Recieved via email on 12/19/22.

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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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 Liscensure Section conducted an annual survey and a follow-up survey on October 11, 2022 to October 14, 2022 and an exit via telephone on October 17, 2022.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews, the facility failed to ensure 5 of 5 exit doors and one interior door to the Special Care Unit (SCU) were equiped with a sounding device that activated when the doors were opened, which were accessible by residents, including a resident (#8) who was intermittently disoriented, wandered, had a history of leaving the facility without staff's knowledge, and resided on the Assisted Living (AL).	D 067	Temporary door alarms in place. Permanent door alarms in place.	10/17/22 11/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mari Riddick, LPN, Adm. TITLE (X6) DATE 12/19/22

Reviewed and acknowledged on 12/19/22. P.D.

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D 067	Continued From page 1 The findings are: Review of the facility's undated policy on a wandering resident revealed: -The Administrator was to be notified of a resident with wandering behaviors. -A resident who was reported to show signs of wandering behavior would be assessed by a healthcare professional at the earliest possible time. -An updated care plan and assessment would be conducted by the facility staff and would indicate the need for supervision. -Staff would provide supervision of residents in accordance with the assessed needs, care plan and current symptoms. -When a resident was determined by the physician to exhibit wandering behaviors, each exit door for resident use would be equipped with a sounding device that was activated when the door was opened. -The door alarms should be activated for 24 hours when there was a known wanderer in the facility. -The alarm system was to be checked daily by management to ensure the alarm system was operational. -If the alarm system was inoperable, the facility would plan for supervision of wandering residents. -Residents would receive direct supervision by the staff until alarms were operable. Review of Resident #8's current FL-2 dated 05/12/22 revealed: -Diagnoses included seizure disorder, hypertension, mental retardation, and peptic ulcer disease. -He was intermittently disoriented. -He exhibiting wandering behaviors.	D 067	Any resident that are showing signs of wandering will be placed on a 15 minute check. The doctor will be notified for further orders. If it become a safety concern for the resident the resident will be one on one and given a 30 day discharge due to safety of the resident. Fence installation outside the facility around the building in place for the facility to identify safety boundaries of residents walking into the road. Temporary door alarms in place. Permanent door alarms in place. Management will check door alarm system daily to ensure all door alarms are operable. Resident will be one on one if displaying wandering concerns in the event the door alarms are not working.	1/13/23 10/17/22 11/30/22 12/5/22 10/12/22

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D 067	Continued From page 2 -He was ambulatory. Review of Resident #8's signed care plan dated 05/12/22 revealed: -He suffered memory loss from underlying health problems. -He was ambulatory. -He was sometimes disoriented. Observation of the front door on 10/11/22 at 8:30am revealed there was no audible alarm when the front door was opened. Observation of the front door on 10/12/22 at 8:30am revealed there was no audible alarm when the front door was opened. Observations of the facility grounds on 10/12/22 at 2:30pm revealed: -Resident #8 and two other residents and a personal care aide (PCA) were standing at the entrance of the facility driveway; Resident #8 was standing in the road and the other two residents and PCA were standing on the side of the road. -The PCA was attempting to lead the residents back to the facility. -Two medication aides (MA) got in the company van, road to end of driveway to pick up the residents. -The residents began walking with the staff member back to the facility. Observations of the facility grounds on 10/12/22 at 3:45 revealed: -Resident #8 was ambulating down the driveway toward the road; he was 100 yards from the facility. -A staff member called to him several times as she was standing in the front of the facility. -Resident #8 returned to the facility.	D 067		

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D 067	Continued From page 3 Observations of the facility grounds on 10/12/22 at 4:58pm revealed: -There was a staff member standing at the end of the driveway, looking down the road. -Two staff members got into the facility van and drove in the direction the staff member at the end of the driveway was looking. -The van returned to the facility at 5:05pm with Resident #8. Observations of the facility on 10/13/22 at 7:50am revealed: -The front door was unlocked, and residents were going in and out of the front door. -There was no alarm box mounted to the wall next to the front door. -There was no audible sound when the front door was opened. Observations of the lounge on the assisted living (AL) main hall on 10/13/22 at 7:58am revealed: -There was a door that exited the facility from the lounge. -There was a red alarm box on the wall next to the door. -There was a pin inserted into the alarm box connected to a cable which was looped on the end. -The cable loop was not over the door handle. -Residents were entering and exiting the door. -There was no audible sound when the residents entered or exited the door. Interview with a PCA on 10/14/22 at 3:38pm revealed: -The cable on the alarm box that connected to the exit door in the lounge on the main hall was easily removed from the door handle because the cord was too long.	D 067		

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-She did not know if management was aware of the cord being too long.
-She had not informed management the cord was too long.
-She had informed the MA a few weeks ago.
-The residents used the door to go outside, although they had been instructed by staff members not to use the exit door
-Third shift staff tried to keep a PCA in or around the lounge on the main hall so no one would exit the facility during the night.

Observations of the lounge on the AL west hall on 10/13/22 at 8:05am revealed:
-There was an exit door leading to the outside of the facility.
-There was no alarm box with a pin mounted to the wall next to the exit door.
-There was no cable on the door handle.
-Residents and staff members were entering and exiting the door.
-There was no audible sound when the exit door was opened.
-The door had a push bar on it to open the door.
-The door did not close completely once it was opened and had to be pushed or pulled closed.

Observations of the lounge on the AL main hall on 10/14/22 at 8:30am revealed:
-The alarm cord was not connected to the door handle.
-The door was opened an inch; there was no audible sound.
-Residents were entering and exiting the door.
-There were no staff present in the lounge on the AL main hall.

Observations of the lounge on the AL west hall on 10/14/22 at 8:42am revealed:
-Residents and staff members were entering and

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exiting the door.
-There was no audible sound when the residents and staff entered and exited the door.

Observations of the interior exit door in the Special Care Unit (SCU) on 10/11/22 at 8:37am revealed the door did not sound when opened and no one responded to the door being opened.

Observations of the SCU on 10/11/22 from 8:10am to 10:22am revealed:
-There was an interior wooden half wall with a gate that divided the SCU from the AL.
-There was a door knob on the gate that had a button lock; the button to lock was on the AL side of the gate.
-Staff were intermittently exiting the SCU by reaching across the gate and turning the lock button unlocking the gate.
-There was a red alarm box on the wooden half wall next to the gate on the SCU side.
-There was a pin inserted into the alarm box connected to a cable which was looped on the end.
-The cable loop was not over the door knob at the gate.
-There was a resident standing with her elbow on the SCU side of the half wall.
-At 10:22am there was an audible siren when staff entered the SCU from the AL.
-The resident who was standing on the SCU side of the gate placed the pin back into the red box to disengage the alarm and the siren stopped.
-There were no staff in the area.

Observations of the SCU on 10/12/22 at 10:00am revealed:
-There was a female resident standing at the interior gate to the SCU; she was talking to a resident from the AL who was standing on the

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other side of the gate.
-The state surveyor entered the SCU and engaged the alarm on the gate by opening the gate which pulled the pin out of the red box.
-The resident standing at the gate on the SCU side silenced the alarm by placing the pin back into the alarm box.
-There were no staff in the area.

Interview with the Assistant Resident Care Coordinator (RCC) on 10/14/22 at 4:26pm revealed:
-The facility had an alarm system connected to all exit doors with megalocks, but the alarm system was not working.
-The key that turned the alarm system on, that controlled the megalocks to all exit doors, would not turn after being inserted.
-The Maintenance Manager found out a few weeks ago that the key would not work.
-The Regional Director (RD) was notified on 10/13/22 by the Administrator that the key to the alarm system would not turn the alarm system on.
-The RD notified the facility's contracted security provider on 10/13/22.
-Second shift staff would turn the alarm system on, when it was working, and it would stay on until the next morning.
-The alarm system controlled all exit doors when it was working.
-When the alarm system was working, the alarm would sound when someone opened the exit door from the inside.
-She did not know how long the alarm system had been broken.
-The facility also had individual alarm boxes mounted to the wall of three exit doors, the exit door at the end of the AL main hall, the exit door in the lounge on the main hall and the SCU door.
-The front door and the exit door in the lounge on

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the west hall did not have individual alarm boxes.
-The individual alarm boxes worked by a pin inserted into the alarm box connected to a cable with a loop.
-The cable loop was connected to the door handle.

Telephone interview with the RD on 10/14/22 at 5:15pm revealed:
-The RD's assistant called the facility's contracted security provider on 10/13/22.
-She was informed a serviceman would be out to the facility on 10/13/22 to work on the alarm box.
-She called the provider again today, 10/14/22, because the serviceman did not come on 10/13/22.
-She was told on 10/13/22 the serviceman would try to come today, 10/14/22.
-She did not know how long the alarm system had been broken.
-She thought the alarm system was working in July 2022.
-She was told yesterday, 10/13/22, by the RD's assistant, the alarm system was not working.

Telephone interview with a service personnel from the facility's contracted security provider on 10/14/22 at 5:34pm revealed:
-The security provider received a call today, 10/14/22, regarding the alarm system not working.
-The facility was informed a serviceman would be out one day next week.
-The security provider was notified about 6 months ago the alarm system was not working.
-The alarm system was old and could not be repaired.
-The facility was given a quote for a new alarm system about 6 months ago.
-The security provider did not hear back from the

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facility regarding the alarm system until today, 10/14/22.

Telephone interview with the Maintenance Manager on 10/14/22 at 5:55pm revealed:
-The alarm key would not turn the alarm system on.
-He realized the alarm system would not turn on last week.
-He did not tell anyone in the facility the alarm system was not working last week.
-He called the facility's contracted security provider last week and they said they would be out here whenever they could.
-Last week was the first time he called the security provider about the alarm system.

Telephone interview with the RCC on 10/17/22 at 10:42am revealed:
-The previous Administrator contacted the facility's contracted security provider about 5 months ago to discuss the non-working alarm system; this was the main alarm system for all the exit doors.
-The facility's contracted security provider informed the previous Administrator the alarm system was not repairable.
-The previous Administrator was given a quote for replacement of the alarm system.
-The alarm system was not repaired at that time and had not worked since.
-The previous Administrator purchased individual door alarm boxes about 5 months ago.
-The alarm boxes where mounted to the walls next to the exit door at the end of the main hallway and at the exit door in the lounge on the main hallway.
-There was no alarm mounted to the walls next to the front door or the exit door in the west hall lounge; she did not know why there was no alarm

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mounted next to these two doors.
-She was aware the residents would remove the cable from the door handle in the main hall lounge.
-All staff were responsible for making sure the alarm in the main hall lounge was connected to the door.
-She informed the current Administrator three months ago the alarm system for the building was broken.
-She did not know what action was taken by the Administrator.

Interview with the Administrator on 10/17/22 at 9:55am revealed:
-He was aware of Resident #8's wandering behavior.
-All exit doors were connected to the alarm system, which was not working at this time.
-The facility's contracted security provider was coming to the facility today, 10/17/22, to repair the alarm system.
-No one had informed him the alarm system was not working properly until 10/14/22.
-He notified the facility's contracted security provider on 10/14/22 that the alarm system was broken.
-He was informed by the facility's contracted security provider on 10/14/22 the alarm system was old and would need to be replaced.
-He did not know the last time the security provider was in the facility to inspect the system.
-The rear door on the AL main hall and the door in the AL lounge on the main hall were secured with an alarm box.
-The alarm box was on the wall next to the doors with a cable that extended over the handle of the door.
-The alarm would sound each time the exit door was opened.

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D 067	Continued From page 10 -He did not know the residents would remove the cable from the door handle in the lounge on the mail hall and exit the building. -There was no alarm on the door in the lounge on the AL west hall or the main front entrance door; the individual door alarm boxes were in place when he started employment about three months ago. -He did not know why there were no individual alarm boxes on the doors on the AL west hall lounge and the main front entrance door. -The PCAs who worked the AL west hall would observe for residents entering and exiting the door in the lounge on the AL west hall the other staff members would observe for residents entering and exiting the main front entrance door. _____ The facility failed to ensure 4 of 5 exit doors were secured and alarmed with a sounding device when the door was opened to prevent a resident with a diagnosis of mental retardation who was intermittently disoriented and wandered (#8) from exiting the facility without the staff's knowledge. On 10/12/22 Resident #8 was observed leaving or having left the facilty three times in a 3-hour time frame. The facility's failure resulted in a substantial risk for serious physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/14/2022. _____ CORRECTION DATE OF THE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2022.	D 067	Temporary alarms in place. Permanent alarms in place.	10/17/22 11/30/22
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings	D 074		

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D 074	Continued From page 11 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure walls and floor coverings were kept clean and in good repair for resident rooms #5 and #30, hallways, hallway entryways, the shower room and the dining room on the assisted living (AL) unit. The findings are: Observations of resident room #5 on 10/11/22 at 8:25am revealed: -There was a build-up of dark brown dirt and dust on the threshold and flooring on the door of the room. -There were black stains and white paint splatters on the vinyl flooring and walls at the door entryway, the room, and bathroom. -There was a build-up of brown and yellow dust and dirt on the top and bottom areas of the baseboard around the room. -There were black stains, scratch marks and worn edges on the flooring throughout the room. -There was an unused dented floor radiator, attached to the wall, with a coating of brown dust and dirt on the top and front sides. -There were black stains and dust particles on the flooring around the radiator.	D 074	Repaired. Will be monitored weekly by housekeeping, maintenance , and administrator. Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator. Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator. Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator. Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator. Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/5/22 11/11/22 11/5/22 11/5/22 10/19/22 11/5/22

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ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 074	Continued From page 12 Interview with the resident in room #5 on 10/11/22 at 8:26am revealed: - He had been in room #5 for 2 to 3 months after moving from another room. -The building was old and needed repairs done to most all of the resident rooms. -Housekeeping staff came into his room to sweep and mop his room and bathroom every other day but was not able to clean the stains and build-up of grime on the flooring and the baseboards. Observation of resident room #30 on 10/11/22 at 8:48am revealed: -There was a build-up of dark brown dirt and dust balls on the threshold and flooring at the door. -There were black stains on the lower edge of the door frame. -There were brown and black patches of stain and scrape marks on the flooring and baseboard in the room. Interview with a resident in room #30 on 10/11/22 at 8:50am revealed: -His room always looked dirty; there were stains on the walls and flooring. -Housekeeping staff would came in to do a light sweeping and mopping. Observations on 10/11/22 at 9:15am of the AL resident hallway revealed: -There were dark brown and black stains on the flooring in the hallway and all the entryways to the resident rooms and the hallway exit doors. -There was a build-up of dust and dirt on the top and bottom edges of the baseboard in the hallway. Observations on 10/11/22 at 9:27am of the AL hall bathroom revealed: -There was a build-up of dark brown dirt and dust	D 074	Terminated current floor contractor and hired a new floor company to service the floors, started and completed in November and is being serviced weekly. Maintenance and Administrator will monitor upkeep of the floors weekly.	11/5/22

Division of Health Service Regulation

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ALPHA MAGNOLIA GARDEN	**930 HWY 158 BUS E** **WARRENTON, NC 27589**

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D 074	Continued From page 13	D 074		
	on the threshold and flooring at the entrance to the large bathroom.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-There was a build-up of brown and black sticky dust, dirt, and bits of broken tiles at the bottom edge of the baseboard in the room.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-The top edge of the baseboard at the open shower area was torn from the wall.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-There was a ramp made of a bed mattress approximately 3 and one-half feet wide and 5 feet long placed in front of the raised step-in shower.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-The covering of the mattress was made of a slick water resistant fabric.			
	-There was a 4-inch gap between the wall and the side edge of the ramp leaving an open space to the floor making a possible trip hazard for a resident stepping out of the shower.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-The wood slat walls surrounding the toilet had cracks in the surface, pieces of wood missing, exposed caulking on the wood and the wall above it making a possible trip hazard.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-There was a build-up of dark brown dirt, dust balls, and dead insect parts behind the toilet.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-There were numerous dark brown and yellow stains on the front and sides of the toilet.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-The water pipes under the sink were stained rusty green and had a build-up of dust and grime.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	-There were bits of broken tiles on the floor under the back of the sink.		Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/16/22
	Interview with a third resident on 10/11/22 at 8:37am revealed: -Housekeeping staff swept the rooms, mopped the floors, and dusted every other day. -There were a lot of stains on the floors and the walls, and the tile had dents and was separating from the floors at the baseboards.			
	Interview with a housekeeper on 10/11/22 at 9:20am revealed:			

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D 074	Continued From page 14 -The facility had 2 housekeepers who swept and mopped the resident rooms every day. -The facility was old and needed repairs and replacement of the flooring due to the stains and broken tiles. -The products used for regular cleaning were not strong enough to clean the stains. - Housekeeping used the cleaning products that they were given, they were not the industrial products used for cleaning. Observation of the AL dining room on 10/11/12 at 12:51pm revealed: -There were brown stains on the flooring in the room. -There was a build-up of dust balls at the bottom and top edges on the baseboard in the room. -There were brown stains on the door and door frame to the kitchen. -The surfaces of the vinyl waterproof tablecloths in the dining room were heavily scratched and showed the felt base. Interview with a dietary aide on 10/11/22 at 1:15 pm revealed: -The tablecloths top surfaces of the tablecloths had been scratched by residents moving the glasses over the tablecloths during mealtimes. -Liquids would settle into the lining and make the top layer of the tablecloth peel off. -Some of the tablecloths had been heavily used and needed to be replaced. -The dietary aide did not know if new tablecloths had been ordered for the AL residents' dining room. Interview with the Administrator on 10/12/22 at 8:10am revealed: -There were 2 housekeepers for the facility with a census of 74 residents.	D 074	Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/5/22
			Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/5/22
			Repaired. Will be monitored weekly by housekeeping, maintenance, and administrator.	11/5/22

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D 074	Continued From page 15 -They were to mop and dust the residents' rooms and clean the bathrooms daily. -There was a maintenance staff to make repairs. -The building was older and the stained flooring needed to be replaced. -The tablecloths in the AL dining room tablecloths needed replacing. -He did not make daily rounds of the facility but relied on staff to let him know if repairs or replacements were needed. Attempted interview with the maintenance staff on 10/11/22 at 9:30am was unsuccessful.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews it was determinded the facicilty failed to ensure oxygen tanks were stored safely. The findings are: Observation of the charting room on 10/11/22 at 3:33pm revealed: -There were two full large portable oxygen tanks sitting unsecured directly on the floor. -There were five full small bottles of oxygen sitting unsecured directly on the floor. -The small bottles of oxygen were sitting next to a shoulder bag used to carry the small bottles.	D 079	Secure rack delivered, tanks removed from directly off the floor. RCC will monitor daily to ensure tanks are secured at all times.	10/26/22

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D 079	Continued From page 16 -There were two more full large portable oxygen tanks sitting unsecured directly on the floor against the wall across from the first two large tanks. -There were four more small bottles of oxygen sitting directly on the floor and unsecured, next to the wall. Interview with the Resident Care Coordinator (RCC) on 10/11/22 at 3:33pm revealed: -A resident had just returned from the hospital with an order for oxygen. -The medical supply company had delivered the oxygen tanks over the weekend and had not provided anything to secure the tanks and bottles. -She had seen they were not secured and was going to call the supply company to provide holders to secure them, but she had not had a chance. -The supply company was due to come back out on Thursday, 10/13/22, but she would call them today, 10/11/22, and have them deliver the holders sooner. -She knew it was a safety concern if the oxygen was not secured. Interview with the Administrator on 10/11/22 at 3:33pm revealed: -He did not know there were unsecured oxygen tanks in the charting room until today, 10/11/22. -He instructed the RCC to contact the oxygen supply company about holders for the oxygen when he first saw the unsecured tanks. -He understood they were a safety risk but did not know anything else about the unsecured tanks. Observation of the charting room on 10/12/22 at 11:35am revealed: -There was a total of 11 oxygen tanks sitting unsecured on the floor in the charting room.	D 079	Large portable tank secured off the floor in a oxygen tank rack. RCC will monitor daily to ensure tanks are secured. Mini tanks removed directly from off the floor, secured in a oxygen tank rack. RCC will monitor daily to ensure all tanks are secured.	10/26/22 10/26/22

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D 079	Continued From page 17 -There were various sizes ranging from small bottles to large portable tanks. -All the tanks were full. Observation of the charting room on 10/14/22 at 8:23am revealed: -There was a total of 11 oxygen tanks sitting unsecured on the floor to the charting room. -There were two full large portable oxygen tanks sitting unsecured directly on the floor. -There were five full small bottles of oxygen sitting unsecured directly on the floor. -The small bottles of oxygen were sitting next to a shoulder bag used to carry the small bottles. -There were two additional large portable oxygen tanks sitting unsecured directly on the floor against the wall across from the first two large tanks; these tanks were full. -There were four additional small bottles of oxygen sitting directly on the floor and unsecured, next to the wall. Interview with the RCC on 10/14/22 at 10:14am revealed: -She had contacted the oxygen supply company on 10/11/22 and requested racks to secure the oxygen tanks. -The supply company said they would deliver the tank holders on 10/12/22. -On 10/13/22, the oxygen supply company was called again, and she requested they provide something to secure the oxygen tanks. -She was waiting for them to bring something out to secure the oxygen tanks. -She was going to call the oxygen supply company again today, 10/14/22, about the tanks. Telephone interview with the Administrator on 10/17/22 at 12:44pm revealed: -He had not checked the oxygen tanks to see if	D 079		

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D 079	Continued From page 18 they were secured. -The RCC was attempting to get racks for the oxygen tanks last week so they would be secured. -The oxygen supply company should have never delivered the oxygen tanks without some way of securing them. Attempted telephone interview with a representative from the oxygen supply company on 10/14/22 at 3:52pm was unsuccessful.	D 079		
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 observations, interviews, and record review, the facility failed to provide personal care for 1 of 6 sampled residents (#7) who was left unclothed and in a soiled bed. The findings are: Review of Resident #7's current FL-2 dated 09/28/22 revealed: -Diagnoses included recent trauma surgery, cognitive memory deficit, dementia, irritable bowel syndrome (IBS), anxiety and depression.	D 269		

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D 269	Continued From page 19 -He was intermittently confused. -He was verbally abusive. -He was non-ambulatory. -He was incontinent at times. -He needed personal care assistance with bathing and dressing. Review of Resident #7's Assessment and Care Plan dated 10/02/22 revealed Resident #7 needed extensive assistance with toileting, ambulation, bathing, dressing, grooming, transferring and supervision with eating Observation of Resident #7 on 10/11/22 at 9:05am during the tour of the assisted living (AL) hall revealed: -Resident #7 was standing beside his bed, wrapped in a bed sheet, waving a pillowcase in the air and yelling "get me out of here". -The resident then sat on the side of his bed and was unclothed beneath the sheet wrapped around him. He was not wearing underwear or an adult incontinent brief. There was a wet adult incontinent brief on the floor beside the bed. Interview with a personal care aide (PCA) on 10/11/22 at 3:35pm revealed: -She worked assisting residents with personal care such bathing assistance, grooming, toileting, dressing and changing adult incontinence briefs. -Staff made rounds every 2 hours checking on resident safety and see if they needed personal care. -Resident #7 would pull off his clothes and take off his adult incontinence briefs. -Resident #7 sometimes wet his bed due to taking off his briefs and urinating. -Resident #7 did not like to wear clothes and did	D 269		

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D 269	Continued From page 20 not keep his sheet over himself when lying on the bed. -Resident #7 did not like to get out of bed but would sit on the side of his bed or lay down to eat his meals. -Resident #7 needed to be checked on more than every 2 hours to be sure he stayed dry. Interview with a second PCA on 10/11/22 at 4:23pm revealed: -All residents were checked on every 2 hours for safety and personal care needs. -Resident #7 urinated frequently and usually needed a dry adult incontinence brief when she made her first rounds on 2nd shift. -The first shift PCAs were to make rounds at the end of the shift to be sure residents were dry before the 2nd shift started. -Resident #7 was routinely changed at 7:00pm after he ate his meal at 6:00pm. -Sometimes Resident #7 urinated before the 7:00pm rounds. -She did not know if other staff checked Resident #7 every 2 hours during the 2nd shift. -There was no activities log for the PCAs to sign for personal care checks for residents. Observation of Resident #7 on 10/11/22 at 4:55pm revealed: - He was in his room on his bed with the lights off and the door closed; he was awake. -He was alone in his room. -He was laying on the bed and he did not have on any clothes or an adult incontinence brief. -He had a sheet draped across his genitals; the sheet was wet with a light, yellow stain. -The mattress did not have a sheet on it and there was a cloth chux pad under Resident #7. -The cloth pad was wet and had a large yellow ring that extended to the edge of the pad.	D 269	On the day of admission management will ensure the resident adl's are added to Quickmar to ensure all adl's needs are met on each resident and 2 hour checks. RCC will add ADL's and administrator will monitor after each admission.	10/14/22

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D 269	Continued From page 21 -He was unshaved. Interview with Resident #7 on 10/11/22 at 5:00pm revealed: -He wanted help and wanted to leave the facility because "the did not take care of him here." -He could not walk without pain due to previous back injury and was afraid to walk without shoes. -He had been left in the bed for days without clothes or food. -He thought he had not eaten in three days. -The staff were not looking after him. -He needed assistance with bathing and toileting. -The staff never checked on him; they just left him lying in the bed. Interview with a third PCA on 10/11/22 at 4:53pm revealed: -Resident #7 was in his room in the bed. -He liked to stay in the bed all day and did not want to get up. -Staff left him in the bed and checked on him. -He did not want to eat meals in the dining room, and he did not want anything to eat or drink. -Staff checked on him every two hours to encourage fluids to keep him hydrated and to be sure he was okay. -No one was assigned to his room; staff shared responsibilities in the Assisted Living (AL). -She did not know the last time staff had checked on him; she was getting ready to see if he wanted to eat dinner. -She had checked on him earlier in the day and he did not want to get up; she did not know what time that was. Interview with a medication aide (MA) on 10/17/22 at 6:40am revealed: -Resident #7 preferred to not wear his clothes and would sometimes remove them.	D 269		

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-Resident #7 would remove his sheets from his bed especially if they were soiled.
-Resident #7 would become agitated and combative when staff tried to dress him, cover him or to assist him to sit or stand.
Resident #7 required more personal supervision and care than the facility's protocol of every 2 hour checks.

