22 as required by the facility's policy.

Review of Resident #1's post-fall evaluation dated 10/11/22 revealed:
-Resident #1 had an unwitnessed fall in her room.
-Resident #1 was found on the floor near a chair in her room.
-The MA completed her section of the post-fall evaluation the Health and Wellness Director

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{D 270}	Continued From page 10 (HWD) did not complete her section of the post-fall evaluation. Review of Resident #1's charting notes, progress notes, incident reports, and post-fall evaluations revealed there was no documentation of 72-hour monitoring, frequent monitoring implemented, there was no documentation Resident #1 was placed on the falling star program, and there was no documentation Resident #1 was placed on the facility's falls management program as required by the facility's falls policy. Interview with the medication aide (MA) on 10/20/22 at 5:29pm revealed: -She recalled Resident #1 had a fall on 10/11/22. -She completed the incident report as required and she believed that she gave the incident report to the HWD. -She was unable to find a copy of the incident report. Interview with the HWD on 10/19/22 at 10:26am revealed: -She did not have an incident report dated 10/11/22. -When a resident had a fall, an incident report should be completed by the MA on duty. -When she received the incident report, she completed the post-fall evaluation. -The facility did not have a specific supervision system related to falls. -The facility's falls protocol for a resident after a fall was to place resident's record in the "hot box." -The resident's record in the hot box was an indication that attention was needed specific to the incident. -In addition to placing the resident's name was placed on the board at the nurse's station.	{D 270}		

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-The only supervision system in place required the MA to check the resident and document each shift for 72 hours after a fall.
-There was no system in place requiring staff to check on the resident within a specific time frequency.
-The staff on the third shift were only required to check on the residents' every 4 to 6 hours.
-She was not aware of the facility's falls policy.
-She was unaware of the levels mentioned in the falls facility's falls policy, the required documentation and interventions.

d. Review of Resident #1's incident report dated 10/12/22 revealed:
-Resident #1 had an unwitnessed fall.
-The resident received a cut/laceration on the back of the head.
-The resident was sent to the hospital.

Review of Resident #1's incident report dated 10/12/22 revealed:
-Resident #1 had an unwitnessed fall.
-The resident hit her head and was sent to the hospital.

Review of Resident #1's post-fall evaluation dated 10/12/22 revealed:
-Resident #1 fell in her bedroom by the door.
-The fall was near a chair.
-The resident was found on her back.
-The resident was confused and trying to take care of another resident before she fell.
-The resident was found by the MA on the floor.
-The post-fall evaluation was completed by the MA but not by the HWD as designated in the facility's policy.

Review of Resident #1's hospital report dated 10/12/22 revealed:

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-Reason for the visit was a fall.
-Resident #1 injured her head in the same location where she was injured her head on 10/01/22.
-The injury already had stitches, therefore no additional stitches were needed.

Review of Resident #1's charting notes, progress notes, incident reports, and post-fall evaluations revealed there was no documentation of 72-hour monitoring, frequent monitoring implemented, there was no documentation Resident #1 was placed on the falling star program, and there was no documentation Resident #1 was placed on the facility's falls management program as required by the facility's falls policy.

Interview with the MA that assisted Resident #1 on 10/19/22 at 3:44pm revealed:
-Around 4:22am, she heard someone yelling for help.
-Prior to hearing the yelling, she heard what sounded like a loud thump.
-When she got to Resident #1's room, the resident was on the floor by the door.
-The resident was bleeding from her head.
-She sent Resident #1 to the hospital.
-No instructions had been given regarding increased supervision or monitoring Resident #1.
-It was common for Resident #1 to get up at night.
-The resident often forgot her walker.
-This was the first fall she had known Resident #1 to have.

Attempted interview with the PCA that found Resident #1 on 10/20/22 at 4:20pm was unsuccessful.

Telephone interview with Resident #1's PCP on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 270}	Continued From page 13 10/20/22 at 3:37pm revealed: -She was aware Resident #1 had a few falls. -There was a fall on 10/01/22, the resident was sent to the hospital and received stitches. -The fall on 10/11/22, she was told by facility staff resulted in no injuries. -There was a fall on 10/12/22, the resident hit her head and was sent to the hospital. -The resident hit her head in the same spot that had a previous injury and she already had stitches. -She had ordered physical therapy (PT) for the resident and she ordered home health to review the stitches. -If there was another fall, she was not made aware of the fall. -When a resident had falls, she recommended increased supervision by facility staff. -This was usually not a written order but a recommendation. -She also suggested more frequent visits to the bathroom to ensure the falls were not resulting from the resident attempting to take herself to the bathroom. -It would be a good idea if staff had documentation to support increased supervision, but she did not suggest documentation. -If the resident was rolling out of bed, she would have ordered a fall mat. Interview with the Health and Wellness Director (HWD) on 10/19/22 at 10:26am revealed: -The facility had not implemented the falling star program for Resident #1. -She had previously asked corporate management about placing an emblem like a leaf outside of a resident's doors indicating the resident was a fall risk, but she was told by corporate management that putting icons like leaves outside the resident's room door was a	{D 270}		

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violation of privacy and not allowed.
-The facility did not have a specific supervision system related to falls.
-The facility did not have a falls protocol.
-After a fall, the resident's record was placed in the "hot box."
-The hot box was an indication something had happened to the resident out of the normal health care need and required special attention.
-The resident's name was put on the board at the nurse's station.
-The only supervision system in place required the MA to check the resident and document each shift for 72 hours after a fall.
-The MA completed the incident report and gave them to her.
-She completed the post-fall evaluations.
-She was unaware Resident #1 had 4 falls from 10/01/22 through 10/22/22.
-There was no system that required staff to check on the residents within a specific time frequency.
-The staff on the third shift were only required to check on the residents' every 4 to 6 hours.
-She was not aware of the facility's falls policy.
-She was unaware of the fall risk levels mentioned in the falls facility's falls policy, the required documentation and interventions.

Interview with the Administrator on 10/20/22 at 5:23pm revealed:
-The facility had a falls protocol.
-The initial part of the falls protocol required staff to begin with implementing at least 3 interventions.
-More interventions were added if the resident continued to fall.
-After a resident had a fall, the resident's name was added to the white board.
-The MA was required to check on the resident at least once for every shift.

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-The MA should document every shift that they checked on the resident.
-If a resident had 3 falls, the staff should be doing increased supervision.
-Interventions should be on the assignment plan.
-Every one of Resident #1's falls required a minimum of 4 interventions.
-Interventions implemented should be based on the resident's responsiveness to the interventions.
-All interventions should be documented, and instructions given to staff.

2. Review of Resident #3's current FL2 dated 06/16/22 revealed diagnoses included dementia without behavioral disturbances, muscle weakness, and abnormalities of gait and mobility.

Review of Resident #3's care plan dated 02/02/22 revealed:
-The resident required supervision with eating.
-She required limited assistance with toileting, bathing, dressing, grooming, and transfers.
-She required extensive assistance with ambulation and used a wheelchair for ambulation.

a. Review of Resident #3's progress note dated 09/04/22 revealed:
-Resident #3 had a fall.
-The resident slid out of her wheelchair onto the floor.
-There were no obvious signs of bruises or injury.

Review of Resident #3's incident report dated 09/04/22 revealed:
-There was documentation Resident #3 fell from a sitting position in her wheelchair on 09/04/22 at 5:45pm.
-The fall was unwitnessed by staff.
-There was no apparent injury documented on

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the incident report.
-Resident #3 was encouraged to call for assistance.
-There were no additional recommended interventions or increased supervision noted on the report.

Review of Resident #3's Post-Fall Evaluation completed and signed by the Health and Wellness Director (HWD)on 10/12/22 revealed:
-The secondary evaluation on the incident report dated 09/04/22 documented the risk factors contributing to the fall "appeared to be compliance with safety issues".
-There were no interventions documented on the report.

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

Refer to the interview with a medication aide (MA) on 10/19/22 at 9:35am.

Refer to the telephone interview with Resident #3's primary care provider (PCP) on 10/19/22 at 10:50am.

Refer to the interview with the Health and Wellness Director (HWD) on 10/19/22 at 10:26am.

Refer to the telephone interview with Resident #3's family member on 10/19/22 at 3:45pm.

Refer to the interview with a second medication aide (MA) on 10/20/22 at 12:35pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:24pm.

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{D 270}	Continued From page 17 Refer to the interview with the Executive Director (ED) on 10/20/22 at 5:00pm b. Review of Resident #3's progress note dated 09/17/22 revealed: -Resident #3 had a fall. -The resident was found on the floor of another resident's bedroom. -The fall was not witnessed by staff. -The resident stated she sat herself on the floor and did not fall. -There were no injuries noted at that time. Review of Resident #3's progress notes revealed: -On 09/18/22 at 3:13pm, resident had no complaints of discomfort or pain, continue to monitor was documented. -On 09/21/22 at 9:27pm, "Post fall: Resident had no complaints of pain this shift. Will continue to observe." Review of Resident #3's incident report dated 09/17/22 revealed: -Resident #3 had an unwitnessed fall. -The resident was found sitting on the floor of another resident's room on 09/17/22 at 3:15pm. -There was no apparent injury documented on the incident report. -There were no recommended interventions or increased supervision noted on the report. Review of Resident #3's progress notes revealed: -On 09/18/22 at 3:13pm, the resident had no complaints of discomfort or pain, continue to monitor. -On 09/21/22 at 9:27pm, "Post fall: Resident had no complaints of pain this shift. Will continue to observe."	{D 270}		

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{D 270}	Continued From page 18 Review of Resident #3's Post-Fall Evaluation completed and signed by the HWD on 10/14/22 revealed: -Identified risk factors contributing to the fall on 09/17/22 was "appeared to be compliance with safety issues". -There were no interventions documented on the report. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable. Refer to the interview with a medication aide (MA) on 10/19/22 at 9:35am. Refer to the telephone interview with Resident #3's primary care provider (PCP) on 10/19/22 at 10:50am. Refer to the interview with the Health and Wellness Director (HWD) on 10/19/22 at 10:26am. Refer to the telephone interview with Resident #3's family member on 10/19/22 at 3:45pm. Refer to the interview with a second medication aide (MA) on 10/20/22 at 12:35pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:24pm. Refer to the interview with the Executive Director (ED) on 10/20/22 at 5:00pm c. Review of Resident #3's progress note dated 10/08/22 at 2:11pm revealed: -Post Fall: the resident was found on the floor of her room on third shift.	{D 270}		

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{D 270}	Continued From page 19 -The fall was not witnessed by staff. Review of Resident #3's incident report dated 10/09/22 at 5:45am revealed: -Resident #3 had an unwitnessed fall. -The resident was found on the floor beside her bed. -There was a scrape/abrasion to her left knee noted at that time. -There were no recommended interventions or increased supervision noted on the report. Review of Resident #3's progress notes dated 10/10/22 at 2:51pm revealed "Post fall: Resident had no complaints of pain or discomfort on this shift. Will continue to monitor." Review of Resident #3's Post-Fall Evaluation completed and signed by the HWD on 10/14/22 revealed: -Identified risk factors contributing to the fall on 10/08/22 was "appeared to be compliance with safety issues". -Increased frequency of monitoring (rounds, group activities) beginning 10/14/22 was listed for Compliance with Safety Interventions on the evaluation. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable. Refer to the interview with a medication aide (MA) on 10/19/22 at 9:35am. Refer to the telephone interview with Resident #3's primary care provider (PCP) on 10/19/22 at 10:50am. Refer to the interview with the Health and	{D 270}		

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Wellness Director (HWD) on 10/19/22 at 10:26am.

