STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025037	A. BUILDING: _____ B. WING _____	R 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROATAN VILLAGE	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigations on December 14, 2022 to December 15, 2022. The complaint investigations was initiated by the Craven County Department of Social Services on November 23, 2022.	D 000		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a resident's FL-2 included complete information and was clarified by the primary care provider (PCP) for 1 of 5 sampled residents (#2) who had incomplete medication orders. The findings are: Review of Resident #2's current FL-2 dated 12/02/22 revealed:	D 238		

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D 238	Continued From page 1 -Diagnoses included type 2 diabetes, hypertension, and major depression. -There was an order for diclofenac sodium gel 2gm (used to treat pain) to right shoulder. -The order did not indicate how often to administer diclofenac sodium gel. -There was an order for desvenlafaxine ER tablet extended release 24 hour (used to treat depression). -The order did not indicate a dosage for desvenlafaxine ER or how often to administer it. -There was an order for hydroxyzine pamoate 25mg (used to treat itching or anxiety). -The order did not indicate how often to administer hydroxyzine pamoate. -There was and order for Lantus pen injector 100 units/milliliter (used to treat high blood sugar). -The order did not indicate a dosage of Lantus or how often to administer it. -There was an order for refresh tears (used to treat dry eyes). -The order did not indicate which eye to administer it in, the dosage, or how often to administer refresh tears. -There was an order for potassium chloride 20meq (used as a supplement). -The order did not indicate how often to administer potassium chloride. -There was an order for Januvia 50mg (used to treat high blood sugar). -The order did not indicate how often to administer Januvia. -There was an order for losartan potassium 50mg (used to treat high blood pressure). -The order did not indicate how often to administer losartan potassium. -There was an order for Norvasc 5mg (used to treat high blood pressure). -The order did not indicate how often to administer Norvasc.	D 238		

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D 238	Continued From page 2 Review of Resident #2's Resident Register revealed she was admitted to the facility from a skilled nursing facility on 11/30/22. Interview with the facility's nurse on 12/14/22 at 2:38pm revealed: -Resident #2 was originally to be admitted to the facility at the end of November 2022. -Resident #2 was not admitted to the facility until the afternoon of 12/06/22. -When Resident #2 was admitted to the facility she noticed that her FL-2 was incomplete, and she sent faxes to the primary care provider (PCP) who completed Resident #2's FL-2 regarding it being incomplete and never received a response. -She did not know if she saved a copy of the faxes she sent to the PCP or not. -Clarification of Resident #2's FL-2 medication orders should have been received within 24 hours of her admission. -Since Resident #2's FL-2 was incomplete the facility used the physician order sheet from Resident #2's prior facility to administer medications to her. Interview with the Special Care Coordinator (SCC) on 12/15/22 at 3:45pm revealed Resident #2's FL-2 should have been clarified with her PCP within 72 hours or her admission. Interview with the Administrator on 12/15/22 at 4:07pm revealed: -Resident #2's FL-2 should have been clarified and corrected prior to her being admitted to the facility. -If Resident #2's FL-2 was not clarified and corrected prior to her being admitted to the facility clarification should have been initiated immediately upon her admission with results	D 238		

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D 238	Continued From page 3 within 24 hours.	D 238		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to provide personal care assistance to 1 of 5 residents sampled (#1) related to incontinence care. The findings are: Review of Resident #1's current FL-2 dated 09/27/22 revealed: -Diagnoses included vascular dementia, seizures, primary open angle glaucoma, chronic kidney disease, cardiac pacemaker, below the knee amputation, chronic obstructive lung disease, and diabetes mellitus. -He was intermittently confused and non-ambulatory. -He was total care for personal care assistance. -He was incontinent of bowel and bladder. Review of Resident #1's hospice care plan dated 11/22/22 revealed: -He was ordered a hospital bed with a pressure	D 269		

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relief mattress.
-He had bowel and bladder incontinence.
-He has hospice aide services ordered three times a week.
-He has wound care services every two days performed by the hospice nurse.

Telephone interview with Resident #1's hospice aide on 12/15/22 at 11:08am revealed:
-She provided personal care including a bath, linen changes when necessary, and personal hygiene care.
-She was scheduled to see Resident #1 three times a week.
-The nurses from the hospice agency did dressing changes on the resident's wounds every two days.
-She had been out to see Resident #1 about five times since he started on hospice.
-One of the times that she went to see Resident #1 his brief was saturated with urine.

Confidential interview with a personal care aide (PCA) revealed there were times when she comes on shift and Resident #1's incontinence brief was saturated through to the sheet.

Interview with Resident #1's family member on 12/14/22 at 1:10pm revealed:
-Resident #1's personal care had improved since he started receiving hospice aide services at the end of November 2022.
-There had been multiple times when she had visited Resident #1 and his incontinence brief was wet.
-She was not sure how often staff came in to check the resident for incontinence.
-Before he started on hospice care, every time she would come to visit him he would be saturated with urine.

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D 269	Continued From page 5 Review of Resident #1's personal care logs for December 2022 revealed there was no documentation of personal care provided. Interview with a PCA on 12/15/22 at 10:00am revealed Resident #1 was provided incontinence care at least every two hours. Interview with the facility's nurse on 12/15/22 at 3:15pm revealed: -She expected residents that required incontinence care performed to be checked on at least every 2 hours. -She was not aware that there were times that Resident #1 had been saturated through his incontinence brief. -It was important for Resident #1 to keep a dry incontinence brief on to prevent further skin breakdown to his sacral wound. -Staff did not document personal care on residents including incontinence care. Interview with the Administrator on 12/15/22 at 4:10pm revealed: -She expected staff to perform incontinence care every 2 hours to residents that required assistance. -Staff did not document on the personal care logs currently because they were told to document by exception.	D 269		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional;	D 276		

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and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on interviews, and record reviews, the facility failed to ensure implementation of orders for 3 of 5 sampled residents (#2, #3, #5) related to fingerstick blood sugar checks (#2) and blood pressure checks (#3, #5).

The findings are:

1. Review of Resident #2's current FL-2 dated 12/02/22 revealed diagnoses included type 2 diabetes.

Review of Resident #2's Resident Register revealed she was admitted to the facility from a skilled nursing facility on 11/30/22.

Interview with the facility's nurse on 12/14/22 at 2:38pm revealed:
-Resident #2 was originally supposed to be admitted to the facility at the end of November 2022.
-Resident #2 was not admitted to the facility until the afternoon of 12/06/22.
-Resident #2's FL-2 was incomplete, so the facility used the physician order sheet from Resident #2's prior facility to administer medications and treatments.

Review of Resident #2's order summary report from the previous facility dated 12/05/22 revealed there was an order for fingerstick blood sugar (FSBS) twice a day.

Review of Resident #2's physician order sheet

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D 276	Continued From page 7 dated 12/09/22 and signed 12/10/22 revealed there was an order for FSBSs before meals and at bedtime. Review of Resident #2's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks twice daily scheduled for 8:00am and 8:00pm. -Resident #2's FSBS was 192 at 8:00am on 12/12/22. -Resident #2's FSBS was 186 at 8:00am on 12/13/22. -Resident #2's FSBS was 255 at 8:00am on 12/14/22. -On 12/07/22 and 12/08/22 the 8:00am FSBS was documented as "X" with no explanation. -On the eMAR Medication Notes it was documented at 8:00am on 12/09/22 under FSBS "unable to collect sample". -On the eMAR Medication Notes it was documented at 8:00am on 12/10/22 and 12/11/22 under FSBS "awaiting pharmacy delivery". -There were no FSBS checks documented for Resident #2 on 12/07/22 to 12/11/22. -Resident #2's FSBS was documented as 189 at 8:00pm on 12/09/22. -Resident #2's FSBS was documented as 251 at 8:00pm on 12/12/22. -Resident #2's FSBS was documented as 242 at 8:00pm on 12/13/22. -On 12/06/22 and 12/07/22 the 8:00pm FSBS was documented as "X" with no explanation. -On the eMAR Medication Notes it was documented at 8:00pm on 12/08/22 "unable to collect sample". -On the eMAR Medication Notes it was documented at 8:00pm on 12/10/22 and 12/11/22 "awaiting pharmacy delivery". -There were no FSBS checks documented for	D 276		