Review of Resident #7's activities of daily living (ADL) log was requested on 10/12/22 at approximately 4:50pm but was not received prior to the survey exit.

Attempted telephone interview with Resident #7's power of attorney (POA) on 10/14/22 at 9:56am was unsuccessful.

Observation of Resident #7's meal on 10/11/22 at 5:10pm revealed:
-A PCA served Resident #7 a meal tray for dinner at his bedside.
-The PCA placed the meal tray on Resident #7's nightstand.
-Resident #7 reached toward the plate and grabbed the slice of bread and quickly took several bites; the resident continued to lie flat in his bed.
-Resident #7 reached toward the plate again and grabbed a handful of bar-b-que and placed it in his mouth.
-The PCA asked Resident #7 to slow down and allow her to set up his plate.
-The PCA placed 3 pillows under Resident #7's upper back and head to elevate him to a 45-degree angle.

Second interview with a PCA on 10/11/22 at 5:20pm revealed:
-She and another PCA were assigned to the main

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D 269	Continued From page 23 hall where Resident #7 resided. -She did not know why Resident #7 had not eaten today, 10/11/22. -She did not get him out of bed in the evening because he did not have a wheelchair. -She and the other PCA made rounds every two hours, providing incontinent care to residents who needed assistance. Interview with a second PCA on 10/11/22 at 5:25pm revealed: -She took care of all the residents; she knew which residents were incontinent and needed assistance. -She started work at 3:00pm; she had not been in Resident #7's room to check on him today, 10/11/22. -She had assisted Resident #7 with incontinent care earlier in the week during second shift. Interview with the RCC on 10/11/22 at 5:25pm revealed: -According to resident #7's family member, he was bedbound and required total care. -Resident #7 did not have a wheelchair or a walker. -Resident #7 was verbally and physically abusive to staff when he was first admitted. -Resident #7 refused care when he was first admitted. -Resident #7 did not allow staff to cut off his hospital bracelet. -Resident #7 did not want to wear clothes and preferred to be naked. -She had put an adult incontinent brief on Resident #7 that morning and she checked on him later in the day and Resident #7 still had an adult incontinent brief on. -She guessed Resident #7 did not have an adult incontinence brief on that evening because	D 269	Meeting with staff, staff will use the facility backup w/c when a resident is in need of a wheelchair and do not have one to use or if a resident wheelchair become inoperable to use. Management will work on the resident receiving their own w/c if needed by the resident, however, will continue to use the facility wheelchair until the resident receives their own wheelchair. Upon admission to the facility management will start a 72hr report to monitor new admissions. At the end of the 72 hour report management will meet to discuss the next steps if needed with the resident to ensure the resident is receiving the care they need. During this meeting management will review the admission paper work, 72 hr report, and speak with previous facility or family members concerning the resident status before the resident was admitted to the facility. Management will meet with the doctor to discuss the current status of the resident and the plan moving forward. Meeting with staff concerning starting a 72hr report. Will be monitored by RCC and LPN Administrator.	12/7/22 12/7/22

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Resident #7 was known to remove them.
-The staff should have been checking on him every two hours.
-The PCAs worked together to ensure resident care was being performed.
-The assignment sheet informed the PCAs which hallway they were working, not which resident they would care for on the hallway.
-She expected the PCAs to make rounds and check on residents every 2 hours and provide the needed care to each resident.
-She or the assistant RCC was responsible for entering the ADLs into the computer.

Observation of Resident #7 on 10/12/22 at 8:20am revealed:
-Resident #7 was lying in bed with a sheet over mattress and a cloth chux under his buttocks.
-Resident #7 donned an incontinent brief and a shirt.
-His breakfast plate was seated on his nightstand.
-He had eaten about ¾ of his breakfast meal.

Interview with Resident #7 on 10/12/22 at 8:20am revealed he had eaten all he wanted.

Interview with a PCA on 10/13/22 at 9:31 am revealed:
-She and another PCA were assigned to the AL main hallway.
-She was not assigned to any specific residents; she and the other PCA took care of all the residents on the hall.
-The PCAs worked as a team to meet the needs of the residents.
-Resident #7 refused to be shaved yesterday (10/12/22) on his scheduled shower day.
-She did not attempt to shave him anymore.
-She documented on the ADL log that Resident #7's personal care had been performed each day.

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D 269	Continued From page 25 -She would document on the ADL log what she had done for Resident #3. Interview with another PCA on 10/14/22 at 3:35pm revealed: -She worked in the AL unit assisting residents with personal care such as bathing assistance, grooming, toileting, dressing or changing their adult incontinence briefs. -PCAs were to make rounds every 2 hours every 2 hours, checking on resident safety and to see if they needed any personal care. -Resident #7 would pull off his clothes and take off his adult incontinence briefs. -Resident #7 sometimes wet his bed due to taking off his adult incontinence briefs. -Resident #7 did not like to wear clothes and did not keep his sheet over himself when lying on the bed. -He did not like to get out of bed but sit on the side of his bed or lay down to eat his meals. -Resident #7 needed to be checked on more than every 2 hours to be sure he stayed dry. Interview with a third PCA on 10/14/22 at 3:38pm revealed: -Resident #7 did not have adult incontinent briefs; the PCAs had to borrow adult incontinence briefs from other residents.. -She told the medication aide (MA) Resident #7 wanted to get out of bed and out of his room. -Third shift staff did not have access to the supply room which contained adult incontinent briefs, depends, and chux. -The PCAs did the best she could on 3rd shift providing personal care with limited supplies. Interview with a fourth PCA on 10/14/22 at 4:23pm revealed: -She worked on the AL side and was assigned to	D 269	Lock removed from incontinent supply room keypad placed on door so it's accessible for nursing staff when needed. Staff have code to keypad and access to incontinent supplies when needed for the residents. Management will reach out to incontinent supply company to ensure all Medicaid residents have incontinent supplies and management will reach out to family of private pay residents to supply incontinent supplies.	11/16/22

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Resident #7's hall.
-All residents were checked on every 2 hours each shift for safety and personal care.
-Resident #7 was a heavy wetter and usually needed an adult incontinent brief change when she made her first round on the shift.
-The first shift staff should always check Resident #7 to be sure he was dry before second shift came to work.
-Resident #7 was routinely changed at 7:00pm after he had eaten dinner around 6:00pm.
-Sometimes Resident #7 was wet before the 7:00pm rounds.
-She would check Resident #7 again before she left at 11:00pm.
-She did not know if staff checked Resident #7 every 2 hours during third shift.

Interview with a MA on 10/17/22 at 6:40am revealed:
-Resident #7 preferred to not wear clothes; he would become combative when staff tried to dress him, cover him or try to assist him to sit or stand.
-If Resident #7 wet his adult incontinent briefs, then take them off and throw them on the floor.
-Resident #7 needed more personal care time to keep him dry and covered than every 2 hours.

Interview with the Assistant Resident Care Coordinator (RCC) on 10/14/22 at 4:20pm revealed:
-There were 2 PCAs assigned to the AL main hallway where Resident #7 resided.
-The PCAs were assigned certain halls to work, but not assigned specific residents to care for.
-The PCAs work together to ensure that residents receive the personal care they needed.
-She did not know why Resident #7 did not receive incontinent care and was not served a

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D 269	Continued From page 27 meal on 10/11/22 until the dinner meal. -The PCAs need to make sure they were checking each resident when making rounds and providing personal care as needed for Resident #7 Interview with the RCC on 10/17/22 at 9:15am revealed: -The facility protocol was for all residents to be observed every 2 hours of the day and night and care given as needed. -Resident #7 required total care from staff. -Resident #7 did not like to wear clothing or his adult incontinent briefs. -Resident #7 needed changing at least three times during the day and through the night. -Resident #7 wet his bed when he did not have on his adult incontinent briefs. -There was no other plan currently in place for personalized care. -On 10/12/22 Resident #7 was found lying in a wet bed just after the morning change of shifts. -Checking Resident #7 every 2 hours was not enough to keep him and his bed dry. -Third shift staff should have checked on Resident #7 and changed him before leaving the facility. -First shift should have checked on him and given him the personal care he needed. Attempted telephone interview with Resident #7's Power of Attorney (POA) on 10/14/22 at 9:56am was unsuccessful.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 270		

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D 270	Continued From page 28 (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 provide supervision according to the resident's assessed needs, care plan, and current symptoms for 2 of 2 sampled residents (#3 and #8) including a resident with history of falls (#3) and a resident who wandered from the facility and law enforcement was notified 8 times from 07/25/22 to 10/08/22 (#8). The findings are: Review of the facility ' s undated policy on a wandering resident revealed: -The Administrator was to be notified of a resident with wandering behaviors. -A resident who was reported to show signs of wandering behavior would be assessed by a healthcare professional at the earliest possible time. -An updated care plan and assessment would be conducted by the facility staff and would indicate the need for supervision. -Staff would provide supervision of residents in accordance with the assessed needs, care plan and current symptoms. -When a resident was determined by the physician to be a wanderer, each exit door for resident use would be equipped with a sounding device that was activated when the door was opened.	D 270	If a resident displays any signs of wandering the resident will be placed on a 15 minute check and the resident doctor and psychiatrist will be notified for possible medication evaluation. If resident continue to display signs of wandering the resident will be issued a 30 day discharge due to the resident safety concern. Administrator will monitor resident and ensure the necessary steps are taken in a situation of a wandering resident. Door alarms operable. New system installed	10/17/22 10/17/22 11/30/22

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D 270	Continued From page 29 -Door alarms should be activated for 24 hours when there was a known wanderer in the facility. -The alarm system was to be checked daily by management to ensure the alarm system was operational. -If the alarm system was inoperable, the facility would plan for supervision of wandering residents. -Residents would receive direct supervision by the staff until alarms were operable. 1. Review of Resident #8 ' s current FL-2 dated 05/12/22 revealed: -Diagnoses included seizure disorder, hypertension, mental retardation, and peptic ulcer disease. -He was intermittently confused. -He was a wanderer. -He was ambulatory. Review of Resident #8 ' s signed care plan dated 05/12/22 revealed: -He suffered memory loss from underlying health problems. -He was ambulatory. -He was sometimes disoriented. Review of the facility ' s undated policy for missing persons revealed: -If a resident was missing, the staff was to search the facility and grounds adjacent to the facility as quickly as possible. -If the resident was not located, the Administrator was to be notified. -The Administrator would notify the law enforcement, the Department of Social Services (DSS), and the family. -When the resident returned to the facility, a new assessment would be completed, and the physician notified.	D 270	Maintenance/management will check door alarm system daily to ensure alarms are operable. Wandering resident will be monitored by 15 minute checks. If door alarms are inoperable a wandering resident will be placed with a staff one on one until alarms are operable. RCC will ensure resident is being monitored and maintenance and administrator will monitor to ensure the door alarms are operable.	12/5/22 10/12/22

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-Written documentation would be maintained in the resident ' s record of the missing person incident and a copy sent to DSS.

Review of the facility ' s 15-minute check log revealed:
-There were six columns on the 15-minute check log.
-Three columns had stamped times every 15 minutes for each shift with a column beside each stamped column for staff initials.
-The time staff columns were as follows: 1st shift from 7:00am to 3:00pm, 2nd shift from 3:00pm to 11:00pm and 3rd shift from 11:00am to 7:00am.
-There was a statement at the bottom of the 15-minute check form that read " The facility staff will initial the 15-minute check form indicating that the staff visually saw the resident at the time initials were entered on the document " .

Review of a local law enforcement report dated 07/25/22 revealed:
-Dispatch received a call from facility staff at 7:02pm Resident #8 left the facility property.
-At 7:17pm law enforcement reported Resident #8 was on facility property.

Interview with the RCC on 10/13/22 at 10:50am revealed the facility staff implemented 15-minute checks on Resident #8 on 07/26/22 at 5:45pm.

Review of Resident #8 ' s progress note dated 08/09/22 revealed:
-There was no time documented on the progress note.
-The Primary Care Provider (PCP) and the Mental Health (MH) Provider were notified of Resident #8 wandering from the facility on 08/09/22.
-The MH Provider ordered one-on-one

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supervision for Resident #8.

Review of Resident #8 ' s 15-minute check log dated 08/09/22 revealed there was documentation he was checked on every 15-minutes from 7:00am on 08/09/22to 7:00am on 08/10/22.

Review of a local law enforcement report dated 08/14/22 revealed:
-Dispatch received a call from facility staff at 6:12am that Resident #8 left the facility walking.
-At 6:27am, Resident #2 was picked up by law enforcement about 200 yards east of the facility and returned to the facility.

Review of Resident #8 ' s 15-minute check log dated 08/14/22 revealed there was documentation he was checked on every 15-minutes from 7:00am on 08/14/22 to 7:00am on 08/15/22, including 6:15am.

Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 08/14/22.

Review of Resident #8 ' s progress note dated 08/15/22 revealed:
-There was no time documented on the progress note.
-The MH provider was notified of Resident #8 wandering from the facility on 08/15/22.
-The MH Provider suggested placing Resident #8 in the Special Care Unit (SCU).

Review of Resident #8 ' s 15-minute check log dated 08/15/22 revealed there was documentation he was checked on every 15-minutes from 7:00am on 08/15/22 to 7:00am

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D 270	Continued From page 32 on 08/16/22. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 08/15/22. Review of a local law enforcement report dated 08/19/22 revealed: -Dispatch received a call from facility staff at 10:59am that Resident #8 left the facility walking. -At 11:10am, Resident #8 was picked up by law enforcement and returned to the facility. Review of Resident #8 ' s 15-minute check log dated 08/19/22 revealed there was no 15-minute check log to review. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 08/19/22. Review of a local law enforcement report dated 09/04/22 revealed: -Dispatch received a call from the facility at 1:43pm that Resident #8 was away from the facility and would not return. -At 2:16pm, law enforcement picked up Resident #8 and returned him to the facility. Review of Resident #8 ' s 15-minute check log date 09/04/22 revealed there was no 15-minute check log to review. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 09/04/22. Review of a local law enforcement report dated 09/14/22 revealed:	D 270		

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D 270	Continued From page 33 -Dispatch received a call from the facility at 7:16am that Resident #8 left the facility walking. -Dispatch received a second call at 7:23am from the facility Resident #8 had returned to the facility. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 09/14/22. Review of a local law enforcement report dated 09/17/22 revealed: -Dispatch received a call from the facility at 6:00pm that Resident #8 left the facility. -At 7:20pm, Resident #8 was returned to the facility by law enforcement. Review of Resident #8 ' s 15-minute check log dated 09/17/22 revealed there was documentation he was checked on every 15-minutes from 7:00am on 09/17/22 to 7:00am on 09/18/22, including 6:00pm, 6:15pm, 6:30pm, 6:45pm, 7;00pm and 7:15pm. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 09/17/22. Review of a local law enforcement report dated 09/25/22 revealed: -Dispatch received a call from the facility at 2:00pm that Resident #8 left the facility walking. -At 3:01pm, facility staff picked Resident #8 up and returned him to the facility. Review of Resident #8 ' s 15-minute check log dated 09/25/22 revealed there was documentation he was checked on every 15-minutes from 7:00am on 09/25/22 to 7:00am	D 270		

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D 270	Continued From page 34 on 09/26/22, including 2:00pm, 2:15pm, 2:45pm and 3:00pm. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 09/25/22. Review of a local law enforcement report dated 10/08/22 revealed: -Dispatch received a call from the facility at 5:44am of a missing person. -At 6:00am, Resident #8 was located at the end of the driveway (about 200 yards from the facility) and returned to the facility. Review of Resident #8 ' s 15-minute check log dated 10/08/22 revealed there was documentation he was checked on every 15-minutes from 7:00am on 10/08/22 to 7:00am on 10/09/22, including 5:45pm. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 10/08/22. Review of Resident #8 ' s progress note dated 10/09/22 revealed: -There was no time written for entry. -Resident #8 left the facility. -Law enforcement was called. -Staff picked Resident #8 up and returned him to the facility. -Resident #8 ' s family was notified. Review of Resident #8 ' s 15-minute check log dated 10/09/22 revealed there was documentation he was checked on every 15-minutes from 7:00am on 10/09/22 to 7:00am	D 270		

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D 270	Continued From page 35 on 10/10/22, except at 7:30am, there were no initials documented. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 10/09/22. Review of Resident #8 ' s progress note dated 10/12/22 revealed: -There was no time written for entry. -Resident left the facility. -Staff picked Resident #8 up and returned him to the facility. -Resident #8 ' s family was notified. Review of Resident #8 ' s 15-minute check log dated 10/12/22 revealed there was documentation he was checked on every 15-minutes from 7:00am on 10/12/22 to 7:00am on 10/13/22. Based on observations, record reviews, and interviews there were no interventions implemented to increase supervision for Resident #8 after wandering from the facility on 10/12//22. Review of Resident #8 ' s PCP visit report dated 08/18/22 revealed: -Resident #8 was stable and voiced no complaints. -Resident #8 had mental retardation. -There was no documentation related to supervision related to wandering or safety concerns. Review of Resident #8 ' s PCP visit report dated 09/13/22 revealed: -Resident #8 was stable and voiced no complaints.	D 270		

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D 270	Continued From page 36 -Resident #8 had mental retardation. -There was no documentation related to supervision related to wandering or safety concerns. Review of Resident #8 ' s PCP visit report dated 10/08/22 revealed: -Resident #8 was stable and voiced no complaints. -Resident #8 had mental retardation. -There was no documentation related to supervision related to wandering or safety concerns. Observation on the facility grounds on 10/12/22 at 2:30pm revealed: -Resident #8 and two other residents and a personal care aide (PCA) were standing at the entrance of the facility driveway; Resident #8 was standing in the road and the other two residents and PCA were standing on the side of the road. -The PCA was attempting to lead the residents back to the facility. -Two medication aides (MA) got in the company van, road to end of driveway to pick up the residents. -The residents began walking with the staff member back to the facility. Interview with a PCA on 10/12/22 at 3:10pm revealed: -She saw Resident #8 and two other residents at the end of the driveway; she brought the residents back to the facility. -Resident #8 would leave the facility walking several times a week. -Sometimes staff could not find Resident #8 in the facility, so staff would look for him on the road in front of the facility. -Resident #8 would be found walking on the road;	D 270		

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the staff would pick him up and bring him back to the facility.
-Resident #8 has walked up to 2 miles from the facility.
-The local law enforcement had to be called sometimes to help locate Resident #8 and the law enforcement would bring him back to the facility.
-The staff tried to watch him so he would not leave the facility, but it was difficult to watch him all the time because there was not enough staff.

Observation of the facility grounds on 10/12/22 at 3:45 revealed:
-Resident #8 was ambulating down the driveway toward the road; he was 100 yards from the facility.
-A staff member called to him several times as she was standing in the front of the facility.
-Resident #8 returned to the facility.

Observation of the facility grounds on 10/12/22 at 4:58pm revealed:
-There was a staff member standing at the end of the driveway, looking down the road.
-Two staff members got into the facility van and drove in the direction the staff member at the end of the driveway was looking.
-The van returned to the facility at 5:05pm with Resident #8.

Interview with a second PCA on 10/12/22 at 5:00pm revealed:
-Resident #8 would leave the facility frequently; the staff would go get him or someone who saw him walking would pick him up and bring him back to the facility.
-Two staff personnel left on the facility vehicle on 10/12/22 at 5:00pm to go get Resident #8 because he had left the facility.
-Resident #8 was supposed to be on 15-minute

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checks, but there was no certain PCA assigned to watch him to see where he was every 15-minutes.

Interview with a MA on 10/12/22 at 5:10pm revealed:
-Resident #8 wandered from the facility many times.
-Resident #8 could not be located at the facility at 4:45pm so she walked to the end of the driveway to look for Resident #8; she saw Resident #8 walking up the road.
-She and another MA picked up Resident #8 in the facility vehicle on 10/12/22 at5:00pm.
-Resident #8 walked to the top of the hill, which was about a half a mile away.
-She did not know how often Resident #8 wandered from the facility.

Interviews with a second MA on 10/12/22 at 5:15pm and 5:31pm revealed:
-She and another MA picked up Resident #8 on 10/12/22 at 5:00pm because he had left the facility walking.
-Resident #8 was picked up about a half a mile from the facility.
-Resident #8 verbalized that he wanted to go home.
-She did not know how often Resident #8 wandered from the facility.
-She was not aware Resident #8 had one-on-one supervision.
-She had not been informed that Resident #8 required one-on-one supervision.
-She did not assign a PCA to Resident #8 for one-on-one supervision.
-No one told her to assign a PCA to Resident #8 for one-on-one supervision.

Interviews with the Resident Care Coordinator

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(RCC) on 10/12/22 at 5:00pm and 5:20pm revealed:
-Two MAs left to pick up Resident #8 because the resident left the facility walking.
-Resident #8 was seen about one-half mile from the facility by another staff, who alerted the facility around 5:00pm on 10/12/22.
-Resident #8 currently had one-on-one supervision which was started about 2 weeks ago.
-There should have been a PCA assigned to Resident #8 at the beginning of 2nd shift on 10/12/22.
-She told the second shift MA to assign a PCA to Resident #8 at the beginning of second shift on 10/12/22.
-She took the assignment sheet down to make changes before 2nd sheet came to work; she had not returned the assignment sheet to the assignment board.

Interview with a PCA on 10/14/22 at 8:06am revealed:
-Resident #8 walked to the end of the driveway twice on 10/12/22.
-The staff had to go get Resident #8 and return him to the facility both times.
-The first time, Resident #8 was by himself, but the second time there were two other residents with him.