Refer to the telephone interview with Resident #3's family member on 10/19/22 at 3:45pm.

Refer to the interview with a second medication aide (MA) on 10/20/22 at 12:35pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:24pm.

Refer to the interview with the Executive Director (ED) on 10/20/22 at 5:00pm

d. Review of Resident #3's progress note dated 10/13/22 at 9:24pm revealed:
-Resident #3 had an unwitnessed fall.
-The resident stated she had to use the bathroom and thought she could get there faster if she walked.
-Resident #3 had no complaints of pain or discomfort at the time.
-Later, on 10/13/22, a skin tear on her left arm near her elbow was noticed.

Review of Resident #3's incident report dated 10/13/22 at 4:15pm revealed:
-Resident #3 had an unwitnessed fall.
-There was a skin tear on the left elbow noted at that time.
-There were no recommended interventions or increased supervision noted on the report?
-The Health and Wellness Director (HWD) reviewed and approved the report on 10/17/22.

Review of Resident #3's progress notes dated 10/14/22 at 2:25pm revealed "Post fall status: Resident had no complaints of pain or discomfort; will continue to monitor."

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{D 270}	Continued From page 21 Review of Resident #1's post-fall evaluations revealed there was no post-fall evaluation completed for the fall which occurred on 10/13/22 at 4:15pm as required by the facility's policy. Interview with the HWD on 10/19/22 at 10:26am revealed: -She routinely completed the post-fall evaluations. -She did not have a post-fall evaluation for Resident #3's fall that occurred on 10/13/22 at 4:15pm. -She did not know why the post-fall evaluation was not completed. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable. Refer to the interview with a medication aide (MA) on 10/19/22 at 9:35am. Refer to the telephone interview with Resident #3's primary care provider (PCP) on 10/19/22 at 10:50am. Refer to the interview with the Health and Wellness Director (HWD) on 10/19/22 at 10:26am. Refer to the telephone interview with Resident #3's family member on 10/19/22 at 3:45pm. Refer to the interview with a second medication aide (MA) on 10/20/22 at 12:35pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:24pm. Refer to the interview with the Executive Director	{D 270}		

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{D 270}	Continued From page 22 (ED) on 10/20/22 at 5:00pm e. Review of Resident #3's progress note dated 10/17/22 at 8:38pm revealed: -Resident #3 was found on the floor during the medication pass on second shift. -The resident said she was going to answer the phone and looking for other people. -No reported injuries or pain. Review of Resident #3's incident report dated 10/17/22 at 8:25pm revealed: -Resident #3 had an unwitnessed fall. -There was no apparent injury. -There were no recommended interventions or increased supervision noted on the report. Review of Resident #3's progress notes dated 10/18/22 at 2:19pm revealed "Post fall status: Resident had no complaints of pain or discomfort on this shift." Review of Resident #3's Post-Fall Evaluation completed and signed by the HWD on 10/18/22 revealed: -Identified risk factors contributing to the fall on 10/17/22 was documented as "appeared to be compliance with safety issues". -Remind the resident to use assistive device and increased frequency of monitoring (rounds, group activities) beginning 10/18/22 was listed for Compliance with Safety Interventions on the evaluation. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable. Refer to the interview with a medication aide (MA) on 10/19/22 at 9:35am.	{D 270}		

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{D 270}	Continued From page 23 Refer to the telephone interview with Resident #3's primary care provider (PCP) on 10/19/22 at 10:50am. Refer to the interview with the Health and Wellness Director (HWD) on 10/19/22 at 10:26am. Refer to the telephone interview with Resident #3's family member on 10/19/22 at 3:45pm. Refer to the interview with a second medication aide (MA) on 10/20/22 at 12:35pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:24pm. Refer to the interview with the Executive Director (ED) on 10/20/22 at 5:00pm _____ Interview with a MA on 10/19/22 at 9:35am revealed: -The staff person that found a resident with a fall routinely reported the incident to the MA on duty at the time: -The MA was responsible to complete an incident report, place the incident report in the medication room, and move the resident's record in the "hot box" area to alert staff the resident had fallen. -MAs were responsible to observe the resident for signs of pain or injury on each of the 3 shifts for three days post fall and document observations in the progress notes. -There was nowhere in the facility's computer record system to document frequency of resident checks except the progress notes. -The staff were supposed to check on residents frequently, but no one had given her a set frequency like every 2 hours or 3 hours.	{D 270}		

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{D 270}	Continued From page 24 -No one had given her instructions regarding increased supervision after a resident had a fall. Telephone interview with Resident #3's PCP on 10/19/22 at 10:50am revealed: -She was aware Resident #3 had a few falls, but 5 falls in 6 weeks was not pointed out to her. -No instructions regarding increased supervision had been given to the staff by her. -She was more concerned that she had ordered urine samples to be obtained for a possible urinary tract infection (UTI) on 08/31/22 and again on 09/28/22. -There were no results of a urinalysis (UA) that were ordered on 08/31/22 and again on 09/28/22. -Residents with UTIs were more prone to falls due to weakness, and sometimes confusion; this could contribute to increased falls. Interview with the HWD on 10/19/22 at 10:26am revealed: -The facility did not have a specific supervision policy related to falls. -After a fall, the resident's record was placed in the "hot box." -The resident's name was put on the white board at the nurse's station. -Resident #3's name was currently on the white board at the nurse's station to observe for falls. -The only supervision system in place required was the MA to check the resident and document each shift for 72 hours after a fall. -The MAs completed the incident reports and gave them to her. -She completed the post-fall evaluations. -She did not have a post-fall evaluation for Resident #3's fall that occurred on 10/01/22 at 2:00am. -She did not see an incident report for the fall that occurred on 10/01/22 at 2:00am.	{D 270}		

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-She was unable to recall the staff that was on duty and reported the incident.
-There was no system in place requiring staff to check on the residents within a specific time frequency.
-The staff on third shift were only required to check on the residents' every 4 to 6 hours.
-She had instructed staff to do frequent checks on Resident #3 but did not give specifics to the frequency of the checks.
-Staff should be going to the residents' rooms and asking the residents if they needed assistance with anything.

Telephone interview with Resident #3's family member on 10/19/22 at 3:45pm revealed:
-The facility had notified her of several falls since 09/05/22.
-She was not sure she knew about a fall on 10/13/22.
-The facility had not discussed with her concerning any type or interventions that they planned to implement to help decrease Resident #3's falls.
-She expected the staff at the facility to supervise the resident, included checking on her for care needs, as often as every 2 hours.
-Resident #3 would not be able to remember to ring a call bell for assistance with getting out of bed or transferring from her wheelchair to the toilet.

Interview with a second MA on 10/20/22 at 12:35pm revealed:
-She had been assigned to create a fall and behavior intervention tracking book 4 weeks ago, but had not completed the assignment.
-The facility did not currently have a system in place to ensure interventions were started promptly and documented related to providing

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{D 270}	Continued From page 26 increased supervision for residents with falls. Interview with the RCC on 10/20/22 at 4:24pm revealed: -The incident report should be done by the person that identified the incident and the report given to the HWD, who completed the post-fall evaluations. -If a resident had a fall, the resident should be observed by the MA on each shift for 72 hours. -The MA should document they observed the resident and status of the resident during that observation (location, what resident was doing, etc.). -Residents should have been checked at least every 2 hours. -When she was hired, she was told to check on the residents every 2 hours. -The HWD had given instructions to check on residents that had fallen frequently, but no explanation was given as to how frequent to check those residents. Interview with the Administrator on 10/20/22 at 5:13pm revealed: -The facility had a falls protocol. -The initial part of the falls protocol required to start with at least 3 interventions. -After a resident had a fall, the resident's name was added to the white board. -The MA was required to check on the resident at least once for every shift. -The MA should document every shift when they checked on the resident. -If a resident had 3 falls, the staff should be doing increased supervision checks. -Interventions should be on the assignment plan. -Interventions implemented should be based on the resident's responsiveness to the inventions. -The HWD was responsible to complete the post	{D 270}		

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{D 270}	Continued From page 27 fall evaluation form provided by the corporate office. -The HWD was responsible to use the post fall evaluation form for guidance and documenting fall interventions to increase supervision and responses to falls. -The HWD should include and implement interventions on the post fall evaluation form, and add interventions with each consecutive fall. -All interventions should be documented, and instructions given to staff by the HWD. -She did not know why there were no increasing interventions documented for Resident #3 after each consecutive fall. -There was no policy for the frequency of monitoring residents with increased falls related to more frequent supervision checks. -The facility staff should be going to residents' rooms to check for care needs like incontinent care, assist with going to the bathroom or meals, based on the individual resident's need. -The HWD was responsible to ensure the facility staff were properly supervising residents. _____ The facility failed to ensure supervision was provided for 2 of 5 sampled residents related to a resident who fell four times in two weeks, had multiple visits to the emergency department and one fall resulting in a head injury with sutures from a laceration (#1); and a resident who fell 5 times in 6 weeks resulting in skin tears from the falls (#3). This failure placed residents at substantial risk for physical harm and neglect and constitutes a Type 2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/19/22 for this violation. CORRECTION DATE FOR THE TYPE A2	{D 270}		