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D 276	Continued From page 8 Resident #2 at 8:00pm on 12/06/22 to 12/08/22 and 12/10/22 to 12/11/22. -There was an entry for FSBS 4 times a day scheduled for 12:00pm with an effective date of 12/12/22. -There was no blood sugar recorded at 12:00pm on 12/12/22 and no documentation as to why. -There was an entry for FSBS 4 times a day scheduled for 8:00pm with an effective date of 12/12/22. -There was no FSBS recorded at 8:00pm on 12/12/22 and no documentation as to why. Interview with Resident #2 on 12/15/22 at 4:22pm revealed: -She did not receive FSBS checks when she was first admitted to the facility. -She thought she did not receive FSBS checks because the facility did not have a blood sugar machine to check her FSBSs. -She did not remember feeling like her blood sugars were too low or too high recently. Interview with a medication aide (MA) on 12/14/22 at 2:09pm revealed: -She was working at the facility when Resident #2 was admitted on 12/06/22. -When Resident #2 was admitted to the facility she had a blood sugar meter, but she did not have any blood sugar strips to use to check her FSBS. -The facility had a stock blood sugar machine that could have been used but she did not like to use it because she did not know how accurate it was. -Other facility staff may have used the house stock blood sugar machine to check Resident #2's FSBS. Resident #2's new blood sugar machine and blood sugar strips arrived at the facility on 12/11/22.	D 276		

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D 276	Continued From page 9 Interview with the facility's nurse on 12/15/22 at 3:23pm revealed: -She thought Resident #2 was admitted to the facility with a blood sugar machine as well as blood sugar strips. -The facility did not have a house stock blood sugar machine. -She did not know why Resident #2 did not receive FSBS checks as ordered when she was admitted but she should have received them twice a day as ordered and then 4 times a day when the order was changed by the PCP. -It was important that Resident #2's FSBSs be checked as ordered because the resident was on insulin that could cause her blood sugars to become too low. Interview with the Administrator on 12/15/22 at 4:04pm revealed she expected primary care provider (PCP) orders to be implemented as ordered. Interview with Resident #2's PCP on 12/15/22 at 2:52pm revealed: -She was concerned that Resident #2's FSBS checks had not be administered for 5 days. -Resident #2 received insulin and it was important to check her FSBSs to make sure they were not too high or too low. 2. Review of Resident #3's current FL-2 dated 09/21/22 revealed: -Diagnoses included dementia, type 2 diabetes, hypertension, hyperlipidemia, anxiety, and depressed mood. -There was an order for daily blood pressure checks. Review of Resident #3's resident register	D 276		

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revealed he was admitted to the facility on 09/23/22.

Review of Resident #3's October 2022 electronic medication administration record (eMAR) revealed:
-There was no entry for daily blood pressure checks.
-There was an entry for 72-hour condition change report that started 10/06/22 that included blood pressure checks, scheduled for 1st shift (7am-3pm), 2nd shift (3pm-11pm), and 3rd shift (11pm-7am).
-Resident #3's blood pressure was documented as part of the 72-hour condition change report on 1st shift for 10/06/22-10/08/22, 10/13/22, 10/15/22-10/17/22, 10/20/22-10/21/22, 10/25/22-10/26/22, and 10/30/22 to 10/31/22.
-Resident #3's blood pressure was documented as part of the 72-hour condition change report on 2nd shift for 10/06/22-10/08/22 and 10/11/22 to 10/31/22.
-Resident #3's blood pressure was documented as part of the 72-hour condition change report on 3rd shift for 10/06/22, 10/10/22, 10/12/22, 10/14/22 to 10/26/22, and 10/28/22 to 10/31/22.
-Resident #3 did not have blood pressures documented on 10/01/22 through 10/05/22 and on 10/09/22 (6 total days).
-Resident #3's documented blood pressures ranged from 110/62 to 179/96.

Review of Resident #3's November 2022 eMAR revealed:
-There was no entry for daily blood pressure checks.
-There was an entry for 72-hour condition change report that started 11/01/22 that included blood pressure checks, scheduled for 1st shift (7am-3pm), 2nd shift (3pm-11pm), and 3rd shift

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(11pm-7am).
-Resident #3's blood pressure was documented as part of the 72-hour condition change report on 1st shift for 11/01/22 to 11/04/22 and 11/07/22.
-Resident #3's blood pressure was documented as part of the 72-hour condition change report on 2nd shift for 11/01/22 to 11/04/22 and 11/06/22 to 11/07/22.
-Resident #3's blood pressure was documented as part of the 72-hour condition change report on 3rd shift for 11/01/22 to 11/03/22 and 11/05/22 to 11/07/22.
-Resident #3's daily blood pressure was not documented on 11/08/22 to 11/30/22 (23 days).
-Resident #3's documented blood pressures ranged from 111/74 to 162/98.

Review of Resident #3's December 2022 eMAR revealed:
-There was no entry for vital signs or daily blood pressures.
-There were no daily blood pressures documented.

Interview with a medication aide (MA) on 12/15/22 at 11:00am revealed:
-She was not aware that Resident #3 was ordered daily blood pressure checks.
-The MAs were responsible for performing blood pressures when ordered.
-The blood pressure order would pop up on the eMAR like a medication when it was due.
-Resident #3 had a fall in October 2022 which is why the entry was on the eMAR for 72-hour condition change report, but it was placed on the eMAR for 1 month rather than 3 days.
-She was not sure who was responsible for adding the blood pressure checks to the eMAR.

Interview with the Special Care Coordinator

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(SCC) on 12/14/22 at 11:15am revealed Resident #3's daily blood pressure checks would be documented on the eMAR.

A second interview with the SCC on 12/15/22 at 3:45pm revealed she was not aware that the pharmacy did not profile vital signs ordered on the eMAR so it was her responsibility to ensure that vital signs including Resident #3's daily blood pressures were placed on the eMAR so the MAs knew to take his blood pressure.

Interview with the Administrator on 12/15/22 at 4:10pm revealed:
-She notified Resident #3's primary care provider (PCP) office via fax that he was not having daily blood pressures completed as ordered.
-It was the responsibility of the SCC or facility nurse to place the order for blood pressures on the eMAR.

Telephone interview with a nurse at Resident #3's PCP office on 12/15/22 at 12:15pm revealed:
-Resident #3 had a history of hypertension which was why he was ordered daily blood pressure checks.
-It was important for Resident #3 to have daily blood pressure checks because of his history of hypertension; and he had blood pressure medications ordered.
-She expected facility staff to complete Resident #3's blood pressure checks daily as ordered.

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

3. Review of Resident #5's current FL-2 dated 03/15/22 revealed:
-Diagnoses included dementia, hypertension,

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hyperlipidemia, hypothyroidism, osteoporosis, and vitamin D deficiency.
-There was an order for weekly blood pressure checks.

Review of Resident #5's October 2022 electronic medication administration record (eMAR) revealed:
-There was no entry for weekly blood pressures.
-There was entry for monthly vital signs; and they were documented on 10/03/22.

Review of Resident #5's November 2022 eMAR revealed:
-There was no entry for weekly blood pressures.
-There was entry for monthly vital signs; and they were documented on 11/07/22.

Review of Resident #5's December 2022 eMAR revealed:
-There was no entry for weekly blood pressures.
-There was entry for monthly vital signs; and they were documented on 12/05/22.

Interview with the Special Care Coordinator on 12/14/22 at 11:15am revealed:
-She was not aware that Resident #5 had weekly blood pressure checks ordered.
-The blood pressures were be documented on the eMAR.

Interview with the Administrator on 12/15/22 at 8:52am revealed she notified Resident #5's primary care provider (PCP) that the weekly blood pressures were not being completed as ordered and the PCP discontinued the order.

