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MAGNOLIA GARDENS	916 S. MARIETTA STREET GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an complaint investigation from 01/10/23 to 01/13/23 and on 01/17/23.	D 000		
D 096	10A NCAC 13F .0307(a)(b)(c) Fire Alarm System 10a NCAC 13F .0307 Fire Alarm System (a) The fire alarm system in adult care homes shall be able to transmit the fire alarm signal automatically to the local emergency fire department dispatch center, either directly or through a central station monitoring company connection. (b) Any applicable fire safety requirements required by city ordinances or county building inspectors shall be provided. (c) In a facility licensed before April 1, 1984 and constructed prior to January 1, 1975, the building, in addition to meeting the requirements of the North Carolina State Building Code in effect at the time the building was constructed, shall be provided with the following: (1) A fire alarm system with pull stations within five feet of each exit and sounding devices which are audible throughout the building; (2) Products of combustion (smoke) U/L listed detectors in all corridors. The detectors shall be no more than 60 feet from each other and no more than 30 feet from any end wall; (3) Heat detectors or products of combustion detectors in all storage rooms, kitchens, living rooms, dining rooms and laundries; (4) All detection systems interconnected with the fire alarm system; and (5) Emergency power for the fire alarm system, heat detection system, and products of combustion detection with automatic start generator or trickle charge battery system capable of operating the fire alarm systems for 24	D 096		

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hours and able to sound the alarm for five minutes at the end of that time. Emergency egress lights and exit signs shall be powered from an automatic start generator or a U/L approved trickle charge battery system capable of operation for 1-1/2 hours when normal power fails.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews, observations and record reviews the facility failed to ensure the fire alarm system was able to transmit the fire alarm signal automatically to the local emergency fire department.

The findings are:

Interview with the Resident Service Director (RSD) on 01/10/23 at 10:00am revealed there were 45 residents in the facility.

Interview with the local Fire Inspector on 01/10/23 at 2:33pm revealed:
-On 01/10/23 he visited the facility to complete an annual fire inspection, and noticed the fire alarm was in trouble mode and needed to be repaired.
-On 01/10/23, he instructed the facility to call the contracted fire system company to repair the fire alarm.

Interview with the RSD on 01/10/23 at 3:00pm revealed
-For the last month, the fire alarm control panel at the medication aide station would alarm for a little while and then stop, but there was no fire and the fire department did not come.

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-She was unsure if the alarm stopped alarming by itself or if the MA turned it off.
-She notified the Owner approximately one month ago and he replied that he would handle it.
-The fire alarm control panel went off 4-5 times during the last month.
-The first time the fire alarm control panel was assessed was today (01/10/23) by the Fire Inspector.

Interview with the Owner on 01/10/23 at 3:10pm revealed:
-He was not aware of any issues with the fire alarm control panel until the Fire Inspector visited today (01/10/23).
-He did not recall the staff bringing this to his attention previously.

Observation of the facility on 01/11/23 at 9:00am revealed the facility's contracted fire alarm system repair company was inspecting the fire alarm system and smoke detectors.

Interview with a representative from the facility's contracted fire alarm system repair company on 01/11/23 at 9:00am revealed:
-On 01/10/23, he was called by the RSD who reported there was an issue with the fire alarm system.
-On 01/11/23, he and his crew tested 71 smoke detectors and found 7 of those smoke detectors were not working.
-In order for a fire alarm system to work the facility needed 2 telephone lines dedicated for the fire alarm system, once the alarm was activated there was a line dedicated to automatically call the central station responsible for notification to the appropriate fire department and the second line was for a backup in case the first line failed.
-He was able to locate and repair the phone line

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in order to repair the fire alarm system.

Telephone interview with the Fire Inspector on 01/13/23 at 11:08am revealed:
-On 01/12/23, after 5:00pm, there were two occasions between 5:00pm and 6:00pm the fire department responded to the facility after the fire alarm was activated.
-When the fire department arrived there was no fire alarm sounding at the facility.
-On 01/12/23, he notified the staff, RSD and the Owner and taught them how to perform a fire watch until the alarm system was repaired.
-On 01/12/23, he directed the staff to use one staff member, every hour to walk around the entire facility and check every room, and closet for signs of a fire and if a fire was observed then that staff member was responsible for calling the fire department and activation of the facility's fire plan.
-He stressed the fact the one staff was to have no other responsibilities, and only be assigned to fire watch.

Interview with a medication aide (MA) on 01/13/23 at 2:30pm revealed:
-On 01/13/23, the RSD told her to perform hourly fire checks which included checking every room and closet on her assigned hall for signs of a fire.
-There were two personal care aides (PCAs) assigned a hall each to complete their fire checks on their assigned halls.
-After she and the two PCAs performed the hourly fire checks, and there was no fire, she completed the fire check list located at the MA desk.
-If there was a fire, she and the PCAs were to call 911.
-She was instructed by the RSD to continue the fire watch, every hour until the fire alarm system

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was fixed, then she was to give the fire watch check sheet to the RSD.
-She also performed her normal MA duties as well as the fire checks.

Interview with a PCA on 01/13/23 at 2:35pm revealed:
-On 01/13/23, the RSD told her to perform hourly fire checks which included checking every room and closet on her assigned hall for signs of a fire.
-She and another PCA and a MA were assigned to one of three halls to perform their hourly fire checks.
-After she, another PCA and a MA performed the hourly fire checks, and there was no fire, reported to the MA on duty.
-If there was a fire, she was to call 911.
-She was instructed by the RSD to continue the fire watch, every hour until the fire alarm system was fixed.
-She also performed her normal PCA duties as well as the fire checks.

Interview with the RSD on 01/13/23 at 11:20am revealed:
-On 01/12/23, the fire department responded to the facility two times within an hour but there was no alarm sounding in the facility.
-On 01/12/13, around 6:30pm, the facility was put on a fire watch.
-The Fire Inspector instructed her that one staff member was to be responsible for fire watch every hour, sign off on them and was to have no other responsibility.
-She was instructed by the Owner to assign 3 staff to complete the hourly fire watches.
-The Owner stated it would take 10 minutes for three staff to complete the fire watches.
-She assigned the three staff to complete the fire watches and the medication aide (MA) would be

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responsible for signing off on the hourly watches.
-She was instructed by the fire inspector the watches were to continue until the system was fixed.
-After the system was fixed she was to call the fire inspector and turn in the fire watch forms.

Interview with the Owner on 01/13/23 at 12:00pm revealed:
-On 01/10/23, the Fire Inspector was here for the facility's annual fire inspection.
-There was an issue with the alarm system and he directed the Maintenance Director to call the facility's contracted fire alarm system repair company.
-On 01/11/23, a representative from the facility's contracted fire alarm system repair company came in and did an inspection of the facility and found 7 out of 71 smoke detectors not working and repaired the fire alarm.
-On 01/12/23, between 5:00pm and 6:00pm the fire department responded to the fire alarm in the facility but the facility did not show an alarm going off.
-On 01/12/23, the Fire Inspector informed him the fire alarm was not working correctly in the facilty and he needed to put staff in charge of hourly fire watches until the alarm system was working correctly.
-On 01/12/23 around 6:30pm, he instructed the RSD to assign three staff to complete the hourly fire watches so it would only take 10 minutes.

_____

The facility failed to ensure the fire alarm system was able to transmit the fire alarm signal automatically to the local emergency fire department dispatch center which resulted in the facility's fire alarm system not working correctly putting 45 residents and staff at risk in case of a fire. This failure was detrimental to the safety of

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D 096	Continued From page 6 the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 01/13/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2023.	D 096		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 4 medication aides (Staff A) who administered medications independently had completed the 10-hour medication aide training within 60 days of completion of the medication aide competency validation clinical skills checklist.	D 125		

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The findings are:

Review of Staff A, medication aide (MA) personnel record revealed:
-She was hired on 05/03/22.
-She completed her medication aide competency validation clinical skills checklist on 09/12/22.
-She completed her 5-hour MA training on 10/02/19.
-She passed the written MA examination on 01/05/23.
-There was no documentation of a 10-hour MA training.
-The 10-hour MA training was due to be completed by 11/10/22.

Review of residents' November 2022 electronic Medication Administration Record (eMARs) revealed Staff A documented administration of medications on 11/12/22, 11/14/22, 11/16/22, 11/22/22, 11/23/22, 11/24/22, 11/26/22, 11/29/22, and 11/30/22, including a controlled substance.

Review of residents' December 2022 eMARs revealed Staff A documented administration of medications on 12/01/22, 12/02/22, 12/05/22, 12/06/22, 12/07/22, 12/10/22, 12/11/22, and 12/15/22, including a controlled substance.

Review of residents' January 2023 eMARs revealed Staff A documented administration of medications on 01/07/23, including a controlled substance.

Attempted telephone interview on 01/13/23 at 11:22am with Staff A was unsuccessful.

Interview with the Resident Service Director (RSD) on 01/11/23 at 5:10pm revealed:

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D 125	Continued From page 8 -She was responsible to supervise the MAs in the facility. -The former Business Office Manager (BOM) was responsible to ensure all staff training requirements were met. -She was currently filling in for the BOM. -The former Administrator left on 11/07/22 and they did not have a current Administrator or an Administrator in Charge (AIC). -The owner was responsible for making sure all personnel records were complete. -She was not aware that Staff A did not have the 10 hour MA training completed. Interview with the Owner on 01/12/23 at 11:25am and 2:52pm revealed: -He was the owner of the facility. -He and the RSD were responsible for the day-to day operations of the facility. -The RSD was responsible for oversight of resident care, and he was responsible for the financial aspects of the facility. -The former BOM was responsible to ensure staff training requirements were met. -The Owner was responsible for making sure all personnel records were complete. -The BOM had kept staff personnel records in her home in November 2022.	D 125		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;	D 137		

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D 137	Continued From page 9 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to verify there were no substantiated findings on the Health Care Personnel Registry (HCPR) for 1 of 6 sampled staff (Staff D) prior to working in the facility. The findings are: Review of Staff D's personnel record revealed: -She was hired on 09/12/22. -She worked as the Business Office Manager (BOM) and a medication aide (MA). -There was no documentation a HCPR check was completed upon hire. -There was documentation a HCPR check was completed on 01/10/23 with no substantiated findings. Interview with the Resident Service Director (RSD) on 01/11/23 at 5:10pm revealed: -The former BOM was responsible to ensure all staff training requirements were met. -She was currently filling in for the BOM. -The former Administrator left on 11/07/22 and they did not have a current Administrator or Administrator in Charge (AIC). -The owner was responsible for making sure all personnel records were complete. -She was not aware Staff D did not have a HCPR check completed prior to employment. Interview with the Owner on 01/12/23 at 11:25am and 2:52pm revealed: -He was not sure what the HCPR entailed but the RSD would handle that. -Before 11/07/22, the previous Administrator was	D 137		

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D 137	Continued From page 10 responsible for all HCPR checks. -There was no Administrator after 11/07/22. -He was not aware Staff D did not have a HCPR check completed upon hire. _____ The facility failed to ensure there were no substantiated findings on the Health Care Personnel Registry (HCPR) for Staff D prior to working in the facility. This failure resulted in an increased risk of abuse, neglect, and exploitation, which was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 01/12/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2023.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (Staff B and Staff D) had completed a criminal background check upon hire.	D 139		

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D 139	Continued From page 11 The findings are: 1. Review of Staff B's, a medication aide (MA), personnel record revealed: -She was re-hired on 01/22/22 as a medication aide (MA). -There was no documentation a criminal background check was completed upon re-hire. -Her previous employment with the facility was terminated on 11/19/21. -There was no consent obtained for a background check. Refer to interview with the Resident Service Director (RSD) on 01/11/23 at 5:10pm. Refer to interview with the Owner on 01/12/23 at 11:25am. 2. Review of Staff D's personnel record revealed: -She was hired on 09/12/22 as the Business Office Manager (BOM) and medication aide (MA). -There was no documentation a criminal background check was completed upon hire. -There was no consent obtained for a background check. Refer to interview with the Resident Service Director (RSD) on 01/11/23 at 5:10pm. Refer to interview with the Owner on 01/12/23 at 11:25am. _____ Interview with the Resident Service Director (RSD) on 01/11/23 at 5:10pm revealed: -The former Business Office Manager (BOM) was responsible to ensure all staff background checks were completed. -She was currently filling in for the BOM.	D 139		

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D 139	Continued From page 12 -The former Administrator left on 11/07/22 and they did not have a current Administrator or Administrator in Charge (AIC). -The owner was responsible for making sure all personnel records were complete. -She was not aware the BOM and Staff B did not have a HCPR check completed prior to employment. Interview with the Owner on 01/12/23 at 11:25am and 2:52pm revealed: -The previous Administrator was responsible for all criminal background checks prior to 11/07/22. -There was no Administrator hired after 11/07/22. -He was responsible for the criminal background checks of the new hires after 11/07/22. -He told new staff to go to the local clerk of court and request a local criminal background check. -He did not know the background checks were to be state-wide. -He was unaware if there was an audit on the staff records to see if the criminal background checks were completed. -He was not aware that Staff B and the Staff D did not have criminal background checks completed upon hire. _____ The facility failed to ensure criminal background checks were completed for Staff B and the Business Office Manager, prior to working in the facility. This failure of not knowing if Staff A and Staff D had a criminal record history placed residents at increased risk of abuse, neglect, and exploitation, which was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 01/12/23.	D 139		

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D 139	Continued From page 13 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2023.	D 139		
D 181	10A NCAC 13F .0602 Management Of Facilities WIth A Capacity Or 10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents (a) In facilities with a capacity or census of 31 to 80 residents, there shall be an administrator on call, which means able to be contacted by telephone, pager or two-way intercom, at all times when not in the building. (For staffing chart, see Rule .0606 of this Subchapter.) This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Owner failed to ensure the overall management, operations, policies and procedures of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to medication administration, health care, residents rights, staffing, Health Care Personnel Registry (HCPR) reporting, nutrition and food service, staffing qualifications, residents funds, controlled substances, controlled substance reporting, adequate food supply, and fire alarm systems. The findings are:	D 181		

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	HAL036036	A. BUILDING: _____ B. WING _____	C 01/17/2023

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MAGNOLIA GARDENS	916 S. MARIETTA STREET GASTONIA, NC 28054

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D 181	Continued From page 14 Interview with the Resident Service Director (RSD) on 01/10/23 at 10:00am revealed: -There were 45 residents' in the facility. -She was in charge of the residents' care and worked as a medication aide (MA) and personal care aide (PCA) as needed. -The facility did not have an Administrator since 11/07/22 when the previous Administrator quit. -She filled in as a PCA and MA on a daily basis due to not enough staff to work. -There was no Administrator there to guide her in the daily operations of the facility. -The Owner was not able to advise her on what to do on a daily basis so she just took care of what she could as things came up. -She was dealing with a staff member who exploited residents by taking their debit cards and using them for their own personal gain, had a resident sign a document which could have given the staff access to a resident's inheritance, and had access to all residents' social security numbers, personal and financial information. -The Owner was notified of the exploitation on 01/02/23 and the staff member was allowed to continue her employment at the facility. -She did not know she was required to notify law enforcement, Department of Social Services (DSS), Health Care Personnel Registry (HCPR), or even the Social Security office until she was directed by someone outside of the facility. -She was too busy filling in as a PCA or MA that her RSD duties were never completed. Interview with the RSD on 01/13/23 at 9:00am revealed: -She was responsible for the day-to-day care and services of the residents. -The owner was responsible for the financial aspects of the facility.	D 181		

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D 181	Continued From page 15 -The owner relied on her for all duties that an Administrator would have and she was not trained as an Administrator. -The owner relied on her to know about how much the staff make and how to do payroll and she did not have the training needed for that. -The owner relied on her to fill in as a PCA or a MA when staff called out of work or did not show up for work, and he did not want to hire new staff. -She worked 16-20 hours a day sometimes and she was tired but the residents needed taken care of. -The owner did not want to hire new staff due to his budget but did not want to pay overtime as well and that's why he expected her to work because she was salary. -Even when the fire system failed and the staff were required to complete fire watches which the Fire Inspector required a single staff with no other duties to complete hourly checks of every room and square inch of the facilty to check for fires, the owner still wanted three staff to complete them in 10 minutes. -She did not know how to complete the duties of an Administrator, so she called her friend who was an Administrator at another facility to help her. -She lived 10 minutes from the facility and the facility staff had her cell phone number in case of an emergency. -The staff also had the owners cell phone number as well, but the staff always called her in order for things to get handled. -The owner lived 20 minutes away from the facility. -There was no Administrator-in-Charge (AIC) who lived within 500 feet of the facility. Interview with the Owner on 01/12/23 at 11:25am revealed:	D 181		

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-He was the owner of the facility and visited the facility on a daily basis for several hours.
-He and the RSD were responsible for the day-to-day operations of the facility.
-The RSD was responsible for the resident care and he was responsible for the financial aspects of the facility.
-He did not know how to complete necessary paperwork such as plans of protection, HCPR reporting forms, payroll for staff, food ordering forms, hiring forms, monthly pay for the residents, and expected the RSD to call her friend who was an Administrator to help complete those tasks.
-He tried to hire another Administrator, but no one officially took the job.
-The previous Administrator was responsible for completion of all tasks consistent with the role of the Administrator and he did not check in with the previous Administrator to see if the bills were paid or if the previous Administrator was completing the tasks of an Administrator.
-He was not familiar with the duties of an Administrator but knew how to run a business.

