STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE AT CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on January 17, 2023 to January 19, 2023.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure each exit door accessible by residents was equipped with a sounding device that was activated when the door opened for the safety of a resident diagnosed with disorientation (#3). The findings are: Observation of the facility on 01/17/23 at 8:55am revealed: -There was an exit door to the facility on the 300 hallway. -The exit door was to the back of the building and	D 067		

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opened into a side parking lot facing another building.
-There were various chairs sitting outside of the exit door, including an empty wheel chair with a towel in it.
-There were smoking receptacles outside of the door.
-There was an alarm that emitted a repeated low tone.
-Staff did not respond when the door was opened.
-Outside contractors had propped the door open and were bringing mattresses in and out of the door.
-There were no staff present on the 300 hallway while the door was propped open.

Observation of an exit door for the smoking area on 01/17/23 at 10:20am revealed the door alarm did not emit an alarm sound when the door was opened.

Observation of the facility on 01/19/23 between 2:56pm-3:07pm revealed:
-There was a door that opened to the outside of the building off the 300 hallway.
-The door had an audible alarm when the door was open, but the alarm stopped when the door was closed.
-No staff checked the outside area when the door alarmed.

Observation of the facility on 01/19/23 revealed:
-The facility has eight doors that were accessible by residents for exiting the facility.
-One of the eight doors were not equipped with a sounding device.
-The exit door beside the medication station on the 100 hallway did not have a sounding device when it was opened.

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-At 3:21 pm the side door on the 100 hallway leading to the 300 hallway in front of the bathroom had a door alarm however, when opened no employee checked to see if residents were exiting the building.
-At 3:23 pm Resident #12 exited the facility from door on the 300 hallway near the smoking area. The sounding device went off and no staff was present to see who exited the door.
-At 3:25 pm surveyor opened the exit door to the 300 hallway opposite the smoking area door and no staff arrived to see if a resident exited the building.
-At 3:28 pm surveyor opened the front door to the facility. The sounding device went off but no staff checked to see who was exiting or entering the facility.
-At 3:31 pm surveyor opened the exit door to the left of the 200 hallway; the sounding device went off and no staff came to see if someone exited or entered the building.

Review of Resident #3's FL-2 dated 01/06/23 revealed:
-Diagnoses included pancytopenia.
-Resident #3 was constantly disoriented.

Review of Resident #3's Personal Care Plan dated 09/28/22 revealed:
-Diagnoses included Bipolar Disorder with psychotic features, lower extremity edema, Parkinsonism, vascular dementia without behavioral disturbance, sensorineural hearing loss bilateral, and noise effects of inner ear bilateral.
-Supervision was required with eating/setup, toileting, ambulation, and transferring.
-Limited assistance was required with bathing, dressing, and grooming.
-The resident had limited ability to ambulate and

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was ambulatory with an aide.
-The resident was disoriented sometimes with a forgetful memory and needed reminders.
-A walker or wheel chair was required for ambulation.

Review of Resident #3's Psychiatry Note dated 12/28/22 revealed:
-The patient appeared to be moderately affected by dementia, and had impairments in memory, mostly short-term, judgement and higher cortical functions, the patient had partial insight into his deficits, and tried to compensate.

Review of the Facility's surveillance system on 01/19/23 revealed:
- Resident #3 exited the building without staff from the 300 hallway to the outside smoking area at 4:39 pm on 01/16/23.
- Resident #3 was noticed sitting in his wheelchair near the wood line of the parking lot from 4:39 pm to 7:15 pm
- At 7:15 pm Resident #3 was observed getting out the wheelchair and walking in the woods between the facility and the adjacent medical building parking lot.
- At 7:15 pm Resident #3 disappears from the camera into the woods.
-Resident #3 was found lying in the adjacent parking lot at 8:09 pm

Interview with a resident on 01/17/23 at 10:10am revealed:
-The doors of the facility remained unlock during the day and night.
-Residents could enter and exit at any time of the day or night.
-He felt unsafe because the doors were not secure.