Telephone interview with Resident #5's PCP on 12/15/22 at 2:50pm revealed:
-Resident #5 was ordered weekly blood

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D 276	Continued From page 14 pressures because of her history of hypertension. -Resident #5's blood pressure had been controlled on blood pressure medications, so she was not concerned about continuing with weekly blood pressure checks. -She was not aware that Resident #5 was not receiving weekly blood pressure checks until notified by the Administrator yesterday (12/14/22). -She expected the facility to carry out orders as written until they were discontinued. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure 1 of 6 residents sampled (#6) was free from physical abuse by a staff member (G) who was witnessed pushing the resident. The findings are: Review of Resident #6's current FL-2 dated 03/10/22 revealed: -Diagnoses included dementia, hypertension, hypercholesterolemia, and anxiety. -She was constantly disoriented.	D 338		

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D 338	Continued From page 15 -She had wandering behaviors and was verbally abusive. -She was semi-ambulatory with a wheelchair. -She required personal care assistance for bathing and dressing. -Her level of care was a memory care unit. Review of Resident #6's Resident Register revealed she was admitted from home to the facility on 03/12/20. Review of Resident #6's current care plan completed 04/05/22 revealed: -She had wandering behaviors, was verbally abusive and resisted care. -She received medications for mental health/behaviors and received mental health services. -She had periods of agitation at times but responded to redirection. -She ambulated with an assisted device (walker as needed). -She had limited upper extremity strength. -She was always disoriented, forgetful needing reminders, and had significant memory loss which required redirection. -She required supervision for eating. -She required limited assistance for ambulation and transferring. -She required extensive assistance for dressing and grooming. -She was totally dependent on staff assistance for toileting and bathing. Observation of the Special Care Unit (SCU) hallway on 12/15/22 from 8:34am to 8:50am revealed: -Staff G, a personal care aide (PCA), was standing next to Resident #6 in the hallway outside of the resident's room.	D 338		

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-Resident #6 was holding on to the hand railing outside of her room.
-Staff G went to remove Resident #6's hand from the hand railing and the resident pulled her hand away.
-Staff G then got behind the resident and placed her hands on Resident #6's shoulder blades.
-Staff G proceeded to push Resident #6 from behind into her room while the resident was leaning back against the staff member.
-The surveyor walked down the hallway to the room, past the dining room where another PCA was with residents.
-Resident #6 began screaming as Staff G was pushing her into the room.
-Staff G slammed the resident's door shut behind her and Resident #6.
-The surveyor could not see what was happening in the room but heard Resident #6 screaming, so the surveyor opened the door.
-Resident #6 was laying on the floor, facing the door with one slipper on and one next to her.
-Resident #6 had her right hand under her head, resting it on the floor.
-Staff G was in Resident #6's room and looked at the surveyor.
-Staff G came to the door, then stated "I did not know that you were going to be here today".
-Staff G then went down the hall to the other PCA and asked her to come help her get Resident #6 off the floor.
-The PCA went into the room with Staff G and Resident #6 was able to get up with one person assistance.
-Staff G then came out to the nurses' station and said that she was going to give Resident #6 "some time to cool off" before she attempted to give her a shower.

Interview with Staff G on 12/15/22 at 9:20am

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revealed:
-She had been a PCA at the facility since 2003 and had worked on the SCU since it opened.
-Prior to working at the facility, she was terminated in 2002 from another assisted living facility for allegedly slapping a resident on the SCU which she stated she was falsely accused of.
-She worked first shift on the SCU, which was 7am-3pm.
-Resident #6 requested to go to the bathroom after breakfast, so this morning around 8:30am she was taking her to her room to go to the bathroom.
-Resident #6 stopped outside of her room and put her hand on the railing, so she removed her hand from the railing.
-Resident #6 would not go into her room, so she pushed her from behind "to help guide and redirect her" into her room.
-She was "guiding the resident by her back".
-She could not recall how Resident #6 ended up on the floor, if she tripped, fell, or lost her balance.
-She thinks Resident #6 may have sat down on the floor.
-She had a "disability" which caused her to have "memory loss" and "forgetfulness" so she could not remember exactly what happened in the room once the door was shut.
-Resident #6 could sometimes be difficult to deal with because she would get an "attitude" with the staff and do things like cuss at them.
-She did not recall a time when Resident #6 was ever physically aggressive with staff members.
-Usually, she could get Resident #6 to calm down by "tickling her or playing games".
-She did not report any behaviors to the medication aide (MA) on duty this morning because there was nothing out of the ordinary

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about Resident #6's behaviors that morning (12/15/22).
-She had not received training in dealing with resident's behaviors on the SCU in "a while, like way before COVID" in 2020.
-She should have notified a MA prior to getting the resident up off the ground which was what the facility policy was when a resident was on the ground.

Review of Staff G, PCA, personnel record revealed:
-She was hired 08/06/03.
-She had a Health Care Personnel Registry (HCPR) check completed on 02/03/05 with no findings.
-She had a criminal background check on 05/07/03.

Interview with a second PCA on 12/15/22 at 10:00am revealed:
-She normally worked on the assisted living (AL) side of the facility but was working on the SCU today to "try new things".
-She was working with residents in the dining room when she heard Resident #6 screaming so she came down the hallway and was behind the surveyor when she "saw Staff G pushing Resident #6 into her room from behind".
-She then saw Staff G slam the door shut behind her and Resident #6.
-Staff G came out of the room and asked her to assist Resident #6 off the floor.
-She went into the room and got Resident #6 up with a one person assist and it did not appear that the resident had any injuries.
-She was aware that Resident #6 had behaviors which included "cussing" but had never been told the resident was combative.

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Review of Resident #6's Incident Observation sheet dated 12/15/22 at 9:04am revealed:
-The report was filled out by the second PCA.
-The incident occurred in Resident #6's room.
-The position of Resident #6 was on her right side by the side of the bed.
-The last time the resident was observed by the second PCA was when she was walking in the hallway.
-The witness description of incident stated "resident was walking the hallway then Staff G was gradually pushing her from back into room. Once in room, door was slammed shut. Staff G opened door and asked her to help assist the resident off the floor because 'she decided to sit down'. The resident was laid on right side with head on floor."

Review of Resident #6's facility progress note dated 12/15/22 at 10:15am revealed:
-The progress note was written by the facility's Administrator.
-The Administrator was notified by the state surveyor that Staff G was witnessed to get behind resident and push her into her room.
-Resident #6's door was shut and when it was opened, resident was in the floor, lying on her right side.
-The Administrator and corporate staff had initiated alleged abuse allegation investigations for the facility.
-The staff member had been suspended pending the result of the investigation.
-A 24-hour initial report for the HCPR was sent to the state.
-The facility nurse performed a skin assessment on the resident with no injuries noted.
-Resident's family and physician were notified.
-The facility would continue the investigation.

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D 338	Continued From page 20 Review of a fax confirmation on 12/15/22 at 12:45pm revealed fax transmission of the 24-hour initial report was sent to the North Carolina HCPR. Interview with the Special Care Coordinator (SCC) on 12/15/22 at 3:45pm revealed: -She was working as the MA on the SCU and one of the AL hallways the morning of 12/15/22. -She was on the AL side of the facility when the incident with Resident #6 occurred. -It was not reported that Resident #6 was having any sort of aggressive or combative behaviors the morning of 12/15/22. -She did not observe anything unusual with Resident #6 the morning of 12/15/22. -Resident #6 could be verbally aggressive and curse at staff but she had never been physically aggressive with staff. -She had never seen Staff G be physically aggressive with any of the residents. Interview with the facility's nurse on 12/15/22 at 3:15pm revealed: -There was no excuse for staff members to physically put their hands on a resident to redirect them. -Resident #6 had poor balance and a shuffled gait which placed her at risk for falls especially when being pushed from behind. -Resident #6 has a history of expressive behavior where she could be animated and expressive with her hands but she was not known to be physically aggressive. -She was not aware of any SCU specific training for staff but it was important for staff working the SCU to have alternative methods for redirection. -She assessed Resident #6 after the incident on 12/15/22 and found no visible bruises to the resident.	D 338		

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-Resident #6 did not complain of any pain after the incident of 12/15/22.

Interview with Administrator on 12/15/22 at 4:10pm revealed:
-Staff G was never known to be physically aggressive with any residents.
-The facility had cameras in the SCU hallway, but they were not working.
-She notified the local county Department of Social Services and had the police department come to complete a report.
-She submitted the 24-hour report to the HCPR for the incident on 12/15/22.
-Staff were trained annually on dementia population residents using the online computer training system.

Telephone interview with Resident #6's primary care provider (PCP) on 12/15/22 at 2:50pm revealed:
-She was following Resident #6 for medical management.
-Resident #6 was being seen by a mental health provider (MHP) for behavioral management.
-She expected that staff would use techniques for redirection of dementia residents that did not require physically putting their hands on a resident.
-It was not appropriate for a staff member to "redirect a resident with their hands" because it could cause injury to the resident and further exacerbate their behavior.

Telephone interview with Resident #6's mental health provider (MHP) on 12/15/22 at 3:30pm revealed:
-She was aware that Resident #6 could be verbally aggressive with staff but was never known to have physical aggression.