Interview with the Dietary Manager (DM) on 01/10/23 at 4:20pm revealed:
-She was told by the food delivery provider if the balance of the current facility's bill was not paid today then there would be no delivery of food tomorrow on 01/11/23.
-She had enough food to complete lunch and supper on 01/11/23 and 01/12/23 but no breakfast and snacks on 01/11/23 and 01/12/23.
-It was the responsibility of the Administrator to handle the payments for food orders but there was no Administrator in the facility and the owner set a strict budget and the food bill balance was over the budget.

Interview with RSD on 01/11/23 at 2:45pm

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revealed:
-If there was an issue at the facility, the staff would report to her and she would notify the Owner.
-The previous management team took the personal funds allowance ledger when they left in November 2022.
-In December 2022, she was handed a bundle of money from the facility's Owner.

Interview with the Owner on 01/11/23 at 10:55am revealed:
-He gave money to the RSD to pay the residents their personal funds.
-He had not paid on the residents' pharmacy bill since he took over on 11/07/22.
-He did not know how to pay the pharmacy bill.
-He did not know how the resident's medication bills were paid to the pharmacy.
-He said he could pay on the pharmacy bills.
-He received a check for the resident balance in their trust account from the previous management team.
-He deposited the check for the personal fund balances in the bank.

Interview with the Dietary Manager on 01/10/23 at 9:38am revealed:
-She was responsible for placing the food order with the facility's contracted food supply company.
-The Owner set the food budget per week to purchase meals and snacks for all of the residents.
-She typically stretched the budgeted amount to purchase five days worth of meals through the facility's contracted food supplier as it was not nearly enough to cover the entire the week.
-For the remaining two days, she went to the grocery store to purchase two days worth of food with her personal funds.

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-She did not always ask to be reimbursed for the groceries since it was not an easy conversation to have with the Owner.
-The facility's contracted food supplier representative was at the facility on 01/10/23 to collect the funds for the previous week's food order and the Owner refused to pay the balance until after 4:00pm which delayed the next food delivery a day (01/12/23).

Interview with the RSD on 01/12/23 at 2:50pm revealed:
-She did not consider herself a supervisor to any of the kitchen staff but she did intervene when situations got "out of hand".
-She spoke to the Owner about ensuring the kitchen had an adequate food supply and the Owner told her that was too much money to spend.
-All of the staff at the facility had chipped in personal funds to purchase items for the residents' meals and or snacks.
-The Owner refused to reimburse her for purchasing office supplies, so she did not bother to ask about reimbursement for food that was purchased for the residents.

Telephone interview with the facility's contracted food supplier's Registered Dietitian on 01/17/23 at 12:19pm revealed:
-The food budget covered meals, snacks, nutritional supplements and kitchen supplies such as plastic wrap/aluminum foil so there was no way the Owner's budgeted amount for one week would be adequate.
-Based on the facility's current menu, the cost per resident per day would be greater than the amount budgeted to provide meals and snacks.

Interview with the Owner on 01/12/23 at 11:32am

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revealed:
-His primary role was to oversee the operations of the facility.
-He was not aware of any issues with the food supply in the kitchen until recently when the Adult Home Specialist (AHS) brought it to his attention; however, he felt that the AHS encouraged the kitchen to order too much food.
-He expected the DM to be able to order everything required to feed residents based on the menu with $1,500 per week.
-He set the food budget for the facility at $1,500 per week based on his previous business experiences with non-healthcare related food service.

Non-compliance was identified at violation levels in the following areas:

1. Based on interviews, observations and record reviews the facility failed to ensure the fire alarm system was able to transmit the fire alarm signal automatically to the local emergency fire department. [Refer to tag 0096 10A NCAC 13F .0307(a) Fire Alarm (Type B Violation)].

2. Based on interviews and record reviews, the facility failed to verify there were no substantiated findings on the Health Care Personnel Registry (HCPR) for 1 of 6 sampled staff (Staff D) prior to working in the facility. [Refer to Tag 137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)].

3. Based on record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (Staff B and Staff D) had completed a criminal background check upon hire. [Refer to Tag 139, 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation)].

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D 181	Continued From page 20 4. Based on record reviews and interviews, the facility failed to ensure the required aide hours for 21 of 48 shifts sampled from 12/24/22 to 01/09/23. [Refer to Tag 219, 10A NCAC 13F .0606 Staffing Chart (Type A2 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs of 1 of 2 sampled residents (Resident #1) related to a prescribed antibiotic not being administered for the full seven-day course, lab work that was not referred to home health and obtained one week after hospitalization, and reporting of daily temperatures greater than 100.4 to the Primary Care Provider (PCP). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 6. Based on observations and interviews the facility failed to provide plate ware that was free from contamination to all the residents in the facility related to using improper chemicals to sanitize dishes, utensils, cups and cookware. [Refer to Tag 283, 10A NCAC 13F .0904(a)(2) Nutrition and Food Service (Type B Violation)]. 7. Based on observations, interviews and record reviews, the facility failed to ensure 4 of 6 sampled residents (Residents #1, #6, #7, and #8) received appropriate therapeutic duets as ordered with orders for a renal and low concentrated sweets diet (#8), a low concentrated sweets and mechanical soft/ground meats diet (#6), supplemental nutritional shakes ordered three times per day (#1) and a low fat/ low cholesterol, low sodium and 60 grams of carbohydrate per meal diet (#7). [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and	D 181		

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D 181	Continued From page 21 Food Services (Type B Violation)]. 8. Based on observations, interviews, and record reviews, the facility failed to protect 45 residents from abuse and exploitation by a staff (Business Office Manager (BOM)) related to a resident's stolen debit card (#3), a stolen facility transportation vehicle, misappropriation of resident's funds (#3), resident verbal abuse (#7), and unauthorized possession of resident's personnel information including social security numbers. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 9. Based on observations, interviews and record reviews, the facility failed to ensure the administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner for 1 of 2 sampled residents (Resident #1) related to an oral antibiotic used to treat urinary tract infections, a medication used to prevent heart attack and stroke, a medication used to treat symptoms caused by antipsychotic medications, a vitamin used to treat mineral and vitamin deficiencies, a medication used to treat constipation, a medication used to treat gastroesophageal reflux disease (GERD) peptic ulcer disease (PUD) and a medication used to treat schizophrenia. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 10. Based on interviews and record reviews, the facility failed to report allegations of misappropriation of residents funds and drug diversion by Staff D to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours for 3 of 3 sampled residents (Residents #3, #4 and #5) and Staff D was allowed to remain	D 181		

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D 181	Continued From page 22 employed. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. _____ The facility failed to ensure there was an Administrator or an Administrator-in-Charge in the facility to protect the residents from serious neglect and exploitation related to a resident who was hospitalized for fever, returned to the facility where he did not receive a full course of an antibiotic, remained febrile then returned to the hospital where he was diagnosed with sepsis and a staff who was suspected of stealing the facility's transportation vehicle, misappropriated residents funds and personal information was not appropriately reported to law enforcement or the Health Care Personnel Registry. These failures resulted in serious neglect which constitutes an A1 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 for this violation on 01/11/23. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2023.	D 181		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter.	D 219		

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Bed Count Position Type First Shift Second Shift Third Shift
21 - 30 Aide 16 16 8
Supervisor Not Required Not Required Not Required
Administrator/SIC In the building, or within 500 feet and immediately available.
31-40 Aide 16 16 16
Supervisor 8* 8* In the building, or within 500 feet and
immediately available.**
Administrator On call
41-50 Aide 20 20 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
51-60 Aide 24 24 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
61-70 Aide 28 28 24
Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40

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hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40
hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8

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Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on record reviews and interviews, the facility failed to ensure the required aide hours for 21 of 48 shifts sampled from 12/24/22 to 01/09/23.

The findings are:

Review of the facility's license revealed the facility had a licensed capacity of 86 residents.

Review of the facility's current census revealed there were 45 residents in the facility.

Review of the staffing requirements based on a census of 45 residents revealed the facility should have staffed 28 aide hours on first shift, 28 aide

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hours on second shift and 24 aide hours on third shift.

Review of the staff timecards dated 12/24/22 revealed:
-There were a total of 26.5 aide hours provided on second shift leaving a shortage of 1.5 aide hours.
-There were a total of 21.0 aide hours provided on third shift leaving a shortage of 3.0 aide hours.

Review of the staff timecards dated 12/25/22 revealed:
-There were a total of 16.0 aide hours provided on first shift leaving a shortage of 12.0 aide hours.
-There were a total of 16.0 aide hours provided on third shift leaving a shortage of 8.0 aide hours.

Review of staff timecards dated 12/26/22 revealed there were a total of 27.0 aide hours provided on first shift leaving a shortage of 1.0 aide hour.

Review of staff timecards dated 12/27/22 revealed there were a total of 22.0 aide hours provided on third shift leaving a shortage of 2.0 aide hours.

Review of staff timecards dated 12/28/22 revealed there were a total of 22.0 aide hours provided on third shift leaving a shortage of 2.0 aide hours.

Review of the staff timecards dated 12/29/22 revealed there were a total of 25.5 hours provided on second shift leaving a shortage of 2.5 hours.

Review of the staff timecards dated 12/30/22 revealed:

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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
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-There were a total of 27.0 hours provided on first shift leaving a shortage of 1.0 aide hour.
-There were a total of 26.0 hours provided on second shift leaving a shortage of 2.0 aide hours.
-There were a total of 22.0 aide hours on third shift leaving a shortage of 2.0 aide hours.

Review of the staff timecards dated 12/31/22 revealed:
-There were a total of 16.0 hours provided on second shift leaving a shortage of 12.0 aide hours.
-There were a total of 16.0 aide hours on third shift leaving a shortage of 8.0 aide hours.

Review of the staff timecards dated 01/01/23 revealed:
-There were a total of 12.0 hours provided on second shift leaving a shortage of 16.0 aide hours.
-There were a total of 8.0 aide hours provided on third shift leaving a shortage of 16.0 aide hours.

Review of the staff timecards dated 01/02/23 revealed there was a total of 16.0 aide hours provided on third shift leaving a shortage of 8.0 aide hours.

Review of the staff timecards dated 01/04/23 revealed:
-There were a total of 16.0 hours provided on second shift leaving a shortage of 12.0 aide hours.
-There were a total of 18.0 aide hours provided on third shift leaving a shortage of 6.0 aide hours.

Review of the staff timecards dated 01/06/23 revealed there were a total of 16.0 aide hours provided on third shift leaving a shortage of 8.0 aide hours.

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D 219	Continued From page 28 Review of the staff timecards dated 01/08/23 revealed there were a total of 22.0 aide hours provided on second shift leaving a shortage of 6.0 aide hours. Review of the staff timecards dated 01/09/23 revealed there were a total of 16.0 aide hours provided on third shift leaving a shortage of 8.0 aide hours. Interview with a MA on 01/10/23 at 10:40am revealed: -She worked double shifts for several days due to staff shortages. -She was getting tired from having to work double shifts. Interview with a second MA on 01/11/23 at 10:35 am revealed: -She worked double shifts someday's. -There was not enough staff to cover all the shifts. Interview with a PCA on 01/10/23 at 9:50am revealed: -She was filling in as a PCA due to staff shortages. -There were not enough MAs or PCAs for all three shifts. Interview with a second PCA on 01/10/23 at 11:00am revealed: -There were not enough staff to cover all three shifts. -She worked extra hours when she was available. Interview with a third PCA on 01/11/23 at 12:15am revealed: -There were not enough staff, and more staff	D 219		

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needed to be hired.
-He did all he could for the residents while he was on duty.

Interview with a fourth PCA on 01/11/23 at 2:20pm revealed:
-She worked several days a week.
-There were not enough staff for all three shifts.
-Some staff worked double shifts.