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D 067	Continued From page 4 Interview with another resident on 01/19/23 at 3:10pm revealed: -He did not go outside frequently. -If he went outside, he used the exit door in the dining room. -He did not recall hearing an alarm sound when the door was opened. Interview with the Office Assistant on 01/19/23 at 3:35 pm revealed: -She did not know the purpose of the sounding devices on the exit doors. -She was an office assistant and did not get involved with other facility duties. Interview with the Maintenance Director on 1.19.2023 at 4:02 pm revealed: -The alarms on the exit doors were set up as a signaling device to alert staff if someone was going out the door. -If he heard the alarm to the exit doors going off he would look to see who went out the door. -Residents at the facility have the right to go out the doors. -There were no residents in the building with a diagnosis that prohibited them from going out the door. -Staff should know to look at the doors to see who was exiting and who was coming in when the alarm went off. Interview with the Maintenance Technician on 1.19.2023 at 4:13 pm revealed: -He did not know the purpose of the signaling devices on the doors. -When the doors opened and the devices went off, he did not know what to do when he heard the alarm. -No one had told him anything about the signaling devices on the exit doors.	D 067		

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-He was not aware of any procedures for the sounding devices on the exit doors.

Interview with Personal Care Aide (PCA) on 01/19/23 at 4:20 pm revealed:
-The door alarms were to alert staff when residents leave the building.
-They want to know who was going in and out of the building.
-All residents could leave the building, there was noone with a diagnosis that prohibited them from leaving the building.
-Anyone in the building with dementia or a mental deficit staff watched them and made sure they did not leave the building; "Those [residents] did not go anywhere".
-Staff were stationed to hear when the door alarms went off.
-She could hear the alarms on the 200 hallway.
-The aide for the 300 hallway monitored the alarms on that hallway and the 100 hallway side doors.

Interview with the Resident Care Coordinator on 01/19/23 at 4:40 pm revealed:
-The purpose of the door alarms were to monitor who left the building.
-The facility staff want to know who was going in and out of the building.

Interview with the Administrator on 01/19/23 at 2:49 pm revealed:
-The facility had door alarms and video cameras to monitor who entered and exited the building.
-There was no resident at the facility with a diagnosis that prohibited them from exiting the facility independently.
-Resident's information was assessed and there was no resident in the building the primary physician or the therapist believed were

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D 067	Continued From page 6 disoriented or a wander. -The facility did two hour checks on all residents for their safety. -Staff were in-serviced and trained on the two hour checks. -Two hour checks began when the Administrator took over the building. -The personal care aides and medication aides were responsible for doing two hour checks. -If a resident was missing after the two hour checks the local police were contacted along with the family, guardian, Social Services, and the physician.	D 067		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 1 sampled residents (Resident #3) known to have multiple falls and disorientation. The findings: Review of Resident #3's FL-2 dated 01/06/23 revealed:	D 270		

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D 270	Continued From page 7 -Diagnosis included pancytopenia. -Resident #3 was constantly disoriented. Review of Resident #3's Personal Care Plan dated 09/23/22 revealed: -Diagnosis included bipolar disorder with psychotic features, and sensorineural hearing loss bilateral. -Supervision was required with eating/setup, toileting, ambulation, and transferring. -Limited assistance was required with bathing, dressing, and grooming. -The resident had limited ability to ambulate and was ambulatory with an aid. -The resident was disoriented sometimes with a forgetful memory and needed reminders. -A walker or wheelchair was required for ambulation. Review of Resident #3's Licensed Health Professional Support evaluation dated 12/22/22 revealed ambulation using assistive devices was required. Review of Resident #3's Psychiatry Note dated 12/28/22 revealed Resident #3 appeared to be moderately affected by dementia, and had impairments in memory, mostly short-term, judgement and higher cortical functions, the resident had partial insight into his deficits, and tried to compensate. Review of Resident #3's Incident Accident Report dated 01/16/23 revealed: -At 8:00 pm the Medication Aide (MA) was informed by residents that Resident #3 slipped on the leaf and hurt his knee. -Resident # 3 was sent to the emergency room (ER) for observation. -The guardian and primary care provider (PCP)	D 270		

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was notified.

Review of Resident #3's Emergency Services transportation report dated 01/03/23 revealed:
-Emergency services transported Resident #3 to the ER for confusion,
-Resident #3 informed EMS, "lately he has been having a considerable amount of confusion and wanted to be checked out".