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D 338	Continued From page 22 -It was not appropriate for staff to push a resident from behind to redirect them. -Staff working with Resident #6 should use alternatives for redirection such as giving the resident some time before asking her again to go to her room. -Pushing a resident from behind was physical abuse and it was unacceptable. _____ The facility failed to keep Resident #6 free from physical abuse related to an observation of Staff G pushing the resident from the back into her room, where she ended up on the floor. The facility's failure resulted in physical abuse of a resident (#6) which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/22 for this violation. THE CORRECTION DATE FOR THE A1 VIOLATION SHALL NOT EXCEED JANUARY 14, 2023.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.	D 344		

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D 344	Continued From page 23 The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure contact with a resident's primary care provider (PCP) for clarification of incomplete orders for 1 of 5 sampled residents (#2) for a medication used to treat high blood sugars. Review of Resident #2's current FL-2 dated 12/02/22 revealed diagnoses included type 2 diabetes. Review of Resident #2's record revealed: -There was an order dated 12/09/22 and signed on 12/10/22 for fingerstick blood sugars (FSBS) before meals and at bedtime. -There were orders for Resident #2 to receive sliding scale insulin, for a FSBS of 150 to 200 - 1 unit, for a FSBS of 201-250 - 2 units, for a FSBS of 251-300 - 3 units, for a FSBS of 301-350 - 4 units, for a FSBS of 351-400 - 5 units, and for a FSBS of 401-450 - 6 units. -There was no indication on the order of which insulin to administer for Resident #2's sliding scale. Interview with the facility's nurse on 12/14/22 at 2:38am revealed: -When she received Resident #2's orders for sliding scale insulin she faxed the order to the facility's contracted pharmacy. -The pharmacy would not honor the order because it was not indicated on the order which insulin to administer to Resident #2. -She was trying to get clarification for which	D 344		

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D 344	Continued From page 24 insulin to administer from the primary care provider (PCP) who wrote the sliding scale order but had not received an answer yet. -She faxed the orders to the PCP's office to receive clarification. Interview with the Administrator on 12/15/22 at 4:07pm revealed: -She expected incomplete orders to be clarified within 24 hours of receiving the order. -The facility had faxed Resident #2's new PCP on 12/14/22 and received clarification of which insulin to administer for Resident #2's sliding scale.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation has not been abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 residents (#2, #5) observed during the medication pass	D 358		

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including errors with rapid-acting insulin (#2), a medication used to thin the blood, an inhaler (#2), and a medication used to treat constipation (#5); and for 3 of 5 residents (#2, #4, #5) sampled for record review including errors with a long-acting insulin (#2), a medication used to treat mood and behavior, an antibiotic used to treat infection (#4), and a medication used to treat hypothyroidism (#5).

The findings are:

1. The medication error rate was 16% as evidenced by the observation of 4 errors out of 25 opportunities, during the 8:00 a.m. medication pass on 12/14/22.

a. Review of Resident #2's current FL-2 dated 12/02/22 revealed:
-Diagnoses included type 2 diabetes.
-There was an order for insulin Lispro 10 units before meals (Lispro is rapid-acting insulin used to lower blood sugar. The manufacturer recommends taking Lispro 15 minutes before or immediately after a meal).

Observation of the 8:00am medication pass on 12/14/22 revealed:
-Resident #2's fingerstick blood sugar (FSBS) was 255 at 7:59am.
-The medication aide (MA) administered Lispro 10 units to Resident #2's right upper abdomen at 8:02am.

Review of Resident #2's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Lispro insulin 10 units before meals scheduled for administration at 7:00am.

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-Lispro insulin 10 units was documented as administered at 7:00am on 12/14/22.

Observation of Resident #2's room revealed breakfast was delivered to her room and left on a bedside table at 8:21am.

Interview with Resident #2 on 12/14/22 at 8:35am revealed she had not eaten breakfast yet and would do so soon.

Second interview with Resident #2 on 12/14/22 at 9:00am revealed:
-She had just gotten up and was getting ready to eat her breakfast.
-No facility staff had been in to see if she had eaten yet or to encourage her to eat breakfast.
-She felt fine and did not feel like she normally did if her blood sugar was too low.

Interview with the MA on 12/14/22 at 2:09pm revealed:
-Lispro insulin should be administered no more than 30 minutes prior to a resident eating their meal.
-Resident #2 ate her meals when she felt like it.
-Facility staff tried to encourage the resident to go to the dining room to eat her meals and often the resident would go late.

Interview with the facility's nurse on 12/14/22 at 2:38pm revealed:
-A rapid-acting insulin such as Lispro should be administered no more than 1 hour before a meal because a resident's blood sugar could go too low.
-Resident #2 was always the last one in the dining room and she ate when she felt like eating.
-Resident #2's primary care provider (PCP) had not been notified to make her aware that the

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resident often ate late after receiving her rapid-acting insulin.

Interview with Resident #2's PCP on 12/15/22 at 2:52pm revealed Resident #2 receiving Lispro an hour before eating could cause her to have a low blood sugar.

b. Review of Resident #2's current FL-2 dated 12/02/22 revealed there was an order for Advair diskus 1 puff inhale twice daily (Advair diskus is an inhaled steroid used to treat asthma and chronic obstructive pulmonary disease. Manufacturer's instructions say to rinse the mouth with water without swallowing after using Advair diskus to help decrease the chance of getting thrush. Thrush is a fungal infection in the mouth).

Observation of the 8:00am medication pass on 12/14/22 revealed:
-Resident #2 received 1 puff of Advair diskus at 8:13am.
-Resident #2 did not rinse her mouth with water after receiving Advair diskus.
-The medication aide (MA) did not offer water to Resident #2 or encourage her to rinse her mouth after receiving Advair diskus.

Review of Resident #2's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Advair diskus 250/50 1 inhalation twice daily rinse mouth after use scheduled for administration at 8:00am.
-Advair diskus was documented as administered at 8:00am on 12/14/22.

Interview with Resident #2 on 12/15/22 at 4:22pm revealed:
-She knew she was supposed to rinse her mouth

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after using Advair diskus.
-The MA did not remind her to rinse her mouth on 12/14/22.

Interview with the MA on 12/14/22 at 2:09pm revealed:
-It was on the eMAR to rinse the mouth after Advair diskus.
-She overlooked having Resident #2 rinse her mouth after Advair diskus on 12/14/22.

Interview with the facility's nurse on 12/14/22 at 2:38pm revealed:
-A resident should rinse their mouth after receiving Advair diskus to prevent them from getting a yeast infection.
-She expected the MA to remind Resident #2 to rinse her mouth after Advair diskus especially since it was listed on the eMAR to do so.

Interview with Resident #2's primary care provider (PCP) on 12/15/22 at 2:52pm revealed she expected Resident #2 to rinse her mouth after Advair diskus to prevent thrush.

c. Review of Resident #2's current FL-2 dated 12/02/22 revealed there was an order for Eliquis 5mg 2 times daily (Eliquis is a blood thinner used to prevent blood clots).

Observation of the 8:00am medication pass on 12/14/22 revealed:
-The medication aide (MA) administered 13 pills to Resident #2 at 8:11am.
-Eliquis 5mg was not administered to Resident #2.

Review of Resident #2's December 2022 electronic medication administration record (eMAR) revealed:

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-There was an entry for Eliquis 5mg twice daily scheduled for administration at 8:00am.
-Eliquis 5mg was documented as administered at 8:00am on 12/14/22.

Interview with the MA on 12/14/22 at 2:09pm revealed:
-She marked on the eMAR that she administered Eliquis 5mg to Resident #2 because she thought she had administered it.
-She highlighted medications on the eMAR before she administered them.
-She noticed that Eliquis 5mg was not highlighted on Resident #2's eMAR when she was documenting what was administered to Resident #2 during the 8:00am medication pass.

Observation of Resident #2's medications on hand on 12/15/22 at 2:00pm revealed there was Eliquis 5mg on the cart that was dispensed for Resident #2 on 12/08/22.

Interview with Resident #2's primary care provider (PCP) on 12/15/22 at 2:52pm revealed:
-She expected Resident #2 to receive Eliquis twice a day as ordered.
-Missing one dose of Eliquis would not cause harm to Resident #2.

d. Review of Resident #5 current FL-2 dated 03/15/22 revealed diagnoses included dementia, hypertension, hypothyroidism, osteoporosis, and Vitamin D deficiency.

Review of Resident #5's physician's orders dated 07/21/22 revealed there was an order for Miralax 17gm daily (Miralax is a laxative used to treat and prevent constipation).