Interview with the Resident Services Director (RSD) on 01/10/23 at 9:20am and 01/11/23 at 11:35am revealed:
-There were no daily census reports available.
-The facility had a census of 45 residents.
-She was responsible for completing the schedule for all personal care aides (PCA) and medication aide (MA) staff.
-There were not enough staff to have the required work hours per shift per day.
-She had to work several days on all three shifts due to staff shortages.
-There was just enough staff for third shift, so she had to fill in often to let them have a day off.
-On 11/07/22, She informed the Owner about the need for more staff and was told the facility had too much staff.
-The Owner believed that because he paid more for overtime, there was too much staff and some needed to be let go.
-She tried on a weekly basis to get the Owner to understand there was overtime because there was not enough staff to meet the regulation for staffing needs for a census of 45 residents so staff, including her were working overtime and they still did not meet the required staffing for 45 residents.
-The facility owner was upset when staff got overtime.
-The facility owner told her he wanted to cut staff

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D 219	Continued From page 30 on each shift. -The Owner was responsible for hiring new staff and did not hire new staff since 11/07/22. Interview with the Owner on 01/11/23 at 10:55am revealed: -He was responsible for hiring new staff. -On 11/07/22, the RSD informed him about the need for more staff to be hired. -He did not believe there was a need for new staff to be hired because there was too much overtime being paid out. -He did not understand the rules and regulations related to staffing a facility with a census of 45 residents. -He denied the RSD's request to hire new staff and told her they needed to decrease staff. Refer to Tag 181, 10A NCAC 13F .0602, Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents. Refer to Tag 273, 10A NCAC 13F .0902(b), Health Care Referral and Follow-up. Refer to Tag 338, 10A NCAC 13F .0909, Resident Rights. Refer to Tag 358, 10A NCAC 13F .1004(a), Medication Administration. _____ The facility failed to ensure there was required aide hours for 21 of 48 shifts resulting in medication aides and personal care aides working double shifts multiple days in a row. Result of staff working double shifts staff was less alert, slower to respond to residents needs and more likely not to perform a task to their full ability. The Resident Services Director (RSD) was unable to perform her daily job duties and	D 219		

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D 219	Continued From page 31 supervise staff because she was rendering care to residents by performing duties such as bathing, toileting, and transferring residents from their beds to wheelchairs due to the facility being short staffed. The RSD worked on the halls performing duties such as personal care aide and medications aide due to being short staffed, which did not allow time for the RSD to verify medication orders, review hospital discharge paperwork thoroughly, ensure medications that were detrimental to residents' health such as medications for chronic pain, hypertension, and mental illness was ordered and delivered to the facility timely. This failure resulted in substantial risk of serious injury, abuse, neglect, or exploitation to all residents and constitutes a Type A2 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131 D-34 on 01/11/23, for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2023.	D 219		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2,	D 235		

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D 235	Continued From page 32 North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents had an FL2 that was updated on annually (#1). The findings are: Review of Resident #1's current FL2 dated 07/21/21 revealed: -An admission date of 02/06/17. -Diagnoses included benign hypertension, chronic obstructive lung disease and anxiousness. Review of Resident #1's record from 01/10/23 to 01/13/23 revealed there was not an updated FL2 completed or signed by the Primary Care Provider (PCP) after 07/21/21. Interview with the Resident Service Director (RSD) on 01/10/23 at 1:00pm revealed: -She was not aware Resident #1 did not have an up to date FL2. -She and the Business Office Manager were responsible for ensuring the FL2s were completed on time; however, she had not audited the residents' records in the last month and was not sure the last time an audit was completed. Interview with Resident #1's PCP on 01/11/23 at 2:00pm revealed: -She was not sure how often FL2s were supposed to be updated. -After a quick review of Resident #1's FL2 dated 07/21/21, she felt the information documented	D 235		

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D 235	Continued From page 33 was still pertinent. -She would need to verify the medication orders for accuracy. Interview with the Owner on 01/12/23 at 11:32am revealed: -The RSD was responsible for contacting the PCP to complete all of the residents' FL2s. -He expected the RSD to follow the state rules.	D 235		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 4 sampled residents (#2) had an assessment and care plan completed within 30 days of admission. The findings are: Review of Resident #2's current FL2 dated 12/23/22 revealed: -There was a diagnosis schizophrenia. -Resident #2 was intermittently disoriented. -Resident #2 required personal care assistance with bathing, feeding, and dressing. Review of Resident #2's Resident Register revealed:	D 259		

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D 259	Continued From page 34 -He was admitted to the facility on 01/11/22. -Assistance was required for bathing (needed reminders to bathe), nail care, shaving, grooming, skin care, mouth care, scheduling appointments. Review of Resident #2's record revealed: -There was no care plan completed 30 days after his admission. -There was an order for incontinent supplies dated 02/17/22. Interview with Resident #2 on 01/11/23 at 12:14pm revealed he required assistance with meal preparation and medication administration. Interview with a personal care aide (PCA) on 01/13/23 at 4:00pm revealed: -The PCAs used the residents' Personal Care Sheet binder to verify care needs of each resident. -Resident #2 did not have a current care sheet in the Personal Care Sheet binder. -Resident #2 was independent with all activities of daily living (ADLs) and only required assistance with linen changes and housekeeping tasks. Interview with the Resident Services Director (RSD) on 01/11/23 at 11:43am and 5:10pm revealed: -She was responsible for completing the resident's care plans. -She did not know Resident #2 did not have a care plan completed. Interview with Resident #2's primary care provider (PCP) on 01/11/23 at 2:10pm revealed: -She was not aware there was no initial care plan for Resident #2. -Resident #2 was independent with ADLs and was aware of his own care needs.	D 259		

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D 259	Continued From page 35 Interview with the Owner on 01/12/23 at 2:52pm revealed: -The RSD was responsible for completing the resident's care plans. -He was not aware that Resident #2 did not have a care plan.	D 259		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs of 1 of 2 sampled residents (Resident #1) related to a prescribed antibiotic not being administered for the full seven-day course, lab work that was not referred to home health and obtained one week after hospitalization, and reporting of daily temperatures greater than 100.4 to the Primary Care Provider (PCP). The findings are: Review of Resident #1's current FL2 dated 07/21/21 revealed diagnoses included benign hypertension, hypercholesterolemia, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), peptic ulcer disease (PUD) and schizoaffective disorder. Review of Resident #1's record revealed:	D 273		

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-The FL2 dated 07/21/21 was the most current one available.
-There were signed physician's orders dated 12/21/21.

Review of Resident #1's nurses notes revealed:
-He was sent to the emergency department (ED) on 12/05/22 at 4:46pm
-He returned to the facility from the hospital on 12/13/22 at 5:51pm.

Review of Resident #1's hospital discharge summary dated 12/13/22 revealed:
-Resident #1 was admitted to the hospital on 12/05/22 at 5:03pm with principal diagnoses which included septic shock, acute cystitis, Escherichia Coli bacteremia, severe protein calorie malnutrition, shock liver, COPD, acute metabolic encephalopathy, elevated troponin, acute kidney injury and lactic acidosis.
-He was discharged back to the facility on 12/13/22.

Review of Resident #1's hospital discharge summary dated 01/06/23 revealed:
-He was admitted to the hospital on 12/30/22 at 2:30pm with principal diagnoses which included sepsis, septicemia, and acute cystitis.
-His white blood cell (WBC) count was 17.22 upon admission (normal range is from 4.5 to 11.0).
-The resident's weigh was 127 pounds on 12/30/22 and 115 pounds at discharge from the hospital on 01/06/23.
-He was discharged back to the facility on 01/06/23.

Review of Resident #1's Home Health Registered Nurse (HHRN) visit note dated 12/30/22 at 1:24pm revealed:

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D 273	Continued From page 37 -On 12/27/22, HHRN was ordered by Resident #1's PCP when the resident was unable to void for disease/medication management and to obtain urinalysis (UA) with culture and sensitivity (C&S). -Diagnoses included unspecified Escherichia coli, sepsis, and protein calorie malnutrition. -The resident had been hospitalized recently for a urinary tract infection (UTI) and had reportedly completed antibiotics related to UTI, but still had a fever. -On 12/30/22 at 1:34pm, Resident #1's vital signs were as follows: blood pressure 130/60, oxygen saturation on room air 92%, respirations 18, temperature 99.5, resting heart rate 135-140 and weight was 135 pounds. -Respiratory assessment revealed the resident was having severe shortness of breath with moderate exertion. -Cardiovascular assessment revealed an arrhythmia of tachycardia. -Functional assessment revealed decreased strength in the bilateral lower extremities and exhaustion. -The facility was notified of the findings, and the resident was sent back to the hospital on 12/30/22 via ambulance to be evaluated. Review of Resident #1's HHRN visit note dated 01/08/23 at 9:50am revealed: -On 01/08/23 at 9:50am, Resident #1's vital signs were as follows: blood pressure 134/62, oxygen saturation on room air 97%, respirations 18, temperature 99.5, resting heart rate 89 and weight 115 pounds. -The resident was recently hospitalized on 12/30/22 due to UTI with sepsis. -The resident was discharged from the hospital on 01/06/23. -Skilled nursing was ordered for	D 273		

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disease/medication management related to sepsis with UTI.
-Respiratory assessment revealed slight shortness of breath with moderate exertion.
-Functional assessment revealed decreased strength, pain and stiffness of bilateral lower extremities.
-The resident was malnourished and continued to have weakness with ambulation and required assistance with ambulation.

a. Review of Resident #1's hospital discharge summary dated 12/13/22 revealed there was a physician's order for cefdinir (an oral antibiotic used to treat urinary tract infections) 300mg, take one capsule every 12 hours for 7 days.

Review of Resident #1's December 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for cefdinir 300mg, one tablet twice daily, scheduled for 8:00am and 8:00pm.
-Cefdinir was documented as administered twice daily from 12/16/22 at 8:00am to 12/20/22 at 8:00pm.
-Cefdinir was documented as not administered twice daily from 12/13/22 at 8:00pm to 12/15/22 at 8:00pm.
-There was no comment for the reason cefdinir was not administered.

Interview with a medication aide (MA) on 01/13/23 at 3:00pm revealed:
-Resident #1 received all of the prescribed cefdinir but she was not able to document it since there was a hold on his eMAR.
-She had not been able to document any of the medications that were administed to Resident #1 from 12/13/22 to 12/15/22 due to the hold on his

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eMAR.

Interview with the Resident Services Director (RSD) on 01/12/23 at 2:50pm and 01/13/23 at 9:00am revealed:
-She was not aware that Resident #1 did not finish his course of cefdinir in December 2022.
-She expected the MA's to alert her if residents missed any medication, notify the PCP and document the missed medications in the eMAR notes.
-If there was an incorrect hold on the eMAR, the MA should have notified her then documented the medications that were administered in the eMAR notes.
-The MA was also responsible for documenting in the resident's progress notes the PCP was notified and what the MA was directed to do and complete a written order if one was given.
-She had not audited the eMARs in the last month due to being very busy.

Interview with Resident #1's PCP on 01/11/23 at 2:00pm revealed:
-She was not informed by the facility that Resident #1 missed four doses of cefdinir.
-Missing four doses of the antibiotic could have contributed to Resident #4 not clearing the infection and lead to his rehospitalization with sepsis on 12/30/22.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 01/12/23 at 9:03am revealed:
-They received an order for cefdinir 300mg twice daily for 7 days on 12/13/22.
-Cefdinir 300mg take 1 tablet twice daily for 7 days, for a quantity 14 tablets, was dispensed to the facility on 12/14/22.
-If the resident did not receive the full 7 day

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course of antibiotic therapy, the infection could remain and not be resolved.

Telephone interview with a Pharmacist at Resident #1's pharmacy on 01/13/23 at 4:01pm revealed:
-Cefdinir 300mg was prescribed as an antibiotic and since four doses were missed it would be considered an incomplete course.
-This could have put Resident #1 at risk for a secondary infection that could be resistant to cefdinir.

b. Review of Resident #1's hospital discharge summary dated 12/13/22 revealed there was an order to obtain labs in one week, which included a complete blood count (CBC) and complete metabolic profile (CMP), due to abnormal lab values during the hospitalization.

Review of Resident #1's record revealed there was no documentation the CBC and CMP were obtained within one week of hospital discharge.

Interview with the RSD on 01/12/23 at 11:11am and 2:50pm revealed:
-The home health agency obtains lab orders for the facility.
-She did not remember an order received to obtain an CBC and CMP for Resident #1, nor did she see an order for a CBC and CMP in his hospital discharge summary dated 12/13/22.
-She was responsible for reading residents' hospital discharge paperwork and scheduling lab work.

Interview with Resident #1's PCP on 01/11/23 at 2:00pm revealed:
-The RSD did not leave Resident #1's hospital discharge summary from his 12/06/22- 12/13/22

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or 12/30/22- 01/06/23 hospitalizations in her folder to be reviewed.
-She was unaware that the hospital wanted Resident #1 to have a CMP and CBC drawn within a week of 12/13/22.
-The facility did not leave any lab work for Resident #1 in her folder to review so she was not sure if the labs were drawn.
-If she reviewed paperwork then she would have initialed the paperwork.

c. Review of Resident #1's signed physician's orders dated 12/21/21 revealed there was an order to check temperature once daily and notify the primary care provider (PCP) for temperature greater than 100.4.

Review of Resident #1's December 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check temperature daily at 8:00am.
-Temperature checks were performed at 8:00am from 12/26/22 to 12/20/22.
-Resident #1's temperature was recorded as 100.9 on 12/17/22, 101.5 on 12/18/22, 100.1 on 12/20/22, and 101.0 on 12/27/22.
-There was no documentation that the PCP was notified.

Review of Resident #1's progress notes revealed:
-On 12/03/22 at 1:45pm the resident was "a little confused" and had a temperature of 102.6.
-On 12/04/22 at 7:43pm the resident had a temperature of 100.6.
-On 12/05/22 at 4:46pm the resident had a temperature of 103.6, he was in the bed, confused, and was having difficulty breathing. The resident's PCP and family were notified and he was sent to the emergency department (ED)

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via ambulance.
-On 12/17/22 at 8:58am his temperature was 100.9, at 1:34pm his temperature was 100.4. and at 6:57pm his temperature was 101.3.
-On 12/19/22 at 8:11am his temperature was 101.5 and at 1:00pm his temperature was 101.6.
-On 12/20/22 at 9:11am his temperature was 101.1, at 11:46am his temperature was 100.8 and at 8:17pm his temperature was 102.1.
-On 12/22/22 at 6:37am his temperature was 102.9 and at 1:20pm his temperature was 101.8.
-On 12/23/22 at 5:53am his temperature was 100.6 and at 1:03pm his temperature was 101.7.
-On 12/25/22 at 4:11pm his temperature was 102.4.
-On 12/26/22 at 7:06pm his temperature was 103.4 and at 8:13pm his temperature was 101.7.
-On 12/27/22 at 6:03pm his temperature was 102.2, at 8:31pm his temperature was 102.1 and at 9:38pm his temperature was 102.3.
-On 12/28/22 at 10:51am his temperature was 100.6 and at 2:09pm his temperature was 100.4.
-On 12/30/22 at 4:44pm, the resident was sent to the ED by the home health nurse with a fever, shortness of breath, elevated heart rate, and lethargy. The resident's PCP and family were notified.
Interview with a MA on 01/11/23 at 12:35pm revealed:
-The MAs were responsible for notifying the PCP for any orders that required notification related to temperatures outside of parameters, missed and/or refused medications.
-After the PCP notification was made, the MAs were responsible for documenting in the eMAR and their findings in the resident's progress notes.

Interview with a second MA on 01/13/23 at 3:00pm revealed:
-Resident #1 had a fever almost daily when he

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returned from the hospital in the middle of December 2022, and she thought the RSD notified his PCP.
-She was not aware of a standing order to contact the PCP if Resident #1 had a fever greater than 100.4.
-If she notified the PCP or RSD about Resident #1's fevers, she would have documented it in the resident's progress notes.

Interview with the RSD on 01/11/23 at 5:01pm revealed:
-She was aware Resident #1 had an order to contact the PCP if his fever was greater than 100.4.
-Typically, the MAs would take Resident #1's temperature and inform her if it was high or she may be the one to take Resident #1's temperature when working as a MA.
-She was responsible for contacting the PCP by a phone call or text message.
-She thought Resident #1's PCP had been informed of his fevers in December 2022 but could not find any documentation.
-She audited the residents' records but had not completed an audit in the last month due to being very busy.

Interview with Resident #1's PCP on 01/11/23 at 2:00pm revealed:
-She assessed Resident #1 at least once a month and knew that he was seen by a HHRN between his two hospitalizations in December 2022.
-The RSD did not inform her that Resident #1 had any fevers above 100.4 in December 2022.
-She was aware that Resident #1 was hospitalized from 12/06/22 to 12/13/22 with sepsis.
-Resident #1's fevers above 100.4 after 12/13/22

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could have indicated that he did not clear the infection.
-If she knew that Resident #1 had experienced multiple fevers above 100.4 after being discharged from the hospital then she would have intervened by repeating a urine culture and starting or extending an antibiotic regimen.
-Her interventions could have prevented Resident #1 from being hospitalized with sepsis again from 12/30/22 to 01/06/23.