Interview with the RCC on 10/13/22 at 10:50am revealed:
-Resident #8 wandered from the facility on 07/26/22.
-The facility staff started 15-minute checks on Resident #8 on 07/26/22.
-The 15-minute checks were started because Resident #8 wandered from the facility.
-Resident #8 ' s MH Provider was notified on

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D 270	Continued From page 40 08/19/22 because Resident #8 continued to wander from the facility. -Resident #8 ' s MH Provider ordered a new medication, one-on-one supervision, and instructed the facility to place Resident #8 in the secure care unit (SCU) on 08/19/22. -She verbally notified the staff on 08/19/22 Resident #8 was to have one-to-one supervision 24 hours a day. -She did not assign a one-on-one PCA to Resident #8. -The MAs were to assign a PCA to Resident #8 for one-to-one supervision each shift. -She attempted to schedule additional staff so Resident #8 would have one-on-one supervision but she was not always able to schedule additional staff. -She did expect the staff to check Resident #8 every 15-minutes if there was no one assigned to provide one-on-one supervision. Interview with a MA on 10/14/22 at 11:15am revealed: -She was aware Resident #8 had wandered from the facility. -Resident #8 had wandered from the facility about 20 times since August 2022. -She had been told by third shift staff Resident #8 had left the facility at night. -She knew local law enforcement had brought Resident #8 back to the facility once and a first shift staff member had picked Resident #8 up on the side of the road and brought him back to the facility on their way to work another time. -The MH provider ordered a medication to help keep Resident #8 calm. -The front door was to be locked, but the resident knew how to release the lock mechanism on the front door. -Resident #8 was on 15-minute checks since July	D 270		

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2022; she was not aware of one-on-one supervision for Resident #8.
-She had not been instructed by management to assign a PCA one-on-one with Resident #8; she had been instructed to " keep an eye on him " .
-She had never assigned a PCA to provide one-one-one supervision with Resident #8.
-There were no additional staff scheduled to assign one-on-one supervision for Resident #8.
-If Resident #8 had a one-on-one PCA, the PCA would be with him all the time for 24 hours a day.

Telephone interview with a deputy with the local law enforcement on 10/17/22 at 9:24am revealed:
-He had been to the facility four times in the past month.
-He had picked up Resident #8 at a location close to town, which was about 2 miles from the facility.
-Another time, he had followed Resident #8 back to the facility as Resident #8 walked about 0.2 miles along the road.
-About a week ago, Resident #8 was on the highway, and he transported Resident #8 back to the facility.
-He was off one day several weeks ago and passed Resident #8 on the road and called it in to dispatch.

Interview with Resident #8 ' s family member on 10/17/22 at 12:27pm revealed:
-She had been notified three times previously of Resident #8 wandering from the facility; she did not recall the dates.
-She was notified on Saturday, 10/08/22, by the facility staff Resident #8 had wandered from the facility; she received a second call that Resident #8 was picked up by a deputy and returned to the facility
-She was notified by a neighbor on Sunday, 10/09/22, resident #8 had wandered from the

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facility.
-The neighbor picked up Resident #8 on the road and returned him to the facility.
-The facility did not notify her of Resident #8 wandering from the facility on 10/09/22.
-She called DSS on Monday, 10/10/22, to discuss Resident #8 ' s safety concerns with the Adult Home Specialist (AHS).
-The AHS did not have any reports of Resident #8 wandering.
-She was not aware the law enforcement had picked Resident #8 multiple times.
-She would like to be notified each time Resident #8 wandered from the facility.

Interview with a neighbor of Resident #8 ' s family on 10/17/22 at 12:45pm revealed:
-Resident #8 was found walking along the edge of the road on Sunday, 10/09/22 around 1:00pm; he was unsteady.
-Vehicles traveling in the direction of Resident #8 would have to stop until there was no oncoming traffic, then swerve into the oncoming traffic lane to pass Resident #8.
-Resident #8 was about one-half mile from the facility.
-He recognized Resident #8 as his neighbor ' s family member.
-He stopped, placed Resident #8 in his car, and returned Resident #8 to the facility.
-The facility was unaware Resident #8 was not in the facility.

Telephone interview with the AHS from the local DSS on 10/17/22 at 11:27am revealed:
-DSS received a phone call on 10/10/22 from Resident #8 ' s family member and was informed Resident #8 wandered from the facility on Saturday, 10/08/22, law enforcement picked up Resident #8, and returned him to the facility.

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D 270	Continued From page 43 -The family member said Resident #8 eloped on Sunday, 10/09/22, and a neighbor had picked Resident #8 up on side of the road and returned him to the facility. -She notified the Administrator on 10/11/22 that she had been made aware of Resident #8 wandering from the facility on 10/08/22 and 10/09/22 by Resident #8 ' s family member. -The Administrator verbalized he was not aware of Resident #8 wandering from the facility on 10/08/22 and 10/09/22; he had not been notified by the staff. -She was not aware Resident #8 had been wandering from the facility since July 2022. -She was not aware law enforcement had been called and involved in looking for Resident #8 and taking him back to the facility multiple times. Interview with the Assistant RCC on 10/14/22 at 4:26pm revealed: -She was aware Resident #8 wandered from the facility. -The PCAs and MAs should document on Resident #8 ' s progress notes each time he wandered from the facility. -She was not aware the staff did not document on Resident #8 ' s progress notes each time the resident wandered from the facility. -The RCC was responsible for ensuring the staff were documenting in Resident #8 ' s record each time he wandered from the facility. -Resident #8 was assigned one-on-one supervision with a PCA when the facility was fully staffed. -When the facility was short-staffed, there was not a PCA available for one-on-one supervision. -There had been times since mid-August 2022 that Resident #8 did not have one-on-one because of callouts. -When there was no PCA available for	D 270		

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one-on-one supervision, the PCAs would check on Resident #8 every 15 minutes.
-The RCC or MA working should ensure that Resident #8 was assigned a one-on-one PCA.
-Resident #8 had wandered from the facility or attempted to wander from the facility every day since mid-July 2022.
-Resident #8 ' s MH Provider ordered 15 minutes checks and a new medication in July 2022; she did not know when one-on-one supervision began.
-She knew law enforcement had been notified on occasions when Resident #8 had wandered from the facility and their assistance was requested to search for him.
-Resident #8 had walked up to 2 miles from the facility when he was located and was picked up and returned to the facility.
-Resident #8 had been placed on 15-minute checks, then increased to one-on-one supervision for 24 hours a day and a new medication was ordered.

Telephone interview with the RCC on 10/17/22 at 10:42am revealed:
-The PCP, the MH Provider and Resident #8 ' s family member should be notified each time he wandered from the facility.
-She did not know the staff were documenting on the 15-minute check logs verifying Resident #8 was in the facility when he had wandered from the facility.
-One-on-one supervision was not available at times on all shifts due to staffing issues.
-The staff continued to do 15-minutes checks when one-on-one was not available.
-She may have been notified twice that Resident #8 had wandered from the facility.
-She did not know the staff were not documenting in the resident ' s record each time he wandered

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D 270	Continued From page 45 from the facility. Interview with the Administrator on 10/12/22 at 5:30pm revealed: -Resident #8 had been wandering away from the facility for about 3 months. -The MH Provider ordered medication, 15-minutes checks which were increased to one-on-one supervision two months ago, and to place Resident #8 in a SCU. -The facility ' s SCU was at capacity. -He had contacted several facilities with a SCU, but Resident #8 did not have a qualifying diagnosis for a SCU. -He was looking for a facility that had a keypad lock so Resident #8 would not be able to leave. -He had been looking for a facility for Resident #8 for about 3 weeks. -The staff were performing 15-minutes checks on Resident #8. Interview with the Administrator on 10/17/22 at 9:55am revealed: -Resident #8 was assigned one-on-one supervision since August 2022. -He was not sure how Resident #8 kept wandering away from the facility. -He did not know Resident #8 did not have one-on-one supervision 24 hours a day as ordered. -He expected the staff to watch Resident #8 24 hours a day to prevent Resident #8 from eloping. -He was not aware of any other training for one-on-one training. -The staff were trained on one-on-one supervision the evening of 10/12/22 and were told to remain with the resident all the time; staff were not to leave Resident #8 ' s side. Attempted telephone interview with Resident #8 '	D 270		

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D 270	Continued From page 46 s Mental Health Provider on 10/17/22 at 10:40am was unsuccessful. Attempted telephone interview with Resident #8 ' s Primary Care Provider on 10/17/22 at 10:42 was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. 2. Review of Resident #3 ' s current FL-2 dated 09/27/22 revealed: -Diagnoses included cirrhosis, dementia, hard of hearing and Aspert Syndrome. -He was intermittently confused. -He was semi-ambulatory -He was incontinent of bladder. Review of Resident #3 ' s Resident Register dated 09/16/22 revealed: -Resident #3 was admitted on 09/16/22. -Resident #3 required assistance with bathing, dressing, shaving, nail care, grooming and toileting. -Resident #3 had significant memory loss and must be directed. -Resident #3 required a wheelchair and walker for mobility. Observation of Resident #3 on 10/11/22 at 8:48am revealed: -He was seated in a wheelchair in the Assisted Living (AL) commons area. -He had a dressing on his right and left elbows. Review of Resident #3 ' s hospice record revealed: -Resident #3 was admitted to hospice services on 09/16/22.	D 270		

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D 270	Continued From page 47 -The nurse was to be called when Resident #3 fell. Review of Resident #3 ' s progress note dated 09/18/22 revealed: -There was no time documented. -Resident #3 attempted to sit in his chair and sat in the floor; no injuries noted. -There was a second entry with no time documented. -Resident #3 was ambulating, misjudged the area between his chair and walkway, walked into his chair and fell, causing a skin tear. -There was no documentation the hospice nurse was notified of either incident. -There was no documnetation the PCP was notified of either incident Observation of Resident #3 on 10/11/22 at 6:16pm revealed: -He ambulated without a wheelchair or a walker down the AL hall to the entrance of the Special Care Unit (SCU) without staff assistance or without staff knowledge. -The main common area in the LA was approximately 8 yards from the entrance to the SCU. -The entrance to the SCU was visible from the hallway at the main common area. -Resident #3 ' s wheelchair was parked in the main common area hallway. -There was a medication aide (MA) administering medication at the main common area hallway and was visible from the SCU entrance, where Resident #3 was standing. -Another resident was trying to redirect Resident #3 back down the hallway to the main common area. -The resident was telling Resident #3 he needed to sit down before he fell.	D 270	Falls will be documented on the incident report. Management will follow-up to ensure the doctor was notified about the fall by the MA on shift at the time. The RCC will give the incident report to the Administrator to ensure resident is receiving the care they need to prevent future falls. If resident is a hospice patient the hospice nurse/ doctor will be notified of each fall to consider alternatives to prevent the falls. If not on hospice the RCC and doctor will look into alternatives to prevent resident from falls such as walker, w/c, rollator, alarm, etc.	10/19/22

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D 270	Continued From page 48 -The resident went to the MA and told her about Resident #3; the MA leaned back and saw Resident #3 but continued to work at the medication cart. -A personal care aide (PCA) came out of another resident ' s room and saw Resident #3 at the SCU entrance. -She tried to get Resident #3 to walk to the main common area with her, but he started to lean forward while walking. -She told Resident #3 to stand in the hallway against the wall while she retrieved his wheelchair. -She had Resident #3 sit in the wheelchair and she took him back to the main common area. Interview with a MA on 10/11/22 at 10:05am revealed: -Resident #3 would stand and attempt to ambulate himself. -He was unable to ambulate independently due to bilateral amputation of toes and generalized weakness. -Resident #3 fell about one week ago; he obtained skin tears on both arms. -Resident #3 had fallen about 5 times since his admission on 09/16/22. -Resident #3 would sit in the common area so the facility staff could watch him closer; if he tried to get up the facility staff would see him and re-direct him. Observation of Resident #3 on 10/12/22 at 8:30 am revealed: -He was seated in his wheelchair in the AL common area. -He had a dark purple area under his right eye. -There was a PCA present in the common area with 15 residents.	D 270		

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D 270	Continued From page 49 Interview with a MA on 10/12/22 at 10:38am revealed: -Third shift reported Resident #3 fell this morning, 10/12/22; she did not know the details of the fall. -Resident #3 fell several times a week because he would try to stand from his wheelchair and walk by himself. -Resident #3 required assistance with ambulating because he was unsteady. -A PCA would sit in the common area with the residents to supervise Resident #3 and any other residents who were in the common area. -There could be as many as 15 to 20 residents in the common area at one time. -The PCA could not sit in the common area at the time because she had to provide personal care to resident at times. -The staff knew to watch Resident #3 closely because he tried to get up and walk by himself. Observation of Resident #3 on 10/12/22 at 11:03am revealed: -He was in the common area standing in front of his wheelchair. -A MA entered the common area and saw Resident #3 standing in front of his wheelchair. -She attempted to get him to sit down in his wheelchair, but he refused. -The MA asked a PCA to ambulate Resident #3 down the hallway. -The PCA ambulated Resident #3 about 25 feet down the hallway and back to his wheelchair. Review of Resident 3 ' s incident reports revealed there were no incident reports to review. Interview with a second MA on 10/12/22 at 2:38pm revealed: -Resident #3 had fallen multiple times while trying to stand from his wheelchair and ambulate.	D 270		

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D 270	Continued From page 50 -She called the hospice agency, the RCC and the family when Resident #3 fell. -She was informed by the RCC to do 15-minute checks on Resident #3 today, 10/12/22. Interview with a PCA on 10/13/22 at 9:44am revealed: -Resident #3 had fallen about four times on 1st shift since he was admitted about a month ago. -She thought Resident #3 had fallen about 5 to 6 times on 2nd and 3rd shift. -Resident #3 was on 2-hour checks; 2-hour checks were documented. -The RCC instructed the PCAs to check on Resident #3 every 15 minutes on 10/12/22; this was the first time she had been instructed to do 15-minute checks on Resident #3. -She did not document that Resident #3 was checked every 15 minutes. Telephone interview with Resident #3 ' s hospice nurse on 10/14/22 at 9:18am revealed: -Resident #3 was admitted to hospice services on 09/16/22. -Resident #3 received a nursing visit twice a week and more if needed and notified by the facility staff. -The hospice agency was to be notified for any changes in Resident #3. -The hospice agency was notified of Resident #3 falling on 09/19/22 and for two falls on 10/12/22. -The hospice agency had not been notified Resident #3 had any additional falls. -Resident #3 was a falls risk; the hospice staff would go over falls risks protocol with a staff member with each nursing visit. -The staff was to notify the hospice agency each time Resident #3 fell. -The hospice agency ordered a geri-chair, and a bed and chair alarm on 10/13/22, after being	D 270	Geri chair delivered to facility for resident. RCC will monitor resident to ensure no falls. No tray is being used with geri chair and resident is doing well. RCC will contiue to monitor daily and moving forward with other residents if needed.	11/4/22

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D 270	Continued From page 51 notified of the falls on 10/12/22. Interview with the Assistant Resident Care Coordinator (RCC) on 10/14/22 at 4:26pm revealed: -She was aware Resident #3 had fallen but did not know how many times he had fallen since admission. -She had been called on 09/24/22 regarding Resident #3 falling; she was called because she was on call. -She instructed the MA to call hospice and let them know Resident #3 had fallen. -She had been notified of a fall on 09/24/22. -She spoke with the RCC on 10/13/22 and asked her to call Hospice regarding Resident #3 ' s multiple falls and to ask for assistance due to his two falls on 10/12/22. -The staff was notified today, 10/13/22, that hospice was ordering a geri-chair, and a bed and chair alarm due to the multiple falls. -Resident #3 had been placed on 15-minute checks after his first fall; she could not remember when the 15-minute checks started. -She did not know if the PCAs were documenting 15-minute checks on Resident #3. Interview with the RCC on 10/17/22 at 10:43am revealed: -She knew Resident #3 had fallen frequently. -Resident #3 fell twice on 10/12/22. -She called Hospice on 10/13/22 to see what could be done to prevent falls. -She thought she had spoken to hospice before regarding Resident #3 falling; she could not recall when she spoke to them. -She had not discussed a geri-chair and a bed or chair alarm with hospice before 10/13/22. -She thought hospice was being notified each time Resident #3 fell and hospice would put	D 270		

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things in place such as the geri-chair and alarms.
-She did not know hospice was not being notified each time Resident #3 fell.
-She asked the staff to do 15-minute checks on Resident #3; she could not remember when she asked the staff to do 15-minute checks on Resident #3.
-She did not know the staff were not documenting the 15-minutes checks on the 15-minute check log.
-She expected the staff to document on the 15-minute check log that they had checked on him.

Telephone interview with the Administrator on 10/17/22 at 9:55am revealed:
-The staff would re-direct Resident #3 when he would stand up from his wheelchair.
-Resident #3 was ordered a geri-chair, bed and chair alarm on 10/13/22.
-The geri-chair was scheduled for delivery today, 10/17/22; the bed and chair alarm were delivered on Friday, 10/14/22.
-He was not aware of a 15-minute check for Resident #3.
-He would have expected the facility staff to implement 15-minutes checks on a resident who had multiple falls.

Review of Resident #3 ' s 15-minute check logs revealed there were no 15-minutes check logs available for review.

Attempted telephone interview with Resident #3 ' s Primary Care Provider on 10/17/22 at 10:42 was unsuccessful.

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

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D 270	Continued From page 53 The facility failed to provide supervision in accordance with each resident ' s assessed needs, care plan, and current symptoms for a resident with a diagnosis of mental retardation who wandered from the facility at least 10 times since 07/25/22, as far as 2 miles from the facility which required the assistance of law enforcement 8 times to retrieve and return him back to the facility, and a resident who had a history of falls, with three falls in two days, resulting in skin tears. The facility ' s failure resulted in in a substantial risk for physical harm and neglect to the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/12/22. Correction date for the Type A2 violation shall not exceed November 9th, 2022.	D 270	Temporary door alarms in place. Permanent door alarms in place. Geri chair in place for resident with history of falls. RCC/Administrator will monitor daily to see if other alternatives should be put in place.	10/17/22 11/30/22 11/4/22
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: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 3 of 3 sampled residents (#1, #2 and #5) related to two residents who refused medications without notifying the physician (#1 and #2); a resident who had elevated blood sugar readings and the physician was not notified (#2); and a resident who refused to wear oxygen and did not have a nebulizer machine for treatments (#5).	D 273		

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D 273	Continued From page 54 The findings are: 1. Review of Resident #2's current FL-2 dated 7/12/22 revealed diagnoses included left middle cerebral artery stroke with severe aphasia, hyperglycemia, diabetes mellitus type 2 with neuropathy and chronic kidney disease stage IV. a. Review of Resident #2's signed physician orders dated 07/19/22 revealed: -There was an order to check Resident #2's fingerstick blood sugar (FSBS) four times daily at 6:00am, 12:00pm, 4:00pm and 8:00pm. -There was an order to notify the Primary Care Provider (PCP) for FSBS reading greater than 400. Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks four times a day with a scheduled time of 6:00am, 12:00pm, 4:00pm and 8:00pm. -There were 25 of 93 documented FSBS readings ranging between 401 to 479 -There was no documentation that the PCP had been notified of the elevated FSBS readings. Review of Resident #2's September 2022 eMAR revealed: -There was an entry for FSBS checks four times a day with a scheduled time of 6:00am, 12:00pm, 4:00pm and 8:00pm. -There were 17 of 69 documented FSBS readings ranging between 402 to 495. -There was no documentation that the PCP had been notified of the elevated FSBS readings. Review of Resident #2's October 2022 eMAR	D 273	PCP was notified, visit with resident during PCP next facility visit. RCC/Administrator will continue to monitor daily. Training on diabetes completed with staff by RN.	10/19/22 11/22/22

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from 10/01/22 to 10/11/22 revealed:
-There was an entry FSBS checks four times a day with a scheduled time of 6:00am, 12:00pm, 4:00pm and 8:00pm.
-There were 2 of 24 documented FSBS readings ranging between 420 to 450.
-There was no documentation that the PCP had been notified of the elevated FSBS readings.

Review of Resident #2's progress notes on 10/12/22 revealed there was no documentation from the staff that Resident #2's PCP had been notified of FSBS readings greater than 400.

Review of Resident #2's laboratory report dated 01/13/22 revealed an A1C of 8.4 (WHAT IS AIC)

Interview with a medication (MA) on 10/12/22 at 10:38am revealed:
-She called Resident #2's FSBS readings greater than 400 to Resident #2's PCP.
-She would document in the eMAR the notification of the PCP, and any new orders given over the phone.
-She would write a telephone order and place the order in the PCP's folder for the PCP to sign on his next visit.
-The signed order would be filed in Resident #2's record after the PCP signed; any MA or manager could file the orders in Resident #2's record.
-She did not realize there was no documentation in the eMAR of the PCP being notified of FSBS readings greater than 400.
-She thought she had documented the notifying the PCP of FSBS readings greater than 400 in the eMAR.

Interview with another MA on 10/13/22 at 2:38pm revealed:
-She would contact the PCP for elevated FSBS

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readings of 400 or greater.
-She would document on Resident #2's progress notes when she notified the PCP.
-She had notified Resident #2's PCP of elevated FSBS readings greater than 400.
-She thought she had documented on Resident #2's progress note, when she notified the PCP of FSBS readings greater than 400.

Interview with the Resident Care Coordinator (RCC) on 10/14/22 at 5:15pm revealed:
-Resident #2's PCP should be called each time Resident #2's FSBS reading was greater than 400.
-Resident #2 had an order to call his PCP for FSBS readings greater than 400 to obtain an order for insulin administration.
-The MAs should document on the eMAR Resident #2's PCP was notified and write a telephone order for any new insulin orders.

Telephone interview with the Administrator on 10/14/22 at 1:23pm revealed:
-The MAs should notify the PCP of FSBS readings greater than 400.
-The notification of the elevated FSBS readings should be documented in the eMAR and on Resident #2's progress notes.
-He was not aware Resident #2 had elevated FSBS readings greater than 400 and the PCP had not been notified.
-He expected the MAs to notify the PCP of elevated FSBS reading greater than 400 and the MAs document the notification in Resident #2's progress notes.

Telephone interview with Resident #2's PCP on 10/12/22 at 11:45am revealed:
-He did not recall being notified of elevated FSBS readings greater than 400.

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D 273	Continued From page 57 -The facility staff should be notifying him for FSBS readings greater than 400. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. b. Review of Resident #2's current FL-2 dated 07/12/22 revealed there was an order for sertraline (used to treat depression) 100mg at bedtime. Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for sertraline 100mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation Resident #2 refused sertraline 25 of 31 opportunities. Review of Resident #2's September 2022 eMAR revealed: -There was an entry for sertraline 100mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation Resident #2 refused sertraline 22 of 30 opportunities. Review of Resident #2's October 2022 eMAR from 10/01/22 to 10/10/22 revealed: -There was an entry for sertraline 100mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation Resident #2 refused sertraline 6 of 10 opportunities. c. Review of Resident #2's current FL-2 dated 07/12/22 revealed there was an order for calcium acetate (used to treat elevated phosphate levels	D 273		

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D 273	Continued From page 58 in the blood) 667mg 2 capsules three times daily before meals. Review of Residents signed physician orders dated 09/19/22 revealed an order for calcium acetate 667mg 3 capsules three times a day before meals. Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for calcium acetate 667mg 2 capsules three times daily before meals with a scheduled administration time of 6:00am, 11:00am and 4:00pm. -There was documentation Resident #2 refused calcium acetate 43 of 93 opportunities. Review of Resident #2's September 2022 eMAR revealed: -There was an entry for calcium acetate 667mg 2 capsule three times daily before meals with a scheduled administration time of 6:00am, 11:00am and 4:00pm from 09/01/22 to 09/20/22. -There was documentation Resident #2 refused calcium acetate 26 times out of 60 opportunities. -There was a second entry for calcium acetate 667mg three capsules 3 times daily before meals with a scheduled administration time of 6:00am, 11:00am and 4:00pm from 09/21/22 to 09/30/22. -There was documentation Resident #2 refused calcium acetate 19 of 30 opportunities. Review of Resident #2's October 2022 eMAR from 10/01/22 to 10/10/22 revealed: -There was an entry for calcium acetate 667mg three capsules 3 times daily before meals with a scheduled administration time of 6:00am, 11:00am and 4:00pm. -There was documentation Resident #2 refused	D 273		

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D 273	Continued From page 59 calcium acetate 15 of 30 opportunities. Review of resident refusal of medications form 10/13/22 revealed: -There was no date indicating which day Resident #2 refused the medication. -Resident #2 refused Fiber Therapy Powder and Creon 36,000. -The PCP signed the form as acknowledgement on 06/04/22. -There was no other resident refusal of medications form available for review. Interview with a medication aide (MA) on 10/12/22 at 10:38am revealed: -Resident #2 refused his medication most of the time. -Resident #2 would take his medications from some MAs, and he would not take his medications from other MAs. -If Resident #2 refused his medication in the morning on dialysis days, she did not offer the medications a second time because he left for dialysis. -She offered Resident #2 his medications a second time on non-dialysis days if he refused the first time. -She did not recall notifying Resident #2's Primary Care Provider (PCP) Resident #2 had refused his medications. Interview with a MA on 10/13/22 at 2:38pm revealed: -She attempted to administer Resident #2 his medications three times before documenting refusal of administration of the medications. -She documented on the eMAR the refusal of all medications. -The MA should document on Resident #2's	D 273	PCP notified of resident refusals, resident seen by PCP on next facility visit. RCC will monitor residents daily to ensure PCP is notified when needed concerning refusals. The facility will document residents refusals on refusal form. RCC/Adm will notify PCP of refusals and will present the refusal form to the PCP during his facility visit. RCC will monitor refusals daily.	10/14/22 11/30/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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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progress notes when medications were refused three days in a row.
-She knew Resident #2 had refused his medications multiple times.
-She was not aware the MAs were not documenting refusals in Resident #2's progress notes.
-The MAs used to document the refusals on a piece of paper and give to the Resident Care Coordinator (RCC), but we have not done that in 6 months.
-The RCC was responsible for notifying the PCP regarding residents refusing their medications.