Observation of the 8:00am medication pass on

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12/14/22 revealed:
-The medication aide (MA) prepared Resident #5's medication including Miralax 17gm in 8oz of water into a Styrofoam cup at 7:55am.
-Resident #5 drank the water with the Miralax in it to take her medications.
-The MA left the cup of Miralax next to the Resident #5; and it was approximately halfway full.
-The MA did not stay to ensure that Resident #5 finished her Miralax.
-At 8:06am a personal care aide (PCA) took Resident #5's Styrofoam cup with approximately half of the Miralax liquid in it and dumped it down the sink in the kitchenette.

Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax 17gm to be administered in 8 oz of liquid daily, scheduled for administration at 8:00am.
-Miralax 17gm was documented as administered on 12/14/22 at 8:00am.

Interview with the PCA on 12/15/22 at 9:20am revealed:
-The MA administering medications on SCU normally told the PCA that there was medication mixed in the styrofoam cup so that she knew not to discard the cup until the resident had finished drinking the medication.
-She did not recall being told by the MA yesterday (12/14/22) that Resident #5 had medication mixed in her cup.
-She discarded the cup with liquid still in it because she was not aware that there was medication in the water.

Interview with the MA on 12/14/22 at 10:30am

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revealed:
-She was not aware that Resident #5 did not finish her entire cup of Miralax.
-The PCA should not have discarded the resident's cup with liquid left in it.
-She should have stayed with Resident #5 to ensure that she drank the entire cup of Miralax.
-Resident #5 was not constipated that she was aware of and had regular bowel movements.

Interview with the Special Care Coordinator (SCC) on 12/14/22 at 11:15am revealed she expected the MA to ensure that Resident #5 received her entire dose of ordered Miralax by staying with her to watch her take all of her medications.

Interview with the facility's nurse on 12/14/22 at 2:40pm revealed:
-It was important for Resident #5 to take the ordered Miralax dose to ensure the effectiveness of the medication.
-She expected the MA to ensure that Resident #5 drank the entire dose of Miralax in order to prevent constipation.
-She was not aware of Resident #5 having any constipation but she was not sure the date of the her last bowel movement.

Interview with the Administrator on 12/14/22 at 3:00pm revealed:
-She expected Resident #5 to complete her entire dose of Miralax as ordered.
-She expected the MA to ensure that Resident #5 received her entire dose of Miralax by watching to make sure that she drank the medication.

Telephone interview with Resident #5's primary care provider (PCP) on 12/15/22 at 2:50pm revealed:

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-Resident #5 was on Miralax for prevention of constipation.
-She expected the resident to receive the full dose of 17gm as ordered but missing half of one dose would not be harmful to the resident.

Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable.

2. Review of Resident #2's current FL-2 dated 12/02/22 revealed diagnoses included type 2 diabetes.

Review of Resident #2's Resident Register revealed she was admitted to the facility from a skilled nursing facility on 11/30/22.

Interview with the facility's nurse on 12/14/22 at 2:38pm revealed:
-Resident #2 was originally to be admitted to the facility at the end of November 2022.
-Resident #2 was not admitted to the facility until the afternoon of 12/06/22.

a. Review of Resident #2's current FL-2 dated 12/02/22 revealed:
-There was an order for Lantus 100 units/milliliter (mL) (Lantus is used to control high blood sugars).
-There was no dosage or administration frequency listed for Lantus.

Interview with the facility's nurse on 12/14/22 at 2:38pm revealed since Resident #2's FL-2 was incomplete the facility used the physician order sheet from Resident #2's prior facility to administer medications to Resident #2.

Review of Resident #2's order summary report

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from the previous facility dated 12/05/22 revealed:
-There was an order for Lantus 30 units every 12 hours for diabetes.
-There was an order for fingerstick blood sugar (FSBS) twice a day.

Review of Resident #2's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus inject 30 units every 12 hours for diabetes scheduled for administration at 8:00am and 8:00pm.
-Lantus 30 units was not documented as administered at 8:00am on 12/07/22 and 12/08/22.
-There was no indication on the eMAR why Lantus was not administered at 8:00am on 12/07/22 and 12/08/22.
-Lantus 30 units was not documented as administered at 8:00pm on 12/06/22 and 12/07/22.
-There was no indication on the eMAR why Lantus was not administered at 8:00pm on 12/06/22 and 12/07/22.
-There was an entry for FSBS checks twice daily scheduled for 8:00am and 8:00pm.
-There were no FSBS checks documented for Resident #2 at 8:00am on 12/07/22 to 12/08/22.
-There were no FSBS checks documented for Resident #2 at 8:00pm on 12/06/22 to 12/08/22.

Interview with a pharmacist at the facility's contracted pharmacy on 12/15/22 at 2:50pm revealed Lantus was first dispensed for Resident #2 on 12/08/22.

Interview with the facility's nurse on 12/15/22 at 3:23pm revealed:
-Resident #2 was admitted to the facility on

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12/06/22.
-The previous facility she came from sent Resident #2's medications with her.
-Resident #2's previous facility did not send any Lantus with her when she was admitted.
-She sent a fax to Resident #2's previous primary care provider (PCP) to get orders for her Lantus.
-It took a few days to receive the orders.
-She did not contact Resident #2's current PCP regarding her Lantus.
-Resident #2 should not have missed 4 doses of Lantus.
-Missing doses of Lantus could cause Resident #2's blood sugars to go too high and cause her to do into a diabetic coma.

Interview with Resident #2's PCP on 12/15/22 at 2:52pm revealed:
-She was concerned that Resident #2 missed 4 doses of Lantus in a row because it could have caused her blood sugars to become too high.
-Fingerstick blood sugars (FSBS) were not being performed on Resident #2 on 12/06/22, 12/07/22, and 12/08/22 as ordered so there was no way to know how high Resident #2's FSBSs were on the days she did not receive Lantus.
-Resident #2's blood sugars being too high could cause damage to her kidneys and eyes.

b. Review of Resident #2's current FL-2 dated 12/02/22 revealed there was an order for Vitamin D3 50000 units every Wednesday (Vitamin D3 is a supplement).

Review of Resident #2's physician progress noted dated 12/09/22 revealed there was an order for Vitamin D3 50000 units at bedtime.

Review or Resident #2's December 2022 electronic medication administration record

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(eMAR) revealed:
-There was an entry for Vitamin D3 50000 units at bedtime on Wednesday scheduled for administration at 8:00pm.
-Vitamin D3 50000 units was not documented as administered at 8:00pm on Wednesday, 12/07/22.
-There was no entry for vitamin D3 50000 units at bedtime.

Observation of Resident #2's medications on hand on 12/14/22 at 2:09pm revealed:
-There was a medication card labeled as Vitamin D3 50000 units at bedtime on Wednesday.
-There were 3 capsules of Vitamin D3 dispensed for Resident #2 on 12/07/22.
-All 3 capsules of Vitamin D3 were still in the medication card.

Interview with a medication aide (MA) on 12/15/22 at 12:02pm revealed:
-She did not know that Resident #2's Vitamin D3 had been changed to daily because it was still listed as weekly on the eMAR.
-If Resident #2's Vitamin D3 order had changed the new orders should have been faxed to the pharmacy by the MA or the facility's nurse.

Interview with the facility's nurse on 12/15/22 at 3:23pm revealed:
-She had been busy doing other things and the primary care provider's (PCP) medication orders from 12/09/22 had not been faxed to the pharmacy yet.
-The orders should have been faxed to the pharmacy when they were received.
-The medication orders could have also been faxed to the pharmacy by the Special Care Coordinator (SCC) or the Administrator.

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Interview with Resident #2's PCP on 12/15/22 at 2:52pm revealed she expected Resident #2 to receive Vitamin D3 every night as ordered.

3. Review of Resident #4's current FL-2 dated 07/14/22 revealed:
-Diagnoses included dementia.
-His level of care was Special Care Unit (SCU).

a. Review of Resident #4's current FL-2 dated 07/14/22 revealed:
-There was an order for quetiapine 25mg (used to treat mood and behavior) at bedtime and every 8 hours as needed for agitation.
-Resident #4 had inappropriate behavior of agitation.