Telephone interview with the scheduler and clinical manager at Resident #1's Home Health provider's office on 01/12/23 a 8:39am and 8:43am revealed:
-Resident #1 was a current patient with skilled nursing.
-The start of care (SOC) visit was done 12/30/22 and the resumption of care (ROC) visit was completed on 01/08/23.

Interview with the Owner on 01/12/23 at 11:32am revealed:
-The RSD was responsible for contacting the PCP.
-He was not involved in auditing the resident's records and was not sure if anyone in the facility was doing it.
-He expected the RSD to do what was necessary for the residents and follow the state rules.

_____

The failure of the facility to to ensure referral and follow-up to meet the routine and acute health care needs of 1 of 2 sampled residents (Resident #1) related to a prescribed antibiotic not being administered for the full seven-day course, lab work that was not referred to home health and obtained within one week after hospitalization, and reporting of daily temperatures greater than 100.4 to the PCP for a resident who was

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D 273	Continued From page 45 hospitalized on 12/05/22 and again on 12/30/22 for sepsis and UTI. This failure resulted in the serious injury and neglect of one resident and constitutes a Type A1 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131 D-34 on 01/11/23, for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2023.	D 273		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic	D 278		

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D 278	Continued From page 46 debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity;	D 278		

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D 278	Continued From page 47 (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 5 sampled residents with an indwelling catheter (Resident #3) had a Licensed Health Professional Support (LHPS) review completed quarterly by an appropriate licensed health professional. The findings are: Review of Resident #3's current FL2 dated 09/08/22 revealed: -Diagnoses included pressure ulcer stage 3 to right buttocks, bronchitis, and chondrocalcinosis right knee. -The resident was semi-ambulatory. -The resident had an indwelling catheter. -The resident required total care with bathing. Review of Resident #3's Care Plan dated 06/02/22 revealed: -He was totally dependent with toileting, ambulation, bathing, dressing, grooming and transfers. -He required supervision with eating	D 278		

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-He required a wheelchair for ambulation.
-He had an indwelling catheter, "not selfcare" was documented.

Review of Resident #3's quarterly review for LHPS tasks revealed:
-The last LHPS review completed by a Registered Nurse (RN) was dated 12/02/2021.
-Documentation on the LHPS form indicated there was a suprapubic catheter intact with clear yellow urine.
-There were no complications noted.

Review of Resident #3's record revealed there was no documentation of home health visits.

Interview on 01/10/23 at 9:50am with personal care aide (PCA) revealed:
-Resident #3 liked to have the catheter bag near his lap.
-The catheter would not drain down the tube when it was elevated.
-Resident #3 cursed the staff when they mentioned the catheter bag should be lower.
-Resident #3 could empty his catheter bag independently.

Interview with a medication aide (MA) on 01/10/23 at 2:50pm revealed:
-Resident #3 had a catheter changed monthly by the home health nurse.
-Resident #3 would not keep his catheter bag low on the wheelchair.
-If staff instructed Resident #3 to lower the catheter, he would get upset.

Interview with Resident #3 on 01/11/23 at 1:00pm revealed:
-He was able to empty the catheter bag on his own and a nurse visited monthly to check on it.

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D 278	Continued From page 49 -The catheter bag was fine where it was (up near his lap). -The urine was draining down the tube, it was fine. Observation on 01/11/23 at 1:00pm revealed: -Resident #3's catheter bag was near the lap area. -The urine in the catheter was brown. -There was more urine in the tube than in the catheter bag due to the catheter was not low enough for the urine to drain down into the bag. Interview with the Resident Service Director (RSD) on 01/10/23 at 2:40pm revealed: -The facility did not have a contracted RN to complete the LHPS reviews. -There had not been a RN on the payroll since 2021. -The previous Administrator knew there was no RN, and had never contracted with one. -The facility owner was informed there was not a contracted nurse for the facility. -The facility owner was informed a contracted nurse had to be paid for the services provided. -The facility owner had not tried to contract with a RN. -Nurses only came into the facility when a resident had a physician's order for home health services. -A nurse from home health would come to the facility monthly to change and flush Resident #3's catheter. -Resident #3 was told to keep his catheter bag lower on the wheelchair. -Resident #3 would not listen and continued to keep the catheter bag near his lap. -Resident #3 would get upset when staff reminded him the catheter bag needed to be lower.	D 278		

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D 278	Continued From page 50 Interview with the Resident Services Director (RSD) on 01/11/23 at 5:10pm revealed Resident #3 did not have a quarterly LHPS review in his record. Interview with the Owner on 01/12/23 at 2:52pm revealed: -He was aware that a RN was responsible to complete the quarterly LHPS reviews. -The facility did not currently employ a RN to complete the LHPS reviews, but planned to hire one. -He was not aware that Resident #3 did not have quarterly LHPS reviews completed.	D 278		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to provide plate ware that was free from contamination to all the residents in the facility related to using improper chemicals to sanitize dishes, utensils, cups and cookware. The findings are:	D 283		

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D 283	Continued From page 51 Observation of the kitchen on 01/10/23 at 10:36am revealed: -There were three containers on a wire rack near the dishwashing machine. -The container of dish detergent and the container of rinse aid were empty. -The third container was labeled "Liquid Laundry Compound 2" and was approximately 75% full of blue liquid. -There was a blue hose that was connected to the dishwashing machine at one end and the other end was in the container of liquid laundry compound 2. Observation of the kitchen on 01/10/23 from 11:56am to 12:02pm revealed: -A dietary aide washed pots and pans with dish detergent in the facility's two compartment sink then put the pots and pans in the dishwasher and ran it. -The dishwasher was ran using the liquid laundry compound during the cycle. -The pots and pans were taken out of the dishwasher and placed on the drying rack. -The dietary aide loaded four plates into the dishwasher and ran it. -The dishwasher was ran using the liquid laundry compound during the cycle. -The dishes were taken out of the dishwasher and set to the side to dry. -The Dietary Manager (DM) took one of the dishes and plated lunch for a resident. Review of Environmental Health Services (EHS) Inspection Report dated 01/04/23 revealed: -The EHS Inspector visited the facility on 01/04/23 due to a complaint that the facility did not have adequate dish detergent. -The EHS Inspector verified the kitchen had dish	D 283		

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detergent, but the kitchen stated it was running low due to a wrong order.
-The kitchen staff were using other methods until new dish detergent was purchased.

Interview with the Housekeeping Supervisor on 01/11/23 at 8:30am revealed:
-She ordered all the chemicals for the facility.
-She was in the kitchen daily and looked at the dish detergent, dish sanitizer and rinse aid to see if she needed to order more.
-The dish detergent, dish sanitizer and rinse aid ran out sometime last week (01/01/23- 01/06/23).
-On two occasions, the chemical company sent laundry detergent instead of chemicals for the dishwasher.
-The next order was scheduled to arrive on 01/12/23.

Interview with the DM on 01/10/23 at 9:38am and 4:20pm revealed:
-An EHS Inspector came to the facility on 01/04/23 and told the kitchen staff to start using paper plates due to not having any dish detergent.
-After the EHS Inspector left, dish detergent was purchased from the store.
-She told the kitchen to start using regular plates on 01/09/23 since the facility ran out of the paper plates.
-The Owner was not informed that the facility ran out of paper plates because she did not want to ask him for money to buy more paper plates.
-The laundry detergent was delivered to the kitchen sometime last week (01/01/23- 01/06/23) and she hooked it up to the dishwasher on 01/06/23 since she did not know what else to do with it but knew it was not the correct chemical for the dishwasher.
-Kitchen staff had been washing dishes in the

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MAGNOLIA GARDENS	916 S. MARIETTA STREET GASTONIA, NC 28054

(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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two-compartment sink, with the purchased dish detergent, then running the dishes through the dishwasher to sanitize them with the laundry detergent.

Interview with a EHS Inspector on 01/10/23 at 3:00pm revealed:
-He was asked to visit the facility on 01/10/23 due to a report that laundry detergent was being used in the dishwasher.
-Using laundry detergent in a dishwasher would not properly clean the dishes, utensils, cups or cookware.
-Laundry detergent would not kill any bacteria that required hot water or chemical sanitization and residents were at risk of exposure to bacteria from raw meats (such as Campylobacter, Salmonella, E. coli and Clostridium perfringens) and any contagious diseases or infections that could be passed by saliva.
-There was no way for the facility to kill bacteria on the dishes, utensils and cups without using a dish sanitizer.
-The facility should stop using the dishwasher until the dish detergent, dish sanitizer and rinse aid were delivered.
-The blue hose attached to the dishwasher would need to be replaced due to contamination with laundry detergent, before the dishwasher could be used again.
-He recommended using paper products and plastic utensils for the residents, but the cookware would require proper cleaning.
-Until the chemicals and new hose arrived, the facility should wash the cookware with dish detergent and water of 110 degrees Fahrenheit or at the manufacturer's recommendation, rinse and sanitize.
-The facility had a two compartment sink so they were required to wash with dish detergent in one

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compartment then rinse with clean water in the other compartment, let the cookware dry on a sanitized surface while the two compartment sink was cleaned, make a 5200 parts per million sanitizer solution in the sink with bleach and water, dip the cookware in the sanitizer, let it air dry then put the cookware away.
-He educated the kitchen staff on this procedure on 01/10/23.

Interview with the Owner on 01/10/23 at 5:00pm revealed:
-Approximately one to three weeks ago staff told him they were out of dish washing supplies and he approved them to order more.
-The kitchen started serving meals on paper plates when they ran out of the dish washing supplies.
-Yesterday (01/09/23), he found out that the kitchen started serving meals on regular plates again.
-He was not informed that they had run out of paper plates and told the kitchen staff to use paper plates until the dish washing supplies arrived.
-He was not aware that laundry detergent had been used in the dishwasher until this afternoon (01/10/23) when the EHS Inspector visited the facility.
-He expected the kitchen staff to only use appropriate chemicals for the dishwasher and to use paper plates until the chemicals arrived.

Interview with the DM on 01/12/23 at 9:23am revealed:
-The EHS Inspector told her to mix bleach and water to make a sanitizing solution for the cookware.
-He did not give her a specific amount of bleach to mix with a specific amount of water and she

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did not think that it required clarification.
-She estimated that she had been using a cup of bleach in enough water to cover the cookware that required sanitizing.
-When the EHS Inspector used the term "50-200" she thought it was related to the hose required for the dishwasher and had not been using test strips to determine the concentration of the sanitizing solution.
-She planned to get the EHS Inspector's phone number from the Maintenance Director and ask for clarification on how to make the sanitizing solution.

Interview with the Owner on 01/12/23/ at 11:32am revealed:
-He did not remember if the EHS Inspector provided specific instructions on how to make a sanitizing solution with bleach and water.
-He was not aware that the kitchen staff did not know how to make a sanitizing solution with bleach and water.
-He said someone would follow up with EHS to get proper instructions on how much bleach to use.

Interview with the DM on 01/13/23 at 10:50am revealed she continued to use approximately a cup of bleach with enough water to cover the cookware.

_____

The facility failed to ensure proper chemicals were being used to sanitize dishware and cookware from bacteria in the dishwasher. Which could result in all residents potentially being exposed to bacteria from raw meat and contagious diseases or illness that were spread through saliva. This failure was detrimental to the health, saftey and welfare of the residents and constitutes a Type B Violation.

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D 283	Continued From page 56 The facility provided a plan of protection in accordance with NCAC 13F .0904(a)(2) on January 10, 2023 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2023.	D 283		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure there was a three-day supply of perishable foods based on the planned menu for 45 residents. The findings are: Review of the planned lunch menu for 01/10/23 revealed loaded baked potato soup, meatball sandwich, oven fried squash, hot spiced apples were to be served. Observation of the lunch meal service on 01/10/23 at 11:30am revealed: -Turkey tetrazzini, green beans and baked spiced apples were served to 45 residents. -A starchy vegetable was not served to 45	D 285		

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residents.

Review of the planned lunch menu for 01/11/23 revealed turkey tetrazzini, baby carrots, sweet potato casserole, dinner roll with margarine and a dessert cart option were to be served.

Observation of the lunch meal service on 01/11/23 at 11:39am revealed:
-Beef stroganoff, mixed vegetables, garlic bread and applesauce was served to 45 residents.
-A starchy vegetable was not served to 45 residents.

Review of the breakfast menu for 01/12/23 revealed vitamin C fortified juice, cereal, eggs, breakfast meat, toasted bread with margarine or jelly and 2% milk were to be served.

Observation of the breakfast meal service on 01/12/23 at 7:30am revealed:
-Grits, scrambled eggs, sausage gravy, a quarter of a hot dog bun, water and coffee with creamer were served to 45 residents.
-Vitamin C fortified juice and 2% milk were not served to 45 residents.

Interview with a resident on 01/12/23 at 8:45am revealed:
-He went to get a snack from the vending machine because he was still hungry from not having enough to eat at breakfast.
-The kitchen was not able to offer second helpings on any of the food that was served this morning (01/12/23) and the portions served were already small.
-The meals that the facility served typically did not fill him up and he bought snacks from the vending machine or the grocery store to feel full.
-The vending machine only had options that

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would be bad for his diabetes, but he did not care because he was starving.
-Everyone would be a lot happier if the kitchen could provide more food.
-The portion sizes at the facility had been small since he was admitted in October 2022.

Interview with two residents on 01/12/23 at 10:00am revealed:
-Sometimes they are served small portions at meals.
-They have not been offered juice in several days.

Interview with a dietary aide on 01/12/23 at 6:25am and 7:35am revealed:
-They have not been able to follow the menu lately due to a limited food supply.
-She served quartered hot dog buns as toast this morning (01/12/23) because that was what they had to work with.
-Residents typically received juice with breakfast but the facility ran out on Monday (01/09/23) and the truck would not arrive until later today.

Interview with a personal care aide (PCA) at 7:30am on 01/12/23 revealed:
-Residents were normally given sliced bread for toast instead of hot dog buns but "I guess the kitchen had to work with what they had".
-Residents were offered juice with breakfast when the kitchen had it.

Review of the regular diet menu compared with the food items available for use in the kitchen on 01/10/23, 01/11/23 and 01/12/23 at 10:01am revealed:
-Loaded baked potato soup was not available for lunch on 01/10/23 and there were no other foods available for appropriate substitutions.
-Vitamin C fortified juice was not available for

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breakfast on 01/11/23 or 01/12/23 and there were no other beverages available for appropriate substitutions.
-Sliced bread for toast was not available for breakfast on 01/11/23 or 01/12/23 and there were no other foods available for appropriate substitutions.
-Sweet potato casserole and a dessert cart option were not available for lunch on 01/11/23 and there were no other foods available for appropriate substitutions.
-There was not 2% milk available for breakfast on 01/12/23 and there were no other beverages available for appropriate substitutions.