Telephone interview with Resident #2's PCP on 10/12/22 at 11:45am revealed:
-The staff documented a list of medications that were refused and placed the list in his folder.
-He reviewed the list of medications refused by Resident #2, signed the form as acknowledgement, and returned the signed form to the RCC.
-He could not recall when he was notified or what medications Resident #2 had refused; he did recall reviewing refusal forms and signing them.
-He would like to be notified when Resident #2 refused his medication 3 times.

Interview with the RCC on 10/13/22 at 10:10am revealed:
-The MAs should offer the medication to Resident #2.
-If Resident #2 refused to take his medication, the MA should offer the medication a second time.
-Resident #2 should be offered his medication three times before the MA documented a refusal on the eMAR.
-The MA would document on a piece of paper the resident's name and what medications were refused and place in her box outside her office

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D 273	Continued From page 61 door. -She would place the refusal of medications list in the PCP's folder for him to review and sign that he was notified. -She did not place these signed notifications of refusal to take medications in Resident #2's record; she kept a file in her office. -The PCP was notified each time the residents had three refusals. -She was responsible for documenting in the resident's record when the PCP was notified for the refusal to take medications. -She was not aware Resident #2 refused his medications. -She was not aware there was no documentation in the resident's record regarding refusal to take medications. -She expected to be notified when the residents were refusing their medication. Telephone interview with the Administrator on 10/14/22 at 1:23pm revealed: -When a resident refused 3 medications the PCP should be notified. The MA should document in the resident's progress note when the PCP had been notified of refused medications. -He was not aware Resident #2 had refused his medications and the PCP had not been notified. -He expected the MAs to notify the PCP and document the notification in Resident #2's progress notes for 3 consecutive refused medications. 2. Review of Resident #5's current FL-2 dated 08/18/22 revealed diagnoses included blindness in both eyes, history of carotid stenosis and closed fracture of the left femur.	D 273		

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D 273	Continued From page 62 Review of Resident #5's hospital after-visit hospital report dated 07/19/22 revealed diagnoses included hypertension, and cerebrovascular accident. a. Review of Resident #5's hospital discharge report dated 10/08/22 revealed: -Resident #5 was transported to the hospital for shortness of breath. -There was an order for 2 liters of continuous oxygen. Observation of Resident #5 on 10/11/22 at 4:54pm revealed; -She was seated on her bed and did not have her oxygen on. -There was an oxygen concentrator and a portable oxygen tank in the room. Observation of Resident #5 on 10/13/22 at 10:19am revealed she was standing in the common area she was not wearing her oxygen and did not have her portable oxygen tank . Observation of Resident #5 on 10/14/22 from 8:16am to 8:59am revealed: -Resident #5 was in the common area without her oxygen tank. -Resident #5 spoke to the medication aide (MA) without her oxygen on. -The MA did not ask Resident #5 about her oxygen. Telephone interview with the physician from the local hospital on 10/13/22 at 3:43pm revealed: -Resident #5 was transported to the local emergency department (ED) for shortness of breath and hypoxia. -Resident #5 was a long-term smoker and had	D 273		

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D 273	Continued From page 63 undiagnosed chronic obstructive pulmonary disease (COPD). -He ordered Resident #5 2 liters per minute (2LPM) continuous oxygen to improve her oxygen saturation. -Resident #5's resting oxygen saturation was 83 to 84 percent; he wanted to improve the percentage as much as possible. -Resident #5 would not appear to have shortness of breath or even appear to breathe hard because her lungs were already damaged from smoke and accustomed to the lower oxygen levels. -Resident #5 had a mood disorder and would not be compliant and would need constant reminders to wear her oxygen. -He expected the facility staff to follow the order for Resident #5's 2LPM of oxygen continuously. -Resident #5 could experience low oxygen saturation without her oxygen and experience shortness of breath and hypoxia again. Interview with Resident #5 on 10/11/22 at 4:54pm revealed: -She did not want to put on her oxygen. -She did not need the oxygen all the time. -Sometimes she would wear the oxygen at night while she slept. -She felt fine and did not need the oxygen to breath. Telephone interview with Resident #5's family member on 10/14/22 at 4:00pm revealed: -On 10/11/22, she had asked the medication aide (MA) about the oxygen and why it was in Resident #5's room. -The MA said she did not know why Resident #5 had oxygen in her room. -The MA did not know if Resident #5 was supposed to wear the oxygen or when she was supposed to wear it.	D 273	If a resident is refusing to wear oxygen the PCP will be notified and staff will document. RCC/Administrator will monitor daily.	11/30/22

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D 273	Continued From page 64 Telephone interview with personal care aide (PCA) on 10/14/22 at 11:32am revealed: -She did not know Resident #5 was supposed to be on oxygen all the time; no one had ever told her. -She had seen the oxygen concentrator and the tank in Resident #5's room, but she had never seen Resident #5 use oxygen. Interview with a MA on 10/13/22 at 10:25am and 2:26pm revealed: -She knew Resident #5 had an order for oxygen; she had to look it up on the eMAR to see the order. -She knew Resident #5 had an oxygen concentrator and oxygen tank in her room. -Resident #5 did not wear her oxygen when she left her room. -Resident #5 wore her oxygen when she was in her room. -She had reminded Resident #5 on Tuesday, 10/11/22, to put her oxygen on when she saw her in her room without it. -Resident #5 smoked a lot and did not wear her oxygen out of her room because she could not wear it while smoking. -Resident #5 would come inside after smoking and not have her oxygen on and sit in the common area. -Resident #5 did not refuse to put her oxygen on and would wear it when she reminded her to put it on. -She had let the Resident Care Coordinator (RCC) know on 10/11/22 that Resident #5 was not wearing her oxygen. -The RCC said she would talk to the family about it; the RCC did not give her any other instructions. -No one said anything about notifying the PCP.	D 273		

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D 273	Continued From page 65 Interview with the RCC on 10/14/22 at 10:14am revealed: -The oxygen was delivered on 10/10/22 by the oxygen supply provider. -The MA had called the supply company on 10/13/22 and requested a cart to put the oxygen in so Resident #5 could move around the facility with the portable oxygen tank. -She had called on 10/11/22 to request the cart for the tank. -There was a shoulder bag for small oxygen bottles that Resident #5 could use when she left her room. -She knew Resident #5 did not wear her oxygen as ordered when outside of her room. -Resident #5 refused to use her oxygen outside of her room because she smoked and would not put it on once she returned from the smoking area. -Resident #5 used her oxygen when she was in her room; she had seen her with her oxygen on in her room on Tuesday, 10/11/22 and yesterday 10/13/22. -The PCAs and the MAs were supposed to redirect Resident #5 when they noticed she did not have her oxygen on. -Refusals were supposed to be documented on the eMAR and then a note would be placed in the folder for the primary care provider (PCP). -The PCP was at the facility once a week on Tuesdays. -The PCP was not contacted via telephone call, only with the notes about refusals. -Any refusals were written on a note for the RCC to address the following day. Interview with the Assistant RCC on 10/14/22 at 5:06pm revealed: -Resident #5 had an order for two liters of continuous oxygen that started after she returned	D 273		

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from the hospital on 10/08/22.
-She had entered the order for the continuous 2 liters of oxygen for Resident #5 into the eMAR.
-Residence #5 was not compliant and would refuse to wear her oxygen; she had to constantly be reminded after she returned from smoking to apply her oxygen.
-Resident #5 would go out to smoke and come back without her oxygen; she had never seen Resident #5 wearing her oxygen outside of her room.
-The MA on each shift was responsible for checking on Resident #5's oxygen and documenting on the eMAR.
-Resident #5 had portable oxygen tanks and a cart; she also had oxygen bags with small bottles she could use but she refused to use them.
-Resident #5 would wear her oxygen when she was in her room that is why it was documented as administered on the eMAR.

Telephone interview with the Administrator on 10/17/22 at 12:25pm revealed:
-He was not familiar with an order for oxygen for Resident #5.
-He was told one day last week by the RCC that Resident #5 was not wearing her oxygen as ordered.
-The MAs and the RCC were responsible for notifying the PCP when Resident #5 refused to wear her oxygen; he did not know if it was documented anywhere.
-He expected the staff to notify the PCP as soon as Resident #5 refused to wear the oxygen.

b. Review of Resident #5's hospital discharge report dated 10/08/22 revealed there was an order for ipratropium bromide-albuterol sulfate (used to treat air flow blockage) 0.5mg-3mg/3ml inhalation every 12 hours.

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D 273	Continued From page 67 Observation of Resident #5's room on 10/11/22 at 4:54pm revealed there was no nebulizer machine in the room for Resident #5 to use. Observation of Resident #5 on 10/14/22 at 8:16am revealed: -Resident #5 was in the common area; the medication aide (MA) administered her medication. -The MA did not ask Resident #5 about her nebulizer or offer to administer it. Telephone interview with the physician from the local hospital on 10/13/22 at 3:43pm revealed: -Resident #5 was transported to the local emergency department (ED) for shortness of breath and hypoxia. -Resident #5 was a long-term smoker and had undiagnosed chronic obstructive pulmonary disease (COPD). -He had ordered the nebulizer treatments for treatment of COPD to help her breathe. -The treatments were ordered twice daily because she would be more comfortable after her nebulizer treatments. -The treatments were ordered twice daily to start but after she saw her primary care provider (PCP), she could reduce the treatments to as needed. -If she did not receive the breathing treatment with the nebulizer, she could experience discomfort when breathing and distress and would need to use her rescue inhaler and possibly end up in the ED again. Interview with Resident #5 on 10/14/22 at 12:21am revealed: -She did not have a nebulizer machine; she had not had one in her room.	D 273	Nebulizer machine received and stored for access to MA. RCC will monitor to ensure nebulizer machines are in place daily.	11/4/22

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D 273	Continued From page 68 -She knew what a nebulizer machine was because she had used one at the hospital before. -She had not had a nebulizer treatment since she had been admitted to the facility a couple of months ago. Telephone interview with Resident #5's family member on 10/14/22 at 4:00pm revealed: -She had not seen a nebulizer machine in Resident #5's room when she had visited on 10/11/22 and 10/14/22. -Resident #5 knew what a nebulizer machine was because she had used one before. Telephone interview with personal care aide (PCA) on 10/14/22 at 11:32am revealed: -She did not know Resident #5 used a nebulizer machine. -She had not seen a nebulizer machine in Resident #5's room. -She had never seen Resident #5 using a nebulizer machine. Interview with a medication aide (MA) on 10/13/22 at 10:25am and 2:26pm revealed: -Resident #5 had a nebulizer machine in her room on Monday, 10/10/22; she had seen it on her night stand. -Resident #5's nebulizer machine was delivered by the pharmacy after Resident #5 returned from the hospital on 10/08/22. -She faxed the orders for the nebulizer machine and the medications to the pharmacy when Resident #5 returned from the hospital. -She did not know where it went to; Resident #5 must have moved it to her closet. -The albuterol vials were in the medication room; she was not sure when they came in. -She did not realize the medication vials for the nebulizer had come in until earlier that day,	D 273	Residents nebulizer machines are stored in the supply room in separate containers with their names labeled on the container. RCC will monitor to ensure nebulizer machine is in place daily.	11/30/22

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D 273	Continued From page 69 10/13/22. -She had mistakenly documented Resident #5 had refused the nebulizer treatments on the eMAR; she should have documented "medication not in from pharmacy". Interview with the RCC on 10/14/22 at 10:14am revealed: -Nebulizers were ordered from the medical supply provider, sometimes they were ordered through the pharmacy, but it depended on the resident's insurance. -She was not aware Resident #5 had an order for a nebulizer machine to be used twice daily. -She had reviewed the orders, but she had missed them in the hospital return notes. -The MAs were responsible for reviewing the hospital return notes for any new orders. -The MA would have ordered the nebulizer machine for Resident #5. -After the MAs reviewed the orders, they placed them in her box for her to review and place into the resident's record. -Resident #5 should have had a nebulizer machine in the facility for her to use. -Resident #5 should not have gone this long without the machine. -She would call the medical supply provider and find out what happened to the nebulizer machine. -If the machine was ordered and delivered and could not be found in the facility, then she should have been notified by the MAs. -The staff would have to look in every room and in closets; another resident could have taken it out of Resident #5's room. Second interview with the RCC on 10/14/22 at 3:42pm revealed: -The medical supply provider had delivered the nebulizer on 10/10/22, the ma had seen they	D 273		

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D 273	Continued From page 70 nebulizer on Resident #5's night stand after it was delivered. -She could not find the nebulizer when she went to look for it in Resident #5's room. -She thought maybe another resident had picked it up and taken it to their room; he was going to search for the nebulizer in other residence rooms. -She had tried to contact the medical supply company to see if she could get a second nebulizer machine delivered for Resident #5 on 10/14/22, but they were closed. Interview with the Assistant RCC on 10/14/22 at 5:06pm revealed: -She did not know Resident #5 had an order for a nebulizer machine. -The hospital usually ordered nebulizers machines when the resident was discharged from the hospital. -She did not know if a nebulizer machine had been delivered to the facility. -Staff had to sign a delivery slip for the nebulizer machine and the slip should have been saved by the staff. -She did not know if Resident #5 used her nebulizer machine because she did not know if it was in the facility. Telephone interview with the Administrator on 10/17/22 at 12:25pm revealed: -He was not aware Resident #5 did not have a nebulizer machine for her treatments. -The RCC was responsible for ordering needed medical equipment for the residents. -The nebulizer machine should have been ordered for Resident #5 as soon as the RCC received the order from the physician. -The RCC should have faxed the order to the medical supply provider for the nebulizer machine.	D 273	Nebulizer machine received and in place. RCC/Administrator will monitor daily. Residents nebulizer machines are stored in the supply room in separate containers with their names labeled on the container. RCC will monitor for compliance of nebulizer machine daily.	11/4/22 12/8/22

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D 273	Continued From page 71 -He was not sure how long delivery would take from the medical supply provider. Attempted telephone interview with a representatibe from the medical supply provider on 10/14/22 at 3:52pm was unsuccessful. 3. Review of Resident #1's current FL-2 dated 07/19/22 revealed: -Diagnoses included schizophrenia, chronic hypothyroidism, hypertension, and lymphedema. -There was an order for amlodipine (used to treat high blood pressure) 10mg once daily. -There was an order for atorvastatin (used to treat high cholesterol) 10mg once daily. -There was an order for levothyroxine (used to treat an enlarged thyroid) 50mcg once daily. Review of Resident #1's physician's order dated 09/15/22 revealed an order for diclofenac (used to treat inflammation) 75mg twice daily. Review of Resident #1's physician's orders dated 09/16/22 revealed there was an order for tramadol (used to treat pain) 50mg twice daily. Review of Resident #1's electronic medication administration record (eMAR) for August 2022 revealed: -There was an entry for amlodipine 10mg once daily scheduled at 8:00am. -There was an entry for levothyroxine 50mcg once daily scheduled at 8:00am. -There was documentation levothyroxine and amlodipine were refused 24 times from 08/01/22 to 08/31/22. Review of Resident #1's eMAR for September 2022 revealed: -There was an entry for amlodipine 10mg once	D 273		

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daily scheduled at 8:00am.
-There was an entry for atorvastatin 10mg once daily scheduled at 8:00am.
-There was an entry for levothyroxine 50mcg once daily scheduled at 8:00am.
-There was documentation amlodipine, atrovastatin, and levothyroxine were refused 24 times from 09/01/22 to 09/30/22.
-There was an entry for diclofenac 75mcg twice daily scheduled at 8:00am and 8:00pm.
-There was documentation diclofenac was refused 15 times from 09/15/22 to 09/30/22.
-There was an entry for tramadol 50mg every 12 hours scheduled at 8:00am and 8:00pm.
-There was documentation on the entry the tramadol was refused on 09/16/22 at 8:00am.
-There was a second entry for tramadol 50mg every 12 hours scheduled at 8:00am and 8:00pm.
-There was documentation on the second entry the tramadol was refused 13 times from 09/20/22 to 09/30/22.

Review of Resident #1's eMAR for 10/01/22 to 10/11/22 revealed:
-There was an entry for amlodipine 10mg once daily scheduled at 8:00am.
-There was an entry for atorvastatin 10mg once daily scheduled at 8:00am.
-There was an entry for levothyroxine 50mcg once daily scheduled at 8:00am.
-There was documentation Resident #1's amlodipine, atorvastatin and levothyroxine was refused 10 times from 10/01/22 to 10/11/22.
-There was an entry for diclofenac 75mcg twice daily scheduled at 8:00am and 8:00pm.
-There was documentation diclofenac was refused 18 times from 10/01/22 to 10/11/22.
-There was an entry for tramadol 50mg every 12 hours scheduled at 8:00am and 8:00pm.
-There was documentation tramadol 50mg was

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D 273	Continued From page 73 refused 18 out of 21 opportunities from 10/01/22 to 10/11/22. Review of Resident #5's after-visit reports from the primary care provider (PCP) from 07/19/22 to 10/08/22 revealed there was no documentation of Resident #5 refusing medication. Interview with Resident #1 on 10/12/22 at 11:42am revealed: -She refused to take amlodipine because years ago she had problems with fluid retention related to amlodipine, so she stopped taking it. -She refused to take her atorvastatin because she was told her cholesterol was only 21 points above the "normal level". -She refused to take her levothyroxine because she had an allergic reaction to it; she did not recall what the reaction was to the levothyroxine. -She also did not need to take levothyroxine after she had surgery on her thyroid; the surgery was "years ago". -She stopped taking diclofenac because it "affected her"; she experienced numbness in her legs after she took it. -She did not know what happened when she took tramadol other than it "affected her" so she could not take it. Interview with a medication aide (MA) on 10/11/22 at 3:38pm revealed Resident #1 refused her medications because she said she did not need them anymore or she was allergic to them. Interview with a second MA on 10/13/22 at 2:26pm revealed: -Resident #1 would refuse her medications because she said she was allergic to them. -She would pop the medications from the medication card and offer it to the resident.	D 273	MA will document refusals on refusal form. PCP will be notified. PCP will review refusal form during facility visits. RCC/ADM will monitor refusals daily.	11/30/22

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D 273	Continued From page 74 -If the resident refused, she would leave and come back in a few minutes and offer the medication again. -She would dispose of the medication when it was refused. -She would attempt to administer the medication three times before she would document a refusal. -Refusals were documented on the eMAR. -If Resident #1 refused her medication three days in a row she would document the refusals in the progress notes in Resident #1's record. -She would notify the Resident Care Coordinator (RCC) if a resident refused their medication three days in a row or all their medications in one medication pass. Telephone interview with a third MA on 10/14/22 at 11:32am revealed: -Resident #1 constantly refused her medications. -She would ask Resident #1 if she wanted to take her medication prior removing it from the bubble pack. -Resident #1 refused her medication so often she did not want to waste tablets which was why she did not remove the tablets from the bubble pack prior to attempting to administer then them. -The MAs knew Resident #1 refused her medication on a regular basis. -She had notified the RCC when Resident #1 began to refuse her medication soon after she was admitted. -The RCC instructed her to continue to attempt to administer Resident #1 her medication. -She did not know if the PCP had been notified about Resident #1's refusals of medication. Interview with the Assistant RCC on 10/14/22 at 5:43pm revealed: -Resident #1 refused her medications most of the time.	D 273		

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D 273	Continued From page 75 -The MAs removed all the medication from the card and placed then in a medication cup to give to Resident #1. -Resident #1 would pick through the medication cup and take the medications that she wanted. -The remainder of the tablets should have been discarded by the MA. -The MA should have only documented the refusal after they attempted to administer Resident #1 her medication. - Resident #1 had the right to refuse her medication. -There had been multiple conversations with Resident #1's PCP about her consistently refusing her medications. -There was nothing documented in her record about the conversations with the PCP; only the documentation of their refusals on the eMAR. -Resident #1 had multiple medications discontinued when she was first admitted to the facility due to refusals. -The PCP did not discontinue the current medications because he wanted her to continue to take them and sometimes Resident #1 would take them. Interview with the RCC on 10/14/22 at 10:14am revealed: -The staff did not notify the PCP about Resident #1's refusals to take medications because he knew about them from "day one". -She heard Resident #1 tell the PCP she was not going to take her medications as ordered. -The PCP documented the conversation in his visit notes when he had his first initial visit with Resident #1. -The PCP told Resident #1 she could find another PCP if she wanted but she decided to keep the current PCP.	D 273		

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D 273	Continued From page 76 Telephone interview with the Administrator on 10/17/22 at 12:44pm revealed: -When a resident refused medications for two days, the PCP was notified. -The notification to the PCP was to be logged in the resident's record. -The PCP would make the decision at the next visit to the facility if he wanted to change or discontinue the medication. -If the PCP gave instructions via telephone, the instructions were to be carried out and documented on the eMAR and the resident's record. -The MAs and the RCC could notify the PCP about medication refusals.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#2), regarding rechecking a blood sugar 15 minutes after experiencing a blood sugar reading between 40 - 80. Review of Resident #2's current FL-2 dated 7/12/22 revealed diagnoses included left middle cerebral artery stroke with severe aphasia,	D 276		

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D 276	Continued From page 77 hyperglycemia, diabetes mellitus type 2 with neuropathy and chronic kidney disease stage IV. Review of Resident #2's signed physician orders dated 07/19/22 revealed: -There was an order to check Resident #2's fingerstick blood sugar (FSBS) four times daily at 6:00am, 12:00pm, 4:00pm and 8:00pm. -There was an order to administer 8 ounces of orange juice and recheck FSBS in 15 minutes for a FSBS readings between 40-60. -The was an order to administer 4 ounces of orange juice and recheck FSBS in 15 minutes for the FSBS readings between 60-80. Review of Resident #3's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks four times a day with a scheduled time of 6:00am, 12:00pm, 4:00pm and 8:00pm. -The was an entry to administer 4 ounces of orange juice and recheck FSBS in 15 minutes for a FSBS readings between 60-80. -On 08/04/22 at 4:00pm there was documentation of a FSBS reading of 69; there was no documentation of administration of 4oz of orange juice or documentation the FSBS was rechecked in 15 minutes. -On 08/13/22 at 4:00pm there was documentation of a FSBS reading of 72; there was no documentation of administration of 4oz of orange juice or documentation the FSBS was rechecked in 15 minutes. -On 08/23/22 at 12:00pm there was documentation of a FSBS reading of 76; there was no documentation of administration of orange juice or documentation the FSBS was rechecked within 15 minutes.	D 276	When a resident is seeing a endocrinologist the RCC/Administrator will ensure no other orders for fsbs, insulin, or other orders to monitor the resident blood sugars interfere with the endocrinologist orders. The endocrinologist orders for the resident fsbs will only be followed for the resident fsbs. Any concerns with resident fsbs being too high or too low will be notified by the resident endocrinologist. RCC will monitor daily. Any resident that is being followed to monitor the resident diagnosis of diabetes will have a protocol in place for further directions on what to do if fsbs is too high or too low. Protocol will identify what is too high or too low for that particular resident. When orange juice is give to assist with increase the fsbs it will be documented in QuickMar or the resident chart along with the recheck amount. RCC will monitor daily.	10/19/22 10/19/22

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D 276	Continued From page 78 Review of Resident #3's September 2022 eMAR revealed: -There was an entry for FSBS checks four times a day with a scheduled time of 6:00am, 12:00pm, 4:00pm and 8:00pm. -There was an entry to administer 8 ounces of orange juice and recheck FSBS in 15 minutes for a FSBS readings between 40-60. -The was an entry to administer 4 ounces of orange juice and recheck FSBS in 15 minutes for a FSBS readings between 60-80. -On 09/14/22 at 8:00am there was documentation of a FSBS reading of 45; there was no documentation of administration of 8oz orange juice or documentation the FSBS was rechecked within 15 minutes -On 09/15/22 at 4:00pm there was documentation of a FSBS reading of 55; there was no documentation of administration of 8oz orange juice or documentation the FSBS was rechecked within 15 minutes. -On 09/25/22 at 8:00pm there was documentation of a FSBS reading of 73; there was no documentation of administration of 4oz of orange juice and or documentation the FSBS was rechecked within 15 minutes. -On 09/26/22 at 8:00am there was documentation of a FSBS reading of 78; there was no documentation of administration of 4oz of orange juice or documentation the FSBS was rechecked within 15 minutes. Interview with a MA on 1012/22 at 10:38am revealed: -When Resident #2's FSBS reading dropped below 80, the MA should administer orange juice and re-check Resident #2's FSBS in 30 minutes. -The MA should document the recheck of the FSBS in the eMAR. -She documented the FSBS reading and the	D 276		

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D 276	Continued From page 79	D 276		

rechecked FSBS reading in the resident's record.
-She thought the order to recheck the FSBS was 30 minutes; she did not realize it was 15 minutes.
-She thought she had documented in the electronic record Resident #2's blood sugar reading when it was rechecked.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 10/12/22 at 11:45am revealed he expected the facility staff to follow orders as written when Resident #2 had a blood glucose reading below 80.