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{D 270}	Continued From page 28 VIOLATION SHALL NOT EXCEED NOVEMBER 18, 2022. [Refer to Tag 0273, 10A NCAC .0902(b) Health Care, Type B Violation]	{D 270}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 residents sampled (#3) related to physician orders for obtaining a urinalysis (UA), obtaining weekly weights, and applying thromboembolic deterrent (TED) hose daily. The findings are: Review of Resident #3's current FL2 dated 06/16/22 revealed diagnoses included dementia without behavioral disturbances, muscle weakness, and abnormalities of gait and mobility. Observation of Resident #3 during medication administration on 10/18/22 at 9:15am revealed: -The resident was seated in a wheelchair. -The resident did not have apparent bruising or bandages. 1. Review of Resident #3 record revealed:	{D 273}		

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{D 273}	Continued From page 29 -On 08/31/22, there was an order for collect urinalysis (UA). -On 09/28/22, there was an order to collect UA and culture (test for antibiotic sensitivity). -There were no laboratory test results available for review for the UA ordered on 08/31/22 or 09/28/22. Review of Resident #3's progress notes revealed: -On 08/31/22 at 9:48am, there was an entry for "Alert Charting note" that listed a new order for urine collection. -There were no additional notes regarding Resident #3's UA ordered on 08/31/22. -On 09/28/22 at 2:27pm, there was an entry for "Alert Charting note" that listed resident has a new order in place for UA. POA (Power of Attorney) was notified. -On 09/28/22 at 8:01pm, there was a general note from electronic medication administration record (eMAR) that read UA and Culture please collect urine specimen via cup from patient for UA. Please mark label clearly with patients name and date of birth (DOB). Please email laboratory [named provider] when ready for pickup. -On 09/29/22 at 6:10am, there was a repeat of general note from electronic medication administration record (eMAR) that read UA and Culture please collect urine specimen via cup from patient for UA. Please mark label clearly with patients name and DOB. Please email laboratory [named provider] when ready for pickup. -On 10/06/22 at 3:30pm, there was general progress note documented for 10/03/22 resident UA was sent out Friday on 09/30/22 and United Parcel Service (UPS) delivered it back on 10/03/22. The Health and Wellness Director (HWD) was notified. The Resident Care Coordinator (RCC) had entered the note.	{D 273}		

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{D 273}	Continued From page 30 -On 10/15/22 at 6:00am, there was a general note from eMAR that read UA and Culture please collect urine specimen via cup from patient for UA. Please mark label clearly with patients name and DOB. Please email laboratory [named provider] when ready for pickup. "Resident said she didn't have to use the bathroom." --On 10/15/22 at 2:56pm, there was a general note from eMAR that read UA and Culture please collect urine specimen via cup from patient for UA. Please mark label clearly with patients name and DOB. Please email laboratory [named provider] when ready for pickup. -On 10/18/22 at 4:32am, there was a general note from eMAR that read UA and Culture please collect urine specimen via cup from patient for UA. Please mark label clearly with patients name and DOB. Please email laboratory [named provider] when ready for pickup. Per the Resident Care Coordinator (RCC) hold up on collections due to need of new lab sending new labels. -On 10/18/22 at 2:47pm, there was a general note from eMAR that read UA and Culture please collect urine specimen via cup from patient for UA. Please mark label clearly with patients name and DOB. Please email laboratory [named provider] when ready for pickup. No UA collected this shift. -On 10/18/22 at 8:19pm and 10/19/22 at 6:45am, there was a general note from eMAR that read UA and Culture please collect urine specimen via cup from patient for UA. Please mark label clearly with patients name and DOB. Please email laboratory [named provider] when ready for pickup was documented with no additional information. Review of Resident #3's progress notes revealed there was no documentation Resident #3's primary care provider (PCP) was notified that	{D 273}		

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{D 273}	Continued From page 31 Resident #3's order for UA and culture from 08/31/22 and 09/28/22 was not completed as ordered. Interview with the HWD on 10/18/22 at 3:50pm revealed: -The UA ordered 08/31/22 was never obtained. -She became aware the UA was not obtained for Resident #3 when Resident #3's PCP reordered the UA and culture on 09/28/22. -She found the order for Resident #3's UA ordered 08/31/22 was entered into the eMAR system by a former staff member incorrectly. -The order never showed up on the eMAR for the facility staff to obtain. -She had not notified the PCP that the UA and culture ordered on 08/31/22 and not obtained. Interview with a medication aide (MA) on 10/19/22 at 10:30am revealed: -The procedure for processing laboratory orders was when an order was written or received via fax the MA working was responsible to enter the order in the facility's electronic medical record system, the eMAR showed the laboratory procedure needed to be done by facility staff for nonblood-based orders; once the order had been completed the MA should discontinue the order in the eMAR system. -She was aware the urine sample collected on 09/29/22 was sent back to the facility on 10/03/22. -She did not inform Resident #3's PCP because that would be the responsibility of the Health and Wellness Coordinator (HWC) or the Health and Wellness Director (HWD). -She informed the RCC on 10/03/22. Interview with Resident #3's PCP on 10/19/22 at 10:50am revealed:	{D 273}		

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-The PCP routinely came to the facility on Wednesdays.
-The PCP looked for the results of the UA ordered 08/31/22 when she came to the facility on 09/28/22.
-She was not notified by the facility regarding Resident #3's order for UA dated 08/31/22 (Wednesday) was never completed.
-She reordered a UA with culture for Resident #3 on her routine visit on 09/28/22 (Wednesday).
-She had not received the results from the UA with culture ordered on 09/28/22.
-On 10/10/22, she was contacted by the laboratory provider to inform her the laboratory had not received the UA with culture from the order that was faxed to the laboratory by the PCP on 09/28/22.
-She contacted the facility on 10/14/22 to request the staff obtain the UA ordered on 09/28/22.
-She had not been contacted regarding Resident #3's UA not done as of 10/19/22.
-She was aware Resident #3 had started falling within the last month to 6 weeks and wanted to rule out urinary tract infection as a contributing factor to the falls.
-She expected UA samples to be collected within 48 hours of ordering or notify her.
-If a sample could not be collected, she would order an in and out catheter collection by home health to expedite the process.
-Her main concern was that untreated urinary tract infections (UTI) could lead to confusion, loss of balance, and even sepsis (severe infection).
-She could not say if Resident #3 had increased falls due to a UTI without results of a UA test.

Second interview with the HWD on 10/20/22 at 9:50am revealed:
-Resident #3 did not have results from a UA available for review because the UA had not been

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sent to the laboratory yet.
-There had been a change to the procedure for pickup of laboratory samples that she was not aware of.
-She had been informed Resident #3 had an outstanding order for UA by the MAs this week, and she had reached out to the laboratory provider for information related to correctly processing UA samples.
-The HWC would be responsible for tracking completion of ordered laboratory test.
-The HWC was new to the facility.
-She had not notified Resident #3's PCP regarding the facility not obtaining the UA and culture as ordered.

Telephone interview with the facility's contracted laboratory on 10/20/22 at 11:58am revealed:
-The facility was responsible to collect urine samples and send the specimen to the laboratory.
-There was no documentation for a UA for Resident #3 within the last 3 months (August 2022, September 2022, or October 2022).

Interview with a MA on 10/20/22 at 12:35pm revealed:
-She was assigned an administrative day on Wednesday each week to assist the HWC and RCC with ensuring physician's orders were added to the eMAR system and general paperwork was completed.
-The order for Resident #3's UA dated 08/31/22 was entered into the eMAR system incorrectly by a former staff member.
-The UA order dated 08/31/22 did not show up on the eMAR screen for MAs to know it needed to be completed.
-The UA order dated 09/28/22 was collected by MA staff and sent out on 09/30/22 via UPS using

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a pickup process that the facility had always used. The sample was returned to the facility on 10/03/22 and she thought the HWD was notified by the RCC.
-The laboratory was called for new mailing labels.
-She did not notify Resident #3's PCP for the UA not completed as ordered because her shift had ended, and she had not followed-up with facility staff.

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

2. Review of Resident #3's current FL2 dated 06/16/22 revealed an order to obtain weekly weights.

Review of Resident #3's diet order dated 06/16/22 revealed an order for a nutritional supplement twice a day.

Review of Resident #3's August 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for please obtain weekly weights every dayshift every Friday for weight loss.
-There were initials documenting weights were obtained on 08/05/22, 08/12/22, 0819/22, and 08/26/22.
-There was no documentation for the value of the weights obtained on the August 2022 eMAR.

Review of Resident #3's computer generated progress notes for August 2022 revealed:
-There was no documentation for Resident #3's weight on the progress notes.
-There was no documentation Resident #3's primary care provider (PCP) was notified.

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{D 273}	Continued From page 35 Review of Resident #3's record revealed weights were documented on Resident #3's eMAR for monthly vitals as follows: -No weights documented for 08/04/22 with no reason documented. -On 09/04/22, weight was documented as 148 pounds. -On 10/04/22, weight was documented as 145 pounds. Based on observation, interviews, and record review, it was determined Resident #3 was not interviewable. Interview with the Health and Wellness Coordinator (HWC) on 10/19/22 at 9:45am revealed: -She had been the HWC for about 5 weeks. -Resident #3's weights were completed as ordered, but the weight value was not documented on the eMAR because the order was not entered into the eMAR system correctly to provide a space for documenting the weight. -The HWC was responsible to verify orders were correctly entered into the eMAR system. -The previous HWC entered Resident #3's order for weekly weights into the eMAR system. -She had not audited records for documentation of treatments like obtaining weights. -The Health and Wellness Director (HWD) was responsible to track residents' weights and she used a Nutrition Tracker to track weights. Interview with Resident #3's Primary Care Provider (PCP) on 10/19/22 at 10:50am revealed: -The PCP routinely came to the facility on Wednesdays. -She ordered weekly weights because Resident #3 had experienced some weight loss on different	{D 273}		

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occasions.
-Resident #3 had been ordered a nutritional supplement and her weight had leveled off.
-The weekly weights were ordered to monitor the resident's weight ongoing since she had cognitive impairment that could affect her eating.
-She did not think Resident #3 had recent weight loss.

Interview with as medication aide (MA) on 10/19/22 at 11:55am revealed:
-She initialed on Resident #3's electronic medication administration record (eMAR) she had obtained a weight on a few occasions in September 2022, and October 2022.
-There was no place on the eMAR to document the value for the weight.
-She did not use the resident's computer notes to document the weight because she did not think about the progress notes as an option.
-She was certain she had documented the weights on a facility 24-hour report sheet but she had no idea if the sheets were kept at the facility.
-She had not notified Resident #3's PCP of the lack of documented weights ordered weekly because the HWC would normally be responsible for notifying the providers for missed medications or procedures.
-She had not informed the HWC that the eMAR did not have a space to document Resident #3's weight.