Interview with the Dietary Manager (DM) on 01/10/23 at 9:38am and on 01/11/23 at 8:32am revealed:
-Most residents were not aware of the food shortage in the kitchen because staff spent their personal funds to buy food for them.
-She had never been able to follow the menu since she was not able to order the food that was needed.
-The weekly food budget covered most items for five days of meals and staff would go to the grocery store to purchase food to get the facility through the next two days of the week.
-When she ordered food from the contracted supplier, she focused on the breakfast food and meats then tried to use what the facility had on hand for sides.
-The facility did not have an emergency food supply because the kitchen had to continuously use the food on the shelves to fill out the planned meals.
-The kitchen staff did not always follow the menu, but "we made sure the residents had something to eat".
-She did not follow the portion sizes on the menu

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because the kitchen did not have the correct ladels, so she served what she thought was enough of each meal item.
-The food delivery order was entered on Tuesdays and delivered on Wednesdays after lunch was served.
-She did not have the ingredients to prepare the planned lunch on 01/10/23 so she decided to substitute part of the lunch that was planned for 01/11/23.
-On 01/11/23, she cooked beef stroganoff with mixed vegetables, garlic bread and applesauce because those items were available in the kitchen.

Interview with the food company representative on 01/13/23 at 11:00am revealed:
-The Owner was frequently upset with how much money the kitchen spent on food through the contracted food supplier.
-She told him the menus were not designed to match his budget but were designed to meet the nutritional needs of residents.

Telephone interview wtih food company's Registered Dietitian on 01/17/23 at 12:19pm revealed meals should have included 2 oz of protein, ½ cup of a starchy vegetable, ½ cup of a non-starchy vegetable, a grain and a fruit served with lunch or supper.

Interview with the Resident Service Director (RSD) on 01/12/23 at 2:50pm revealed:
-She was aware that the kitchen struggled to purchase enough food for the residents.
-All of the staff had purchased something to help supplement what the kitchen could provide so the residents would have something to eat.

Interview with the Owner on 01/12/23 at 11:32am

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D 285	Continued From page 61 revealed: -He gave the DM a strict budget to follow when she ordered from the contracted food supply company and expected the DM to stay within budget to order everything she needed. -He was not aware of the rule that required facilities to have a three-day supply of perishable foods based on the menu. -He thought the facility had plenty of food.	D 285		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to document any substitutions made to the menu. The findings are: Observation during the kitchen tour on 01/10/23 at 9:30am revealed there was not a food substitution list available. Review of the planned menu for the lunch service on 01/10/23 revealed loaded baked potato soup, meatball sandwich, oven fried squash and baked spiced apples were to be served.	D 292		

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D 292	Continued From page 62 Observation of the lunch meal served on 01/10/23 at 11:40am revealed: -Turkey tetrazzini, green beans, baked spiced apples, water and iced tea was served to the residents. -Loaded baked potato soup, meatball sandwich and oven fried squash was not served during the lunch meal service on 01/10/23. Review of the planned menu for the lunch service on 01/11/23 revealed turkey tetrazzini, baby carrots, sweet potato casserole, a dinner roll with margarine and a dessert cart were to be served. Observation of the lunch meal served on 01/11/23 at 11:39am revealed: -Beef stroganoff, mixed vegetables (carrots, peas and corn), garlic bread, applesauce, water and iced tea was served to the residents. -Turkey tetrazzini, sweet potato casserole, a dinner roll and a dessert cart were not served during the lunch meal service on 01/11/23. Review of the planned menu for the breakfast service on 01/12/23 revealed vitamin C fortified juice, cereal, eggs, breakfast meat, toasted bread with margarine or jelly and 2% milk were to be served. Observation of the breakfast meal served on 01/12/23 at 7:30am revealed: -Grits, scrambled eggs, sausage gravy, a quartered hot dog bun, coffee and water was served to the residents. -Toasted bread, vitamin C fortified juice and 2% milk were not served during the breakfast meal service on 01/12/23. Interview with a dietary aide on 01/12/23 at 6:25am and 7:35am revealed:	D 292		

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D 292	Continued From page 63 -The Dietary Manager (DM) or cook typically prepared the meals and sometimes she prepared breakfast. -The DM did not tell her what to prepare for breakfast this morning (01/12/23) and the facility had not been able to follow the menu lately due to a limited food supply. -She chose to serve grits, eggs and sausage gravy since that it what they had in the kitchen. -She did not document menu substitutions. Interview with the DM on 01/10/23 at 9:38am, on 01/11/23 at 8:32am and at 1:21pm revealed: -She had been filling in as the cook recently. -She had a binder to record menu substitutions but did not document anything in it because she made substitutions to almost every meal, therefore the binder would be very full. -She had to substitute frequently due to financial restraints and used the menu as a guide of what to prepare by substituting food based on what was available in the kitchen. -When substituting foods, she ensured the substitutions were within the same food group. -She always included a meat, starch, vegetable and dessert with the meal. -The previous Administrator knew she had experience working in a kitchen so she did not receive any training for the DM position, but she had completed the food service orientation training. Interview with the Owner on 01/12/23 at 11:32am revealed: -He was not aware the kitchen had a difficult time following the menu due to the budget. -He did not know the rules involved with making menu substitutions or that menu substitutions were supposed to be recorded.	D 292		

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D 300	Continued From page 64	D 300		
D 300	10A NCAC 13F .0904(d)(3)(B) 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: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure at least two fruit servings listed on the facility menu were served to the residents in the facility. The findings are: Review of the facility menu seven-day week-at-glance menu revealed the breakfast meal on 01/12/23 was to consist of one-half cup of vitamin C fortified juice and the dinner meal was to consist of one-half cup of blushing pears. Observation on 01/10/23 at 10:01am of the facility's food supply revealed there was six 109-ounce cans of diced pears, three 109-ounce cans of country apples, sixty 4-ounce servings of applesauce and a box of 50 bananas.	D 300		

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D 300	Continued From page 65 Observation on 01/12/23 at 7:30am of the breakfast meal service revealed no fruit or vitamin C fortified 100% fruit juice was served to the residents. Observation on 01/12/23 at 4:15pm of the dinner meal service revealed no fruit or vitamin C 100% fruit juice was served to the residents. Interview with two residents on 01/12/23 at 10:00am revealed they have not been offered juice in several days. Interview with a personal care aide (PCA) on 01/12/23 at 7:30am revealed the residents were sometimes offered fruit juice at breakfast, but the residents only had the choice of water or coffee to drink this morning. Interview with a dietary aide on 01/12/23 at 7:35am revealed: -The residents were offered juice at breakfast, when the facility had it. -The facility ran out of juice on 01/09/23 and it should arrive on the delivery truck later today. Interview with the Dietary Manager (DM) on 01/11/23 at 8:32am and 1:21pm revealed: -She ordered the meals and snacks for the facility on a weekly basis. -The weekly food budget prevented her from ordering everything that the menu called for, so she tried to focus on ordering breakfast food and meat. -She made sure to serve meat, starch, one vegetable and dessert with every meal. -She knew residents were supposed to be served fruit on a daily basis and was not sure why she did not serve fruit with dinner on 01/12/23.	D 300		

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D 300	Continued From page 66 Telephone interview with the facility's contracted menu supplier's Registered Dietitian on 01/17/23 at 12:19pm revealed: -The meals that were being served by the facility were inadequate because they were not following the menu. -COVID-19 related supply chain issues had improved and any current shortages should not limit the facility from serving nutritionally adequate meals. -For the meals served on 01/12/23, the facility was short two servings of fruit. -Residents should be served two servings of fruit per day and one serving should be rich in vitamin C. -Vitamin C was an antioxidant that aided in wound healing, iron absorption, immunity and prevention of infections. Interview with the Owner on 01/12/23 at 11:32am revealed: -He did not expect the kitchen to serve everything that was listed on the menu because it was difficult to get everything with the COVID-19 related food shortages. -He knew the facility served nutritious meals because he looked at the food prepared and thought it was nutritious. -He did not compare the meals served to what was planned on the menu and was unaware of the daily nutritional requirements.	D 300		
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	D 310		

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D 310	Continued From page 67 supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 4 of 6 sampled residents (Residents #1, #6, #7, and #8) received appropriate therapeutic duets as ordered with orders for a renal and low concentrated sweets diet (#8), a low concentrated sweets and mechanical soft/ground meats diet (#6), supplemental nutritional shakes ordered three times per day (#1) and a low fat/ low cholesterol, low sodium and 60 grams of carbohydrate per meal diet (#7). The findings are: 1.Review of Resident #8's current FL2 dated 07/29/22 revealed: -Diagnoses included congestive heart failure and hypertension. -There was an order to check and record blood sugar twice weekly and an order for Januvia 50mg daily (a medication used with diet and exercise to control high blood sugar). -There was no diet order listed on the FL2. Review of Resident #8's physician's order sheet dated 06/02/22 revealed an order for a renal, low concentrated sweets (LCS) diet. Review of the facility's diet list on 01/10/23	D 310		

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revealed Resident #8 was to be served a renal diet and LCS diet.

Review of the facility's posted menu for the lunch meal service on 01/10/23 revealed turkey tetrazzini, green beans, baked spiced apples, dinner roll, water and iced tea was to be served to the residents.

Review of the renal and LCS therapeutic diet menus for the lunch meal service for 01/11/23 revealed turkey tetrazzini, baby carrots, buttered corn and a dessert cart was to be served to the residents.

Observation of the lunch meal service on 01/10/23 at 11:30am revealed:
-Resident #8 was served turkey tetrazzini with gravy, green beans, baked apples, water and iced tea.
-Resident #8 requested seconds and received a second helping of turkey tetrazzini with gravy..
-Resident #8 consumed 100% of her meal and 100% of the second helping of turkey tetrazzini with gravy.

Interview with the Dietary Manager (DM) on 01/10/23 at 9:38am revealed:
-She had been filling in for the cook lately.
-The renal diet avoided fried foods and the LCS diet received a sugar substitute instead of real sugar.

Telephone interview with the facility's contracted menu company's Registered Dietitian on 01/17/23 at 12:19pm revealed:
-The renal and LCS diet should have been served turkey tetrazzini without the gravy since the gravy was high in sodium.
-The green beans and baked spiced apples were

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acceptable to serve to Resident #8.
-"Dessert cart" referred to pies and cakes but the LCS diet should have received a diet pie/cake or fruit.

Interview with Resident #8's Primary Care Provider (PCP) on 01/11/23 at 2:00pm revealed:
-Resident #8's cardiologist recommended that she be on a renal diet to limit her sodium intake.
-Resident #8 was also ordered a LCS diet to help control her blood sugar.

Telephone interview with a representative at Resident #8's cardiology office on 01/12/23 at 8:42am revealed:
-Resident #8 diagnoses included hypertension, stage 3 chronic kidney disease, an ejection fraction of 25-30% (a measure of how much blood the heart pumps out with each contraction), fluid overload and congestive heart failure.
-Resident #8 was last seen by the Cardiologist on 06/14/22, with difficulty breathing due to worsening of her congestive heart failure.
-The Cardiologist recommended a low sodium diet for Resident #8 to help prevent increased fluid retention, increased blood pressure and an increased risk of heart disease.
-Resident #8's history of stage 3 chronic kidney disease decreased the body's ability to remove excess sodium which put her at a higher risk for increased blood pressure and further damage to the kidneys.
-An intake of more than 1500 mg of sodium per day could increase fluid retention around the heart and lungs leading to difficulty breathing and chest pain.
-An ejection fraction of 25-30% can lead to chest pain, increased heart rate, difficulty breathing, fatigue and rapid weight gain.
-An ejection fraction less than 30% indicated the

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heart's pumping ability was severely below normal which could lead to edema, chest pain, difficulty breathing, weakness and an increased risk of developing a dangerous arrhythmia that could cause death.

Refer to interview with the DM on 01/10/23 at 9:38am.

Refer to interview with the facility's PCP on 01/11/23 at 2:00pm.

Refer to interview with the Owner on 01/12/23 at 11:32am.

2. Review of Resident #6's current FL2 dated 07/01/22 revealed:
-Diagnoses included stroke and history of a motor vehicle accident with hemiparesis (weakness on one side of the body).
-There was diet order listed on the FL2.

Review of Resident #6's physician's order sheet dated 01/07/22 revealed an order for a mechanical soft/ground meats and low concentrated sweets (LCS) diet.

Review of the facility's diet list on 01/10/23 revealed Resident #6 was to be served a mechanical soft and LCS diet.

Review of the facility's posted menu for the lunch meal service on 01/10/23 revealed turkey tetrazzini, green beans, baked spiced apples, dinner roll, water and iced tea was to be served.

Review of the mechanical soft and LCS therapeutic diet menu for the lunch meal service for 01/11/23 revealed ground turkey in tetrazzini, baby carrots, sweet potato casserole and a

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D 310	Continued From page 71 dessert cart. Observation of the lunch meal service on 01/10/23 at 11:30am revealed: -Resident #6 was served turkey tetrazzini with turkey that was cut into small pieces, green beans, applesauce, iced tea and water. -Resident #6 did not choke while eating and ate 100% of his meal. Interview with the Dietary Manager (DM) on 01/11/23 at 1:21pm and 01/12/23 at 9:23am revealed: -The mechanical soft diet required the meat to be cut into small pieces. -She did not know that the mechanical soft therapeutic diet menu had ground turkey in tetrazzini on it. -She thought serving the turkey tetrazzini as it was would be fine since the meat was already cut into small pieces. -The previous DM broke the kitchen's blender in the spring of 2022, and she did not have a way to prepare ground food. -She took over as the DM in October 2022 and did not readdress the broken blender with the Administrator at that time. Interview with the Resident Service Director (RSD) on 01/11/23 at 5:01pm revealed she was not aware the kitchen did not have a working blender and could not prepare ground food. Telephone interview with the facility's contracted menu company's Registered Dietitian on 01/17/23 at 12:19pm revealed: -The mechanical soft diet could have chopped or ground meat depending on the resident's ability but since the diet order was ground meat then the turkey in the tetrazzini should have been ground.	D 310		

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-Green beans and applesauce were acceptable to serve to Resident #7.
-"Dessert cart" referred to pies and cakes but the LCS diet should have received a diet pie/cake or fruit.

Interview with Resident #6's Primary Care Provider (PCP) on 01/11/23 at 2:00pm revealed:
-Resident #6 had a history of a stroke which was most likely why he was ordered a mechanical soft diet with ground meats.
-She was not sure when the diet was originally ordered.
-Strokes could result in difficulty during chewing and swallowing so following a mechanical soft diet with ground meat would decrease his chances of choking.
-She was not aware that Resident #6 had not been served ground meat and would like him to continue on a mechanical soft diet with ground meats.

Interview with the Owner on 01/11/23 at 11:32am revealed he was not aware that the kitchen did not have a working blender.

Refer to interview with the DM on 01/10/23 at 9:38am.

Refer to interview with the facility's PCP on 01/11/23 at 2:00pm.

Refer to interview with the Owner on 01/11/23 at 11:32am.

3. Review of Resident #1's current FL2 dated 07/21/21 revealed:
-Diagnoses included chronic obstructive lung disease (COPD), peptic ulcer disease and gastroesophageal reflux disease (GERD).

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-There was an order for a regular diet and a nutritional shake three times per day with meals due to weight loss.

Review of Resident #1's signed physician order sheet dated 06/02/22 revealed an order for a regular diet and a nutritional supplement three times per day.

Review of the facility's diet list on 01/10/23 revealed Resident #1 was to be served a regular diet.

Observation of the lunch meal service on 01/10/23 from 11:30am to 12:20pm revealed:
-Resident #1 was served water and iced tea to drink with his lunch.
-He drank all of the iced tea but did not drink any of the water.
-Resident #1 was not offered a nutritional shake with his meal.

Interview with the Dietary Manager (DM) on 01/11/23 at 1:21pm revealed the medication aides (MA) gave out nutritional supplements to residents.

Observation of the walk-in refrigerator in the kitchen on 01/10/23 at 10:02am and on 01/12/23 at 6:31am revealed an unopened box of vanilla flavored nutritional shakes that was not labeled with a resident's name.