Interview with the Assistant Resident Care Coordinator (RCC) on 10/14/22 at 4:20pm revealed:
-Resident #2 was to be given orange juice and have his FSBS rechecked in 15 minutes after consuming the orange juice with blood sugar readings below 80.
-The MAs should follow the orders for a low blood glucose reading and document what actions were taken.

Interview with the RCC on 10/13/22 at 10:10am revealed:
-Resident # 2 had orders from his PCP to treat blood glucose readings below 80.
-She did not audit the eMARs or progress notes to see if the MAs followed the orders as written and documented the results.
-She expected the MA to follow the orders as written.

Telephone interview with the Administrator on 10/14/22 at 1:23pm revealed:
-He was unaware that the MAs were not rechecking Resident #2's FSBS within 15 minutes after the FSBS reading was less than 80 and documenting the recheck in the electronic record.

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D 276	Continued From page 80 -He expected the MAs to administer orange juice and recheck Resident #2's blood sugar as ordered after a low FSBS reading.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews and record reviews, the facility failed to ensure the kitchen and food storage areas including the floors and walls, refrigerators/freezer, dishwasher, oven, fryer, storage areas, plating area and dining room were kept clean, orderly and free of contamination. The findings are: Review of the county Food Establishment Inspection Report dated 07/01/22 revealed: - There was a demerit for having debris below equipment that needed to be cleaned. -There was dirty, stained towel lying next to an open box of bananas beside the food prep table. -The score of the review on 07/01/22 was 92.5 (7.5 demerits). Observation of the kitchen on 10/13/22 at 8:46am revealed: -There were dark brown and yellow stains on the	D 282	Deep cleaning schedule started, will complete deep cleaning weekly moving forward. Administrator will monitor the deep cleaning of dietary weekly.	10/19/22

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D 282	Continued From page 81 walls throughout the room. =There were brown stains and white paint spots on the linoleum in the room. -There was a build-up of black and brown particles in the corners of the room. -There was a broom and dustpan against the wall just inside the kitchen door, there were particles of food on the floor around the broom. -There was a gray stained mop bucket with mop, two-thirds full of gray water, positioned next to the left wall. -There was a 24" wind fan with dust on the blades standing on the floor next to the double refrigerator and across from the food plating counter. -There was a build-up of gray dust particles on the lower vent slats of the refrigerator. -There was a dirty stained towel placed on a food cart beside an open box of bananas. -There was a build-up of small dried chunks of food in the food drain below the dishwasher. -There was a build-up of yellow and brown food particles on the dishwasher and on the floor below the dishwasher. -There was a tray of spoons on the cart above tubs of liquid cleaning products. -There was an open full industrial trash can beside the food plating counter. -There was a build-up of a brown greasy substance coating the stove grates, the outside of the stove, the fryer beside the stove and the large back splash of the stove. -The fryer grills were coated with a yellow-black sticky substance. -The shelves of the food plating counter and sheet pan storage were coated with a brown sticky substance. There were dark brown and yellow stains on the walls in the storage room -There were brown stains and white paint spots	D 282	Corrected. Administrator will monitor weekly. Corrected. Administrator will monitor weekly. Corrected. Administrator will monitor daily. Corrected. Administrator will monitor daily. Removed. Administrator will monitor daily. Corrected. Administrator will monitor weekly. Corrected. Administrator will monitor daily. Corrected. Administrator will monitor daily. Corrected. Administrator will monitor daily. Corrected. Administrator will monitor daily. Replaced. Administrator will monitor daily. Corrected. Administrator will monitor weekly. Corrected. Administrator will monitor weekly. Corrected. Administrator will monitor weekly. Corrected. Administrator will monitor weekly.	10/19/22 10/19/22 10/19/22 10/19/22 10/19/22 10/19/22 10/14/22 10/14/22 10/14/22 10/19/22 10/21/22 10/19/22 10/19/22 10/19/22 10/19/22

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D 282	Continued From page 82 on the linoleum in the storage room. -There was a build-up of black and brown particles in the corners of the storage room. -There was a build-up of a brown rust colored substance below the cartons of liquid whole eggs in the refrigerator of the storage room. -There was a coating of brown dust particles on the covering of the wall air conditioner. -There was a large torn bag of charcoal turned over onto the floor in the storage room. -There were white food particles and yellow stains on the floor of the double freezer containing packages of frozen chicken. Observation of the dietary storage room on 10/13/22 at 9:18am revealed: -There was a notice that read "Attention all Dietary Staff" dated 08/12/22 taped to the refrigerator. -Directions for staff were to check a kitchen notebook for daily cleaning duties. Interview with a dietary aide (DA) on 10/12/22 at 10:45am revealed: -There was no schedule for cleaning the kitchen, there was only the Dietary Manager (DM) and herself to cook and clean. -The kitchen needed a thorough cleaning and some appliances needed replacing. -The kitchen floor was swept and mopped each day. -The floor needed replacing; there were stains that would never come out. Interview with a second DA on 10/13/22 at 9:27am revealed:. -There were only 2 dietary staff to cook and clean. -The Administrator posted a cleaning schedule about 2 to 3 months ago.	D 282	Corrected. Administrator will monitor weekly. Corrected. Administrator will monitor daily. Corrected. Administrator will monitor weekly. Corrected. Administrator will monitor daily. Corrected. Administrator will monitor daily.	11/2/22 10/19/22 10/19/22 10/19/22 10/19/22

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D 282	Continued From page 83 -The dietary staff used a spray detergent to clean the grease on all hard surfaces, but it was not very effective. -The kitchen never had a good deep cleaning or steam cleaning. -She could not remember the last time the kitchen had a thorough cleaning. -The flooring and some of the carts needed to be replaced. -There needed to be more staff to be available to clean and to clean more often. Interview with the DM on 10/13/22 at 10:22am revealed: -The kitchen was swept and mopped every day by the DAs. -He and another staff alternated days of being cook for all the residents' meals. -He was not sure what a deep cleaning was, and the kitchen never had a steam cleaning to remove grease and built-up dirt. -He swept and mopped every evening and wiped off the stove and fryer. -He did not remember when staff tried to remove the grease from the counter and oven surfaces. Interview with the Administrator on 10/13/22 at 10:45am revealed: -He oversaw the dietary department. -The whole kitchen needed a full remodeling with new appliances. -it would need a strong steam cleaning to remove the grease and grime. -Staff needed training on how to store foods correctly to ensure there was no contamination. -There was a need to have more staff to keep the kitchen clean. -He did not routinely make a tour of the kitchen and storage areas; the DM would let him know if there were any concerns.	D 282		

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D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide table service utensils consisting of at least a knife, fork, and spoon used to assist the residents in eating their meals. The findings are: Review of the posted dietary menu for the lunch meal on 10/11/22 at 11:45am revealed residents were to be served salmon patties with lemon dill sauce, creamy coleslaw, potato wedges, wheat dinner roll with margarine, and spiced fruit cup, and chocolate pudding with milk, coffee and tea beverages. 1. Observation of the AL dining room on 10/11/22 at 11:50am revealed: -A staff was laying place settings on the dining room tables. -The place settings consisted of one napkin, one table spoon or soup spoon, and one fork per	D 287		

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D 287	Continued From page 85 resident. -There were no knives placed at any of the residents ' tables for the residents to use to cut their meat or potato wedges. Observation of the lunch meal for the AL on 10/11/22 from 12:15pm to 12:50pm revealed: -Some residents used a fork to pick at their salmon patty to break it apart to eat. -Some residents picked up their salmon patty with their hands and took bites of the patty to eat it. -Some residents used their fork to pick at their potato wedge to break it apart or held the potato wedge in their hands to break it into smaller pieces to eat. -No dietary staff asked if a resident wanted a knife to cut their salmon patty or potato wedges to make it easier to eat their meal. Interview with a resident on 10/11/22 at 12:25pm revealed: -Residents were not given knives to use at meals. -Staff did not include knives when they made the place settings at the tables. -About six months ago, they were given knives to use at meals and some residents would take the knives back to their rooms to keep. -No knives were bought to replace the ones taken out of the kitchen and knives were no longer placed on the tables at meals. -Staff did not offer residents knives to use at meals. -He requested to have a knife to use at a meal about 2 weeks ago and was told there were no knives in the kitchen for residents to use at mealtime. Interview with a second resident on 10/12/22 at 8:50am revealed: -He liked to help set the utensils on the tables for	D 287	Knives were ordered to offer to residents during mealtimes. Administrator will monitor weekly.	10/13/22

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the residents ' meals.
-He was told by the previous Resident Care Coordinator (RCC) how to place the napkins, forks, and spoons.
-Knives were not to be placed at the tables.
-They did not have enough knives to give to the residents.
-If a resident wanted to use a knife, they would have to ask for one.
-No staff would ask a resident if they needed or wanted a knife to use.
-Some residents and the RCC had a meeting some months ago about the use of knives at meals.
-Only 5 residents said they wanted a knife to use at meals.
-Since then, no knives were placed on the tables at mealtimes.
-If a resident had difficulty cutting their meat or other food, they would need to ask for a knife to use.

Interview with the dietary manager (DM) on 10/13/22 at 9:45am revealed:
-Knives had been taken from the dining room a couple of months ago; an order was made to replace them.
-Currently there were 5 to 6 knives available for residents to use at meals; the census was 74.
-No resident asked for a knife to use at meals.
-If a resident wanted a knife to use for their meal, they needed to ask for one.

Interview with the Administrator on 10/12/22 at 10:00am revealed:
-The place settings for meals in the AL did not include knives.
-He did not know why knives were not a part of the residents' place setting or why staff was not asking residents if they wanted or needed a knife

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to cut their food.
-He was not told by dietary staff there were not enough knives for the residents to use to cut their food at their meals.
-He would order enough knives for the residents to have to use for their meals.

Attempted telephone interview with the previous RCC on 10/12/22 at 9:00am was unsuccessful.
2. Observation of the lunch meal service in the Special Care Unit (SCU) on 10/11/22 at 12:30pm revealed:
-There were 18 residents in the dining room; the tables were not preset for the meal.
-Each resident was served their plate of food and was given a spoon and a napkin.
-The residents were served a chopped fried fish patty, diced potatoes, coleslaw and chocolate pudding.

Observation of the lunch meal service in the SCU on 10/12/22 at 12:26pm revealed:
-There were 19 residents in the dining room; the tables were not preset for the meal.
-An enclosed food cart with the platted food was delivered to the SCU by a dietary aide.
-The personal care aides (PCA) served the plated food and beverages.
-There was a bin of soup spoons on the food cart; there were no forks or knives on the cart.
the PCAs gave each one of the residents a soup spoon and no other silverware.

Interview with two PCAs on 10/12/22 at 12:26pm revealed:
-The residents in the SCU did not get a knife with their meals because their food was always chopped from the kitchen.
-The residents in the SCU did not always get a fork with their meals.

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D 287	Continued From page 88 -One of the PCAs thought the residents had forks at the breakfast meal that day, 10/12/22. -The second PCA could not remember the last time the residents in the SCU had a fork to eat with. -The kitchen sent the silverware on the food cart and they gave the residents what was on the cart to eat with. Interview with the medication aide (MA) on 10/12/22 at 12:30pm revealed: -She had worked in the SCU for years and the residents never had a knife to use. -The residents in the SCU did not need a knife because all the residents were served a chopped diet. -The residents also had dementia and did not need a knife or a fork because they would get irritated and use the forks and knives as a weapon or throw them. -She had seen a resident try to stick a fork in another resident; it had been years ago, and she could not remember how long ago. -She had also seen a resident in the SCU throw a fork in the dining room; it had been years ago. -She could not say any of the residents would do that now, but they could get irritated. Interview with a dietary aide (DA) on 10/12/22 at 12:53pm revealed: -She usually set up the food delivery cart for the SCU but today it was set up when she came in. -She sent a fork and a spoon for each resident when she set up the delivery cart for the SCU. -She did not check the food delivery cart today, 10/12/22, before she sent it to the SCU, so she did not know it only had spoons on it. -She had never sent knives to the SCU; the previous owner had instructed the kitchen not to send knives to the SCU.	D 287		

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D 287	Continued From page 89 -She was told not to send knives to the SCU because the previous owner was scarred the residents would hurt each other with them. Interview with the Kitchen Manager (KM) on 10/12/22 at 12:35pm revealed: -The DA who delivered the food cart to the SCU put the silverware on the cart. -The resident in the SCU were supposed to have a fork, knife and spoon to eat their meals with. -Staff trained each other on how to set up the food delivery cart and what to put on it. -There was not a list of what to include on the delivery cart. -He did not check the food delivery cart to ensure everything was on it, including a fork and a knife for the residents. -He knew there were forks on the cart for breakfast that morning, 10/12/22 because he saw the DA gathering them to put on the delivery cart. -There were not enough knives for the residents in the SCU to have knives; the Administrator had purchased more knives that day, 10/12/22 so he would send them to the SCU after he had them washed. Interview with the Administrator on 10/17/22 at 11:39am revealed: -He did not know why the residents in the SCU were only given spoons to eat with; there were plenty of forks and knives available. -He was aware the residents in the SCU were only given spoons to eat with about a month ago and he questioned the staff about it; he was told by staff that some of the residents could not have a knife and a fork. -He did not think there were any residents who could not have a fork and a knife in the SCU. -He was aware that the residents in the SCU were required to have a fork, a knife and a spoon	D 287		

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D 287	Continued From page 90 as part of a place setting. -He had purchased enough spoons and knives for the entire facility a few weeks ago. -He had instructed the staff to provide the forks and knives for the SCU residents because it was a dignity issue. -Staff were probably doing it because it was a practice that was continued from the previous Administrator. -He had not had the chance to observe meals in the SCU since he had purchased the forks and knives.	D 287		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure eight ounces of milk was served twice daily to residents in the Assisted Living (AL) and the Special Care Unit (SCU). The findings are:	D 299		

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D 299	Continued From page 91 Review of the resident census dated 10/11/22 revealed: -There were 74 residents. -Twenty residents resided on the special care unit (SCU). Observation of the reach-in refrigerator on 10/11/22 at 10:50am revealed there were 4 full gallons of nonfat milk dated 10/19/22 available for serving to residents. Based on review of the resident census, there would need to be 9.25 gallons of milk available per day to serve 74 residents two, 8-ounce glasses of milk daily. Review of the Cycle II menu for 10/11/22 to 10/13/22 revealed 8 fluid ounces of 2% milk was to be served to residents for breakfast, lunch and dinner. Observation of the lunch meal service on the assisted living (AL) on 10/11/22 at 12:25pm revealed: -Water and lemonade were served to the residents from the beverage cart. -There was no milk on the beverage cart to offer to the residents. -Staff did not ask residents if they would like milk with their meal. -No residents were offered milk to drink with their meal. Observation of the dinner meal service on the AL on 10/11/22 at 5:15pm revealed: -Water and lemonade were served to the residents from the beverage cart. -There was no milk on the beverage cart to offer to the residents. -Staff did not ask residents if they would like milk	D 299	Residents are being offered milk twice daily. Administrator will monitor daily.	10/13/22

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D 299	Continued From page 92 with their meal. -No residents were offered milk to drink with their meal. Observation of the lunch meal service in the Special Care Unit (SCU) on 10/11/22 at 12:30pm revealed: -There were 18 residents in the dining room. -Each resident was served lemonade and water. -Staff did not ask residents if they would like milk with their meal. -No residents were offered milk to drink with their meal. Observation of the lunch meal service in the SCU on 10/12/22 at 12:26pm revealed: -There were 19 residents in the dining room. -Staff did not ask residents if they would like milk with their meal. -No residents were offered milk to drink with their meal. Observation of the reach-in refrigerator on 10/11/22 at 5:35pm revealed: -There were 4 full gallons of nonfat milk on the shelf after the lunch and dinner meals were served. -No resident was served an 8 -ounce glass of milk to drink with their meal. Interview with a resident on 10/11/22 at 12:35pm revealed: -Residents were not served milk to drink at any time except for breakfast when cereal was served. -She did not know why the residents were not served milk except with cereal. Interview with a second resident on 10/12/22 at 7:50am revealed:	D 299		

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-She liked to drink milk with her breakfast and other meals, but milk was only served at breakfast.
-Dietary staff did not offer milk to residents.
-If a resident wanted milk to drink, they would have to ask for it.

Interview with a third resident on 10/12/22 at 8:50am revealed:
-Some residents, who resided on the AL, and the previous Resident Care Coordinator (RCC) had a meeting about a year ago to find out how many residents drank milk.
- Only 5 residents said they wanted milk to drink with their meals.
-After the meeting, milk was only served with breakfast or if a resident asked for milk.

Interview with a personal care aide/dietary aide (PCA) on 10/12/22 at 10:15am revealed:
-The PCA distributed snack foods and beverages in the dining room or took snacks to residents' rooms
-The snacks were usually peanut butter crackers, shortbread cookies or oatmeal cookies.
-The beverage was water unless the resident had their own soda to drink.
-Milk was not served at snack time unless a resident asked a dietary staff for it.
-She picked up the already fixed snack cart in the kitchen and brought it into the dining room to distribute to residents.
-She did not know why milk was not offered to residents at snack time.

Interview with the Dietary Manager (DM) on 10/13/22 at 10:00 am revealed:
-Milk was being wasted serving it at meals as most residents did not want to drink it.
-Milk was being used for cold cereal and to put in

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D 299	Continued From page 94 coffee. -if a resident wanted milk to drink, they would need to ask for it and staff would get it for them. Attempted telephone interview with the previous RCC on 10/13/22 at 10:30am was unsuccessful. Interview with the Administrator on 10/13/22 at 10:45am revealed: -He was not aware of the regulation for facility residents having two 8- ounce glasses of milk per day for each resident. -He was not aware the dietary menu had a recommendation for three 8- ounce glasses of milk per day. -He did not purchase enough milk to offer two 8-ounce glasses of milk per day per resident.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve therapeutic diets as ordered by the physician for 1 of 1 sampled residents (#4), who had an order for a no concentrated sweets diet.	D 310		

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D 310	Continued From page 95 The findings are: Review of Resident #4's current FL-2 dated 11/04/22 revealed diagnoses of included cerebrovascular accident (CVA), hypertension, type II diabetes and chronic dysphagia (trouble swallowing). Review of a signed physician's order for Resident #4 dated 12/03/21 revealed there was an order for a no concentrated sweet diet (NCS). Observation of the posted diet lists on 10/11/22 at 11:50am of the posted residents' diet lists revealed: -There was a Main Hall diet list for residents; Resident #4 's diet was listed as NCS. -There was a Therapeutic diet listing; Resident #4 was listed as NCS. -There was a diabetics residents' listing; Resident #4 was on the list. Observation of the kitchen on 10/11/22 at 12:00pm revealed: -There were no sugar free sweeteners stored in the kitchen for NCS diet beverages. -There were no sugar free foods stored in the kitchen for NCS diet foods. Observation of the lunch meal on 10/11/22 at 12:25pm revealed Resident #4 was served pureed salmon patty, coleslaw and potatoes with sugar-sweetened chocolate pudding to eat and sugar-sweetened lemonade to drink; Resident #4 ate all his meal and drank the 8 oz. glass of lemonade. Review of the dietitian's Cycle II menu for NCS diets revealed Resident #4 was to be served sugar free applesauce (chocolate pudding was	D 310	Dietary staff will serve residents the appropriate diet according to doctor orders. RCC/ Administrator will meet with staff concerning diets and will keep the diet binder in the dietary updated with most current diet order. Anytime there are any changes to a resident diet the updated diet order will be placed in the dietary binder. Administrator and RCC will monitor daily.	10/13/22

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not on the NAS menu) and 8 oz. of skim milk (lemonade with sugar was not on the NCS menu).

Observation of the lunch meal on 10/12/22 at 12:30pm revealed Resident #4 was served pureed beef stir-fry with vegetables on rice, a dinner roll and sugar-sweetened chocolate pudding to eat and sugar-sweetened nectar thickened lemonade to drink; Resident #4 ate all his meal and drank the 8 oz. glass of lemonade.

Review of the dietitian's Cycle II menu for NCS diets revealed Resident #4 was to be served sugar free chocolate pudding and 8 oz. of skim milk (lemonade with sugar was not on the NCS menu).

Attempted interview with Resident #4 on 10/11/22 at 12:50pm was not successful.

Interview with a dietary aide on 10/12/22 at 9:00am revealed:
-She was taught by a co-worker to refer to the Diabetes list when offering residents their meals, beverages and snacks.
-If a resident's name was on that list, they would be given a little less food to eat than the regular diets.
-She did not know about sugared or non-sugared beverages; she would deliver what drinks were placed on the cart to the resident's tables.

Interview with the Dietary Manager (DM) on 10/11/22 at 12:58pm revealed:
-Resident #4 had diabetes and had a NCS diet order.
-Resident #4 had a NCS diet and should not have been served the lemonade with sugar but they had no sugar free lemonade in stock in the

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kitchen.
-Resident #4 should have been given sugar free applesauce instead of the sugar-sweetened chocolate pudding.
-Staff were to go by the dietitian ' s order when plating Resident #4 ' s meals.
-He was the only staff working in the kitchen for the lunch meal and plated all the residents ' meals.
-The assistant Resident Care Coordinator (ARCC) ordered the foods according to the dietary menus.
-The stock of artificial sweetened foods and beverages ran out and they had not yet received the last order from the supplier.
-He had not noticed when the artificial sweetened foods and beverages ran out.
-He would have to send the dietary aide to the grocery store to purchase sugar free foods and beverages.