Telephone interview with Resident #3's family member on 10/19/22 at 3:45pm revealed:
-She was Resident #3's Power of Attorney (POA).
-Resident #3 had experienced some weight loss a few months ago but seemed to be holding steady weight since she started a nutritional supplement.
-Resident #3's clothes continued to fit her well.

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{D 273}	Continued From page 37 Interview with a second MA on 10/20/22 at 12:35pm revealed: -She was assigned an administrative day on Wednesday each week to assist the HWC and Resident Care Coordinator (RCC) with ensuring physician's orders were added to the eMAR system and general paperwork was completed. -The order for Resident #3's weight tracking on every Friday was entered into the eMAR system incorrectly by a previous staff member. -There was a place to document the week weight value on the eMAR. -The MAs could document weights in the residents' computer progress notes. -Any MA could go into the eMAR system and change the resident's order for weights to provide a space for documenting weekly weights on the eMAR. -If there was documentation in the progress notes, then there was no way to determine if staff had notified Resident #3's PCP of missing weekly weight values. -She audited medication carts compared to orders on the eMAR, but she did not audit the eMARs for documentation related to weight orders. Interview with the Executive Director (ED) on 10/20/22 at 5:00pm revealed: -The Health and Wellness Director (HWD) and/or the HWC were responsible to ensure orders were entered correctly into the computer system. -Resident #3 should be on a Nutrition Tracker used by the facility for tracking residents that had been identified for weight loss and were on a nutritional supplement. -The ED had access to the Nutrition Tracker folder but there was no information available for review.	{D 273}		

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{D 273}	Continued From page 38 3. Review of Resident #3's orders revealed an order dated 08/31/22 for thromboembolic deterrent (TED) hose apply daily for swollen feet. Observation of Resident #3 during medication administration on 10/18/22 at 9:15am revealed: -The resident was seated in a wheelchair and wearing slide on shoes. -The resident was not wearing TED hose. Observation of Resident #3 on 10/18/22 at 4:00pm revealed: -The resident was not wearing TED hose and was wearing slip on shoes. -The residents feet appeared slightly swollen but not extending over the shoe band. Interview with the dayshift medication aide (MA) on 10/18/22 at 9:20am revealed: -Resident #3 was not wearing her TED hose this morning. -Resident #3's TED hose had been missing since 10/14/22. -The MA was unable to locate Resident #3's TED hose to put on as ordered daily. -She looked everywhere in the resident's room this morning. -She would have to order more from the contracted pharmacy to come in on 10/19/22. -She had not notified Resident #3's primary care provider (PCP) that Resident #3 did not have TED hose to wear for 4 days. Review of Resident #3's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for TED hose- apply in the morning and remove at bedtime for edema scheduled for 8:00am and 8:00pm.	{D 273}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 39 -There were 4 of 30 opportunities when TED hose was documented as not applied or removed; on 09/12/22 at 7:56am not applied, on 09/13/22 at 8:00pm not removed, on 09/20/22 at 8:00am and 8:00pm not applied or removed, and on 09/22/22 at 8:00am not applied. Review of Resident #3's October 2022 eMAR revealed: -There was an entry for TED hose- apply in the morning and remove at bedtime for edema scheduled for 8:00am and 8:00pm. -There were 4 of 30 opportunities from 10/10/22 to 10/18/22 when TED hose was documented as not applied or removed; on 10/10/22 at 10:11am not applied, on 10/14/22 at 8:46am not applied not able to locate on 10/17/22 at 9:29am not applied cannot locate, and on 10/18/22 at 8:00am not applied not able to locate, will call pharmacy. Based on observation, interviews and record review, it was determined Resident #3 was not interviewable. Interview with a second dayshift MA on 10/19/22 at 10:30am revealed: -There were days when staff could not find Resident #3's TED hose and had to document not applied. -She had not notified Resident #3's PCP any day she was not able to locate and apply the TED hose. Interview with Resident #3's PCP on 10/19/22 at 10:50am revealed: -She expected Resident #3's TED hose to be applied daily in the morning and removed at night as ordered. -Resident #3 had bilateral swelling in her feet and the TED hose were ordered to treat the swelling.	{D 273}		

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{D 273}	Continued From page 40 -She had not observed Resident #3 when she was not wearing TED hose. -She had no documentation she was notified when Resident #3's TED hose were not applied. -The facility should notify her anytime a resident was not receiving treatments as ordered. -The facility could text her or message through the providers telephone messaging system any time of day or night and any day of the week. Telephone interview with Resident #3's family member on 10/19/22 at 3:45pm revealed: -She was Resident #3's Power of Attorney (POA) and visited Resident #3 several times a week. -There were days when she visited Resident #3 and the resident was not wearing her TED hose. -Resident #3 would sometimes hide things in her room but she did not know if the resident had ever hidden her TED hose. -Staff had not informed her of days when the resident was refusing or not wearing her TED hose. Interview with a third MA on 10/20/22 at 12:58pm revealed: -The evening staff were supposed to remove the TED hose, rinse the hose, and drape them over the bathroom sink to dry overnight for the morning staff to apply. -Sometimes the TED hose were inadvertently put in the resident's laundry which caused a problem in locating until the laundry was returned. -The MA was responsible to apply TED hose or ensure the personal care staff had applied Resident #3's TED hose and to document on the eMAR each morning. -She had not notified Resident #3's PCP, the HWD or the HWC when the resident's TED hose were not applied. -She looked for Resident #3's TED hose in her	{D 273}		

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{D 273}	Continued From page 41 room but documented as not applied when she could not find the TED hose. _____ Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 residents sampled (#3) related to physician orders for obtaining UA for a resident who had experienced 5 falls in the last 6 weeks which could have increased falls due to an undiagnosed UTI, and not obtaining weekly weights as ordered for the resident that had a history of weight loss and was ordered a nutritional supplement to maintain weight. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/19/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 03, 2022.	{D 273}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	{D 310}		

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{D 310}	Continued From page 42 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure therapeutic diets (pureed) for 2 of 3 sampled residents (Residents #2 and #6) were served as ordered. The findings are: 1. Review of Resident #2's current FL2 dated 02/04/22 revealed diagnoses included dementia, hypertension and hyperlipidemia. Review of Resident #2's physician's order dated 06/22/22 revealed an order for speech therapy to evaluate and treat for dysphagia. Review of the speech therapist recommendations diet order dated 07/21/22 revealed a recommendation for a pureed diet. Review of the facility's therapeutic diet list posted in the kitchen (no date) revealed Resident #2 was to be served a pureed diet. Review of the facility's pureed therapeutic diet menu dated 10/18/22 revealed a resident ordered a pureed diet was to be served pureed seafood or chicken, pureed potatoes, pureed vegetables, pureed bread, pureed cakes, pudding or pureed fruit. Observation of the lunch meal served Resident #2 on 10/18/22 at 12:15pm revealed: -Resident #2 was sitting at the dining room table. -Resident #2 was unable to physically feed herself. -A medication aide (MA) provided feeding assistance to Resident #2 for the lunch meal. -Resident #2's meal consisted of creamed soup, macaroni and cheese and pureed lima beans.	{D 310}		

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{D 310}	Continued From page 43	{D 310}		

-The macaroni and cheese were thick and clumped together, the texture was not smooth.
-There were one-fourth and one-fifth inch pieces of noodles observed in the macaroni and cheese.
-The MA mashed the noodles using the resident's fork.
-Resident #2 consumed more than half of the macaroni and cheese.

Interview with the MA feeding Resident #2 on 10/20/22 at 11:44am revealed:
-She had observed that Resident #2's meal was correctly pureed.
-The resident had pieces of whole noodles in the macaroni and cheese.
-She mashed up the noodles so the resident could eat them.
-She had complained many times to the Food Service Director (FSD) regarding Resident #2's pureed meal not being accurately prepared.
-The resident was unable to eat the food because there were chunks of food in what was supposed to be a pureed meal.
-There was one cook that refused to get the pureed meals correct and she had reported the cook to the FSD, but nothing had been done about the cook.

Interview with Resident #2's Primary Care Provider (PCP) on 10/20/22 at 3:37pm revealed:
-Resident #2 had dysphagia with swallowing difficulty.
-Resident #2 had a speech therapy evaluation a few months ago and a pureed diet was recommended.
-Resident #2 mostly received feeding assistance from staff, but it was still important the resident's meal was served as ordered.

Based on observation, record review and

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{D 310}	Continued From page 44	{D 310}		

interview, it was determined Resident #2 was not interviewable.

Refer to the interview with the cook on 10/18/22 at 12:45pm.

Refer to the interview with the Food Service Director (FSD) on 10/18/22 at 1:33pm.

Refer to the interview with the Administrator on 10/18/22 at 1:05pm.

2. Review of Resident #6's current FL2 dated 01/14/22 revealed there were no diagnoses and no diet listed on the FL2.

Review of Resident #6's diet order dated 05/10/22 revealed an order for a pureed diet.

Review of the facility's therapeutic diet list posted in the kitchen (no date) revealed Resident #2 was to be served a pureed diet.

Review of the facility's pureed therapeutic diet menu dated 10/18/22 revealed a resident ordered a pureed diet was to be served pureed seafood or chicken, pureed potatoes, pureed vegetables, pureed bread, pureed cakes, pudding, or pureed fruit.

Observation of Resident #6's lunch meal on 10/18/22 from 12:18pm to 12:48pm revealed:
-Resident #6's meal consisted of creamed soup, macaroni and cheese and pureed lima beans.
-The macaroni and cheese were thick and clumped together, the texture was not smooth.
-Resident #6 feed herself and received no feeding assistance from staff.
-Resident #6 ate her food slowly and appeared to feel mash her food between her tongue and the

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{D 310}	Continued From page 45	{D 310}		

roof of her mouth.
-Resident #6 first ate the pureed lima beans, then started to consume the macaroni and cheese.
-While eating the macaroni and cheese Resident #6 started spitting food out of her mouth.
-There were one-fourth and one-fifth inch pieces of noodles observed in the macaroni and cheese.

Interview with a MA on 10/18/22 at 12:43pm revealed:
-She had often observed the meal prepared by the cook which had whole chunks of food.
-When she identified the chunks of food, she took them out of the resident's food.
-If there were chunks of food in Resident #6's meal she usually spit it out.
-Resident #6 spit out chunks of food often at meal time because the food was not pureed correctly.
-She did not know if the was problem with the kitchen's food processor not working correctly as the reason why pureed foods were not the correct consistency.