Review of Resident #1's November 2022, December 2022 and January 2023 electronic medication administration records (eMAR) revealed there was not an entry for a nutritional shake three times per day with meals.

Interview with Resident #1 on 01/13/23 at

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10:41am revealed he did not remember the last time the facility offered him a nutritional shake.

Interview with a first shift MA on 01/13/23 at 12:22pm revealed:
-She had given Resident #1 the nutritional shake in the past, but the facility had been out of them for a few weeks.
-She was not aware there were nutritional shakes in the walk-in refridgerator.

Interview with a second shift MA on 01/13/23 at 3:00pm revealed she started working at the facility in February 2022 and was not aware of a time that Resident #1 received a nutritional shake.

Interview with the Resident Service Director (RSD) on 01/13/23 at 11:24am revealed:
-She was told the facility had been out of nutritional shakes for one to two days due to the contracted food company experiencing procurement issues and was not aware there were nutritional shakes in the walk-in refridgerator.
-If a resident received a nutritional supplement, then it would be listed on their eMAR.
-She remembered Resident #1 refused to drink nutritional shakes in October 2021.
-She took a couple of months off and when she came back in February 2022, the nutritional shakes were no longer on Resident #1's eMAR so she thought the order had been discontinued.
-She was not aware of Resident #1's physician's order dated 06/02/22 for a nutritional supplement three times per day.

Review of Resident #1's Home Health Registered Nurse (HHRN) visit notes dated 12/30/22 and 01/08/23 revealed Resident #1 weighed 135

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pounds on 12/30/22 and 115 pounds on 01/08/23.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 01/13/23 at 12:48pm revealed:
-She remembered ordering the nutritional shakes for Resident #1 to drink three times per day and she did not remember discontinuing that order.
-She was not aware the facility stopped offering Resident #1 the nutritional shakes.
-Resident #1 had always been thin and the nutritional shakes were originally ordered in 2021 due to weight loss.
-She was not aware that Resident #1 was diagnosed with severe protein calorie malnutrition during a hospitalization in December 2022 or of any recent weight changes.
-If Resident #1 would drink the nutritional shakes, then she wanted him to receive them three times per day.

Refer to interview with the facility's PCP on 01/11/23 at 2:00pm.

Refer to interview with the Owner on 01/12/23 at 11:32am.

Attempted telephone interview with Resident #1's HHRN on 01/17/23 at 4:15pm was not sucessful.

4. Review of Resident #7's current FL2 dated 07/01/22 revealed:
-Diagnoses included type 2 diabetes mellitus, stage 3 chronic kidney disease, hypertension and morbid obesity.
-There was no diet order listed on the FL2.

Review of Resident #7's hospital discharge orders signed 08/15/22 revealed an order for a 60 gram carbohydrates per meal, low sodium, low

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D 310	Continued From page 76 fat/low cholesterol, no caffeine diet. Review of the facility's diet list on 01/10/23 revealed Resident #7 was to be served a Mediterranean diet and had allergies to black pepper and turkey. Review of the facility's posted menu for the dinner meal service on 01/12/23 revealed hotdog with a bun, baked beans, coleslaw, ice cream, water and iced tea was to be served. Review of the facility's low fat/low cholesterol, low sodium therapeutic diet menu for the dinner meal service on 01/12/23 revealed a low sodium hamburger on a bun, low sodium green beans, sweet potato tots and pears was to be served. Observation of the dinner meal service on 01/12/23 at 4:15pm revealed Resident #7 was served a hotdog on a bun, baked beans, coleslaw, ice cream, water and iced tea and consumed 100% of meal. Interview with a dietary aide on 01/11/23 at 12:01pm revealed the Mediterranean diet was for residents that had allergies to certain foods. Interview with the Dietary Manager (DM) on 01/11/23 at 1:21pm revealed: -She was told by the previous DM that the Mediterranean diet involved "a lot of fish" but she could not afford to serve a lot of fish to Resident #7. -She did not have a therapeutic diet menu for the Mediterranean diet and had not thought to request one from the contracted menu company or ask the contracted Registered Dietitian for guidance. -She did not think any of the residents were on a	D 310		

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D 310	Continued From page 77 low fat/low cholesterol diet. Telephone interview with the facility's contracted menu company's Registered Dietitian on 01/17/23 at 12:19pm revealed: -The facility did not have a Mediterranean diet menu and she would expect them to refer to the low fat/low cholesterol menu. -The low concentrated sweets (LCS) menu had an average of 60 grams of carbohydrates per meal. -The hotdog should not have been served to Resident #7 due to the high fat and sodium content. -Cole slaw, baked beans and ice cream were acceptable to serve to Resident #7. Interview with Resident #7's Primary Care Provider (PCP) on 01/11/23 at 2:00pm revealed: -She was informed that he was discharged from the hospital in August 2022 with an order for a Mediterranean diet and the previous Administrator told her that he would try to accommodate the diet order. -She was not aware the kitchen did not have a menu for a Mediterranean diet. -She thought Resident #7 requested to be on a Mediterranean diet while in the hospital and that was why it was on his discharge orders. Refer to interview with the DM on 01/10/23 at 9:38am. Refer to interview with the facility's PCP on 01/11/23 at 2:00pm. Refer to interview with the Owner on 01/12/23 at 11:32am. Interview with the Dietary Manager (DM) on	D 310		

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D 310	Continued From page 78 01/10/23 at 9:38am and on 01/11/23 at 1:21pm revealed: -She decided to serve the lunch that was planned for Wednesday (01/11/23) due to not having the necessary foods to serve the planned meal for today. -She was only able to serve the planned main entrée for the meal, since she did not have the vegetables that were listed on the menu. -The facility's weekly food budget prevented her from serving therapeutic diets when they required residents to be served different food from the regular diet. -She did not routinely look at the therapeutic diet menus due to not being able to accommodate the meals in the kitchen's food budget. Interview with the facility's Primary Care Provider (PCP) on 01/11/23 at 2:00pm revealed she expected the diet orders to be followed as closely as possible, if the diets could not be followed then she expected to be informed. Interview with the Owner on 01/12/23 at 11:32am revealed: -He was not aware that therapeutic diets were not being served due to budgetary constraints. -He expected the DM to prepare and serve resident's meals based on their diet orders. _____ The facility failed to ensure that a resident with a history of hypertension, stage 3 chronic kidney disease and congestive heart failure (#8) was not served a renal diet which could result in increased risk of heart disease and a resident with history of weight loss as well as recent weight loss (#1) did not receive nutritional shakes three times per day. This failure was detrimental to the resident's health, safety and welfare and constitutes a Type B Violation.	D 310		

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D 310	Continued From page 79 The facility provided a plan of protection in accordance with NCAC 13F .0904(e)(4) on January 11, 2023 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2023.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to protect 45 residents from abuse and exploitation by a staff (Business Office Manager (BOM)) related to a resident's stolen debit card (#3), a stolen facility transportation vehicle, misappropriation of resident's funds (#3), resident verbal abuse (#7), and unauthorized possession of resident's personnel information including social security numbers. The findings are: a. Review of Resident #3's current FL2 dated 09/08/22 revealed diagnoses included pressure ulcer stage 3 to right buttocks, bronchitis, and chondrocalcinosis right knee. Review of Resident #3's Care Plan dated	D 338		

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06/02/22 revealed:
-He was totally dependent with toileting, ambulation, bathing, dressing, grooming and transfers.
-He required supervision with eating
-He required a wheelchair for ambulation.

Interview with a personal care aide (PCA) on 01/12/23 at 6:25am revealed:
-The middle to the end of December 2022, The Business Office Manager (BOM) told her about using a new credit card to get airline tickets for her son and many night in a hotel for her, her husband and her son.
-The BOM also during that time bought a new cell phone and a cell phone plan.

Review of Resident #3's bank statement revealed:
-There were hotel visits purchased on 12/05/22, 12/07/22, 12/12/22, 12/14/22 and 12/15/22.
-There were mobile phone carrier and recurring mobile phone carrier fees on 12/08/22 and 12/20/22.
-There was a purchase to an airline with travel protection on 12/14/22.

Interview with the Resident Care Director (RSD) on 01/10/23 at 10:00am revealed:
-Resident #3's debit card was located in the office she shared with the BOM.
-Resident #3's debit card was in the desk drawer of the BOM, in a locked box.
-On 01/02/23, she found the box unlocked and the card was missing.
-She added that to the police report when she called on 01/02/23.
-The BOM was to use the card for purchases for Resident #3 only.
-There was no one to check behind the BOM for

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purchases made using Resident #3's debit card because there was no Administrator for the facility.
-The Owner was responsible after 11/07/22 because there was no Administrator.

Interview with Resident #3 on 01/10/23 at 11:30am revealed:
-He gave the BOM his card for safe keeping when he was admitted to the facility.
-He received his December 2022 bank statement in the mail and saw the charges on his statement and his money was gone so he talked to the RSD and she explained what the BOM did.
-The BOM had his card and used it for things he had not authorized.
-There were a lot of charges on his December 2022 bank statement that he did not authorize.
-He was very upset and anxious because his debit card was stolen.
-He could not pay his rent at the facility, the pharmacy bill or purchase things like snacks, shampoo, deodorant and stuff he wanted to buy.
-He did not understand how someone could use his card without his permission.

b. Interview with Resident Service Director (RSD) on 01/10/23 at 10:00am revealed:
-On 01/02/23, she was going to talk to BOM after 90 controlled medications were missing out of the pharmacy locked control medications box in her office.
-She waited because she wanted to talk to the Owner first.
-Before she talked to the Owner, BOM sated she was going to the Social Security office to take care of some resident's checks.
-She told BOM that the Social Security off was closed on 01/02/23 and she wanted to talk to her about missing controlled medications but BOM

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disappeared with the facility's transportation vehicle without permission.
-She did not report the facility's transportation vehicle taken without permission to the police at all because she felt the missing controlled medications and the debit card were more important.
-She did report the facility's transportation vehicle was taken by the RSD without permission to the Owner on 01/02/23.
-Residents depended on the use of the facility's transportation vehicle to go to the store to buy personal care needs, the bank and the staff depended on the facility vehicle to go to the store to purchase food and facility supply's.
-On 01/03/23, the facility's transportation vehicle showed up in the facility's parking lot, locked and no one dropped off the keys.
-On 01/05/23, the BOM's husband brought back the keys to the facility's transportation vehicle.

Interview with a resident 01/10/23 at 10:00am revealed:
-On 01/10/23 he needed to go to store to get personal items and food.
-The RSD told him that the facility's transportation vehicle was stolen and she could not take him until it was returned.
-It was hard for him because he depended on the staff to take him where he needed to go because he could not drive and it was harder now because the facility's transportation vehicle was stolen.
-He was worried that he could not get to the bank, store or to see his urologist.

Interview with a second Resident on 01/11/23 at 1:59pm revealed he was told he would be taken to the Social Security office to take care of his check and to the store to buy personal care items but he was told by the RSD the facility's

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transportation vehicle was stolen and he could not go until it was returned.

Interview with the Owner on 01/12/23 at 11:25am revealed:
-The BOM took the facility's transportation vehicle without permission and he did not call the police and he did not know why.
-The facility was without the vehicle for several days and even when it was returned late one night, the BOM would not return the keys until she received her paycheck.

c. Interview with Resident Services Director (RSD) on 01/11/23 at 2:45pm revealed:
-The previous management team took the personal funds allowance ledger when they left in November 2022.
-In December 2022 she was handed a bundle of money from the Owner.
-The Owner told her to pay the residents their personal funds money.
-She had no idea what to do about the personal funds.
-She did not know what amount of money to give the individual residents.
-She had no idea the residents needed to pay on their pharmacy bills from their personal funds account.
-She received guidance from the Adult Home Specialist on the amount of personal funds the residents were to receive.
-She gave the residents their money in December 2022 and January 2023 and documented it so she would know the amount each resident received.

Interview with the Owner on 01/11/23 at 10:55am revealed:
-He gave personal funds money to the RSD to

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pay the residents that one time in December 2022 and 01/06/23.
-He had not paid on the resident's pharmacy bill since he took over on 11/07/22.
-He did not know how to pay the pharmacy bill.
-He did not know how the resident's medications bills were paid to the pharmacy.
-He received a check for the resident balance in their trust account in the amount from the previous management team.
-He deposited the check for the personal fund balances in the bank.

Interview with five sampled residents on 01/10/23 from 9:45am to 10:00am revealed they received their personal funds allowance for December 2022 and January 2023.

d. Review of Resident #7's current FL2 dated 07/01/22 revealed:
-Diagnoses included morbid obesity.
-Resident #7 was intermittently confused, non-ambulatory and incontinent of bowel and bladder.

Interview with a third shift personal care aide (PCA) on 01/12/23 at 5:45am revealed:
-Resident #7 had bilateral lower extremity amputations and was wheelchair bound.
-She had to mop Resident #7's floor every morning because he urinated on the floor every night; however, when she took away his cigarette privileges he would stop urinating on the floor to get the cigarettes back.
-Resident #7 would fall out of his wheelchair frequently so she moved his wheelchair just out of his reach at night and then moved it back to his bedside around 5:00am.
-She thought Resident #7 fell out of his wheelchair for attention because the falls were

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never "that bad".
-She followed Resident #7 when he was in the hallway so she could catch him before he fell out of the wheelchair.
-Resident #7 was heavy and difficult to lift into his wheelchair so she would tell him "don't fall on my shift, I don't have time for this".

Interview with Resident #7 on 01/12/23 at 3:15pm revealed:
-He required help getting into his wheelchair.
-He soiled himself approximately once a week at night due to not being able to get to the bathroom on time.
-The night shift staff told him he was too old to be soiling himself.
-A medication aide (MA) on first shift had taken away his cigarette privileges for about 24 hours, once or twice a week to punish him for soiling his bed.
-He did not like being criticized for soiling the bed or having his cigarette privileges taken away, but he had not told anyone about these incidents.
-He slid out of his wheelchair, at times, but did not remember staff being mean to him when they helped him back into his wheelchair.

Interview with the RSD on 01/13/23 at 3:56pm revealed:
-She and the MAs controlled the distribution of residents' cigarettes.
-Staff cannot restrict cigarettes from residents who have behaviors, and she was not aware of anyone's cigarettes bring taken away due to behaviors.

Interview with the Owner on 01/12/23 at 11:32am revealed he expected the RSD to ensure the state rules were followed and residents were respected by all staff.