Attempted interview with Resident #4's Responsible Person on 10/13/22 at 2:42pm was unsuccessful.

Interview with the assistant RCC on 10/12/22 at 9:10am revealed:
-She checked the kitchen's inventory and the menus when ordering supplies weekly.
-The food service provider came every Tuesday making deliveries.
-Sugar-free lemonade and sugar-free pudding were not available on the last delivery.
-Dietary management should have bought the foods needed for Resident #4 ' s NCS diet.
-She did not know why the dietary staff did not ensure Resident #4 received the NCS meal as ordered.

Review of Resident #4's e-MARs finger stick

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blood sugar (FSBS) readings for August 2022, September 2022 and October 2022 revealed:
-The FSBS range for August 2022 was 91-176.
-The FSBS range for September 2022 was 102-169.
-The FCBS range for October 2022 was 115-187.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 10/13/22 at 2:27pm revealed:
-The PCP was not aware Resident #4 was not given the ordered diet of NCS to assist in the management of diabetes.
-Resident #4's disease had been stable on the NCS diet in the past and he wanted it to continue.
-Staff needed teaching on the diabetes disease and what a NCS diet was for.
-Resident #4's last labwork was done on 07/30/22; Resident #4's A1c was 5.5.
-He expected the dietary staff to carry out his orders for the NCS diet for Resident #4.

Interview with the Administrator on 10/12/22 at 11:50am revealed:
-The DM was responsible for preparing and serving the residents' meals according to the menus and physicians' diet orders.
-The assistant RCC was responsible for sending the dietary orders to the food service company.
-There were posted dietary orders in the kitchen for the staff to follow for each resident.
-He was not aware Resident #4's NCS meals were not being served according to the physician's order.
-He was not aware there was no sugar-free pudding or sugar-free lemonade to serve to Resident #4.
-Staff should have gone to the grocery store to purchase what was needed to serve the NCS diet instead of serving the wrong diet to Resident #4.

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	HAL093010	A. BUILDING: _____ B. WING _____	R 10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide daily activities for the residents who resided in the Special Care Unit (SCU) and the Assisted Living (AL). The findings are: 1. Review of the daily activties schedule for the Special Care Unit (SCU) on 10/11/22 revealed: -The was a daily activity list posted on the wall in the main hallway of the SCU. -There were seven activities listed with times and durations posted next to them. -At 9:00am, exercise, stretching, and walking were listed for 30 minutes. -At 10:00am, singing, ball toss, and snack were listed for one hour. -At 11:00am, reminiscing and oldies videos were listed for 30 minutes. -At 2:00pm, folding, hula hoop, ball toss, or parachute were listed for 30 minutes. -At 4:00pm, current events, folding, or manicures were listed for 30 minutes. -At 7:00pm, bible reading, music, or singing were listed for one hour. -At 9:00pm, one on one time with residents that	D 317		

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D 317	Continued From page 100 were up and active which included manicures, easy listening, walking, folding, and hair brushing for one hours. Observation of the SCU on 10/11/22 at 10:30am revealed: -The residents sat in a television room with the television on. -There were 14 to 15 residents in the room at a time. -Some of the residents slept in their seats. -The television was not visible from all the seats in the front part of the room due to a wall. -The lights in the room were on and off throughout the day. -There were two personal care aides (PCAs) who stood in the open doorway. -One resident stood at the entrance gate to the Assisted Living (AL) side of the facility and talked to residents in the AL. Observation of the SCU on 10/12/22 at 10:07am revealed: -There were 15 residents in the television room; five residents were sleeping. -There was music playing on a small radio and the television was on. -The lights to the back part of the room were off. Interview with a resident who resided in the SCU on 10/13/22 at 3:08pm revealed: -There used to be activities but it had been "a while" since any were done. -The staff did not do them anymore. -She liked bible study, exercise, bingo, and having her nails done. -There had not been any activities done in a long time and she missed them. Interview with a PCA on the SCU on 10/12/22 at	D 317	Activity board on the SCU will be removed and updated with a different activity calendar to change activities daily. Administrator will monitor activities daily.	12/9/22

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D 317	Continued From page 101 10:08am revealed: -She and another PCA had painted four residents' fingernails the day before, 10/11/22. -No one had asked them to paint their fingernails she did it because she wanted to do something for the residents. -She asked most of the residents if they wanted their fingernails painted and most of them said no. -A named PCA did exercises with the residents when she worked. Refer to interview with a personal care aide (PCA) on 10/13/22 at 10:43am. Refer to interview with the Resident Care Coordinator (RCC) on 10/14/22 at 9:34am. Refer to the telephone interview with the Administrator on 10/17/22 at 11:39am. 2. Review of the activities schedule posted in the Assisted Living (AL) on 10/11/22 revealed: -On 10/11/22 at 10:00am, snacks were offered until 10:30am and store runs were scheduled from 11:000am to 12:00pm. -Oldies videos was listed without a start time or a duration. -On 10/12/22, ball toss was offered from 9:00am to 10:00am, music was scheduled from 11:00am to 12:00pm. -Bible reading was listed without a start or stop time. Observation of the common area in the Assisted Living (AL) on 10/11/22 at 10:15am revealed there were 17 residents seated in the common area with the television on. Observation of the common area in the AL on	D 317		

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D 317	Continued From page 102 10/12/22 at 11:38am revealed there were 19 residents sitting in the area without staff; the television was on. Interview with a personal care aide (PCA) on 10/14/22 at 11:46am revealed: -She had not seen activities done in a long time. -There was a PCA who did some activities with the residents, but she had stopped doing them for some reason. -Sometimes she would play bingo with the residents because it was better than them just sitting with nothing to do. -The residents liked bingo and would play when she offered it. Interview with a medication aide (MA) on 10/13/22 at 10:37am revealed: -Different staff would play bingo with the residents about three times a week. -The residents in the AL loved to play bingo and win prizes. -There was a PCA who used to do activities, but she had stopped about a month ago. -The residents used to take walks around the yard with the PCA and would do bible study with her until she stopped. -A lot of the residents smoked all day because there was not anything else to do. -The PCA could get residents to participate in activities if there were prizes or food involved. -The transportation staff would take residents to the store and one at a time if they wanted to go out when he ran to the store. -Most of the residents would sit in the main television room and watch television all day. -Residents did not complain to her about being bored. Refer to interview with a personal care aide	D 317		

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D 317	Continued From page 103 (PCA) on 10/13/22 at 10:43am. Refer to interview with the Resident Care Coordinator (RCC) on 10/14/22 at 9:34am. Refer to the telephone interview with the Administrator on 10/17/22 at 11:39am. _____ Interview with a personal care aide (PCA) on 10/13/22 at 10:43am revealed: -She used to do the activities for the facility. -She did not want to do them anymore, so she stopped a month ago. -No one was doing activities since she stopped. -She did activities in the SCU and the AL when she did them. -She did exercises, bible study, and she did one on one with residents who needed them bedside. -About 50 percent of the residents participated in the activities when she conducted them. -Some of the residents told her they missed her doing activities. -The residents told her they were bored without her doing activities. Interview with the Resident Care Coordinator (RCC) on 10/14/22 at 9:34am revealed: -She was the Activities Director as well as the RCC. -She wrote the monthly calendar for the facility. -Activities had not been done that week because she had been "swamped" and did not have time. -She had an Assistant Activities Director, but she had quit sometime in August 2022. -It was a struggle to be the Activities Director and the RCC at the same time. -About thirty residents would participate in the activities when it was something they liked. -The residents loved to play bingo and would play it every day.	D 317		

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D 317	Continued From page 104 -There were a lot of smokers in the facility and they did not leave the smoking area if they were smoking, even to do activities. -There were two residents she did one on one activities with because of behaviors. -Residents were taken in small groups to the store so they could go shopping. -It had been hard to do activities due to staffing shortages; sometimes she would have to work as a medication aide and not be able to do activities. -She was trying to hire an Assistant Activities Director for the facility. Telephone interview with the Administrator on 10/17/22 at 11:39am revealed: -The RCC was responsible for the activity programs and the calendar. -The RCC delegated the activities to staff to conduct. -He did not assist with the activities. -He knew activities included singing, bible study, and manicures. -He did not notice any activities being done with residents the week before. -He saw manicures being done for residents the week before in the SCU. -He also saw bingo with about 20 residents and bible study with about 15 residents in the AL about a week ago. -He felt there was enough activities being done and enough variety. -Residents never complained to him about the lack of activities.	D 317		
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,	D 338		

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D 338	Continued From page 105 Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were treated with dignity and respect including a resident (#9) who had to wear hospital gowns because he did not have a change of clothes to wear while his clothes were being washed. The findings are: Observation of Resident #9 on 10/11/22 at 5:14pm revealed: -He was sitting outside of the main entrance and had on two hospital gowns. -One gown was tied in the back with a second one facing forward that was open in the front. -He had on thick yellow socks with antiskid pads on the bottom. Observation of Resident #9 on 10/12/22 at 4:28pm revealed he was sitting outside of one of the exit doors and was wearing a yellow hospital gown. Observation of Resident #9 on 10/14/22 at 4:00pm revealed he was in his bed in his room and was wearing a hospital gown and yellow antiskid socks. Observation of Resident #9's room on 10/14/22 at 3:59pm revealed: -He did not have an assigned dresser for his clothes. -He had a closet with two t-shirts hanging from hangers. -There was a dirty hospital gown on the floor of the closet.	D 338	Clothes were purchased for the resident to wear. Administrator will monitor clothing of residents daily. When the facility receives an admission and the resident comes without clothing the facility will reach out to POA, guardian, family, etc. to receive clothing for the resident. If there is no success with those contacts the facility will purchase clothing for the resident to wear to get him started until there is assistance with funds to purchase the resident clothing. Administrator will monitor as needed for new admissions.	10/13/22 10/13/22

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D 338	Continued From page 106 -The was a hospital bag with a pair of soiled sweat pants in them on the floor of the closet. Interview with Resident #9 on 10/11/22 at 6:00pm revealed: -He did not have clothes to wear because they were soiled and had to be washed. -He had gone to the hospital a couple of days ago and he wore the hospital gowns back to the facility. -He thought he had been in the hospital gowns for two days. -He was told his clothes were in the laundry to be washed. -He only had one pair of pants and one shirt to wear. Interview with Resident #9 on 10/14/22 at 4:08pm revealed: -He had one pair of pants, one shirt and one sweat shirt to wear. -The staff provided him with a set of clothes yesterday, 10/13/22. -His clothes were being washed so he would have something to wear. -The hospital gave him gowns to wear when he left the hospital. -He did not have any clothes when he was admitted to the facility from the hospital. -He would prefer to wear clothes over the hospital gown; he preferred to wear pants and a shirt. Interview with the Resident Care Coordinator (RCC) on 10/11/22 at 5:45pm revealed: -Resident #9 had one change of clothes. -She told the laundry staff to wash and dry his clothes this afternoon, 10/11/22, because they were dirty. -Resident #9 had gone to the hospital everyday since he had been admitted on 10/06/22.	D 338		

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D 338	Continued From page 107 -He had come back from the hospital with the two hospital gowns. -She tried to find more clothes from the clothes the facility had but they did not have his size. -She was going to speak to the Administrator about getting more clothes for Resident #9. -She did not think Resident #9 had a guardian yet and had no one to call about bringing more clothes for him. Interview with the RCC on 10/14/22 at 4:09pm revealed: -The Administrator had sent a staff to purchase a change of clothes for Resident #9 on 10/12/22. -The facility was attempting to get in touch with his family to purchase clothes for Resident #9. -If the family would not purchase clothes, she thought the facility would provide clothing for him. -It was not acceptable for him to remain in a hospital gown and not have clothes to wear. Telephone interview with the Administrator on 10/17/22 at 11:59am revealed: -Resident #9 was admitted to the facility from the hospital on 10/04/22. -He had a change of clothes when he was admitted from the hospital; he did not recall how many changes of clothes he had. -He knew when he was admitted he was wearing a hospital gown. -The facility had purchased two changes of clothes for him on 10/13/22; two pants and two shirts were purchased. -Resident #9 had multiple hospital gowns from the hospital. -Resident #9 wore the hospital gowns at night; the staff would wash them during the day.	D 338		

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D 344	Continued From page 108	D 344		
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. 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 reviews and interviews, the facility failed to clarify a medication order with the prescribing physician for 1 of 5 sampled residents (#2) for a medication used to lower sugar. The findings are: Review of Resident #2's current FL-2 dated 7/12/22 revealed diagnoses included left middle cerebral artery stroke with severe aphasia, hyperglycemia, diabetes mellitus type 2 with neuropathy and chronic kidney disease stage IV. Review of Resident #2's signed physician orders dated 07/19/22 revealed: -There was an order for FSBS protocol to hold Novolog for fingerstick blood sugar (FSBS) readings 81-184. -There was an order for Sliding Scale Insulin (SSI) to administer 0 units for FSBS 0-250.	D 344	When a resident is seeing a endocrinologist the RCC/Administrator will ensure no other orders for fsbs, insulin, or other orders to monitor the resident blood sugars interfere with the endocrinologist orders. The endocrinologist orders for the resident fsbs will only be followed for the resident fsbs. Any concerns with resident fsbs being too high or too low will be notified by the resident endocrinologist. RCC will monitor daily. Any resident that is being followed to monitor the resident diagnosis of diabetes will have a protocol in place for further directions on what to do if fsbs is too high or too low. Protocol will identify what is too high or too low for that particular resident. When orange juice is give to assist with increase the fsbs it will be documented in QuickMar or the resident chart along with the recheck amount. RCC will monitor daily.	10/14/22 10/14/22

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D 344	Continued From page 109 Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry to hold insulin for FSBS less than 184. -There was no documentation Resident #2's insulin was held due to a FSBS reading less than 184. -There was an entry to give Resident #2 zero units of insulin for FSBS readings between 0 - 250. -There was documentation Resident #2's insulin was not administered 31 of 68 opportunities. Review of Resident #2's August 2022 eMAR revealed: -There was an entry to hold insulin for FSBS less than 184. -There was no documentation Resident #2's insulin was held due to a FSBS reading less than 184. -There was an entry to give Resident #2 zero units of insulin for FSBS readings between 0 - 250. -There was documentation Resident #2's insulin was not administered 28 of 47 opportunities. Review of Resident #2's August 2022 eMAR revealed: -There was an entry to hold insulin for FSBS less than 184. -There was no documentation Resident #2's insulin was held due to a FSBS reading less than 184. -There was an entry to give Resident #2 zero units of insulin for FSBS readings between 0 - 250. -There was documentation Resident #2's insulin was not administered 13 of 19 opportunities.	D 344	When a resident is seeing a endocrinologist the RCC/Administrator will ensure no other orders for fsbs, insulin, or other orders to monitor the resident blood sugars interfere with the endocrinologist orders. The endocrinologist orders for the resident fsbs will only be followed for the resident fsbs. Any concerns with resident fsbs being too high or too low will be notified by the resident endocrinologist. RCC will monitor daily. Any resident that is being followed to monitor the resident diagnosis of diabetes will have a protocol in place for further directions on what to do if fsbs is too high or too low. Protocol will identify what is too high or too low for that particular resident. When orange juice is give to assist with increase the fsbs it will be documented in QuickMar or the resident chart along with the recheck amount. RCC will monitor daily. The resident PCP will be contacted for clarification of orders when needed. The facility will send all fsbs and insulin orders to the pharmacy to be entered into Quickmar. The facility will follow up to ensure there are no duplicate orders of fsbs and insulin. RCC will monitor daily. Training on diabetes with staff completed by RN.	10/14/22 10/14/22 10/14/22 11/22/22

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D 344	Continued From page 110 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/12/22 at 8:58am revealed: -The facility staff would fax the orders to the pharmacy. -The pharmacy entered all orders onto Resident #2's eMAR. -The pharmacy had not noticed there were two entries on the eMAR for FSBS ranges and when to hold Resident #2's insulin. -The pharmacy had not been notified by the facility to remove an entry from Resident #2's eMAR regarding when to hold Resident #2's insulin. Interview with a MA on 10/12/22 at 10:38am revealed: -She knew Resident #2 had a SSI order and received insulin beginning with a blood sugar reading of 251. -If Resident #2 had a blood sugar reading of 250 or less, he did not receive insulin -She had not noticed the order to hold Resident #2's insulin for a blood sugar reading of 184 or less. -She did not know there was a second order to home insulin for blood sugar readings of 184 or less. -She used the SSI to administer Resident #2's insulin; she held Resident #2's insulin if the FSBS reading was 250 or less. Telephone interview with Resident #2's PCP on 10/12/22 at 11:45am revealed: -The facility staff should follow the blood sugar protocol for blood sugar readings. -He was aware of the SSI order for Resident #2, and to hold insulin with FSBS readings of 250 or less.	D 344		

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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 344	Continued From page 111 -He did not realize Resident #2 had another order to hold insulin with FSBS readings of 184 or less. -He had not been notified by the facility staff to clarify Resident #2's hold order for FSBS readings. Interview with the Assistant Resident Care Coordinator (RCC) on 10/14/22 at 4:26am revealed: -She had not noticed there were two different orders of Resident #2's eMAR with two different FSBS reading ranges to hold insulin. -The MAs had not reported there were two different orders of Resident #2's eMAR with two different FSBS reading ranges to hold insulin. Interview with the RCC on 10/13/22 at 10:10am revealed: -She did not realize Resident #2 had two different hold orders for blood sugar readings. -The MAs had not informed her there were conflicting orders for holding insulin for Resident #2. -She would have expected a MA to bring it to her attention so the order could be clarified. Telephone interview with the Administrator on 10/14/22 at 1:23pm revealed: -He was not aware Resident #2 had two orders with different instructions for blood sugar readings. -The MAs should notify the PCP when orders needed to be clarified. -He expected the MAs or RCC to notify the PCP for clarification when there were conflicting orders.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 112 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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 6 sampled residents (#2, #3, #5 and #8), related to a medication for inflammation (#2); a medication for seizures (#3, #8), and an emergency inhaler, a nebulizer treatment, and a medication to for inflammation, (#5). The findings are: 1. Review of Resident #5's current FL-2 dated 08/18/22 revealed diagnoses included blindness in both eyes, history of carotid stenosis, and closed fracture of the left femur. Review of Resident #5's hospital after-visit report dated 07/19/22 revealed diagnoses included hypertension, and cerebrovascular accident. Review of Resident #5's hospital discharge report dated 10/08/22 revealed Resident #5 was transported to the hospital for shortness of breath on 10/06/22. a. Review of Resident #5's hospital discharge	D 358		

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D 358	Continued From page 113 report dated 10/08/22 revealed there was an order for ipratropium bromide-albuterol sulfate (used to treat or prevent symptoms associated with lung disease) 0.5mg-3mg/3ml inhalation every 12 hours. Review of Resident #5's electronic medication administration record (eMAR) for October 2022 revealed: -There was an entry for ipratropium solution albuterol give one vial every twelve hours scheduled at 8:00am and 8:00pm. -There was documentation Resident #5 refused the ipratropium albuterol on 10/11/22. -There was documentation Resident #5 was administered the ipratropium-albuterol 7 of 8 opportunities from 10/10/22 to 10/13/22. Observation of Resident #5's medication on hand on 10/13/22 at 10:24am revealed: -There were six pouches of ipratropium bromide-albuterol sulfate 0.5mg-3mg; each pouch had five 3ml vials. -There were 30 of 30 vials of ipratropium bromide-albuterol sulfate available for administration. Observation of Resident #5's room on 10/11/22 at 4:54pm revealed there was no nebulizer machine in the room for Resident #5 to use. Observation of Resident #5's room on 10/14/22 at 12:21pm revealed there was not a nebulizer in the room. Observation of Resident #5 on 10/14/22 at 8:16am revealed: -Resident #5 was in the common area; the medication aide (MA) administered her medication.	D 358	Nebulizer machine received and stored away for easy access to MA. RCC will monitor daily.	11/4/22

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D 358	Continued From page 114 -The MA did not ask Resident #5 about her nebulizer or offer to administer it. Interview with Resident #5 on 10/14/22 at 12:21pm revealed: -She did not have a nebulizer machine; she had not had one in her room. -She knew what a nebulizer machine was because she had used one at the hospital before. -She had not had a nebulizer treatment since she had been admitted to the facility a couple of months ago. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/12/22 at 4:16pm revealed: -Resident #5 had a current order dated 10/08/22, for ipratropium bromide-albuterol 0.5mg-3mg/3ml inhalation every 12 hours. -Thirty, 3ml-amp vials of ipratropium bromide-albuterol vials were dispensed on 10/08/22; a 15-day supply was dispensed. -The ipratropium bromide-albuterol vials were not on a cycle fill and would need to be ordered by the facility when more were needed. -Ipratropium bromide-albuterol was also known as DuoNeb and was used in a nebulizer for breathing treatments; Resident #5 would need a nebulizer to use the ipratropium bromide-albuterol vials. -Ipratropium bromide-albuterol was used to treat chronic obstructive pulmonary disease (COPD) by opening the airways to the resident could breath. -If Resident #5 was not administered the ipratropium bromide-albuterol in a breathing treatment she could experience exacerbation of her COPD symptoms and have trouble breathing or catching her breath.	D 358		

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D 358	Continued From page 115 Telephone interview with the physician from the hospital on 10/13/22 at 3:43pm revealed: -Resident #5 was evaluated at the local emergency department (ED) for shortness of breath and hypoxia on 10/08/22. -Resident #5 was a long-term smoker and had undiagnosed COPD. -He had ordered the nebulizer treatments to treat her COPD to help her breath. -The treatments were ordered twice daily because she would breathe better and be more comfortable after her nebulizer treatments. -If she did not receive the breathing treatment with the nebulizer, she would experience discomfort when breathing and distress and would need to use her rescue inhaler and possibly end up in the ED again. -He expected the facility to follow the orders he had written. Interview with a medication aide (MA) on 10/13/22 at 10:25am revealed: -Resident #5 had a nebulizer machine in her room. -She did not realize Resident #5's ipratropium bromide vials were in the overstock medication. -Resident #5 refused the nebulizer treatments anyway. -She did not know why there was documentation of administration of the ipratropium bromide treatments on the eMAR, it must have been documented by mistake. Interview with the Resident Care Coordinator (RCC) on 10/14/22 at 10:41am revealed: -She had not seen the order for the ipratropium bromide on Resident #5's hospital discharge report. -She was not aware Resident #5 did not have a nebulizer machine so she could be administered	D 358		

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her ipratropium bromide as ordered.
-The MAs were responsible for ensuring the nebulizer machines were available and medication was administered as ordered.
-If the machine was ordered and could not be found in the facility then she should have been notified by the MAs.
-The staff would have to look in every room and in closets; another resident could have taken it out of Resident #5's room.

Interview with the Assistant RCC on 10/14/22 at 5:06pm revealed:
-She did not know Resident #5 had an order for ipratropium bromide nebulizer treatments.
-She did not know if Resident #5 had a nebulizer machine to administer the ipratropium bromide.
-The MAs should not have documented the medication as administered on the eMAR if they were not administering the treatments.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 10/17/22 at 12:58pm was unsuccessful.

Refer to the interview with a medication aide (MA) on 10/12/22 at 10:38am.

Refer to the interview with a second MA on 10/13/22 on 2:38pm.

Refer to the interview with the Assistant RCC on 10/14/22 at 4:26pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/13/22 at 10:10am.

Refer to the telephone interview with the Administrator on 10/14/22 at 1:23pm.