Interview with Resident #6's Primary Care Provider (PCP) on 10/20/22 at 3:37pm revealed:
-Resident #6 was ordered a pureed diet for a reason.
-Right off hand she was unable to recall exactly why Resident #6 was ordered a pureed diet.
-Resident #6 should not be spitting out chunks of food from a pureed diet.
-She had not observed Resident #6's meal and she not aware the resident's meal was not pureed accurately.
-She expected Resident #6's meals served to be pureed as ordered.

Based on observation, record review and interview, it was determined Resident #6 was not interviewable.

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{D 310}	Continued From page 46 Refer to the interview with the cook on 10/18/22 at 12:45pm. Refer to the interview with the Food Service Director (FSD) on 10/18/22 at 1:33pm. Refer to the interview with the Administrator on 10/18/22 at 1:05pm. _____ Interview with the cook on 10/18/22 at 12:45pm revealed: -He put the macaroni and cheese in the food processor. -He added water to the macaroni and cheese. -His process to ensure pureed consistency was after blending food in the processor he put the food in a pastry bag. -If the food comes through the pastry bag it was pureed consistency. -He did not check the food to ensure it was pureed because it went through the pastry bag. -He did not know the macaroni and cheese had chunks of noodles. -The pieces of noodles added up to only a couple of whole noodles. Interview with the FSD on 10/18/22 at 1:33pm revealed: -The cook had been trained how to accurately prepare pureed meals. -The cook had been told to look at the purees to ensure there was nothing solid in the purees. -He sometimes checked the cook's meals but not every day. -He would provide additional training to the cook. Interview with the Administrator on 10/18/22 at 1:05pm revealed:	{D 310}		

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{D 310}	Continued From page 47 -She had not observed meals and did not realize the cook did not prepare pureed meals correctly. -She was sure the FSD had trained the cook, but not sure if the meals were observed by the FSD. -She expected therapeutic diets to be served as ordered.	{D 310}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure medications were administered as ordered by the physician for 3 of 5 sampled residents (Residents #1, #4 and #5) with orders for a medication to prevent blood clots and pain reliever, a medication for thyroid deficiency, and to assist with urinary tract flow and a medication to reduce cholesterol (#1); a medication for anxiety and depression and a controlled pain medication (#4); and a nutritional supplement (#5). The findings are: 1. Review of Resident #1's current FL2 dated 08/24/22 revealed diagnoses included dementia, major depressive disorder, hypothyroidism, osteoarthritis, hemiplegia and hemiparesis and	{D 358}		

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{D 358}	Continued From page 48 anxiety. a. Review of Resident #1's current FL2 dated 08/24/22 revealed a medication order for aspirin 81mg once daily (used to treat mild pain and prevent blood clots). Observation of medication administration on 10/18/22 at 9:31am revealed: -The medication aide (MA) prepared 6 oral medications for administration to Resident #1. -Vazalore (generic name is aspirin) 81mg capsule was not included in the medications administered to Resident #1 at 9:31am. Review of Resident #1's September and October 2022 progress notes revealed there was documentation aspirin 81mg was not available on the following dates: 10/18/22, 10/16/22, 10/15/22, 10/10/22, 10/02/22, 09/26/22, 09/22/22, 09/20/21, 09/19/21, and 09/19/22. Review of Resident #1's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81mg once daily scheduled for administration at 9:00am. -There was documentation aspirin 81mg was administered 15 out of 21 opportunities from 09/08/22 through 09/29/22. -There was documentation aspirin 81mg was not administered 7 days on 09/18/22, 09/19/22, 09/20/22, 09/21/22, 09/22/22, 09/26/22 by the medication aide (MA) documenting aspirin was not available. -There was no documentation aspirin 81mg was administered on 09/30/22 and there was no documentation why the medication was not administered.	{D 358}		

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{D 358}	Continued From page 49 Review of Resident #1's October 2022 eMAR revealed: -There was an entry for aspirin 81mg once daily scheduled for administration at 9:00am. -There was documentation aspirin 81mg was administered 11 out of 18 opportunities. -There was documentation aspirin 81mg was not administered 7 days on 10/01/22, 10/02/22, 10/10/22, 10/12/22, 10/15/22, 10/16/22 and 10/18/22 by the MA documenting aspirin was not available. Observation of Resident #1's medications on hand at the facility on 10/19/22 at 9:30am revealed: -Aspirin 81mg was available for administration under a generic name (vazalore) and was dispensed on 08/30/22 with a quantity of 30 capsules. -There were 15 capsules remaining. Telephone interview with Resident #1's Primary Care Provider (PCP) on 10/20/22 at 3:37pm revealed: -She was not aware Resident #1's aspirin was not administered as ordered. -If the MA was aware the medication was not on the medication cart, she should have been made aware the pharmacy was contacted to inquire about the aspirin. Interview with the morning MA on 10/18/22 at 1:08pm revealed: -She had documented aspirin 81mg as not available on the medication cart to administer. -She did not read the label on the vazalore bubble pack to see it was the same as aspirin. -She had not been told by the other MA that vazalore was a capsule form of aspirin 81mg.	{D 358}		

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{D 358}	Continued From page 50 Interview with the Health and Wellness Director (HWD) on 10/18/22 at 1:14pm revealed: -The MAs should be reading the eMARs using the 3-step verification when passing medications. -The 3-step verification included reading the eMAR, pulling the medication and reading the label completely on the medication, rechecking the medication container comparing it to the eMAR, then administering the medication. -The MA should have administered vazalore 81mg to Resident #3 for aspirin 81mg. Interview with a second MA on 10/19/22 at 10:24am revealed: -She previously thought Resident #1's aspirin 81mg was not available, but then realized the aspirin 81mg was under a generic name. -She did not make the MAs aware of the aspirin 81mg under a generic name. Interview with the Administrator on 10/20/22 at 4:53pm revealed: -If the MA was unable to find a resident's medication on the medication cart, they should let someone know. -The MA should call the pharmacy and should let her and the HWD also know. b. Review of Resident #1's current FL2 dated 08/24/22 revealed medication orders included an order for atorvastatin calcium 40mg once daily (used to lower cholesterol). Review of Resident #1's September and October 2022 progress notes revealed there was documentation atorvastatin 40mg was not available on the following dates: 10/07/22, 10/04/22, 09/22/22, and 09/21/22. Review of Resident #1's September 2022	{D 358}		

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electronic medication administration record (eMAR) revealed:
-There was an entry for atorvastatin calcium 40mg once daily scheduled for administration at 9:00am.
-There was documentation atorvastatin calcium 40mg was administered 17 out of 21 opportunities from 09/08/22 through 09/30/22.
-There was documentation atorvastatin 40mg once daily was not administered for 4 days on 09/20/22, 09/21/22, 09/22/22 by the medication aide (MA) documenting atorvastatin was not available.
-There was no documentation why atorvastatin 40mg was not administered on 09/14/22.

Review of Resident #1's October 2022 eMAR revealed:
-There was an entry for atorvastatin 40mg once daily scheduled for administration at 9:00pm.
-There was documentation atorvastatin 40mg was administered 13 out of 17 opportunities.
-There was documentation atorvastatin 40mg was not administered for 4 days on 10/04/22, 10/07/22, 10/13/22 and 10/14/22 by the MA documenting atorvastatin was not available.

Observation of Resident #1's medications on hand at the facility on 10/19/22 at 9:30am revealed:
-Atorvastatin 40mg was available for administration.
-On 10/14/22, 5 tablets of atorvastatin were dispensed, and there was 1 tablet remaining.

Telephone interview with a pharmacist at the facility's contract pharmacy on 10/19/22 at 12:08pm revealed:
-The pharmacy dispensed 8 tablets of atorvastatin on 40mg on 09/21/22.

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-The pharmacy dispensed 5 tablets of atorvastatin 40mg on 10/14/20.
-The pharmacy dispensed 28 tablets of atorvastatin 40mg on 10/17/22 to start the resident on the cycle fill system.
-The pharmacy initially received medication orders for Resident #1 on 09/08/22.
-The orders received were mostly over-the-counter medications.
-On 09/21/22, the pharmacy received an order for atorvastatin 40mg.
-The pharmacy dispensed 8 tablets of atorvastatin 40mg to administer until the designated cycle fill date.
-The cycle fill date would have been on 09/17/22, so the next cycle fill date would be on 10/17/22.
-Unless Resident #1 came to the facility with some atorvastatin tablets, the 8 tablets sent by the pharmacy would have lasted until 09/29/22.
-Resident #1's medications were not set-up on automatic cycle fill until 10/17/22, so the facility needed to call and request a refill of atorvastatin.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 10/20/22 at 3:37pm revealed:
-She was not aware Resident #1's atorvastatin 40mg was not administered as ordered.
-If the MA was aware the medication was not available for administration and resident missed doses of the medication, she wanted to know.
-She expected Resident #1's medications to be administered as ordered.
-A resident should not miss a medication without her being informed.