Review of Resident #3's Emergency Services transportation report dated 01/16/23 revealed:
-Emergency services responded to a call pertaining to Resident #3 on 01/16/23 at 9:00 pm
-A resident at the facility found Resident #3 outside the facility and alerted staff.
-Staff found Resident #3 outside lying on his side in the cold around 9:00 pm.
-It was unknown when the resident fell or how long he was outside.
-Staff mentioned that Resident #3 was in a wheelchair, not completely ambulatory and typically could only walk to the bathroom, so it was surprising to find Resident #3 walked all the way outside by himself.
-Staff stated they were concerned about a urinary tract infection due to the Resident #3's recent urine output.
-The resident stated 2/10 pain above his left hip region.
-Staff mentioned the resident had a history of Parkinson-like disease and dementia.
-Resident #3 was found oriented to self only but at baseline per staff due to dementia.
-He was transferred to the emergency room.

Review of Resident #3's Hospital Discharge report dated 12/20/22 revealed:
-Resident #3 had decreased cognition, impaired judgement, gait deviation, was a falls risk,

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impaired balance, and decreased mobility and endurance.
-He was found to have severe pancytopenia and admitted for further work-up.
-He had decreased activity tolerance, impaired dynamic balance, and deficits in fine motor control.
-He also had impaired safety awareness and increased fall risk that impacted independent participation in activities of daily living.
-He was found to have poor insight into his deficits and a decreased awareness of safety.

Review of Resident #3's Hospital discharge dated 01/16/23 revealed the resident was seen at the ER for a few falls on that date.

Review of Resident #3's Home Health Assessment dated 12/25/22 revealed:
-Maximum assistance was needed entering and leaving the residence.
-Ambulation requires assistance, dependent for activities of daily living, he had an impaired gait, and limited endurance.
-Generalized weakness due to diagnosis of congestive heart failure.
-He was a fall risk, due to generalized weakness.
-He required assistive device for safe ambulation and mobility.
-He needed one person assist for all safe transfers, mobility, stairs, and maneuvering uneven surfaces.
-He was oriented to person, place, time, and situation, however he was intermittently confused.

Interview with Resident #3 on 01/17/23 at 11:45 am revealed:
-The resident reported he fell in the leaves and went to the hospital for an magnetic resonance imaging (MRI).

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-When he fell he hit his knee on the cement.
-He had been in the hospital for 2 days after the fall.
-He fell because he had to urinate, so he got out of the wheelchair and walked in the woods.

Interview with a resident on 01/17/23 at 11:20 am revealed:
-Resident #3 was found in the parking lot of the business center adjacent to the facility.
-Resident #3 was on the ground in the parking lot in the fetal position shivering from the cold.
-The resident first noticed Resident #3 sitting in the smoking section outside by the wood line.
-The resident went inside and later that evening staff were looking for him and he told them he last saw him sitting by the woods.
-The resident went outside to look for him and just saw his wheelchair in the place the resident was last noticed.
-The resident did not see Resident #3 near his wheelchair or outside and could not see far because it was dark.
-The resident, another resident and the Personal Care Aide (PCA) walked through a path in the woods behind the building leading to the adjacent parking.
-Resident #3 was laying in the cul-de-sac of the adjacent parking lot down a hill.
-The second resident went back to the facility and got Resident #3's wheelchair.
-The two residents, and the PCA picked the resident up and put him in the wheelchair.
-He wheeled Resident # 3 from the adjacent parking lot to the front city sidewalk and to the facility.

Interview with another resident on 01/17/23 at 3:00 pm revealed:
-Resident #3 was missing on 01/16/23.

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-Staff noticed Resident #3 was not in the building and they were asking people if they had seen him.
-Staff were looking throughout the building for Resident #3.
-He informed staff he last saw Resident #3 sitting in his wheelchair outside before dark.
-He,and the first resident, and the PCA walked through the woods looking for Resident #3.
-They searched with a flashlight and the staff shined the light down the hill and Resident #3 was noticed laying on the pavement down the hill in the adjacent parking lot.
-He went to the building to get Resident #3's wheelchair.
-He and another resident picked up Resident #3 and put him in the wheelchair and brought him back to the building.
-He thought it was around 10:00 pm when they found Resident #3.