Interview with a pharmacist at the facility's contracted pharmacy on 12/15/22 at 10:17am revealed:
-There was only one active order for quetiapine fumarate on file for Resident #4 and that was quetiapine fumarate 25mg every 8 hours as needed.
-There was no active order for quetiapine fumarate 25mg at bedtime for Resident #4.
-Sixty tablets of quetiapine fumarate 25mg every 8 hours as needed was last dispensed for Resident #4 on 10/11/22.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for quetiapine fumarate 25mg at bedtime scheduled for administration at 8:00pm.
-Quetiapine fumarate 25mg was documented as administered at 8:00pm on 10/01/22 to 10/31/22.
-There was an entry for quetiapine fumarate 25mg every 8 hours as needed for

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agitation/insomnia.
-Quetiapine fumarate 25mg every 8 hours was not documented as administered 10/01/22 to 10/31/22.

Review of Resident #4's November 2022 eMAR revealed:
-There was an entry for quetiapine fumarate 25mg at bedtime scheduled for administration at 8:00pm.
-Quetiapine fumarate 25mg was documented as administered at 8:00pm on 11/01/22 to 11/30/22.
-There was an entry for quetiapine fumarate 25mg every 8 hours as needed for agitation/insomnia.
-Quetiapine fumarate 25mg every 8 hours was not documented as administered 11/01/22 to 11/30/22.

Review of Resident #4's December 2022 eMAR revealed:
-There was an entry for quetiapine fumarate 25mg at bedtime scheduled for administration at 8:00pm.
-Quetiapine fumarate 25 mg was documented as administered at 8:00pm on 12/01/22 to 12/06/22 and 12/09/22 to 12/10/22.
-Quetiapine fumarate 25mg was not documented as administered at 8:00pm on 12/07/22 to 12/08/22 and 12/11/22 to 12/13/22 with a notation of "awaiting pharmacy delivery".
-There was an entry for quetiapine fumarate 25mg every 8 hours as needed for agitation/insomnia.
-Quetiapine fumarate 25mg every 8 hours was not documented as administered 12/01/22 to 12/14/22.

Observation of medications on hand for Resident #4 on 12/15/22 at 11:14am revealed there was no

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quetiapine fumarate 25mg on the cart for Resident #4.

Interview with a medication aide (MA) on 12/15/22 at 11:18am revealed:
-It was the MA's responsibility to request refills on resident's medications.
-She did not work at night, so she did not know how long Resident #4 had been out of quetiapine fumarate.
-Resident #4 got agitated sometimes but she had not noticed him getting more agitated than normal.

Interview with Special Care Coordinator (SCC) on 12/15/22 at 3:45pm revealed:
-There were stickers on resident's medication bubble packs that indicated when a medication needed to be refilled.
-Resident #4's quetiapine fumarate should have been refilled by a MA when the sticker indicated it needed to be refilled.
-If MAs were administering Resident #4's as needed quetiapine because that was all they had they should have contacted his primary care provider (PCP) for an order for the bedtime quetiapine fumarate.
-She had not noticed any increased behaviors or agitation with Resident #4.

Interview with the facility's nurse on 12/15/22 at 3:23pm revealed:
-MAs should not have used Resident #4's as needed quetiapine fumarate but should have contacted his PCP to get an order for his bedtime quetiapine fumarate.
-Resident #4's quetiapine fumarate should have been ordered by a MA at least 5 days before he ran out of it.
-MAs usually faxed orders to the pharmacy for

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residents.
-Resident #4 should not have gone without his quetiapine fumarate.
-She had not noticed any increase in behaviors with Resident #4.

Interview with Resident #4's mental health provider (MHP) on 12/15/22 at 3:17pm revealed:
-Resident #4 was originally on quetiapine fumarate as needed.
-She eventually had to schedule his quetiapine fumarate at bedtime too because he was having an increase in his behaviors.
-Resident #4 was prescribed a scheduled dose of quetiapine fumarate at bedtime because he got agitated and was also having trouble sleeping and it was also being used to treat hypersexual behaviors that he was having.
-She did not know that Resident #4 had gone several days without his scheduled quetiapine fumarate.
-She was concerned that Resident #4 had gone several days without his scheduled quetiapine fumarate because he was at risk for increased agitation, poor sleep, and an increase in hypersexual behaviors.

Based on observations, interviews, and record reviews it was determined that Resident #4 was not interviewable.

b. Review of Resident #4's physician order sheet dated 10/07/22 revealed there was an order for erythromycin 5mg/gram 1 application into lower left eyelid 3 times a day for 7 days (Erythromycin is an antibiotic used to treat infection).

Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:

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-There was an entry for erythromycin 5mg/gram apply 1 application into lower left eyelid 3 times a day for 7 days scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-There was a start date of 10/07/22 and a stop date of 10/25/22.
-Erythromycin 5mg/gram was documented as administered to Resident #4 at 8:00am, 2:00pm, and 8:00pm on 10/07/22 to 10/25/22.
-Erythromycin 5mg/gram was documented as administered 3 times a day for 19 days instead of 7 days.

Interview with a pharmacist at the facility's contracted pharmacy on 12/15/22 at 10:17am revealed:
-A 3.5-gram tube of erythromycin was dispensed for Resident #4 on 10/07/22.
-The tube of erythromycin that was dispensed for Resident #4 would last 18 to 20 days if administered as ordered.

Interview with a MA on 12/15/22 at 11:18am revealed:
-A MA should have removed Resident #4's erythromycin from the medication cart after he received it for 7 days.
-The facility nurse, Special Care Coordinator (SCC), or the pharmacy entered start and stop dates on the eMAR for resident's medications.
-If a MA saw that the stop date for Resident #4's erythromycin was wrong on the eMAR they should have notified the SCC or facility nurse.
-She did not notice that Resident #4's stop date on the eMAR for erythromycin was wrong and she continued to administer the medication because it was popping up on the eMAR to be administered.

Interview with the facility's nurse on 12/15/22 at

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3:23pm revealed:
-She expected medication aides (MA) to administer medications as ordered by the physician.
-Once Resident #4 had received 7 days of erythromycin a MA should have removed the medication from the cart.
-The pharmacy or a MA entered stop dates on eMARS for residents.
-Resident #4's stop date for his erythromycin was entered incorrectly on his eMAR.
-If the pharmacy entered the incorrect stop date for Resident #4's erythromycin it was still the facility's responsibility to make sure the resident only received 7 days of his medication as ordered.

Interview with Resident #4's primary care provider (PCP) on 12/15/22 at 2:52pm revealed:
-She ordered a 7-day course of erythromycin for Resident #4 in October 2022 because he had a stye in his eye.
-Receiving a longer course of erythromycin was not harmful to Resident #4 but she expected it to only be administered 7 days as ordered.
4. Review of Resident #5 current FL-2 dated 03/15/22 revealed diagnoses included dementia, hypertension, hypothyroidism, osteoporosis, and Vitamin D deficiency.

Review of Resident #5 current FL-2 dated 03/15/22 revealed diagnoses included dementia, hypertension, hypothyroidism, osteoporosis, and Vitamin D deficiency.

Review of Resident #5's physicians orders dated 11/03/22 revealed:
-There was an order to discontinue Synthroid 75mcg (Synthroid is a medication used to treat and manage hypothyroidism).

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D 358	Continued From page 42 -There was an order to start Synthroid 88mcg, take one tablet daily. Review of Resident #5's subsequent physician's orders dated 11/11/22 revealed: -There was an order to discontinue Synthroid 88mcg. -There was an order to start Synthroid 125mcg, take one tablet daily. Observation of Resident #5's medications on hand on 12/15/22 at 11:15am revealed: -There was Synthroid 88mcg on the medication cart for Resident #5 with the other daily medications that the resident received. -There was Synthroid 75mcg in the bottom of the medication cart with Resident #5's name where extra medication was kept in a plastic bag. Observation of Resident #5's medications on hand on 12/15/22 at 11:25am revealed: -Staff located Resident #5's Synthroid 125mcg in the office with other overstock medications. -The Synthroid 125mcg was filled on 11/15/22 for 90 tablets (90-day supply). -There were 90 tablets in the Synthroid 125mcg bottle and the silver seal over the medication bottle was intact. Review of Resident #5's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Synthroid 75mcg daily, scheduled for administration at 6:00am. -Synthroid 75mcg was documented as administered on 11/01/22 to 11/07/22 at 6:00am. -There was an entry for Synthroid 88mcg daily, scheduled for administration at 8:00am. -Synthroid 88mcg was documented as administered on 11/08/22 to 11/12/22 at 8:00am.	D 358		