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D 358	Continued From page 117 b. Review of Resident #5's hospital discharge report dated 10/08/22 revealed there was an order for albuterol sulfate HFA 90mcg actuation aerosol inhaler (used as a rescue inhaler), inhale two puff four times daily as needed for shortness of breath or wheezing. Review of Resident #5's electronic medication administration record (eMAR) for October 2022 revealed: -There was an entry for albuterol HFA inhaler, inhale two puffs four times daily as needed for shortness of breath or wheezing. -There was documentation Resident #5 had used the inhaler from 10/10/22 to 10/13/22. Observation of Resident #5's medication on hand on 10/13/22 at 10:24am revealed there was not an albuterol sulfate HFA 90mcg actuation aerosol inhaler available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/12/22 at 4:16pm revealed: -Resident #5 had a current order dated 10/08/22, for albuterol sulfate HFA 90mcg inhale two puffs four times daily as needed for shortness of breath or wheezing. -One albuterol inhaler was dispensed to the facility on 10/08/22. -The albuterol inhaler was used as an emergency inhaler to open the airways when trying to breath. -If the albuterol inhaler was not available for Resident #5 to use, she would continue to experience shortness of breath. Telephone interview with the physician from the hospital on 10/13/22 at 3:43pm revealed: -Resident #5 was evaluated at the local	D 358	Medication ordered and in the building. RCC/Adm will continue to monitor daily.	10/19/22

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emergency department (ED) for shortness of breath and hypoxia.
-Resident #5 was a long-term smoker and had undiagnosed chronic obstructive pulmonary disease (COPD).
-Resident #5 was ordered a rescue albuterol sulfate inhaler when she experienced shortness of breath or wheezing.
-The inhaler was a back up to her oxygen and nebulizer treatments and a rescue inhaler and would open her airways enough for her to breath comfortably.
-Resident #5 had a mood disorder and could be non-compliant with medical orders so she might need the rescue inhaler.
-He expected the facility to have the inhaler available for administration; without the rescue inhaler, Resident #5 could end up in the ED again.

Interview with Resident #5 on 10/14/22 at 12:21am revealed:
-She knew what an inhaler was; she had used one prior to being admitted to the facility.
-She had not used a rescue inhaler because she had not had shortness of breath or any trouble breathing since she had returned from the hospital on 10/08/22.

Interview with a medication aide (MA) on 10/13/22 at 10:25am revealed:
-Resident #5 did not have an albuterol sulfate inhaler available for administration.
-Resident #5 had not had wheezing or shortness of breath so she had not needed the inhaler.
-She did not know what Resident #5 would do if the rescue inhaler was needed but not available for her to use.
-She would call the pharmacy and request the inhaler be dispensed that day, 10/13/22.

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D 358	Continued From page 119 Interview with the Resident Care Coordinator (RCC) on 10/14/22 at 10:41am revealed: -She had looked for Resident #5's albuterol inhaler herself on 10/13/22 and could not find it. -She did not know if it had been reordered from the pharmacy; she did not know if it could be reordered from the pharmacy. -It was probably in the overstock somewhere and needed to be found. -She expected the inhaler to be available for Resident #5 if she needed it for shortness of breath and to keep her from going back to the hospital. Interview with the Assistant RCC on 10/14/22 at 5:06pm revealed: -She did not know Resident #5 had an order for albuterol sulfate HFA 90mcg actuation aerosol inhaler. -If the pharmacy delivered an albuterol inhaler to the facility for Resident #5 then it should have been put on the medication cart and be available for administration. -She did not know where the inhaler was; it could still be in the overflow medication or on the wrong cart. Attempted telephone interview with Resident #5's primary care provider (PCP) on 10/17/22 at 12:58pm was unsuccessful. Refer to the interview with a medication aide (MA) on 10/12/22 at 10:38am. Refer to the interview with a second MA on 10/13/22 on 2:38pm. Refer to the interview with the Assistant RCC on 10/14/22 at 4:26pm.	D 358		

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D 358	Continued From page 120 Refer to the interview with the Resident Care Coordinator (RCC) on 10/13/22 at 10:10am. Refer to the telephone interview with the Administrator on 10/14/22 at 1:23pm. c. Review of Resident #5's hospital discharge report dated 10/08/22 revealed there was an order for prednisone (used to treat inflammation) 20mg once daily for five days. Review of Resident #5's electronic medication administration record (eMAR) from 10/10/22 to 10/14/22 revealed: -There was an entry for prednisone 20mg once daily for five days scheduled at 8:00am. -There was documentation Resident #5 refused the prednisone on 10/11/22. -There was documentation Resident #5 was administered the prednisone on 10/10/22, 10/12/22 and 10/13/22. -There was documentation on the entry on 10/13/22 the prednisone was discontinued. Observation of Resident #5's medication on hand on 10/13/22 at 10:24am revealed: -There were five tablets of prednisone 20mg dispensed on 10/08/22. -There were three of five prednisone 20mg tablets available for administration. Interview with Resident #5 on 10/14/22 at 12:21am revealed she did not know what medications she took. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/12/22 at 4:16pm revealed: -Resident #5 had an order dated 10/08/22 for	D 358		

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prednisone 20mg once daily for five days.
-There were five tablets of prednisone 20mg dispensed on 10/08/22.
-Prednisone was used to decrease the inflammation in the lungs so there would be more room in the tissues so they could expand more while breathing.
-Resident #5 would need be administered the prednisone for the five consecutive days to effectively reduce the inflammation.
-If Resident #5 was not administered the prednisone as ordered, she could experience exacerbation of shortness of breath.

Telephone interview with the physician from the hospital on 10/13/22 at 3:43pm revealed:
-Resident #5 was evaluated at the local emergency department (ED) for shortness of breath and hypoxia on 10/08/22.
-Resident #5 was a long-term smoker and had undiagnosed chronic obstructive pulmonary disease (COPD).
-He had ordered prednisone for Resident #5 to treat her COPD.
-The prednisone would decrease the inflammation in her lungs and prevent further attacks.
-Resident #5 would need to be administered the prednisone constitutively for five days after leaving the hospital to be affective.

Interview with a medication aide (MA) on 10/13/22 at 10:25am revealed:
-Resident #5 had refused the prednisone once that she knew of, but she did not know why it was discontinued on the eMAR.
-She thought the PCP had discontinued it for some reason.
-There were times when a resident had a medication ordered for a set number of days; the

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D 358	Continued From page 122 eMAR would be set up to discontinue the medication at the end of the length of days. Interview with the Resident Care Coordinator (RCC) on 10/14/22 at 10:41am revealed: -Refusals of prednisone should have been documented on the eMAR. -The amount of prednisone tablets available for administration and the eMAR did not match because; there were extra prednisone tablets available. -On 10/13/22, there should have been two tablets available for administration, not the three that were available. -If there was documentation Resident #5 was administered the prednisone but there were extra tablets available for administration, then Resident #5 was not administered the prednisone as ordered. -There should not have been documentation the prednisone was administered on the eMAR when it was not administered. -She did not know why the prednisone was documented as discontinued before it was due to be finished. Interview with the Assistant RCC on 10/14/22 at 5:06pm revealed: -If there were extra prednisone tablets available for administration, Resident #5 was not administered her prednisone as ordered. -She did not know why the prednisone was discontinued on the eMAR before it was finished being administered. -Sometimes there was an automatic end date for medications that were administered for a limited number of days. -The prednisone should have shown on the eMAR for another day because it was a five-day dose.	D 358		

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D 358	Continued From page 123 -There should not have been documentation of administration of Resident #5's prednisone on the eMAR if it was not administered. Attempted telephone interview with Resident #5's primary care provider (PCP) on 10/17/22 at 12:58pm was unsuccessful. Refer to the interview with a medication aide (MA) on 10/12/22 at 10:38am. Refer to the interview with a second MA on 10/13/22 on 2:38pm. Refer to the interview with the Assistant RCC on 10/14/22 at 4:26pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/13/22 at 10:10am. Refer to the telephone interview with the Administrator on 10/14/22 at 1:23pm. 2. Review of Resident #2's current FL-2 dated 7/12/22 revealed diagnoses included left middle cerebral artery stroke with severe aphasia, hyperglycemia, diabetes mellitus type 2 with neuropathy and chronic kidney disease stage IV. Review of Resident #2's physician's order dated 09/13/22 revealed an order for methylpred (used to treat inflammation) 4mg 10 day tapered dose. Review of Resident #2's September 2022 from 09/15/22 to 09/20/22 electronic medication administration record (eMAR) revealed: -Methylpred 4mg was started on 09/15/22 at 7:30am. -There was an entry on 09/15/22 for methylpred 4mg two tablets scheduled for administration at	D 358		

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7:30am and 8:00pm and one tablet at 1:00pm and 6:00pm.
-There was documentation methylpred was administered on 09/15/22 at 1:00pm, 6:00pm and 8:00pm.
-There was an exception documented on 09/15/22 at 7:30 am; the exception was resident refusal.
-There was an entry on 09/16/22 for methylpred 4mg one tablet scheduled for administration at 7:30am, 1:00pm and 6:00pm and two tablets at 8:00pm.
-There was documentation methylpred was administered on 09/16/22 at 6:00pm and 8:00pm.
-There was an exception documented on 09/16/22 at 7:30am and 1:00pm; the exception was out of the facility.
-There was an entry on 09/17/22 for methylpred 4mg one tablet scheduled for administration at 7:30am, 1:00pm, 6:00pm and 8:00pm.
-There was documentation methylpred was administered on 09/17/22 at 1:00pm and 8:00pm.
-There was an exception documented on 09/17/22 at 7:30am, and 6:00pm; the exceptions were resident refused and out of facility.
-There was an entry on 09/18/22 for methylpred 4mg one tablet scheduled for administration at 7:30am, 1:00pm and 8:00pm.
-There was documentation methylpred was administered on 09/18/22 at 7:30am and 1:00pm.
-There was an exception documented on 09/18/22 at 8:00pm; the exception was resident refused.
-There was an entry on 09/19/22 for methylpred 4mg one tablet scheduled for administration at 7:30am and 8:00pm.
-There were exceptions documented on 09/19/22 at 7:30am and 8:00pm; the exception was out of facility.
-There was an entry on 09/20/22 for methylpred

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D 358	Continued From page 125 4mg one tablet scheduled for administration at 7:30am. -There was an exception documented on 09/20/22 at 7:30am; the exception was resident refused. Observation of Resident #2's medications on hand on 10/12/22 at 11:59am revealed: -There was a box with a prescription label on the outside of the box which read "methylpred 4mg take as directed". -There were 21 tablets of methylpred 4mg dispensed on 09/14/22. -The box contained a bubble pack of methylpred 4mg, tapered dose for 6 days to be administered as follows; 6 tablets on day 1, 5 tablets on day 2, 4 tablets on day 3, 3 tablets on day 4, 2 tablets on day 5 and 1 tablet on day 6. -There was 1 tablet missing from day 1 and 2 tablets missing from day 4. -There were 18 of 21 tablets remaining. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/11/22 at 4:34pm revealed: -The pharmacy received a signed physician's order on 09/13/22 for methylpred 4mg tapered dose. -The pharmacy dispensed 21 tablets (a 6-day supply) of methylpred 4mg on 09/14/22. Interview with a medication aide on 10/12/22 at 10:38am revealed: -She had not noticed the methylpred pack still on the medication cart. -She did not know why 18 tablets remained, when it was a 6-day tapered dose. -She thought she had administered methylpred to Resident #2 the days she worked. -It was an oversight that she did not administer	D 358	Resident PCP notified of missed doses. PCP follow-up with resident on next facility visit. RCC/Adm will monitor daily.	10/19/22

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D 358	Continued From page 126 Resident #2 his methylpred as ordered. Interview with the Assistant Resident Care Coordinator (RCC) on 10/14/22 at 4:26pm revealed she did not know why Resident #2 had so many tablets of methylpred remaining. Interview with the RCC on 10/13/22 at 10:10am revealed Resident #2 was not administered methylpred as ordered. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 10/17/22 at 10:42 was unsuccessful. Refer to the interview with a medication aide (MA) on 10/12/22 at 10:38am. Refer to the interview with a second MA on 10/13/22 on 2:38pm. Refer to the interview with the Assistant RCC on 10/14/22 at 4:26pm. Refer to the interview with the RCC on 10/13/22 at 10:10am. Refer to the telephone interview with the Administrator on 10/14/22 at 1:23pm. 3. Review of Resident #3's current FL-2 dated 09/27/22 revealed diagnoses included cirrhosis, dementia, hard of hearing, and Apert Syndrome. a. Review of Resident #3's discharge summary dated 09/14/22 revealed there was an order for Keppra (used to treat seizures) 500mg twice a day. Review of Resident #3's September 2022	D 358		

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electronic medication administration record (eMAR) from 09/14/22 to 09/30/22 revealed:
-There was an entry for Keppra 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Keppra was administered at 8:00pm on 09/14/22; at 8:00pm on 09/16/22 and at 8:00am and 8:00pm on 09/15/22 and from 09/17/22 to 09/30/22.
-There was an exception documented on 09/16/22 at 8:00am; the exception was out of facility.
-There was documentation Keppra 500mg was administered 32 times from 09/14/22 at 8:00pm to 09/30/22 at 8:00pm.

Review of Resident #3's October 2022 eMAR from 10/01/22 to 10/12/22 revealed:
-There was an entry for Keppra 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Keppra was administered at 8:00am and 8:00pm from 10/01/22 to 10/06/22 and 10/08/22 to 10/11/22 and 8:00am on 10/07/22 and 10/12/22.
-There was an exception documented on 10/07/22 at 8:00pm; the exception was resident refused.
-There was documentation Keppra 500mg was administered 22 times from 10/01/22 at 8:00am to 10/12/22 at 8:00am

Observation of Resident #3's medications on hand on 10/12/22 at 11:59am revealed:
-There was a bubble pack containing Keppra 500mg tablets available for administration with a dispensed dated of 09/14/22.
-The instruction for administration on the bubble pack read "take one tablet twice daily".
-There were 18 of 60 tablets remaining in the

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D 358	Continued From page 128 bubble pack. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/12/22 at 4:23pm revealed the pharmacy dispensed 60 tablets (30-day supply) of Keppra 500mg for Resident #3 on 09/14/22 and 10/09/22. Interview with a MA on 10/13/22 on 2:38pm revealed she did not know why Resident #3 had more Keppra on hand than he should. Interview with the Assistant RCC on 10/14/22 at 4:26pm revealed she did not know why Resident #3 had so many tablets of Keppra remaining. Interview with the RCC on 10/13/22 at 10:10am revealed Resident #3 was not administered Keppra as ordered. Attempted telephone interview with Resident #3's Primary Care Provider on 10/17/22 at 10:42 was unsuccessful. Refer to the interview with a (MA) on 10/12/22 at 10:38am. Refer to the interview with a second MA on 10/13/22 on 2:38pm. Refer to the interview with the Assistant RCC on 10/14/22 at 4:26pm. Refer to the interview with the RCC on 10/13/22 at 10:10am. Refer to the telephone interview with the Administrator on 10/14/22 at 1:23pm. b. Review of Resident #3's hospital discharge	D 358		

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summary dated 09/14/22 revealed there was an order for risperidone (used to treat mood) 25mg twice daily.

Review of Resident #3's September 2022 electronic medication administration record (eMAR) from 09/14/22 to 09/30/22 revealed:
-There was an entry for risperidone 0.25mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation risperidone was administered at 8:00pm on 09/14/22; at 8:00pm on 09/16/22 and at 8:00am and 8:00pm on 09/15/22 and from 09/17/22 to 09/30/22.
-There was an exception documented on 09/16/22 at 8:00am; the exception was out of facility.
-There was documentation risperidone 0.25mg was administered 32 times from 09/14/22 at 8:00pm to 09/30/22 at 8:00pm.

Review of Resident #3's October 2022 eMAR from 10/01/22 to 10/12/22 at 8:00am revealed:
-There was an entry for risperidone 0.25mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation risperidone was administered at 8:00am and 8:00pm from 10/01/22 to 10/06/22 and from 10/08/22 to 10/11/22 at 8:00am on 10/07/22 and 10/12/22.
-There was an exception documented on 10/07/22 at 8:00pm; the exception was resident refused.
-There was documentation risperidone 0.25mg was administered 22 times from 10/01/22 at 8:00am to 10/12/22 at 8:00am

Observation of Resident #3's medications on hand on 10/12/22 at 11:27am revealed:
-There was a bubble pack containing risperidone

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D 358	Continued From page 130 0.25mg tablets available for administration with a dispensed date of 09/14/22. -The instruction for administration on the bubble pack read "take one tablet twice daily. -There were 18 of 60 tablets remaining in the bubble pack. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/12/22 at 4:23pm revealed the pharmacy dispensed 60 tablets of risperidone 0.25mg for Resident #3 on 09/14/22 and 10/09/22. Interview with a MA on 10/13/22 on 2:38pm revealed she did not know why Resident #3 had more risperidone on hand than he should. Interview with the Assistant RCC on 10/14/22 at 4:26pm revealed she did not know why Resident #3 had so many tablets of risperidone remaining. Interview with the RCC on 10/13/22 at 10:10am revealed Resident #3 was not administered risperidone as ordered. Attempted telephone interview with Resident #3's Primary Care Provider on 10/17/22 at 10:42 was unsuccessful. Refer to the interview with a medication aide (MA) on 10/12/22 at 10:38am. Refer to the interview with a second MA on 10/13/22 on 2:38pm. Refer to the interview with the Assistant RCC on 10/14/22 at 4:26pm. Refer to the interview with the RCC on 10/13/22 at 10:10am.	D 358		

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D 358	Continued From page 131 Refer to the telephone interview with the Administrator on 10/14/22 at 1:23pm. 4. Review of Resident #8's current FL-2 dated 05/12/22 revealed diagnoses included seizure disorder, hypertension, and peptic ulcer disease. Review of Resident #8's physician's order dated 08/12/22 revealed there was an order for clonazepam (used to treat depression and anxiety) 0.5mg ½ tablet twice daily. Review of Resident #8's August 2022 electronic medication administration record (eMAR) from 08/12/22 to 08/31/22 revealed: -There was an entry for clonazepam 0.5mg ½ tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation clonazepam 0.5mg ½ tablet was administered at 8:00pm on 08/12/22 and 8:00am and 8:00pm from 08/13/22 to 08/31/22. -There was documentation clonazepam 0.5mg ½ tablet was administered 39 times from 08/12/22 at 8:00pm to 08/31/22 at 8:00pm Review of Resident #8's September 2022 eMAR revealed: -There was an entry for clonazepam 0.5mg ½ tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation clonazepam 0.5mg ½ tablet was administered at 8:00am and 8:00pm from 09/01/22 to 09/30/22. -There was documentation clonazepam 0.5mg ½ tablet was administered 60 times from 09/01/22 at 8:00am to 09/30/22 at 8:00pm Review of Resident #8's October 2022 eMAR	D 358		

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D 358	Continued From page 132 from 10/01/22 to 10/13/22 revealed: -There was an entry for clonazepam 0.5mg ½ tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation clonazepam ½ tablet 0.5mg was administered at 8:00am and 8:00pm from 10/01/22 to 10/12/22 and at 8:00am on 10/13/22. -There was documentation clonazepam 0.5mg ½ tablet was administered 25 times from 10/01/22 at 8:00am to 10/12/22 at 8:00am Observation of Resident #8's medications on hand on 10/12/22 at 11:27am revealed: -There was a bubble pack containing clonazepam 0.5mg ½ tablets available for administration with a dispensed date of 09/14/22. -The instruction for administration on the bubble pack read "take one tablet twice daily. -There were 12 of 30 ½ tablets remaining in the bubble pack dated 09/14/22 and 60 of 60 1/2 tablets remaining that were dispensed on 10/11/12/ Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/14/22 at 12:30pm revealed: -The pharmacy received an order for clonazepam 0.5mg ½ tablet twice a day on 08/12/22. -The pharmacy dispensed 60-1/2 tablets of clonazepam 0.5mg (a 30-day supply) on 08/12/22, 09/14/22 and 10/11/22. Based on observations, interviews, and record reviews there were 180 clonazepam 0.5mg one-half tablets dispensed from 08/12/22 to 10/11/22 with 124 documented as administered with 72 of 180 ½ tablets remaining for administration, when there should have been 56 ½ tablets remaining.	D 358	Resident psychiatrist was notified and seen during next psychiatrist facility visit. RCC/Adm will continue to monitor daily.	10/19/22

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D 358	Continued From page 133 Interview with a MA on 10/13/22 on 2:38pm revealed she did not know why Resident #8 had more clonazepam on hand than he should. Interview with the Assistant RCC on 10/14/22 at 4:26pm revealed she did not know why Resident #8 had so many tablets of clonazepam remaining. Interview with the RCC on 10/13/22 at 10:10am revealed Resident #8 was not administered clonazepam as ordered. Attempted telephone interview with Resident #8's Mental Health Provider on 10/17/22 at 10:40am was unsuccessful. Attempted telephone interview with Resident #8's Primary Care Provider on 10/17/22 at 10:42 was unsuccessful. Refer to the interview with a medication aide (MA) on 10/12/22 at 10:38am. Refer to the interview with a second MA on 10/13/22 on 2:38pm. Refer to the interview with the Assistant RCC on 10/14/22 at 4:26pm. Refer to the interview with the RCC on 10/13/22 at 10:10am. Refer to the telephone interview with the Administrator on 10/14/22 at 1:23pm. _____ Interview with a medication aide (MA) on 10/12/22 at 10:38am revealed: -The Resident Care Coordinator (RCC) and the	D 358		

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D 358	Continued From page 134 Assistant RCC were responsible for the medication cart audits weekly. -She did not know if the RCC and Assistant RCC counted medications on hand when they audited the mediation cart. -She did not know the last time the medication carts were audited. Interview with a second MA on 10/13/22 on 2:38pm revealed: -She would compare the bubble pack to the eMAR, prepare the medication, administer the medication, then sign the eMAR. -Medication cart audits were completed by the RCC or the Assistant RCC. -She did not know the last time the RCC or Assistant RCC did a medication cart audit. -She knew the Assistant Regional Director (ARD) did a medication cart audit last week. Interview with the Assistant RCC on 10/14/22 at 4:26pm revealed: -The RCC was responsible for auditing the medication carts weekly. -The RCC would look for discontinued medications, expired medications, and ensure all medications on the eMAR were in the medication cart to be administered. -The Administrator had audited the medication carts recently. -She had not audited the medication cart. Interview with the RCC on 10/13/22 at 10:10am revealed: -She was responsible for the medication cart audits. -She had not done a medication cart audit in the past three months due to high influx of admissions. -The ARD completed a medication cart audit on	D 358		

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D 358	Continued From page 135 10/03/22 and emailed her findings to the Administrator. -She was not made aware of any findings from the medication cart audit completed by the ARD. -The Administrator did the medication cart audits the past 3 weeks. -She did not receive any documentation of findings from the medication cart audit completed by the Administrator. -When she did the medication cart audit, she would print the physician's orders and compare with the medications on the medication cart to ensure all the medications were available for administration. -She would remove any expired or discontinued medications. -Someone from the pharmacy audited the medication carts every 3 months. -She did not count medications on hand of scheduled medications when she audited the medication cart. -She expected the MAs to administer medications as ordered. Telephone interview with the Administrator on 10/14/22 at 1:23pm revealed: -The RCC was responsible for medication cart audits weekly. -The audits should consist of looking for expired medications, discontinued medications, to ensure all medications listed on the eMAR were on the medication cart. -The PCP would send a prescription directly to the pharmacy. -The pharmacy would enter the new order into the eMAR. -The pharmacy would send a copy of the order with the delivery of the medication. -The copy of the order should be filed in the resident's record.	D 358		

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D 358	Continued From page 136 -If the PCP wrote prescriptions in the facility, the RCC would fax the orders to the pharmacy. -The pharmacy would deliver the medication the same day if they received the order for the 2:00pm deadline, if not the medication would be delivered the next day shipment. _____ The facility failed to ensure medications were administered as ordered to a resident who had recently been admitted to the hospital for shortness of breath and had medications ordered at discharge by the physician at the hospital for breathing assistance that were not being administered or were not available for administration (#5). The facility's failure was detrimental to the health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/14/22. _____ Correction date for the Type B violation shall not exceed December 1, 2022.	D 358	PCP was notified of the missed medications. Residents were seen by the PCP during the next facility visit. RCC will monitor daily. Detailed cart audit was completed by the pharmacy and all medications are in the building. RCC will monitor weekly. Cycle meds was started for all residents to keep a closer look on resident medications monthly. RCC will monitor weekly.	10/19/22 11/3/22 11/25/22
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367		

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D 367	Continued From page 137	D 367		

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, record reviews and interviews, the facility failed to ensure the electronic medication administration records were accurate for 3 of 3 sampled residents (#1, #2, and #3) including for a finger-stick blood sugar reading (#2), a medication used to treat depression (#3), and a medication used to treat pain and inflammation (#1).