Interview with the medication aide (MA) on 10/18/22 at 9:10am revealed:
-When Resident #1 was admitted to the facility sometime in the month of September 2022, she

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{D 358}	Continued From page 53 was unable to remember if the resident had atorvastatin 40mg when she was admitted. -She recalled having a difficult time getting some of Resident #1's medications but was unable to recall why atorvastatin was not available. -She recalled contacting the pharmacy to ask about Resident #1's atorvastatin, but she was unable to remember the response given by the pharmacy. -She did not document the contact with the pharmacy, and she did not document the reason why the medication was not available. -She was unable to recall if she made the Health and Wellness Director (HWD) and the Administrator aware Resident #1's atorvastatin was not available for administration. -She thought there was a problem with medications being in the facility and not placed on the medication cart. -Audits of the medication cart were done every other week but they only checked for expired medications. -The audits were done by the assistant health and wellness coordinator. -That position was recently vacant, the person in that position had not starter to work. Interview with the Health and Wellness Director (HWD) on 10/19/20 at 10:26am revealed: -She was not aware Resident #1's atorvastatin 40mg was not administered as ordered. -If a medication was not on the medication cart, the MA should contact pharmacy to find out why the medication was not delivered. -If there was a problem getting Resident #1's atorvastatin, the MA should let her know. Interview with the Administrator on 10/20/22 at 4:53pm revealed: -If the MA was unable to find Resident #1's	{D 358}		

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{D 358}	Continued From page 54 atorvastatin 40mg on the medication cart, the MA should contact the pharmacy to inquire why the medication was not delivered. -If the MA was still unable to get the medication, the MA should make her and HWD aware the medication was not available for administration. c. Review of Resident #1's current FL2 dated 08/24/22 revealed medication orders included an order for flomax 0.4mg once daily (used to treat urinary tract problems). Review of Resident #1's September and October 2022 progress notes revealed there was documentation flomax 0.4mg was not available on the following dates: 09/25/22, 09/24/22, 09/23/22, 09/22/22, 09/20/22, 09/19/22, 09/17/22, and 09/16/22. Review of Resident #1's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for flomax 0.4mg was scheduled for administration at 9:00am. -There was documentation flomax 0.4mg was administered 11 out of 21 opportunities from 09/08/22 through 09/30/22. -There was documentation flomax 0.4mg once daily was not administered 10 days on 09/16/22, 09/17/22, 09/18/22, 09/19/22, 09/20/22, 09/21/22, 09/22/22, 09/23/22,09/24/22 and 09/24/22 by the medication aide (MA) documenting flomax was not available. -There was no documentation why flomax was not available. Review of Resident #1's October 2022 eMAR revealed there were 2 missing doses of flomax 0.4mg; on 10/01/22 and on 10/12/22 when resident was at the hospital.	{D 358}		

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{D 358}	Continued From page 55 Observation of Resident #1's medications on hand at the facility on 10/19/22 at 9:30am revealed: -Flomax 0.4mg was available for administration. -The pharmacy dispensed 28 capsules of flomax on 09/26/22. -There were 19 capsules remaining. Telephone interview with a pharmacist at the facility's contract pharmacy on 10/19/22 at 12:08pm revealed: -The pharmacy dispensed 28 capsules of flomax on 09/26/22. -The medication had not been refilled since. -If the facility had documentation of administering flomax prior to 09/26/22, they did not request the medication from their pharmacy. -If the flomax 0.4mg was administered as ordered there should be 5 to 6 doses remaining. Telephone interview with Resident #1's Primary Care Provider (PCP) on 10/20/22 at 3:37pm revealed: -She was not aware Resident #1's flomax was not administered as ordered. -If the MA knew the medication was not available for administration and Resident #1 was not administered flomax, she wanted to be notified. -She expected Resident #1's medications to be administered as ordered. -A resident should not miss a medication without her being informed. Interview with the medication aide (MA) on 10/18/22 at 9:10am revealed: -When Resident #1 was admitted to the facility, the resident had some medications. -She was unable to recall if flomax was one of the medications Resident #1 had when she was	{D 358}		

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admitted.
-There was a problem getting Resident #1's flomax.
-The pharmacy should have been contacted and there should be documentation of the communication with the pharmacy on the progress notes or charting notes.
-She was unable explain why there was no documentation by her on the progress notes for charting notes related to her contacting the pharmacy about Resident #1's flomax not being available.
-She did not recall if she let any management know that flomax was not available.

Interview with the Health and Wellness Director (HWD) on 10/19/20 at 10:26am revealed:
-She was not aware Resident #1's flomax 0.4mg was not administered as ordered.
-If a medication was not on the medication cart, she expected the MA to contact pharmacy and find out what happened to the medication.
-She started working at the facility about a month prior to Resident #1's admission to the facility and she was not made aware the resident's flomax was not administered.
-The facility had no documentation or records regarding medications that came with Resident #1 to the facility.

Interview with the Administrator on 10/20/22 at 4:53pm revealed:
-If Resident #1's atorvastatin was not available, the MA was supposed to contact the pharmacy and find out why.
-There should be no reason a resident was without a medication.
-She expected medications to be administered as ordered.

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{D 358}	Continued From page 57 d. Review of Resident #1's current FL2 dated 08/24/22 revealed medication orders included an order for levothyroxine 75mcg one tablet once daily (used to treat thyroid deficiency). Review of Resident #1's September and October 2022 progress notes revealed there was documentation levothyroxine 75mcg was not available on the following dates: 09/26/22, 09/25/22, 09/24/22, 09/23/22, 09/21/22, 09/19/22, and 09/18/22. Review of Resident #1's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 75mcg one time a day was scheduled for administration at 6:00am. -There was documentation levothyroxine 75mcg was administered 12 out of 21 opportunities from 09/08/22 through 09/30/22. -There was documentation levothyroxine 75mcg one time a day was not administered 9 days on 09/18/22, 09/19/22, 09/20/22, 09/21/22, 09/23/22, 09/24/22, 09/25/22 and 09/26/22 by the medication aide (MA) documenting flomax was not available. -There was no documentation why levothyroxine 75mcg was not administered on 09/22/22. -There was no documentation why levothyroxine 75mg was not available. Review of Resident #1's October 2022 eMAR revealed there were 2 missing doses of flomax 0.4mg; on 10/01/22 and on 10/12/22 when the resident was at the hospital. Observation of Resident #1's medications on hand at the facility on 10/19/22 at 9:30am revealed:	{D 358}		

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{D 358}	Continued From page 58 -Levothyroxine 75mcg was available for administration. -The pharmacy dispensed 30 tablets of levothyroxine 75mcg on 09/12/22. -There were 10 tablets remaining. Telephone interview with a pharmacist at the facility's contract pharmacy on 10/19/22 at 12:08pm revealed: -The pharmacy dispensed 30 tablets of levothyroxine 75mcg on 09/26/22. -The medication was not dispensed again until 10/17/22, which would start the facility's cycle on 10/19/22. -If the facility had documentation of administering levothyroxine prior to 09/26/22, they did not get the medication from their pharmacy. -If levothyroxine was administered as ordered, there should be 7 to 8 doses remaining. Telephone interview with Resident #1's Primary Care Provider (PCP) on 10/20/22 at 3:37pm revealed: -She was not aware Resident #1's levothyroxine was not administered as ordered. -She expected Resident #1's levothyroxine to be administered as ordered. -If the facility was unable to obtain the medication, then she wanted to be notified. Interview with the medication aide MA on 10/18/22 at 9:10am revealed: -When Resident #1 was admitted to the facility, some medications came with the resident. -She was unable to recall if levothyroxine was one of the medications. -It was the facility's policy, if a medication not available to contact the pharmacy and let the HWD know. -The would have documented on the progress	{D 358}		

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note if she contacted the pharmacy.
-She was unable explain why there was no documentation by her on the progress notes for charting notes related to her contacting the pharmacy regarding Resident #1's levothyroxine 75mcg not being available.

Interview with the Health and Wellness Director (HWD) on 10/19/20 at 10:26am revealed:
-She was not aware Resident #1's levothyroxine was not available for administration.
-If a medication was not on the medication cart, she expected the MA to contact pharmacy and find out why the medication was not available.
-She started working at the facility about a month prior to Resident #1's admission to the facility and she was not made aware the resident's levothyroxine was not available.
-The facility had no documentation for records regarding medications that came with Resident #1 to the facility.

Interview with the Administrator on 10/20/22 at 4:53pm revealed:
-If Resident #1's levothyroxine was not available for administration.
-There should be no reason why a resident was without a medication.
-She expected medications to be administered as ordered.

Based on observation, record review and interviews it was determined Resident #1 was not interviewable.
2. Review of Resident #4's current FL2 dated 08/17/22 revealed diagnoses included Alzheimer's disease and anxiety.

a. Review of Resident #4's current FL2 dated 08/17/22 revealed there was an order for

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duloxetine (an antidepressant medication used to treat depression and anxiety) 60mg daily.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for duloxetine 60mg scheduled daily at 9:00am.
-There was documentation duloxetine 60mg was not administered 13 out of 18 opportunities from 10/01/22 through 10/18/22.

Review of Resident #4's Progress Notes revealed duloxetine 60mg was documented as not administered 13 times from 10/01/22 through 10/18/22 due to the medication not being available in the facility for administration.

Observation of medication on hand for Resident #4 on 10/19/22 at 11:20am revealed:
-There was one cycle-fill medication card for duloxetine 60mg, take 1 tablet daily.
-The duloxetine medication card included a start date on 10/19/22 and there were 27 tablets out of 28 total dispensed tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 10/19/22 at 11:50am revealed:
-Resident #4's duloxetine was a cycle-fill medication, so it was automatically refilled every 28 days.
-The last two packaging dates for Resident #3's duloxetine were on 09/14/22 and 10/12/22, with a quantity of 28 tablets dispensed each time.
-The date printed on the medication cards was the date the cycle-fill began, so the medication card that was packaged on 09/14/22 would have a start date of 09/21/22, and the medication card packaged on 10/12/22 would have a start date of

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{D 358}	Continued From page 61 10/19/22. -Resident #4's duloxetine was delivered to the facility on 09/19/22 and the Resident Care Coordinator (RCC) signed the delivery receipt. Interview with the RCC on 10/19/22 at 3:30pm revealed there were no empty medication cards for Resident #4's duloxetine in the tote to go back to the pharmacy, which indicated there was no excess tablets and all 28 tablets were used. Interview with a medication aide (MA) on 10/19/22 at 4:00pm revealed: -She had documented Resident #4's duloxetine as not administered due to medication not available three times in October 2022. -She had notified the hospice nurse in person on 10/12/22, that Resident #4 did not have duloxetine, which was the first day she worked and noticed the duloxetine was not in the medication cart. -The hospice nurse told her that she would follow-up on it and reorder the prescription. -On 10/15/22, Resident #4 still did not have duloxetine available for administration so she called the pharmacy and was told that they could not refill the medication because it was a cycle-fill medication and should not have run out before the next cycle started. Telephone interview with Resident #4's hospice nurse on 10/20/22 at 11:00am revealed: -If Resident #4 needed a refill of an as-needed (PRN) medication, the MAs contacted hospice rather than the primary care provider (PCP). -Since duloxetine was a scheduled medication, it was part of the cycle-fill program at the facility's contracted pharmacy. -She was at the facility on 10/12/22 and one of the MAs requested a refill for Resident #4's	{D 358}		

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duloxetine, but she did not send another refill of the medication since it was a cycle-fill prescription and should not have run out.
-She had not noticed any increase in depression symptoms or behaviors for Resident #4 during the last month.