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D 338	Continued From page 86 e. Interview with a medication aide (MA) on 01/11/23 at 12:35pm revealed: -On 01/03/23, a resident informed her that she was getting an inheritance worth a million dollars and the BOM, was going to put the money in BOM's personal account. -On 01/03/23, she informed the RSD and the RSD talked to the resident immediately after she told the RSD. Interview with a resident on 01/11/23 at 1:10pm revealed: -Her nephew came to the facility in December 2022 informing her that she would receive part of a million dollar inheritance soon. -She told the BOM about the inheritance. -The BOM told her she would loose her benefits and she could put the money in the BOM's personal account to protect the money. -The BOM gave her a paper to sign that the BOM would to give to the lawyers to take care of her portion of the inheritance. -She thought she was supposed to sign the paper because she did not want to loose her benefits. -She did not read the paper and signed it. -She did not know what happened after she signed the paper. -She told the RSD sometime last week sometime after she heard the BOM did some bad things. Interview with a PCA on 01/12/23 at 6:00am revealed: -Sometime around the last week of December 2022, a resident told her that she was receiving a million dollar inheritance. -The resident told her the BOM convinced her to sign a document that would allow the resident's money to be deposited into the BOM's personal account.	D 338		

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D 338	Continued From page 87 -She told the RSD about what she was told not long after the resident told her. Interview with the RSD on 01/10/23 at 10:17am revealed: -Sometime around 01/02/23, a resident told her that she was getting a million dollar inheritance and the BOM had her sign a paper to put the money into the BOM's personal account so she would not loose her benefits. -The resident told her that she signed a document which she did not read and was told by the BOM it was for the lawyer to handle the money. -The resident told her because she heard bad things that the BOM had done, and she was concerned that the BOM took advantage of her and was stealing her money. -She told the resident she did not know if this was true. -She did not know if the resident received her inheritance or not because there was no documentation in the resident's funds ledger. -The BOM had access to the resident's funds, banking information, and personal identification such as their social security numbers because that was apart of her job duties as the BOM. -She did not investigate the resident's complaint any further because she became too busy with other things and was dealing with the theft of another resident's debit card and the facility's transportation vehicle. -She did not report the resident's concerns or complaint to the police or the HCPR. -It was very possible the BOM did take advantage of a resident because the BOM and was capable to accessing resident's financial information, also there was no one to check behind the BOM to make sure the BOM was doing her job and the residents' personal identification information such	D 338		

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D 338	Continued From page 88 as their social security numbers, and the date of birth were kept secured and private. _____ The facility failed to ensure residents were free of abuse and exploitation resulting in a resident's social security deposit missing funds from his account and unable for him to pay his rent, pharmacy bill and purchase personal items (#3), free of abuse of a resident who smoking privileges were taken away by staff because he soiled himself (#7), a delay in reporting a staff to the HCPR and investigation when a resident's debit card and personal identification was stolen resulting in all residents being placed in a substantial risk of further exploitation. This failure placed all residents in the facility at substantial risk of serious abuse, exploitation and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 01/12/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2023.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure the administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner for 1 of 2 sampled residents (Resident #1) related to an oral antibiotic used to treat urinary tract infections, a medication used to prevent heart attack and stroke, a medication used to treat symptoms caused by antipsychotic medications, a vitamin used to treat mineral and vitamin deficiencies, a medication used to treat constipation, a medication used to treat gastroesophageal reflux disease (GERD) peptic ulcer disease (PUD) and a medication used to treat schizophrenia.

The findings are:

Review of Resident #1's current FL2 dated 07/21/21 revealed diagnoses included benign hypertension, hypercholesterolemia, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), peptic ulcer disease (PUD) and schizoaffective disorder.

Review of Resident #1's hospital discharge summary dated 12/13/22 revealed:
-Resident #1 was admitted to the hospital on 12/05/22 at 5:03pm with principal diagnoses which included septic shock, acute cystitis, E. Coli bacteremia, severe protein calorie malnutrition, shock liver, COPD, acute metabolic encephalopathy, elevated troponin, acute kidney injury and lactic acidosis.

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D 358	Continued From page 90 -He was discharged back to the facility on 12/13/22. Review of Resident #1's progress notes revealed he returned to the facility on 12/13/22 at 6:00pm. Interview with Resident #1 on 01/13/23 at 10:41am revealed he did not know what medication he was prescribed and he did not know how many medications he was supposed to take each day. a. Review of Resident #1's hospital discharge summary dated 12/13/22 revealed there was a physician's order for cefdinir (an oral antibiotic used to treat urinary tract infections) 300mg, take one capsule every 12 hours for 7 days. Review of Resident #1's December 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for cefdinir 300mg, one tablet twice daily, scheduled for 8:00am and 8:00pm. -Cefdinir was documented as not administered twice daily from 12/13/22 at 8:00pm to 12/15/22 at 8:00pm. -There was no comment for the reason cefdinir was not documented as administered. Telephone interview with a Pharmacist at Resident #1's pharmacy on 01/13/23 at 4:01pm revealed: -Cefdinir 300 mg was prescribed as an antibiotic and since four doses were missed it would be considered an incomplete course. -This could have put Resident #1 at risk for a secondary infection that could be resistant to cefdinir.	D 358		

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Telephone interview with the Pharmacist at the facility's contracted pharmacy on 01/12/23 at 9:03am revealed:
-They received an order for cefdinir 300mg twice daily for seven days on 12/13/22.
-Cefdinir 300mg take 1 tablet twice daily for seven days, for a quantity 14 tablets, was dispensed to the facility on 12/14/22.
-She expected the resident to take the full seven-day course of the medication to get the desired effect.
-If the resident did not receive the full seven-day course of antibiotic therapy, the infection could remain and not be resolved.

Interview with Resident #1's primary care provider (PCP) on 01/11/23 at 2:00pm revealed:
-She was aware of Resident #1's hospitalized from 12/06/22 to 12/13/22 due to sepsis.
-She was not aware that Resident #1 did not complete the seven-day course of cefdinir after being discharged from the hospital.
-Not completing the course of the antibiotic could have contributed to Resident #1 being hospitalized from 12/30/22 to 01/06/23 with sepsis.

Refer to interview with a medication aide (MA) on 01/13/23 at 3:00pm.

Interview with the Resident Services Director (RSD) on 01/12/23 at 2:50pm revealed she was not aware that Resident #1 did not finish his course of cefdinir.

Refer to interview with the RSD on 01/12/23 at 2:50pm.

b. Review of Resident #1's current FL2 dated 07/21/21 revealed there was an order for aspirin

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(used to prevent heart attack and stroke) EC 81mg, one tablet daily.

Review of Resident #1's signed physician's orders dated 12/21/21 revealed there was an order for aspirin EC 81mg, one tablet daily.

Review of Resident #1's December 2022 eMAR revealed:
-There was an entry for aspirin EC 81mg, one tablet daily, scheduled for 8:00am.
-Aspirin was documented as not administered daily from 12/06/22 to 12/15/22.
-There was no comment for the reason aspirin was not documented as administered.

Refer to interview with a MA on 01/13/23 at 3:00pm.

Refer to interview with the RSD on 01/12/23 at 2:50pm.

c. Review of Resident #1's current FL2 dated 07/21/21 revealed there was an order for benztropine (used to treat symptoms caused by antipsychotic medications) 1mg, one tablet every 12 hours.

Review of Resident #1's signed physician's orders dated 12/21/21 revealed there was an order for benztropine 1mg, one tablet every 12 hours.

Review of Resident #1's December 2022 eMAR revealed:
-There was an entry for benztropine 1mg, one tablet twice daily, scheduled for 8:00am and 8:00pm.
-Benztropine was documented as not administered twice daily from 12/06/22 at 8:00pm

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to 12/15/22 at 8:00pm.
-There was no comment for the reason benztropine was not documented as administered.

Refer to interview with a MA on 01/13/23 at 3:00pm.

Refer to interview with the RSD on 01/12/23 at 2:50pm.

d. Review of Resident #1's current FL2 dated 07/21/21 revealed there was an order for calcium 600mg - vitamin D (used to treat mineral and vitamin deficiencies), one tablet twice daily with food.

Review of Resident #1's signed physician's orders dated 12/21/21 revealed there was an order for calcium 600mg - vitamin D3 10mcg, one tablet twice daily with food.

Review of Resident #1's hospital discharge summary dated 12/13/22 revealed there was a physician's order for calcium carbonate with vitamin D, 600mg - 10mcg (400unit), take one tablet daily.

Review of Resident #1's December 2022 eMAR revealed:
-There was an entry for calcium 600mg - vitamin D3 10mcg, one tablet twice daily, scheduled for 7:30am and 5:30pm.
-There was a second entry for calcium 600mg - vitamin D3 10mcg, one tablet daily, scheduled for 8:00am, with a start date of 12/14/22.
-Calcium with vitamin D3 was documented as not administered daily from 12/14/22 at 8:00am to 12/15/22 at 8:00am.
-There was no comment for the reason calcium

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with vitamin D3 was not documented as administered.

Refer to interview with a MA on 01/13/23 at 3:00pm.

Refer to interview with the RSD on 01/12/23 at 2:50pm.

e. Review of Resident #1's current FL2 dated 07/21/21 revealed there was an order for docusate sodium (used to treat constipation) 100mg, one capsule twice daily.

Review of Resident #1's signed physician's orders dated 12/21/21 revealed there was an order for docusate sodium 100mg, one capsule twice daily.

Review of Resident #1's December 2022 eMAR revealed:
-There was an entry for docusate sodium 100mg, one capsule twice daily, scheduled for 8:00am and 8:00pm.
-Docusate sodium was documented as not administered twice daily from 12/06/22 at 8:00pm to 12/15/22 at 8:00pm.
-There was no comment for the reason docusate sodium was not documented as administered.

Refer to interview with a MA on 01/13/23 at 3:00pm.

Refer to interview with the RSD on 01/12/23 at 2:50pm.

f. Review of Resident #1's current FL2 dated 07/21/21 revealed there was an order for famotidine (used to treat GERD and PUD) 20mg, one tablet twice daily.

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D 358	Continued From page 95 Review of Resident #1's signed physician's orders dated 12/21/21 revealed there was an order for famotidine 20mg, one tablet twice daily. Review of Resident #1's hospital discharge summary dated 12/13/22 revealed there was a physician's order for famotidine 20mg, take one tablet daily. Review of Resident #1's December 2022 eMAR revealed: -There was an entry for famotidine 20mg, one tablet twice daily, scheduled for 8:00am and 8:00pm that was discontinued on 12/14/22 at 9:00am. -There was a second entry for famotidine 20mg, one tablet daily, scheduled for 8:00am. -Famotidine was documented as not administered daily from 12/14/22 to 12/15/22 at 8:00am. -There was no comment for the reason famotidine was not documented as administered. Refer to interview with a MA on 01/13/23 at 3:00pm. Refer to interview with the RSD on 01/12/23 at 2:50pm. g. Review of Resident #1's current FL2 dated 07/21/21 revealed there was an order for olanzapine (used to treat schizophrenia) 20mg one tablet at bedtime. Review of Resident #1's signed physician's orders dated 12/21/21 revealed there was an order for olanzapine 20mg one tablet at bedtime. Review of Resident #1's hospital discharge	D 358		

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D 358	Continued From page 96 summary dated 12/13/22 revealed there was a physician's order for olanzapine 10mg, take one tablet at bedtime. Review of Resident #1's December 2022 eMAR revealed: -There was an entry for olanzapine 20mg, one tablet at bedtime, scheduled for 8:00pm, that was discontinued on 12/14/22 at 9:00am. -There was an entry for olanzapine 10mg, one tablet at bedtime, scheduled for 8:00pm, that started on 12/13/22. -Olanzapine 10mg was documented as not administered at bedtime from 12/13/22 to 12/15/22 at 8:00pm. -There was no comment for the reason olanzapine was not documented as administered. Refer to interview with a MA on 01/13/23 at 3:00pm. Refer to interview with the RSD on 01/12/23 at 2:50pm. _____ Interview with a MA on 01/13/23 at 3:00pm revealed: -There was a time or two that a resident had a hold order on their eMAR while out of the facility and it did not get lifted upon the resident's return to the facility. -Typically, the Resident Services Director (RSD) would catch the mistake and fix it the next morning. -Resident #1 had a hold order on his eMAR when he returned to the facility from a hospitalization in December 2022 and she could not document on his eMAR. -She gave Resident #1 all of his prescribed medications but did not document it anywhere.	D 358		

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D 358	Continued From page 97 Interview with the RSD on 01/12/23 at 2:50pm revealed: -She had the ability to edit the eMAR and could enter a hold when a resident was out of the facility. -It was possible that she entered the message "Resident out of the facility 06 Dec 2022 to 16 Dec 2022" and forgot to lift the hold when Resident #1 returned to the facility. -If that was the case, she expected a MA to bring it to her attention so she could lift the hold. -If an MA was not able to document that medication was administered on the eMAR, the medication should have been documented in the eMAR notes. -She expected the MA's to administer resident's medications as prescribed and alert her if they were not able to. -She was not aware that Resident #1 was not given any medications after his return from the hospital on 12/13/22, 12/14/22 or 12/15/22. Interview with the Owner on 01/12/23 at 11:25am and 2:52pm revealed: -He was not aware Resident #1 had an incorrect hold on his eMAR on 12/13/22 and 12/14/22. -The RSD was over the clinical operations at the facility and he expected her to ensure all medications were administered as ordered. -He was not sure if the RSD audited the eMARs. _____ The facility failed to ensure residents medications were administered as ordered for a resident with an order for an oral antibiotic related to a recent hospitalization for UTI and sepsis, and other routine medications that were not administered upon return from the hospital (#1) putting the resident at risk for infection to remain untreated which resulted in the resident being readmitted to the hospital. This failure was detrimental to the	D 358		

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D 358	Continued From page 98 health of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 01/12/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2023.	D 358		
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 2 sampled residents related to pain medications (#4 and #5). The findings are: Review of the facility's undated Controlled Substance Policy revealed: -Documentation of controlled substances will be maintained by the facility and will be available for review. -The controlled drug sign out sheet will be kept in	D 392		

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D 392	Continued From page 99 the resident's record a. Review of Resident #4's current FL2 dated 12/29/22 revealed diagnoses included hypertension, recent right hip replacement, idiopathic neuropathy, and difficulty walking. Interview with Resident #4 on 01/11/23 at 1:59pm revealed: -On 12/3022, a medication aide (MA) brought him his 8:00pm pain medication but the tablet she gave him was a tylenol. -He refused to take it and requested his prescribed oxycodone/acetaminophen 7.5/325mg. -He knew the difference in the two tablets. -On 01/01/23, the MA told him there were some of his oxycodone/acetaminophen 7.5/325mg tablets missing and the pharmacy would send some over soon but he received all of his doses without running completely out. Review of Resident #4's physician's order dated 12/29/22 revealed an order for oxycodone/acetaminophen 7.5/325mg three times a day. Review of Resident #4's December 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for oxycodone/acetaminophen 7.5/325mg three times a day. -Oxycodone/acetaminophen 7.5/325mg was documented as administered on 12/29/22 at 8:00pm, 12/30/22 to 12/30/22 at 8:00am, 2:00pm and 8:00pm, and 12/31/22 at 8:00am. -The oxycodone/acetaminophen was documented as administered 5 out of 8 opportunities.	D 392		

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D 392	Continued From page 100 Review of Resident #4's January 2023 eMAR revealed: -There was an entry for oxycodone/acetaminophen 7.5/325mg three times a day. -Oxycodone/acetaminophen 7.5/325mg was documented as administered 01/01/23 at 2:00pm and 8:00pm, 01/02/23 at 2:00pm and 8:00pm, 01/04/23 at 2:00pm and 8:00pm, 01/05/23 at 2:00pm and 8:00pm, 01/06/23 at 8:00am, 2:00pm and 8:00pm, 01/07/23 at 8:00am and 2:00pm, 01/08/23 at 8:00pm, 01/09/23 at 8:00am, 2:00pm and 8:00pm, and 01/10/23 at 8:00am. -The oxycodone/acetaminophen was documented as administered 18 out of 30 opportunities. Observation of Resident #4's medications available for administration on 01/10/23 4:28pm revealed: -On the medication cart there was one 30 count bubble pack of oxycodone/acetaminophen 7.5mg/325mg with a printed label indicating 90 tablets that were dispensed on 12/29/22 with 19 tablets available to administer. -There were three 30 count bubble packs of oxycodone/acetaminophen 7.5mg/325mg with a printed label indicating 90 tablets were dispensed on 01/07/23 and 30 tablets remaining in each bubble pack available to administer in the Resident Care Director's (RSD) office in a plastic pharmacy tote. Review of Resident #4's Controlled Substance Sheet (CSCS) for oxycodone/acetaminophen 7.5mg/325mg three times a day dated 12/29/22 revealed: -There were 90 tablets of oxycodone/acetaminophen 7.5mg/325mg	D 392		

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dispensed from the pharmacy on 12/29/22.
-The first tablet was signed out on 12/29/22 and the last tablet was signed out on 01/06/23 leaving a balance of 0.
-There was no documentation oxycodone/acetaminophen 7.5mg/325mg was signed out on 01/06/23 at 8:00pm, 01/07/23 at 8:00am and 2:00pm, 01/09/23 at 8:00am, 2:00pm and 8:00pm, and 01/10/23 at 8:00am.