The findings

1. Review of Resident #2's current FL-2 dated 7/12/22 revealed diagnoses included left middle cerebral artery stroke with severe aphasia, hyperglycemia, diabetes mellitus type 2 with neuropathy and chronic kidney disease stage IV.

Review of a pharmacy memo from the Pharmacist at the facility's contracted pharmacy revealed:
-The memo was not dated.
-The pharmacy requested to discontinue Resident #2's blood sugar checks on Monday, Wednesday and Friday before breakfast related to a new fingerstick blood sugar order before meals and at bedtime.
-The pharmacy requested to discontinue Resident #2's blood sugar checks on Tuesday,

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D 367	Continued From page 138 Thursday, Saturday and Sunday related to a new fingerstick blood sugar order (FSBS) order before meals and at bedtime. -The PCP signed the memo in agreement of the recommendation on 06/27/22. Review of Resident #2's July 2022, August 2022, September 2022 and October 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check blood sugar before breakfast on Monday, Wednesday and Friday. -There was an entry to check blood sugar on Tuesday, Thursday, Saturday and Sunday. -There was an entry to check blood sugar four times a day before meals and at bedtime. Interview with a medication aide (MA) on 10/12/22 at 10:38am revealed: -She was not aware the order to check blood sugar readings Monday, Wednesday and Friday before breakfast was still on the eMAR. -She was not aware the order to check blood sugar readings Tuesday, Thursday, Saturday and Sunday was still on the eMAR. -Discontinued orders were faxed to the pharmacy by the Resident Care Coordinator (RCC). -The pharmacy would discontinue the order on the eMAR. Interview with the RCC on 10/13/22 at 10:10am revealed: -She did not realize the blood sugar checks before breakfast on Monday, Wednesday and Friday where on the eMARs. -She did not realize the daily blood sugar checks for Tuesday, Thursday, Saturday and Sunday were still on the eMARs. -She was responsible for faxing discontinued orders to the pharmacy.	D 367	Fsbs orders corrected. RCC will continue to monitor daily. RCC/Administrator will notify the PCP and pharmacy when a duplicate order is in place or if similar orders are in place to clarify what should be discontinued and what should be continued. RCC will monitor for duplicate orders weekly and when a new order is started or discontinued.	10/19/22 10/21/22

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D 367	Continued From page 139 -She thought she had faxed the discontinued orders for the blood sugar checks to the pharmacy. Telephone interview with the Administrator on 10/14/22 at 1:23pm revealed: -The MAs should recognize when there were duplicate orders on the eMAR. -The MAs should notify the RCC or call the pharmacy to see why there were duplicate orders on the eMAR. -Orders were faxed to the pharmacy by the RCC. -He expected all orders to be faxed to the pharmacy when written to maintain accuracy of eMARs. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable. 2. Review of Resident #3's current FL-2 dated 09/27/22 revealed diagnoses included cirrhosis, dementia, hard of hearing and Aspert Syndrome. Review of Resident #3's hospital discharge summary dated 09/16/22 revealed there was an order for sertraline (used to treat depression) 50mg daily. Review of Resident #3's September 2022 electronic medication administration record (eMAR) from 09/17/22 to 09/30/22 revealed: -There was an entry for sertraline 50mg 1 tablet daily scheduled for administration at 8:00am. -There was documentation that sertraline was administered each morning at 8:00am from 09/17/22 to 09/30/22. -There was a second entry for sertraline 50mg 1 tablet daily scheduled for administration at 8:00am.	D 367		

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D 367	Continued From page 140 -There was documentation for the second entry that sertraline was administered at 8:00am on 09/17/22 and from 09/19/22 to 09/30/22. Review of Resident #3's October 2022 eMAR from 10/01/22 to 10/12/22 revealed: -There was an entry for sertraline 50mg 1 tablet daily scheduled for administration at 8:00am. -There was documentation that sertraline was administered each morning at 8:00am from 10/01/22 to 10/12/22. -There was a second entry for sertraline 50mg 1 tablet daily scheduled for administration at 8:00am. -There was documentation for the second entry that sertraline was administered each morning from 10/01/22 to 10/12/22 at 8:00am. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/12/22 at 4:23pm revealed: -She did not know why there were two entries on the eMAR for sertraline. -The pharmacy had not received a request to delete one of the entries from the eMAR. Interview with a MA on 10/13/22 at 2:38pm revealed: -She had noticed sertraline was entered on the eMAR twice. -She would document on one entry that medication was administered and on the other entry she would circle her initials and document duplicate entry as reason medication was not administered. -She had not mentioned the duplicate order to the RCC. -She had not notified the pharmacy of the duplicate entry. -She had not thought to mention it to the RCC or	D 367	PCP notified and seen by PCP during next facility visit. Duplicate order corrected. RCC will monitor weekly and when a new order is started or discontinued. RCC/Administrator will check new medication orders to ensure no duplicate orders are in place for residents. RCC/Administrator will notify PCP and pharmacy of any duplicate orders to clarify which orders should be discontinued and what order should be continued.	10/19/22 10/21/22

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D 367	Continued From page 141 notify the pharmacy. Interview with the RCC on 10/13/22 at 10:10am revealed: -She was not aware that Resident #3's sertraline was entered on the eMAR twice. -The MAs had not reported to her that sertraline was entered on the eMAR twice. -The MAs should have reported to her that sertraline was entered on the eMAR twice. -The MAs could have called the pharmacy and asked them to remove one of the entries of sertraline. -She did not know why the MAs were documenting the sertraline was administered twice. Telephone interview with the Administrator on 10/14/22 at 1:23pm revealed: -The MAs should recognize when there were duplicate orders on the eMAR. -The MAs should notify the RCC or call the pharmacy to see why there were duplicate orders on the eMAR. -Orders were faxed to the pharmacy by the RCC. -He expected all orders to be faxed to the pharmacy when written to maintain accuracy of eMARs. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. 3. Review of Resident #1's current FL-2 dated 07/19/22 revealed diagnoses included schizophrenia, chronic hypothyroidism, hypertension, and lymphedema. Review of Resident #1's physician's order dated 09/15/22 revealed an order for diclofenac (used	D 367		

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D 367	Continued From page 142 to treat pain and inflammation) 75mg twice daily. Review of Resident #1's electronic medication administration record (eMAR) for 09/15/22 to 09/30/22 revealed: -There were two entries for diclofenac 75mg twice daily scheduled at 8:00am and 8:00pm. -There was documentation on the first entry diclofenac was administered beginning at 8:00pm on 09/16/22; there were 15 administrations and 14 refusals documented from 09/16/22 to 09/30/22. -There was documentation on the second entry diclofenac was administered beginning at 8:00pm on 09/15/22; there were 16 administrations and 15 refusals documented from 09/15/22 to 09/30/22. Review of Resident #1's eMAR for 10/01/22 to 10/11/22 revealed: -There were two entries for diclofenac 75mg twice daily scheduled at 8:00am and 8:00pm. -There was documentation on both entries' diclofenac was administered 3 times and refused 18 times from 10/01/22 to 10/11/22. Telephone interview with the pharmacist from the facility's contracted pharmacy on 10/12/22 at 11:42am revealed: -Resident #1 had a current order for diclofenac 75mg twice daily. -Diclofenac was an anti-inflammatory usually ordered to treat arthritis pain or any other pain due to inflammation. -The pharmacy entered medication orders on the eMAR based on orders sent to them. -No one notified them about a duplicate entry for diclofenac on the eMAR. Interview with a medication aide (MA) on	D 367	PCP notified and resident was seen by PCP during next facility visit. Duplicate order was corrected. RCC will monitor weekly and when a new order is started or discontinued. RCC/Administrator will check when a new medication order is written to ensure it is not a duplicate. If a duplicate order is noticed the RCC/Administrator will notify the PCP and pharmacy to see which medication should be discontinued and which medication continued. RCC will monitor weekly and when a new order is started or discontinued.	10/19/22 10/21/22

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D 367	Continued From page 143 10/13/22 at 2:26pm revealed: -She had noticed the duplicate diclofenac orders on the eMAR. -She continued to document on both entries, but she only administered Resident #1 the diclofenac once. -She thought she had mentioned the duplicate order to the RCC, but she was not sure when. Interview with the RCC on 10/14/22 at 10:14am revealed: -She was responsible for reviewing the eMARs for accuracy, but the MAs were supposed to notify her when there were issues. -She was not aware there were duplicate entries for Resident #1's diclofenac. -The MAs had not told her the diclofenac was on the eMAR twice; the MAs should have told her. -The MAs could call the pharmacy and request to have the duplicate entry removed from the eMAR. -The MAs should not have documented on both entries for the diclofenac; there should have been an exception noted on the second entry. -She did not know why the MAs were documenting Resident #1's diclofenac as administered twice. Telephone interview with the Administrator on 10/17/22 at 12:44pm revealed: -The RCC was responsible for checking the eMAR for accuracy and should have caught the duplicate entries for diclofenac on Resident #1's eMAR. -The MAs should have let the RCC know about the duplicate entry when they found it on the eMAR and not continued to document on both entries. -He expected the RCC and the MAs to communicate and to ensure the eMAR is accurate.	D 367		

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D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 2 of 3 sampled residents (#1 and #3). 1. Review of Resident #3's current FL-2 dated 09/27/22 revealed diagnoses included cirrhosis, dementia, hard of hearing and Apert Syndrome. Review of resident #3's physician orders dated 09/23/22 revealed an order for lorazepam (used to treat anxiety) 0.5mg three times daily. Review of Resident #3's September 2022 electronic medication administration record (eMAR) from 09/24/22 at 2:00pm to 09/30/22	D 392		

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D 392	Continued From page 145	D 392		

revealed:
-There was an entry for lorazepam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation lorazepam was administered on 09/24/22 at 2:00pm and 8:00pm, on 09/25/22, from 09/27/22 to 09/29/22 at 8:00am, 2:00pm and 8:00pm, and on 09/26/22 and 09/30/22 at 8:00am and 8:00pm.
-There were exceptions documented on 09/26/22 and 09/30/22 at 2:00pm; the exceptions were resident out of facility and resident refused.

Review of Resident #3's October 2022 eMAR from 10/01/22 to 10/13/22 at 8:00am revealed:
-There was an entry for lorazepam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation lorazepam was administered three times daily from 10/01/22 to 10/06/22 and from 10/08/22 to 10/11/22 at 8:00am, 2:00pm and 8:00pm; on 10/07/22 at 8:00am and 2:00pm; and on 10/13/22 at 8:00am.
-There was exceptions documented on 10/07/22 at 8:00pm; the exception was resident refused.

Review of Resident #3's controlled substance count sheet (CSCS) for lorazepam 0.5mg dispensed on 09/24/22 revealed:
-On 09/27/22 at 8:00pm lorazepam 0.5mg was documented on the eMAR as administered but not on the CSCS.
-On 09/29/22 at 8:00pm lorazepam 0.5mg was documented on the eMAR as administered but not on the CSCS.
-On 09/30/22 at 8:00pm lorazepam 0.5mg was documented on the eMAR as administered but not on the CSCS.
-On 10/02/22 at 8:00pm lorazepam 0.5mg was documented on the eMAR as administered but

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D 392	Continued From page 146 not on the CSCS. -On 10/02/22 at 8:00pm lorazepam 0.5mg was documented on the eMAR as administered but not on the CSCS. -On 10/04/22 at 8:00pm lorazepam 0.5mg was documented on the eMAR as administered but not on the CSCS. -On 10/06/22 at 8:00pm lorazepam 0.5mg was documented on the eMAR as administered but not on the CSCS. -On 10/11/22 at 8:00pm lorazepam 0.5mg was documented on the eMAR as administered but not on the CSCS. Review of Resident #3's CSCS on 10/12/22 for lorazepam 0.5mg dispensed on 09/24/22 for 90 tablets revealed 48 tablets remained matching the quantity on hand for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/12/22 at 4:23pm revealed: -The pharmacy received an order for lorazepam 0.5mg on 09/24/22. -The pharmacy dispensed 90 tablets of lorazepam 0.5mg on 09/24/22. Refer to the interview with a medication aide (MA) on 10/13/22 at 2:38pm. Refer to the interview with a MA on 10/14/22 at 11:38am. Refer to the interview with the Assistant Resident Care Coordinator (RCC) on 10/14/22 at 4:26pm. Refer to the interview with the RCC on 10/13/22 at 10:10am. Refer to the telephone interview with the	D 392	Medication documentation order corrected. RCC will monitor narcotics documentation daily. RCC/Administrator will complete routine checks on the controlled documentation form and quickmar to ensure medication is given and documented. RCC will monitor narcotics documentation daily.	10/19/22 10/21/22

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D 392	Continued From page 147 Administrator on 10/14/22 at 1:23pm. 2. Review of Resident #1's current FL-2 dated 07/19/22 revealed diagnoses included schizophrenia, chronic hypothyroidism, hypertension, and lymphedema. Review of Resident #1's physician's orders dated 09/15/22 revealed there was an order for tramadol (used to treat pain) 50mg twice daily. Review of Resident #1's electronic medication administration record (eMAR) for September 2022 revealed: -There was an entry for tramadol 50mg every 12 hours scheduled at 8:00am and 8:00pm. -There was documentation on the entry the tramadol was administered on 09/15/22 at 8:00pm and refused on 09/16/22 at 8:00am. -There was documentation the tramadol was discontinued on the entry. -There was a second entry for tramadol 50mg every 12 hours scheduled at 8:00am and 8:00pm. -There was documentation on the second entry for tramadol from 09/20/22 to 09/30/22. -There was documentation on the entry the tramadol was administered eight times and refused 13 times from 09/20/22 to 09/30/22. -There was nothing documented on the eMAR from 09/16/22 at 8:00pm to 09/20/22 at 8:00am. -Tramadol 50mg was documented as administered nine out of 29 opportunities from 09/15/22 to 09/30/22. Review of Resident #1's eMAR for October 2022 revealed: -There was an entry for tramadol 50mg every 12 hours scheduled at 8:00am and 8:00pm. -There was documentation tramadol 50mg was administered three out of 21 opportunities from	D 392		

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D 392	Continued From page 148 10/01/22 to 10/11/22. -There was documentation tramadol 50mg was refused 18 out of 21 opportunities from 10/01/22 to 10/11/22. Observation of Resident #1's medication on hand on 10/11/22 at 3:38pm revealed there was no tramadol 50mg available for administration. Interview with Resident #1 on 10/12/22 at 11:42am revealed: -She did not take the tramadol because she was allergic to the tramadol. -The order for tramadol had not been discontinued. Telephone interview with the pharmacist from the facility's contracted pharmacy on 10/12/22 at 11:42am revealed: -There was a current order for Resident #1 for tramadol 50mg every 12 hours. -Fourteen tablets of tramadol 50mg were dispensed on 09/20/22; there were no other dispense dates for the tramadol. -Resident #1's Tramadol was not on a cycle fill and had to be reordered by the facility. -Control logs were sent to the facility with the medication when it was dispensed. -The pharmacy kept documentation of pick ups and returns of controlled substances from facilities; request for pick ups and returns were also documented. -Resident #1's tramadol was not returned to the pharmacy and there was no documentation the facility had requested a pick up for Resident #1's tramadol. Interview with the medication aide (MA) on 10/11/22 at 3:38pm revealed: -Resident #1 refused her tramadol 50mg because	D 392	PCP notified and resident was seen by PCP during next facility visit. Order corrected. RCC will monitor daily. RCC/Administrator will notify PCP when resident refuses to take medication because of resident concerns from taking the medication in the past before being admitted t the facility. RCC will monitor daily.	10/19/22 10/21/22

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D 392	Continued From page 149 Resident #1 said she was allergic to it; she did not remember ever administering Resident #1's tramadol. -She did not recall ever seeing Resident #1's tramadol on the medication cart. -She thought it had been discontinued. Interview with a second MA on 10/13/22 at 2:26pm revealed: -Resident #1 refused her tramadol because she said she was allergic to it. -She did not pop Resident #1's tramadol from the medication card until she asked if she would take them because Resident #1 always refused them. -Resident #1 had never taken her tramadol. -She did not know what happened to Resident #1's tramadol; she could not recall the last time she had seen it on the medication cart. -She would document refusals on the eMAR, she had mistakenly documented administration of the tramadol. -She did not recall seeing a control log for Resident #1's tramadol. Interview with the Assistant Resident Care Coordinator (ARCC) on 10/14/22 at 5:06pm revealed: -Resident #1 refused the tramadol and never took it because she said she was allergic to it. -Staff should not document administration of medication if they did not administer Resident #1 her medication. -Resident #1's tramadol was sent back to the pharmacy on third shift about three weeks ago; she did not know who sent it back. -She did not see documentation of the return of the tramadol. -The control log should have remained at the facility even if the tramadol was returned to the pharmacy.	D 392		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 10/17/2022

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D 392	Continued From page 150 -She could not say were the tramadol log sheet was. Interview with the Resident Care Coordinator (RCC) on 10/14/22 at 3:42pm and 4:58pm revealed: -She could not locate the log sheet for Resident #1's tramadol. -The log sheet was supposed to be kept in the medication room in a bin with the other controlled medication log sheets. -She did not know where Resident #1 log sheet had gone and why it was not in the bin. -If the tramadol was returned to the pharmacy there should have also been documentation of the return; she could not find documentation that the tramadol had been returned to the pharmacy. -She was responsible for the control log sheets. -She could not explain where the control log was for Resident #1's tramadol. Telephone interview with the Administrator on 10/17/22 at 12:44pm revealed: -The control logs were to document the count for the control medications like Resident #1's tramadol for record keeping. -The MAs were supposed to document the number of tramadol tablets Resident #1 had available from shift to shift. -The MAs were not supposed to leave until the controlled medications were counted and signed off on. -The RCC was responsible for maintaining the control logs in a log book. -He was concerned there was no control log for the tramadol because without the log there was no telling where the medication went. Refer to the interview with a medication aide (MA) on 10/13/22 at 2:38pm.	D 392		

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D 392	Continued From page 151 Refer to the interview with a MA on 10/14/22 at 11:38am. Refer to the interview with the Assistant Resident Care Coordinator (RCC) on 10/14/22 at 4:26pm. Refer to the interview with the RCC on 10/13/22 at 10:10am. Refer to the telephone interview with the Administrator on 10/14/22 at 1:23pm. _____ Interview with a medication aide (MA) on 10/13/22 at 2:38pm revealed: -When administering controlled substances, she prepared the medication for administration and signed the controlled substance count sheet (CSCS). -She noticed the count was incorrect at times. -She started initialing the bubble pack when she prepared a controlled substance for administration. -She notified the Resident Care Coordinator (RCC) when the count was incorrect. Interview with a MA on 10/14/22 at 11:38am revealed: -She signed the CSCS when she prepared the controlled substance for administration. -She signed the electronic medication administration record (eMAR) after the medication was administered. -She did not know why the CSCS and the eMAR did not match. Interview with the Assistant RCC on 10/14/22 at 4:26pm revealed: -She signed the CSCS when she prepared the controlled substance for administration.	D 392		

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D 392	Continued From page 152 -She also signed the bubble pack next to the bubble where she punched the controlled substance. -She was not aware the MAs signed the eMAR when the medication was administered but did not sign the CSCS. -The MA should sign the CSCS each time a controlled substance was administered. -The CSCS should be compared with medications on hand with each medication cart audit to ensure the count was correct. The CSCS log should be compared with the eMAR with each medication cart audit to ensure the MA who signed the eMAR was the same MA who signed the CSCS. Interview with the RCC on 10/13/22 at 10:10am revealed: -The MAs did not sign the CSCS each time a controlled substance was administered. -She corrected the CSCS at the end of each month because the CSCS would be incorrect. -She reminded the MAs to sign the CSCS when preparing the controlled substance for administration. -She expected the MAs to document on the CSCS each time a controlled substance was prepared for administration. Telephone interview with the Administrator on 10/14/22 at 1:23pm revealed: -The MAs should sign the CSCS each time a controlled substance was removed from the bubble pack. -He expected the CSCS to be signed by the MA who administered the controlled substance each time it was administered.	D 392		

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D 468	Continued From page 153	D 468		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure 4 of 6 sampled staff (Staff A, Staff B, Staff C, and Staff D) completed 6 hours of special care unit (SCU) training within the first week of employment and 20 hours of SCU	D 468		

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D 468	Continued From page 154 training the first six months of working in the SCU. 1. Review of staff A's, personal care aide (PCA) record revealed: -Staff A was hired on 03/24/2022. -There was no documentation Staff A completed 6 hours of SCU orientation. -There was no documentation Staff A completed 20 hours of additional SCU training during her first six months of employment. Interview with Staff A on 10/17/22 at 2:40pm revealed: -She worked as a housekeeper mostly on weekends and she was sometimes asked to work in the SCU. -She was given a little training on how to do personal care for residents with dementia by the other SCU staff. -She was had not completed 6 hours of training to work in the SCU. -She did not know she needed 6 hours of training to the SCU before working in the SCU. -She started working in the SCU on her first day. -She was not given more training, she "caught on" what to do to help the residents. -She was not told she needed 20 hours of SCU training in the first six months of working in the SCU. Refer to interview with the Administrator on 10/17/22 at 3:05pm. Review of Staff B's medication aide (MA) personnel record revealed: -Staff B was hired on 08/10/1996. -There was no documentation Staff B completed 6 hours of SCU orientation. -There was no documentation Staff B completed	D 468	Dementia and SCU trainings completed by RN. Administrator will monitor for compliance of trainings weekly and upon hiring new applicants.	11/22/22 & ongoing

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D 468	Continued From page 155 20 hours of SCU training during her first six months of employment. 2. Interview with Staff B 10/17/22 at 2:20pm revealed: -She started working at the facility in 1996 and was given SCU orientation when the unit opened but did not remember how many hours of training she received. -The documents for her SCU training should be in her personnel record. Refer to interview with the Administrator on 10/17/22 at 3:05pm. 3. Review of Staff C's PCA personnel record revealed: -Staff C was hired on 02/23/2010. -There was no documentation Staff C completed 6 hours of SCU orientation. -There was no documentation Staff C completed 20 hours of SCU training during her first six months of employment. Attempted interview with Staff C on 10/17/2022 at 3:05pm was unsuccessful. Refer to interview with the Administrator on 10/17/2022 at 3:05pm. 4. Review of Staff D's MA personnel record revealed: -There was no documentation Staff D completed 6 hours of SCU orientation. -There was no documentation Staff D completed 20 hours of SCU training during her first six months of employment Attempted interview with Staff D on 10/17/22 at 3:00pm was unsuccessful.	D 468		

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D 468	Continued From page 156 Refer to interview with the Administrator on 10/17/2022 at 3:05pm. Interview with the Administrator on 10/17/2022 at 3:08pm revealed: -He was not aware Staff A, B, C and D did not have documentation for the 6- hour training or the 20 -hour training in their personnel records. -He was aware of the 6-hour orientation SCU staff needed the first week to work in the SCU. -He was not aware of any SCU training currently being done for staff to work in the SCU. -He was not aware of the 20-hour training SCU staff needed to complete in the first 6 months of working in the SCU. -He did not know if SCU staff's personnel records had been audited for completeness. -He needed to audit all SCU personnel records to ensure SCU staff were offered the training required to work in the SCU and the documentation was placed in their personnel records.	D 468		