Interview with a second MA on 10/20/22 at 11:30am revealed:
-She had documented Resident #4's duloxetine as not administered due to medication not available three times in October 2022.
-She had called the pharmacy to request the refill be sent but was told by the pharmacy it had already been filled with the rest of her cycle-fill medications.
-She did not remember which day she had called the pharmacy.
-The pharmacy sent totes of cycle-fill medication cards to the facility at the end of second shift or start of third shift every 28 days.
-The third shift MAs were responsible for switching out the batch of medication cards when the new cycle-fill medication totes came from the pharmacy.
-If a first shift MA noticed a medication card was missing the morning after the cycle-fill medication cards were switched out, they could check the pharmacy totes in the medication room because medications did not get sent back to the pharmacy right away.
-She did not know how long the pharmacy totes with the old medication cards stayed in the medication room before being sent back to the pharmacy.
-She had not noticed any increase in depression symptoms or behaviors for Resident #3 during the last month.

Interview with the Health and Wellness Director

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{D 358}	Continued From page 63 (HWD) on 10/20/22 at 12:00pm revealed: -She was not aware that Resident #4 had missed 13 doses of duloxetine in October 2022. -After Resident #4 had missed the first two doses of duloxetine, she expected the MA to notify her so that she could either look for the medication card or contact the PCP and pharmacy. -The MAs were trained that all medications should be reordered when they were down to the last week of remaining tablets so that the medication would not run out. -Resident #4's duloxetine was a cycle-fill medication and would have been delivered on 09/21/22, so there was no reason it should not have been administered. -The third shift MA was responsible for switching out the cycle-fill medication cards in the medication carts, and the current HWC had worked with the RCC to audit and switch out the batch of cycle-fill medications in September 2022. -During the cycle-fill audit the HWC and RCC, each residents' medication list would have been printed out and compared it to the packing slip and medications delivered from the pharmacy. Interview with the RCC on 10/20/22 at 12:10pm revealed: -The September 2022 delivery of cycle-fill medications started 09/21/22 so Resident #4 should have had enough duloxetine to get to the October 2022 delivery of cycle-fill medications. -She had documented Resident #4's duloxetine as administered on 10/10/22 so she thought the medication must have been available to administer in the medication cart. -She did not know why the other MAs would be documenting that the medication was not available. -She tried to find the packing slip she signed to acknowledge the delivery of Resident #4's	{D 358}		

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medications in September 2022 but could not find it.
-She and the current HWC had audited all the medications that came from the pharmacy for the medication cycle starting 09/21/22 and ending 10/18/22 and there were no medications missing.
-She had not noticed any change in Resident #4's behavior in the last month.

Telephone interview with Resident #4's PCP on 10/20/22 at 3:45pm revealed:
-She had not received any notification from the facility regarding Resident #4 missing doses of duloxetine or needing a refill, but those notifications could have gone to either hospice or the psychiatric nurse practitioner (NP).
-She had last seen Resident #4 on 10/05/22 which was one day after the MAs started documenting her duloxetine as not available and the MAs had not mentioned the missed doses to her during that visit.
-The psychiatric NP had seen Resident #4 on 08/23/22 for her recent admission to the facility and had listed the visit diagnoses as dementia and moderate depression.

Interview with the Executive Director (ED) on 10/20/22 at 4:50pm revealed:
-She was not aware Resident #4 had missed 13 doses of duloxetine in October 2022.
-Resident #4's duloxetine was a cycle-fill medication so
should not have run out.
-If a medication was not received with the new batch of cycle-fill medications or could not be found on the medication cart, the MA was responsible for notifying the HWD right away.

Based on observation, record review and attempted interview, it was determined Resident

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{D 358}	Continued From page 65 #4 was not interviewable. Attempted telephone interview with Resident #4's psychiatric NP on 10/20/22 at 5:15pm was unsuccessful. Attempted telephone interview with a third MA on 10/20/22 at 5:30pm was unsuccessful. b. Review of Resident #4's current FL2 dated 08/17/22 revealed there was an order for Norco (hydrocodone-acetaminophen, a Schedule II controlled drug used to treat pain) 7.5-325mg, take 1 tablet twice daily. Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Norco 7.5-325mg take 1 tablet twice daily scheduled daily at 9:00am and 9:00pm. -There was documentation Norco 7.5-325mg was not administered 4 out of 35 opportunities from 10/01/22 through 10/18/22. Review of Resident #4's Progress Notes revealed Norco 7.5-325mg was documented as not administered 4 times from 10/01/22 through 10/18/22 due to the medication not being available in the facility for administration. -There was one medication card for Norco 7.5-325mg. Observation of medication on hand for Resident #4 on 10/19/22 at 11:20am revealed: -The date on the medication card was 05/16/22 and there were 22 tablets out of 30 total dispensed tablets remaining. -The date on the medication card was 05/16/22	{D 358}		

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and there were 22 tablets out of 30 total dispensed tablets remaining.
-There was a sticker on the medication card documenting the order had changed and to check the current order on the eMAR.

Interview with a medication aide (MA) on 10/19/22 at 11:22am revealed:
-Resident #4's Norco 7.5-325mg tablets used to be ordered to take as-needed (PRN) so that was why the card was from May 2022.
-The Norco 7.5-325mg order changed to scheduled twice daily after she was admitted to the facility, so the Resident Care Coordinator (RCC) placed the order change sticker on the medication card, and they started using that card after the previous card ran out.
Telephone interview with a representative from the facility's contracted pharmacy on 10/19/22 at 11:50am revealed:
-Resident #4 had an order for Norco 7.5-325mg take one tablet twice daily.
-On 08/29/22, the pharmacy dispensed 60 tablets of Norco 7.5-325mg for Resident #4 to the facility.
-They had not received any new prescriptions for scheduled Norco for Resident #4 since.
-The pharmacy received a new prescription from the hospice doctor on 10/13/22 for Norco 7.5-325mg take one tablet every 8 hours as needed.
-On 10/13/22 they dispensed to the facility Norco 7.5-325mg take one tablet every 8 hours as needed, for a quantity of 45 tablets for Resident #4.
-They had dispensed 30 tablets of as-needed Norco 7.5-325mg on 05/16/22 for Resident #4 when she resided
at another facility owned by the same company.

Interview with a second MA on 10/19/22 at

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{D 358}	Continued From page 67 4:00pm revealed: -She had administered Resident #4's last dose of Norco 7.5-325mg on 10/12/22 and notified the hospice nurse in person that day that a refill was needed. -The hospice nurse told her she would have a refill sent to the pharmacy. -The MAs were responsible for notifying hospice when an as-needed medication was down to the last 5 doses so that a refill could be sent before the medication ran out. -She had not worked the week prior to Resident #4 running out of Norco 7.5-325mg, so she did not know if anyone had requested a refill prior to her shift on 10/12/22. -When a refill was requested during the day, the pharmacy delivered it later that night on the same day. Telephone interview with Resident #4's hospice nurse on 10/20/22 at 11:00am revealed: -If Resident #4's Norco 7.5-325mg was running low, the facility staff would need to notify her to have a refill sent. -She was notified by a MA at the facility on 10/12/22 that Resident #4 was out of Norco 7.5-325mg, take 1 tablet twice daily. -She had contacted hospice's medical director for a refill but instead he wrote a new prescription for Norco 7.5-325mg take one tablet every 8 hours as needed, and never refilled the scheduled dose. -She was contacted by staff at the facility a second time, on 10/17/22, to request a refill of the scheduled Norco 7.5-325mg so they were in the process of completing that refill. -Resident #4 was admitted to the facility with a	{D 358}		

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humerus fracture and always reported she had pain;
there was no increase in her complaints of pain during her last visit with Resident #4 on 10/12/22.

Interview with a third MA on 10/20/22 at 11:30am revealed:
-She had documented Resident #4's Norco as not administered on 10/13/22.
-Since there was no medication card with Norco 7.5-325mg tablets to be administered twice daily scheduled, she documented it as not administered and administered one of her PRN pain medications.
-She thought when Resident #4 was admitted to the facility she came from the other facility with a card for PRN Norco 7.5-325mg, which was the medication card they were currently using for her.
-She had not used the Norco 7.5-325mg from the medication card dated 05/16/22 because the order on the medication card was to take PRN, and at that time she did not have a PRN Norco 7.5-325mg order.
-When Resident #4's Norco was running low, the MAs were supposed to contact hospice for a refill, but she did not because she was told the refill had already been requested.

Interview with the Health and Wellness Director (HWD) on 10/20/22 at 12:00pm revealed:
-She was not aware that Resident #4 had missed doses of Norco 7.5-325mg between the dates of 10/12/22 and 10/14/22.
-The MAs were supposed to call hospice to request a refill of Resident #4's Norco when the quantity of
tablets left was within one week of running out.

Interview with the Resident Care Coordinator (RCC) on 10/20/22 at 12:10pm revealed:

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{D 358}	Continued From page 69 -The pharmacy had been notified by one of the MAs, she could not remember who or when, that Resident #4 needed a refill of Norco 7.5-325mg to be taken twice daily scheduled. -The pharmacy had advised the MA that a physician written prescription was needed to obtain the refill, so the MA contacted hospice and the hospice doctor had prescribed Norco 7.5-325mg PRN instead. -Since the medication card for Norco the facility had on hand from May 2022 for Resident #4 was the same dose, she had placed an "order change" sticker on the card and the MAs were using that supply until the pharmacy sent the refill of scheduled Norco. -Hospice should have refilled the medication before it ran out because the hospice nurses checked quantities of medication remaining while they were at the facility visiting the residents. Telephone interview with Resident #4's primary care provider (PCP) on 10/20/22 at 3:45pm revealed: -Resident #4 had been on Norco 7.5-325mg for at least 6 months for chronic knee pain. -The order had changed from PRN to twice daily scheduled after Resident #4 fractured her humerus and was admitted to the facility. -She had not received any refill requests for Resident #4's Norco 7.5-325mg during the month of October 2022, but staff probably would have called hospice for that. -Resident #4 had not mentioned any increase in her pain level, but at her baseline she reported her pain being a level 8 out of 10 in her knee. Interview with the Executive Director on 10/20/22 at 4:50pm revealed: -She was not aware Resident #4 had missed doses of Norco 7.5-325mg.	{D 358}		