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D 358	Continued From page 43 -There was an entry for Synthroid 125mcg daily, scheduled for administration at 8:00am. -Synthroid 125mcg was documented as administered on 11/13/22 to 11/30/22 at 8:00am. Review of Resident #5's December 2022 eMAR from 12/01/22 to 12/14/22 revealed: -There was an entry for Synthroid 125mcg daily, scheduled for administration at 8:00am. -Synthroid 125mcg was documented as administered on 12/01/22 to 12/06/22 at 8:00am. -There was an entry for Synthroid 125mcg daily, scheduled for administration at 6:00am. -Synthroid 125mcg was documented as administered from 12/07/22 to 12/14/22 at 6:00am. Interview with the Special Care Coordinator (SCC) on 12/15/22 at 3:45pm revealed: -When Resident #5's Synthroid order changed it was the staff member who received the orders responsibility to pull the old dose of medication off the medication cart and replace it with the new medication. -Resident #5's family member picked up the new Synthroid dose of 125mcg from the pharmacy and gave it to the SCU staff, but she was not sure who received that medication. Interview with the facility nurse on 12/15/22 at 3:15pm revealed: -She was not aware that Resident #5 was not receiving the correct dose of Synthroid. -It was important for Resident #5 to receive the ordered dose of Synthroid to treat low thyroid levels. -She was not aware of any cart audits that were currently taking place at the facility. Interview with the Administrator on 12/15/22 at	D 358		

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D 358	Continued From page 44 4:10pm revealed: -As part of the corrective plan from the previous survey, she and the Business Office Manager (BOM) had completed cart audits through the first two weeks of November 2022. -She was not aware that Resident #5 was not receiving her ordered dose of Synthroid. Telephone interview with Resident #5's primary care provider (PCP) on 12/15/22 at 2:50pm revealed: -Resident #5 was receiving Synthroid to help treat her hypothyroidism. -Resident #5 not receiving her increased dose of Synthroid as ordered would not cause any acute issues for the resident because it would take time to build up her TSH levels. -She expected Resident #5 to receive her medications as ordered, including her Synthroid. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable. _____ The facility failed to ensure medications were administered as ordered for 2 of 2 residents during the medication pass where a resident did not eat breakfast within 30 minutes of being administered short acting insulin which could have caused the resident's blood sugar to drop (#2). Residents did not have medications available for administration including a long acting insulin which could cause the resident's blood sugar to become too high which could cause damage to her kidneys and eyes (#2) and a medication used to treat behaviors (#4). Resident #5 was not receiving the correct dosage of a thyroid replacement medication. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a	D 358		

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D 358	Continued From page 45 Continuing Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/22 for this violation.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed a resident taking his medications for 1 of 5 residents sampled (#3) leaving the medications next to the resident's breakfast plate in the Special Care Unit (SCU) where there were 12 other residents present. The findings are: Review of the facility's Medication Administration policy, dated 08/23/22, revealed the staff member administering a medication must stay with the	D 366		

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resident and observe that the resident has safely consumed the medication.

Review of Resident #3's current FL-2 dated 09/21/22 revealed:
-Diagnoses included dementia, type 2 diabetes, hypertension, hyperlipidemia, anxiety, and depressed mood.
-He was constantly disoriented and semi-ambulatory with a walker.
-He had wandering behaviors.
-His level of care was a memory care unit.
-There was an order for Aspirin 81mg daily (Aspirin is an anti-inflammatory medication used preventively for heart health).
-There was an order for Metformin 500mg every morning (Metformin is a medication used to manage diabetes).
-There was an order for Zoloft 100mg, take 1 and ½ tablet (150) daily (Zoloft is an anti-depressant used to treat symptoms of depression).
-There was an order for Nadolol 20mg daily (Nadolol is a medication used to treat hypertension).

Observation of the Special Care Unity (SCU) dining room on 12/14/22 from 7:48am until 8:15am revealed:
-There were 11 residents seated at the tables in the dining room eating breakfast at 7:48am.
-There were 2 personal care aides (PCA) and 1 medication aide (MA) in the room.
-Resident #3 was seated at a table with 3 other residents.
-Resident #3 was eating breakfast and there was a clear plastic medication cup next to the resident with 4 and ½ pills in it.
-At 7:50am one of the PCA went down the hall to get another resident out of their room and walked them to the dining hall.

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-The MA was administering medications to other residents in the dining room.
-At 8:00am, after the surveyor asked a PCA Resident #3's name, a PCA prompted Resident #3 to take the medications from the cup.
-At 8:01am, Resident #3 swallowed his medications.

Review of Resident #3's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Aspirin 81mg daily, scheduled for administration at 8:00am.
-Aspirin 81mg was documented as administered on 12/14/22 at 8:00am.
-There was an entry for Metformin 500mg every morning, scheduled for administration at 8:00am.
-Metformin 500mg was documented as administered on 12/14/22 at 8:00am.
-There was an entry for Nadolol 20mg daily, scheduled for administration at 8:00am.
-Nadolol 20mg was documented as administered on 12/14/22 at 8:00am.
-There was an entry for Zoloft mg take 1 and ½ tablet (150mg) daily, scheduled for administration at 8:00am.
-Zoloft 100 mg 1 and ½ tablet was documented as administered on 12/14/22 at 8:00am.

Observation of Resident #3's medications on hand on 12/15/22 revealed the medications left at with the resident on the morning of 12/14/22 were Aspirin, Metformin, Zoloft (1 and ½ tablet), and Nadolol.

Interview with a PCA on 12/15/22 at 9:20am revealed:
-She saw the surveyor go look at the medication cup next to Resident #3 on 12/14/22 during breakfast, which prompted her to go have the

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resident take the medication.
-She was not a MA.
-She worked on the SCU first shift.
-Resident's medications being left next to their plates for them to take was a "daily occurrence".
-She never saw any residents try to take another resident's medications.
-A lot of the SCU residents were forgetful, so they needed reminding to take their medications.
-There were approximately 3 residents that wandered on the SCU.

Interview with the MA on 12/14/22 at 10:30am revealed:
-She administered Resident #3's medications during the morning medication pass on 12/14/22.
-She was not aware that he did not take his medications.
-When she was turning around to return to the medication cart located in the dining room, he had the clear medicine cup to his mouth.
-She assumed he swallowed the medications when he put the cup to his mouth.
-Resident #3 did not like to be "hovered over" when he was taking his medications, so she didn't stand over him while he took his medications.
-She should have ensured that Resident #3 took his medications.
-She was not aware of a time that a resident took other residents' medications.
-It was the facility's policy to observe residents taking their medications unless the resident had self-administration orders.
-Resident #3 did not have self-administration orders for medication administration.

Interview with the Special Care Coordinator (SCC) on 12/14/22 at 11:15am revealed:
-She expected MAs to observe residents take

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their medications, especially on the SCU.
-There were residents on the SCU that had wandering behaviors.
-She would expect MAs to watch the resident take their medications because "someone could come by and take it".
-She was not aware that the MAs left medications at Resident #3's table at breakfast.

Interview with the facility's nurse on 12/14/22 at 2:40pm revealed:
-Resident #3 did not have self-administration orders.
-Medications should not be left with the residents to take themselves, especially on the SCU because residents have memory problems.
-She expected the MA to watch residents take their medications per the facility's policy.
-She was concerned for resident safety with medications left out because there were known wanderers on the SCU.
-She was not aware of any residents taking other residents' medications.

Interview with the Administrator on 12/14/22 at 3:00pm revealed:
-She expected MAs to observe residents take their medications per the facility's policy.
-It was important for residents to be observed taking their medications for resident safety and to ensure that residents were receiving their proper medications.

Telephone interview with a Registered Nurse at Resident #3's primary care provider (PCP) office on 12/15/22 at 12:15pm revealed she expected Resident #3 to be observed taking his medications because one of the reasons he was in a facility was to help with medication management.

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D 366	Continued From page 50 Telephone interview with the facility's contracted mental health provider (MHP) on 12/15/22 at 3:30pm revealed: -She expected residents were observed by MAs administering their medications to ensure that they have taken their medications. -It was a safety concern that resident's medications were left beside the resident in a room with other residents because of the SCU population with residents that were forgetful and had dementia. Based on observations, interviews and record reviews, it was determined that Resident #3 was not interviewable. _____ The facility failed to ensure residents were observed taking their medications when administered on the Special Care Unit where there were residents that were forgetful and had dementia. There were medications left on the dining table next to a resident with other residents seated at the table. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/30/22 for this violation.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	D 367		

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D 367	Continued From page 51 (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medication administration records were complete and accurate for 2 of 5 residents sampled (#2, #5). The findings are: Review of the facility's Medication Administration policy, dated 08/23/22 revealed: -In the event a medication is withheld, refused, or given at a time other than the scheduled time, staff administering the medication will circle the MAR space provided for the drug and dose and enter a note into the record as to the reason. -As required or indicated the resident Medication Administration Record (MAR) will reflect date/time the medication was given, dosage, route of administration, injection site if applicable, any complaints or symptoms for which an as needed medication was administered and effectiveness,	D 367		

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and signature and title of the individual administering the medication.