Telephone interview with the facility's contracted pharmacy technician on 01/10/23 at 3:35pm revealed:
-Oxycodone/acetaminophen 7.5/325mg three times a day, containing 90 tablets, a 30-day supply, was dispensed on 12/29/22.
-Oxycodone/acetaminophen 7.5/325mg three times a day, containing 90 tablets, a 30-day supply, was dispensed on 01/07/23.

Review of Resident #4's CSCS compared to mediations on hand, December 2022 and January 2023 eMAR revealed:
-There were 45 of 157 doses of oxycodone/acetaminophen not documented on the December 2022 and January 2023 eMAR.
-There were 48 of 157 doses of oxycodone/acetaminophen not reconciled.

Refer to interview with RSD on 01/10/23 at 10:00am.

Refer to interview with the Owner on 01/10/23 at 11:30am.

b. Review of Resident #5's current FL2 dated 07/18/22 revealed:
-Diagnoses included acute osteomyelitis of the right ankle and foot, and Charcot foot (a rare, progressive, deforming disease of the bone and

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joints).
-An order for Oxycodone 10mg every six hours.

Interview with Resident #5 on 01/11/23 at 2:11pm revealed on 01/01/23, the MA told him that some of his Oxycodone was missing but he did not run out because the facility called the pharmacy and it was replaced.

Review of Resident #5's subsequent physician orders dated 10/18/22 revealed:
-An order for Oxycodone 10mg three times a day.
-The Oxycodone was to begin when last supply of Oxycodone ran out on 10/27/22.

Review of Resident #5's October 2022 eMAR revealed:
-An entry for Oxycodone 10mg three times a day was documented as administered from 10/27/22 to 10/31/22 at 8:00am, 2:00pm, and 8:00pm.
-The oxycodone was documented as administered 15 out of 15 tablets.

Review of Resident #5's November 2022 eMAR revealed:
-An entry for Oxycodone 10mg every six hours was documented as administered on 11/01/22 to 11/24/22 at 8:00am, 2:00pm and 8:00pm, 11/25/22 at 8:00am, 11/26/22 at 8:00pm, and 11/27/22 to 11/30/22 at 8:00am, 2:00pm and 8:00pm.
-The Oxycodone was documented as administered 86 out of 90 tablets.

Review of Resident #5's December 2022 eMAR revealed:
-An entry for Oxycodone 10mg every six hours was documented as administered on 12/01/22 to 12/31/22 at 8:00am, 2:00pm and 8:00pm.
-The Oxycodone was documented as

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administered 90 out of 90 tablets.

Review of Resident #5's January 2023 eMAR revealed:
-An entry for Oxycodone 10mg every six hours was documented as administered on 01/01/23 to 01/09/23 at 8:00am, 2:00pm and 8:00pm and 01/10/23 at 8:00am.
-The Oxycodone was documented as administered 28 out of 28 tablets.

Observation of Resident #5's medications available for administration on 01/10/23 4:28pm revealed:
-On the medication cart there was a 30 count bubble pack of Oxycodone 10mg with a printed label indicating 90 tablets were dispensed on 01/07/23 with 26 tablets remaining.
-There were two 30 count bubble packs of Oxycodone 10mg with a printed label indicating 90 tablets were dispensed on 01/07/23 with 30 tablets remaining in each bubble pack available to administer in the RSD's office, in a plastic pharmacy tote.

Review of Resident #5's CSCS for Oxycodone 10mg three times a day revealed:
-There were 90 tablets of Oxycodone 10mg dispensed from the pharmacy on 10/27/22.
-The first tablet was signed out on 11/15/22 and the last tablet was signed out on 01/10/23 leaving a balance of 26.
-There was no documentation Oxycodone 10mg was signed out on 11/25/22 at 2:00pm and 8:00pm, 11/26/22 to 01/08/23 at 8:00am, 2:00pm and 8:00pm and 01/09/23 at 8:00am.

Telephone interview with the facility's contracted pharmacy technician on 01/10/23 at 3:35pm revealed:

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D 392	Continued From page 104 -Oxycodone 10mg three times a day, containing 90 tablets, (a 30-day supply), was dispensed on 10/27/22. -Oxycodone 10mg three times a day, containing 90 tablets, (a 30-day supply), was dispensed on 11/26/23. -Oxycodone 10mg three times a day, containing 21 tablets, (a 7-day supply), was dispensed on 12/22/22. -Oxycodone 10mg three times a day, containing 69 tablets, (a 23-day supply), was dispensed on 01/02/23. -Oxycodone 10mg three times a day, containing 90 tablets, (a 30-day supply), was dispensed on 01/07/23. Review of Resident #5's CSCS compared to mediations on hand, October 2022, November 2022, December 2022 and January 2023 eMAR revealed: -There were 135 of 141 doses of oxycodone/acetaminophen not documented on the October 2022, November 2022, December 2022 and January 2023 eMAR. -There were 55 of 141 doses of oxycodone/acetaminophen not reconciled. Refer to interview with RSD on 01/10/23 at 10:00am. Refer to interview with the Owner on 01/10/23 at 11:30am. _____ Interview with RSD on 01/10/23 at 10:00am revealed. -The MAs were responsible for administering the controlled medications and documenting it on the eMAR and the CSCS. -The MAs were responsible for end of shift count with the next shift's MA to make sure the	D 392		

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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 392	Continued From page 105 controlled medications in the controlled medications drawer matched the amount shown on the CSCS. -There were no shift count sign off sheets for the MAs documenting the shift counts were performed. -There were no discrepancies reported to her prior to 01/01/23. -There were no audits completed on the CSCS to make sure they were being completed. -She did not know the CSCS were not being completed by the MAs and that there were missing controlled medication tablets until 01/01/23. Interview with the Owner on 01/10/23 at 11:30am revealed: -The RSD was responsible for all resident care and services including controlled medications accountability. -He was not aware the controlled medications were accounted for by documenting on the CSCS or if the shift counts were being performed.	D 392		
D 393	10A NCAC 13F .1008 (b) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock.	D 393		

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	HAL036036	A. BUILDING: _____ B. WING _____	C 01/17/2023

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D 393	Continued From page 106	D 393		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to properly store excess supply of Schedule II medications under double lock and proper supervision upon receipt of controlled medications for 2 of 2 sampled residents (#4 & #5).

The findings are:

Review of the Facility's undated Controlled Substance Policy revealed:
-Controlled substances may be stored together n a common location or container but will be double locked.
-Scheduled II medications may be stored together in a common location but will be double locked.

Observation of the Resident Service Director's (RSD) office on 01/10/23 from 10:00am to 10:15am revealed:
-The main door to the office was unlocked and staff were walking in and out of the office.
-There was a plastic pharmacy tote with an interlocking lid.
-The plastic pharmacy tote was locked on the left hand side with a padlock and the padlock on the right hand side was unlocked.
-The interlocking lid on the right side was gapped open approximately 1/4 of a inch.
-There were scheduled II medications in the plastic pharmacy tote.

1. Review of Resident #4's current FL2 dated 12/29/22 revealed:
-Diagnoses included hypertension, recent right hip replacement, idiopathic neuropathy, and difficulty walking.

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D 393	Continued From page 107 -An order for Percocet 10/325mg every six hours as needed for pain. Review of Resident #4's subsequent physician's order dated 12/29/22 revealed and order for oxycodone/acetaminophen 7.5/325mg three times a day. Observation of Resident #4's medications available for administration on 01/10/23 4:28pm revealed: -On the medication cart there was one 30 count bubble pack of oxycodone/acetaminophen 7.5mg/325mg with a printed label indicating 90 tablets that were dispensed on 12/29/22 with 19 tablets available to administer. -There were three 30 count bubble packs of oxycodone/acetaminophen 7.5mg/325mg with a printed label indicating 90 tablets were dispensed on 01/07/23 and 30 tablets remaining in each bubble pack available to administer in the Resident Care Director's (RSD) office in a plastic pharmacy tote. Telephone interview with the facility's contracted pharmacy technician on 01/10/23 at 3:35pm revealed: -Oxycodone/acetaminophen 7.5/325mg three times a day, containing 90 tablets, a 30-day supply, was dispensed on 12/29/22. -Oxycodone/acetaminophen 7.5/325mg three times a day, containing 90 tablets, a 30-day supply, was dispensed on 01/07/23. Refer to interview with RSD on 01/10/23 at 10:00am. Refer to interview with the Owner on 01/10/23 at 11:30am.	D 393		

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D 393	Continued From page 108 2. Review of Resident #5's current FL2 dated 07/18/22 revealed: -Diagnoses included acute osteomyelitis of the right ankle and foot, and Charcot foot (a rare, progressive, deforming disease of the bone and joints). -An order for Oxycodone 10mg every six hours, Review of Resident #5's subsequent physician orders dated 10/18/22 revealed: -An order for Oxycodone 10mg three times a day. -The Oxycodone was to begin when last supply of Oxycodone runs out on 10/27/22. Observation of Resident #5's medications available for administration on 01/10/23 4:28pm revealed: -On the medication cart there was a 30 count bubble pack of Oxycodone 10mg with a printed label indicating 90 tablets were dispensed on 01/07/23 with 26 tablets remaining. -There were two 30 count bubble packs of Oxycodone 10mg with a printed label indicating 90 tablets were dispensed on 01/07/23 with 30 tablets remaining in each bubble pack available to administer in the RSD's office, in a plastic pharmacy tote. Telephone interview with the facility's contracted pharmacy technician on 01/10/23 at 3:35pm revealed: -Oxycodone 10mg three times a day, containing 90 tablets, (a 30-day supply), was dispensed on 10/27/22 and would need to be refilled on 11/26/22. -Oxycodone 10mg three times a day, containing 90 tablets, (a 30-day supply), was dispensed on 11/26/22 and would need to be refilled on 12/26/22. -Oxycodone 10mg three times a day, containing	D 393		

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D 393	Continued From page 109 21 tablets, (a 7-day supply), was dispensed on 12/22/22 and would need to be refilled on 12/28/22. -Oxycodone 10mg three times a day, containing 69 tablets, (a 23-day supply), was dispensed on 01/02/23 and would need to be refilled on 11/26/22. -Oxycodone 10mg three times a day, containing 90 tablets, (a 30-day supply), was dispensed on 01/07/23, a new prescription due to a reported 60 tablets of Oxycodone 10mg missing. _____ Interview with RSD on 01/10/23 at 10:00am revealed: -She shared an office with the Business Office Manager (BOM). -She, the BOM and the Owner were the only staff who had keys to her office. -She was the only person who had keys to the pharmacy-controlled mediation box in her office. -On 12/29/22, was the last time she accessed the pharmacy-controlled mediation box. -The office door was always locked unless she or the BOM was in the office. -On 01/01/23, around 9:30pm, she found that there were 30 tablets of oxycodone/acetaminophen 7.5/325mg missing from Resident #4 out the pharmacy-controlled mediation box in her office. -On 01/01/23 she unlocked her office door, and the pharmacy-controlled mediation box was locked on both ends with pad locks, but the pharmacy-controlled mediation box was pried open in the middle to right hand side. -She could not lock the right hand side of the tote back after she opened it on 01/01/23. Interview with the Owner on 01/10/23 at 11:30am revealed the RSD was responsible for securing medications because he did not know how to	D 393		

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D 393	Continued From page 110 secure schedule II medications.	D 393		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to report allegations of misappropriation of residents funds and drug diversion by Staff D to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours for 3 of 3 sampled residents (Residents #3, #4 and #5) and Staff D was allowed to remain employed. The findings are: Review of Staff D's personnel record revealed: -Date of hire was 09/12/22. -She was hired as a Business Office Manager (BOM) and a medication aide (MA). -There was a HCPR 24 hour investigation reported filled out and faxed into the HCPR on 01/06/23 at 3:51pm related to Resident #5's sixty missing Oxycodone 10mg tablets. -There was a HCPR 24 hour investigation report filled out and faxed into the HCPR on 01/06/23 at 4:10pm related to Resident #3's missing debit card. -There was a HCPR 24 hour investigation	D 438		

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D 438	Continued From page 111	D 438		

reported filled out and faxed into the HCPR on 01/06/23 at 4:16pm related to Resident #4's thirty missing oxycodone/acetaminophen 7.5/325mg tablets.
-There was no required 5-day report completed by the facility prior to exit on 01/17/23.

Interview with the Resident Service Director (RSD) on 01/10/23 at 10:00am revealed:
-On 01/01/23, she found that there were 30 tablets of oxycodone/acetaminophen 7.5/325mg missing from Resident #4 and 60 tablets of Oxycodone 10mg missing from Resident #5.
-On 01/03/23, Resident #3 came to her and enquired about his debit card that was kept in a locked box in the office she shared with Staff D.
-On 01/03/23, she went to the locked box in Staff D's desk and found out Resident #3's debit card was missing.
-She and Resident #3 called the bank and found out that unauthorized charges in the amount of approximately $1300.00 were made and his account was frozen.
-On 01/02/23, Staff D took the facilty's transport vehicle without permission after being asked what happened to the missing 90 controlled medications.
-She did not notify the HCPR within 24 hours after she found out 90 tablets of the controlled medications were missing, Staff D took the facility's transport vehicle, or a resident's debit card was missing and had unauthorized charges on it from December 2022.
-She did not complete an investigation because she notified the police on 01/02/23 and she did not know she was supposed to.
-Staff D did not return to the facility after 01/02/23 but was allowed to continue employment.
-She was responsible for notification to the Owner and she did not know she was to report the

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D 438	Continued From page 112 allegations to the HCPR within 24-hours. -She did not know she was responsible for completing the 5-day report which included her investigation of the allegation. -She did not initiate the investigation and she did not fill out the 5-day report. Interview with the Owner on 01/10/23 at 11:30am revealed: -On 01/01/23, the RSD reported to him there were 90 missing controlled medications from two different residents. -He did not call the police but the RSD did on 01/02/23. -He did not know there was a HCPR report to be completed within 24 hours or that a 5-day report which included their investigation was to be completed. -The HCPR 24-hour report, and the 5-day report would have been the responsibility of the Administrator and they have not had an Administrator since 11/07/22. _____ The facility failed to ensure allegations of larceny and exploitation were reported to the HCPR related to Staff D using a resident's debit card to pay for personal purchases and two residents missing controlled substances. This failure resulted in allegations made against Staff D not being investigated. This failure placed all residents at risk of further exploitation, which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 01/10/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 3,	D 438		

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D 438	Continued From page 113 2023.	D 438		