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{D 358}	Continued From page 70 -She expected MAs to reorder a medication either through hospice or the resident's PCP seven days prior to the medication running out. -If a medication was not available for administration on the day it was due, the MA should notify the HWD so that a refill could be requested right away. Based on observation, record review and attempted interview, it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident #4's psychiatric NP on 10/20/22 at 5:15pm was unsuccessful. Attempted telephone interview with a fourth MA on 10/20/22 at 5:30pm was unsuccessful. 3. Review of Resident #5's current FL2 dated 06/16/22 revealed: -Diagnoses included dementia and anxiety disorder. -There was an order for Vitamin B12 (a nutritional supplement to treat Vitamin B12 deficiency) 1000mcg daily. Review of Resident #5's pharmacy recommendation form dated 08/31/22 revealed: -The pharmacy had completed a record review for Resident #5 on 08/23/22. -The pharmacist notated that Resident #5 was currently taking a Vitamin B12 supplement and her B12 level was elevated at 1,547 pg/mL (normal range being 211-911 pg/mL) during the serum blood draw lab she had completed on 03/31/22. -The pharmacist recommended reducing or stopping Resident #5's Vitamin B12 supplement or replacing it. with a multivitamin instead.	{D 358}		

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{D 358}	Continued From page 71 -Resident #5's primary care provider signed the new order to discontinue Vitamin B12. Review of Resident #5's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin B12 1000mcg take one tablet once daily scheduled at 8:00am for vitamin insufficiency. -There was documentation that 28 doses of Vitamin B12 were administered from 09/01/22 through 09/30/22. Review of Resident #5's September 2022 eMAR revealed: -There was an entry for Vitamin B12 1000mcg take one tablet once daily scheduled at 8:00am for vitamin insufficiency. -There was documentation that Vitamin B12 was administered daily from 10/01/22 through 10/18/22. Observation of medication on hand for Resident #5 on 10/19/22 at 11:15am revealed: -There was one medication card for Vitamin B12 1000mcg tablets, take one tablet daily. -There was a dispensed date of 10/19/22 with 27 tablets out of 28 total dispensed tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 10/19/22 at 11:50am revealed: -Resident #5 had a current order for Vitamin B12. -They had not received an order to discontinue Vitamin B12 on 08/31/22. Interview with the Health and Wellness Director (HWD) on 10/20/22 at 10:20am revealed: -The primary care provider (PCP) was at the	{D 358}		

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facility writing orders every Wednesday.
-After signing an order, the PCP placed the order into a folder on her desk, and the folder was then given to either the Resident Care Coordinator (RCC) or one of the MAs who had office hours some Wednesdays just to process orders.
-To process orders, the RCC or MA would enter the order into the eMAR, fax the order to the pharmacy, and remove the medication from the medication cart if needed.
-The RCC or MA was responsible for having another MA complete a second check of her work and starting an order tracking sheet for the HWD to complete a third check and ensure accuracy.
-There were no staff responsible for completing audits of the eMARs.

Interview with the RCC on 10/20/22 at 12:10pm revealed:
-Once a new order was signed by the PCP, the order went to the one MA who worked in the office on Wednesdays to process the PCP orders.
-The MA was responsible for faxing orders to the pharmacy, entering the order into the eMAR, and removing medication from the medication cart if needed.
-She had never seen an order to discontinue Resident #5's Vitamin B12 supplement.

Interview with a MA on 10/20/22 at 12:40pm revealed:
-She worked in the role of MA every day except for Wednesdays, when she was given office hours to help process the PCP's orders.
-Once the PCP signed an order, the order was given to the HWD who gave the order to The MA to process.
-She would enter the order into the eMAR and fax the order to the pharmacy, then have either the

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{D 358}	Continued From page 73 RCC or another MA check behind her to ensure accuracy. -The order and order tracking sheet were given back to the HWD to complete a third check on the new order. -She did not remember seeing an order to discontinue Resident #5's Vitamin B12 supplement. -If the order had been placed in the HWD's folder, she would have processed it and there would be an order tracking form. -She had checked, and an order tracking form was never started for the order to discontinue Resident #5's Vitamin B12 supplement. -She did not know how the order ended up in in Resident #5's record without being processed. Telephone interview with Resident #5's PCP on 10/20/22 at 3:45pm revealed: -The last time she had ordered Resident #5's serum B12 lab to be drawn was in March 2022. -She remembered signing the order to discontinue Resident #5's Vitamin B12 supplement at the recommendation of the pharmacist. -She was not concerned about any adverse effects for not stopping Resident #5's Vitamin B12 supplement, but she expected that if she wrote an order to discontinue a medication, it would be discontinued within a day's time. Interview with the Executive Director on 10/20/22 at 4:50pm revealed: -She was not aware that Resident #5 had been receiving a Vitamin B12 supplement daily since it had been discontinued on 08/31/22. -When the PCP wrote a new order, the order was given to the MA who did office hours on Wednesdays to process, or another MA if the first was not available that day.	{D 358}		

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{D 358}	Continued From page 74 -If the order was in Resident #5's record without being removed from the eMAR or faxed to the pharmacy, the order was somehow missed. Based on observation, record review and attempted interview, it was determined Resident #5 was not interviewable.	{D 358}		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based observation, record review and interviews the facility failed to contact the Primary Care Provider (PCP) for 1 of 5 sampled residents (Resident #6) regarding pharmacy recommendations not to crush a medication. The findings are: Review of Resident #6's current FL2 dated 02/04/22 revealed: -Diagnoses included dementia, hypertension and hyperlipidemia. -Medication orders included an order for donepezil 10mg once daily (used to treat Alzheimer's disease). Review of Resident #6's orders revealed: -There was an order dated 02/28/22 for donepezil	D 406		

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10mg in the evening.
-Review of a physician's order sheets dated 03/09/22 and 06/08/22 revealed orders to crush Resident #6's medications.
-There were orders for donepezil 10mg once daily.

Review of a pharmacy regimen review dated 08/23/22 revealed:
-Resident #6 had orders to crush her medications.
-The pharmacist completing the medication review documented donepezil should not be crushed.
-The pharmacist suggested contacting Resident #6's PCP to get the medication changed to a dissolvable medication.

Review of Resident #6's August 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for donepezil 10mg once daily scheduled for administration at 7:30pm.
-There was documentation donepezil 10mg was administered daily at 7:30pm from 08/01/22 through 08/31/22.

Review of Resident #6's September 2022 eMAR revealed:
-There was an entry for donepezil 10mg once daily scheduled for administration at 7:30pm.
-There was documentation donepezil 10mg was administered daily at 7:30pm from 09/01/22 through 09/30/22.

Review of Resident #6's October 2022 eMAR revealed:
-There was an entry for donepezil 10mg once daily scheduled for administration at 7:30pm.
-There was documentation donepezil 10mg was

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administered daily at 7:30pm from 10/01/22 through 10/19/22.

Observation of Resident #6's medications on hand at the facility on 10/20/22 at 11:41am revealed:
-Donepezil 10mg was available for administration.
-The medication was a beige colored small round tablet.

Interview with a pharmacist at the facility's contracted pharmacy on 10/20/22 at 10:53am revealed:
-The donepezil 10mg that was dispensed for Resident #6 was time released and should not be crushed, broken in half or chewed.
-The effects of crushing the medication maybe increase the rate of absorption.
-The facility should have made the resident's physician aware of the pharmacist's recommendation so the medication could be switched out for another medication.
-The medication should be switched out for an orally dissolving tablet (ODT).
-The resident's physician had to write an order to change the current donepezil 10mg to the dissolvable tablet.

Interview with the medication aide (MA) on 10/20/22 at 4:12pm revealed:
-She administered Resident #6's donepezil 10mg between 7:00pm and 8:00pm.
-She crushed all Resident #6's medications, including donepezil.
-No one made her aware donepezil 10mg should not be crushed.

Interview with the Health and Wellness Director (HWD) on 10/19/20 at 10:26am revealed:
-She was not aware of the recommendation not

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D 406	Continued From page 77 to crush Resident #6's donepezil 10mg. -When the pharmacist made recommendations, they were given to her. -She missed seeing the recommendation regarding Resident #6's donepezil 10mg. Telephone interview with Resident #6's Primary Care Provider (PCP) on 10/20/22 at 3:37pm revealed: -Resident #6 had an order to crush all her medications because the resident had swallowing difficulty. -She was not made aware of the pharmacist recommendation not to crush Resident #6's donepezil and to change it to a dissolvable tablet. -She was in the facility weekly and she could be contacted by text, phone call or fax. Based on observation, record review and interviews it, was determined Resident #6 was not interviewable.	D 406		
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:	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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D935	Continued From page 78 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 interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff who administered medications met the requirements related to employment verification as a medication aide or completion of the 5-10 or 15 hours of medication aide training (Staff B) prior to passing medications and within 60 days of hire. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on	D935		

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D935	Continued From page 79	D935		

02/04/22.
-There was documentation Staff B passed the state approved written medication aide test on 01/03/18.
-The was no MA employment verification available for review.
-Staff B had a Medication Administration Clinical Skills Competency Validation checklist completed on 06/29/22.
-There was no documentation Staff B had completed the 5, 10 or 15 hours of medication aide training.

Observation of the morning medication pass on 10/18/22 at 9:38am revealed Staff B was assigned to a medication cart and was observed passing medication to a resident.

Review of a resident's August, September, and October 2022 electronic medication administration records (MARs) revealed Staff B documented administering medications on 6 days from 08/01/22 to 08/31/22, on 6 days from 09/01/22 to 09/30/22, and 4 days from 10/01/22 to 10/18/22.

Interview with Staff B on 10/20/22 at 12:18pm revealed:
-She had worked as a MA at another facility prior to coming to the current facility.
-She received training and orientation for the current facility by a corporate nurse at a sister facility.
-There was a corporate nurse who gave her some training and checked her off on her Medication Administration Clinical Skills Validation competency.
-She had received the 15-hour training at the previous facility where she worked but the facility was no longer in operation.

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D935	Continued From page 80 -She had no proof of completing the 15 hours of medication training at the previous facility where she was employed. -She had not received medication aide training (5 hours, 10 hours, or 15 hours training) since she started working at the current facility. Interview with the Business Office Manager (BOM) on 10/20/22 at 12:08pm revealed: -She was responsible to maintain the personnel records in her office. -The nursing staff, specifically the Health and Wellness Director (HWD) would be responsible to ensure staff administering medications had completed all required qualifications and training. -She had not audited personnel records for medication aide requirements. Interview with the Executive Director (ED) on 10/20/22 at 3:00pm revealed: -The ED had been a corporate nurse prior to assuming her current position as ED in August 2022. -The HWD was responsible for ensuring MAs received required trainings and checklists for administering medications. -Staff B was sent to a sister facility for medication aide orientation and training in the corporate policies. -The facility's current HWD was still in orientation and training for her position and would not have known to audit Staff B's personnel record for verification on 5 -10 or 15-hours of medication training within 60 days of hire as a MA.	D935		