1. Review of Resident #5 current FL-2 dated 03/15/22 revealed diagnoses included dementia, hypertension, hypothyroidism, osteoporosis, and Vitamin D deficiency.

a. Review of Resident #5's physicians orders dated 11/03/22 revealed:
-There was an order to discontinue Synthroid 75mcg (Synthroid is a medication used to treat and manage hypothyroidism).
-There was an order to start Synthroid 88mg, take one tablet daily.

Review of Resident #5's subsequent physician's orders dated 11/11/22 revealed:
-There was an order to discontinue Synthroid 88mcg.
-There was an order to start Synthroid 125mcg, take one tablet daily.

Observation of Resident #5's medications on hand on 12/15/22 at 11:15am revealed:
-There was Synthroid 88mcg on the medication cart for Resident #5 with the other daily medications that the resident received.
-There was Synthroid 75mcg in the bottom of the medication cart with Resident #5's name where extra medication was kept.

Observation of Resident #5's medications on hand on 12/15/22 at 11:25am revealed:
-Staff located Resident #5's Synthroid 125mcg in the office with other backstock medications.
-The Synthroid 125mcg was filled on 11/15/22 for 90 tablets (90-day supply).
-There were 90 tablets in the Synthroid 125mcg bottle and the silver seal over the medication

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	HAL025037	A. BUILDING: _____ B. WING _____	R 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROATAN VILLAGE	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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bottle was intact.

Review of Resident #5's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Synthroid 75mcg daily, scheduled for administration at 6:00am.
-Synthroid 75mcg was documented as administered on 11/01/22 to 11/07/22 at 6:00am.
-There was an entry for Synthroid 88mcg daily, scheduled for administration at 8:00am.
-Synthroid 88mcg was documented as administered on 11/08/22 to 11/12/22 at 8:00am.
-There was an entry for Synthroid 125mcg daily, scheduled for administration at 8:00am.
-Synthroid 125mcg was documented as administered on 11/13/22 to 11/30/22 at 8:00am.

Review of Resident #5's December 2022 eMAR from 12/01/22 to 12/14/22 revealed:
-There was an entry for Synthroid 125mcg daily, scheduled for administration at 8:00am.
-Synthroid 125mcg was documented as administered on 12/01/22 to 12/06/22 at 8:00am.
-There was an entry for Synthroid 125mcg daily, scheduled for administration at 6:00am.
-Synthroid 125mcg was documented as administered from 12/07/22 to 12/14/22 at 6:00am.

Refer to interview the Special Care Coordinator (SCC) on 12/15/22 at 3:45pm.

Refer to interview with the facility's nurse on 12/15/22 at 3:15pm.

Refer to interview with the Administrator on 12/15/22 at 4:10pm.

Based on observations, interviews, and record

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reviews it was determined that Resident #5 was not interviewable.

b. Review of Resident #5's physician's orders dated 07/21/22 revealed there was an order for Miralax 17gm daily (Miralax is a laxative used to treat and prevent constipation).

Observation of the 8:00am medication pass on 12/14/22 revealed:
-The medication aide (MA) prepared Resident #5's medication including Miralax 17gm in 8oz of water into a Styrofoam cup at 7:55am.
-Resident #5 drank the water with the Miralax in it to take her medications.
-The MA left the cup of Miralax next to the Resident #5; and it was approximately halfway full.
-At 8:06am a personal care aide (PCA) took Resident #5's Styrofoam cup with approximately half of the Miralax liquid in it and dumped it down the sink in the kitchenette.

Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax 17gm to be administered in 8 oz of liquid daily, scheduled for administration at 8:00am.
-Miralax 17gm was documented as administered on 12/14/22 at 8:00am.

Interview with a MA on 12/14/22 at 10:30am revealed:
-She documented Resident #5's Miralax as administered on 12/14/22 at 8:00am because she thought that the resident drank the entire cup of liquid.
-If she was aware that the resident did not finish the medication, she would have documented

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accordingly.
-If a medication was not administered, then

Refer to interview the Special Care Coordinator (SCC) on 12/15/22 at 3:45pm.

Refer to interview with the facility's nurse on 12/15/22 at 3:15pm.

Refer to interview with the Administrator on 12/15/22 at 4:10pm.

Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable.

2. Review of Resident #2's current FL-2 dated 12/02/22 revealed:
-Diagnoses included Type 2 Diabetes and hypertension.
-There was an order for Eliquis 5mg twice a day (Eliquis is a blood thinner used to prevent blood clots).

Observation of the 8:00am medication pass on 12/14/22 revealed:
-The medication aide (MA) administered 13 pills to Resident #2 at 8:11am.
-Eliquis 5mg was not administered to Resident #2.

Review of Resident #2's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Eliquis 5mg twice daily scheduled for administration at 8:00am.
-Eliquis 5mg was documented as administered at 8:00am on 12/14/22.

Interview with the MA on 12/14/22 at 2:09pm

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revealed:
-She marked on the eMAR that she administered Eliquis 5mg to Resident #2 because she thought she had administered it.
-She highlighted medications on the eMAR before she administered them.
-She noticed that Eliquis 5mg was not highlighted on Resident #2's eMAR when she was documenting what was administered to Resident #2 during the 8:00am medication pass.

Refer to interview the Special Care Coordinator (SCC) on 12/15/22 at 3:45pm.

Refer to interview with the facility's nurse on 12/15/22 at 3:15pm.

Refer to interview with the Administrator on 12/15/22 at 4:10pm.

3. Review of Resident #4's current FL-2 dated 07/14/22 revealed:
-Diagnoses included dementia
-There was an order for quetiapine fumarate 25mg (used to improve mood and behavior) at bedtime.

Review of Resident #4's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for quetiapine fumarate 25mg at bedtime scheduled for administration at 8:00pm.
-On the eMAR Medication Notes quetiapine fumarate 25mg was documented as "awaiting pharmacy delivery" on 12/07/22, 12/08/22, 12/11/22, and 12/13/22.
-On 12/12/22 there was no documentation that quetiapine fumarate 25mg was administered at 8:00pm and there were no notes in the eMAR

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D 367	Continued From page 57 Medication Notes for 12/12/22. -Quetiapine fumarate 25mg was documented as administered at 8:00 pm on 12/09/22 and 12/10/22. Observation of medications on hand for Resident #4 on 12/15/22 at 11:14am revealed there was no quetiapine fumarate 25mg on the cart for Resident #4. Interview with a pharmacist at the facility's contracted pharmacy on 12/15/22 at 10:17am revealed 60 tablets of Seroquel 25mg was last dispensed for Resident #4 on 10/11/22. Interview with a medication aide (MA) on 12/15/22 at 11:18pm revealed: -She did not work at night, so she did not administer Resident #4's quetiapine fumarate. -Since Resident #4's eMAR Medications Notes stated that he was out of quetiapine fumarate 12/08/22 and 12/11/22 then he would not have had any quetiapine fumarate to administer on 12/09/22 and 12/10/22. -MAs should document accurately on the eMAR if a medication was not administered. Refer to interview the Special Care Coordinator (SCC) on 12/15/22 at 3:45pm. Refer to interview with the facility's nurse on 12/15/22 at 3:15pm. Refer to interview with the Administrator on 12/15/22 at 4:10pm. _____ Interview with the Special Care Coordinator (SCC) on 12/15/22 at 3:45pm revealed it was the MA responsibility to document accurately and completely on the electronic medication	D 367		

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D 367	Continued From page 58 administration record (eMAR). Interview with the facility's nurse on 12/15/22 at 3:15pm revealed: -It was expected that the MA document correctly on the eMAR. -If the medication was not administered there should be a reason documented as to why it was not administered. -She was not aware of any chart audits currently in place to look at accuracy of eMAR but there was a plan to start them in the future. Interview with the Administrator on 12/15/22 at 4:10pm revealed she expected the MA to document on the eMAR according to facility policy.	D 367		