Interview with the Administrator on 01/18/23 at 10:48 pm revealed:
-Resident #3 walked in the woods and fell.
-The first resident was walking with him and saw him fall on the ground.
-The first resident informed the MA about Resident #3 and the MA and the resident both helped Resident #3 back into the wheelchair and got him into the building.
-The Med Aide contacted the Administrator and the Guardian was notified.
-Resident #3 was allowed to go outside alone.
-Resident #3 defecated in the woods at times and was known to defecate around the building.

Interview with PCA on 01/18/23 at 4:09 pm revealed:
-She arrived at work for her 8:00 pm shift and she noticed the MA talking to another resident about

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D 270	Continued From page 12 Resident #3. -The resident indicated he did not see Resident #3 in his wheelchair. -The resident saw Resident #3 walking away from the building. -She and the resident along with a second resident searched outside for Resident #3. -They walked through a path in the woods behind the building and found Resident #3 balled up on the ground in the parking lot beside the building. -He walked through the woods and tripped over the sticks and was crawling on the pavement. -He was found at the bottom of the hill in the next parking lot; he must have slid down the hill. -Ever since his roommate left, his behavior was different; he would wander in other rooms. -She had never seen Resident #3 outside the building or attempt to go somewhere alone. -She had never seen him in the woods prior to this event. -She followed protocols once he was found and took him to the MA. Observation of surveillance video dated 01/16/23 revealed: -Resident #3 exited the building from the 300 hallway to the outside smoking area at 4:39 pm -At 4:39 pm multiple residents were in the area smoking cigarettes. -Resident #3 was noticed sitting in his wheelchair near the wood line of the parking lot from 4:39 pm to 7:15 pm -At 7:15 pm it was dark outside and Resident #3 was noticed sitting in the same spot. -No staff were noticed checking on Resident #3 between 4:39 pm and 7:15 pm -At 7:15 pm Resident #3 was observed getting out the wheelchair and walking in the woods between the facility and the adjacent medical building parking lot.	D 270		

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-At 7:15 pm Resident #3 disappeared from the camera into the woods.
-At 8:09 pm a staff took Resident #3's empty wheelchair into the building.
-At 8:09 pm multiple people were walking outside in the dark in the smoking area.
-Two residents and a staff were noticed walking toward a path behind the building in the woods.

Review of the Weather forecast for 01/16/23 revealed:
-The temperature on 01/16/23 at 7:51 pm was 47 degree Fahrenheit (F).
-The high temperature on 01/16/23 was 57 degree F and the low was 23 degrees F.

Interview with Resident #3's PCP on 01/18/23 at 1:20 pm revealed:
-She was not aware of an FL-2 that indicated Resident #3 was disoriented constantly.
-In her opinion Resident #3 was not disoriented constantly.
-Resident #3 was going through several health conditions.

Interview with Resident #3's Guardian on 01/18/23 at 4:35 pm revealed:
-She was not aware of the resident having a diagnosis of disorientation.
-She previously informed the facility Resident #3 was not to leave the facility without family or staff.
-He could go outside independently.
-She had a conversation with the Resident Care Coordinator (RCC) about his altered mental status.

Interview with a MA on 01/18/23 at 4:46 pm revealed:
-The aide was not aware of any cognitive impairments or disorientation with Resident #3.

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-There were no special supervision guidelines for Resident #3.
-Resident #3 was required to be in a wheelchair.
-The MA had never noticed Resident #3 attempting to leave the building.
-Resident #3 did not wander and was not disoriented.

Interview with another MA on 01/19/23 at 9:30 am revealed:
-Resident #3 stressed about his medical condition and medical appointments.
-He had not seen any changes in Resident #3's orientation or any anxiety attacks.

Interview with Resident #3's PCP on 01/19/23 at 2:39 pm revealed:
-She was going to change the diagnosis on the FL-2 from disoriented constantly.
-Resident #3 was going through a lot of medical changes including a recent heart attach and tent placement and she did not believe he was disoriented constantly.

Interview with the Administrator on 01/19/23 at 2:49 pm revealed:
-Resident #3 was not disoriented constantly; the diagnosis on the FL-2 came from the hospital and that was his level of functioning while at the hospital.
-Resident # 3 was confused in December 2022 because his hemoglobin was low.
-Resident #3's guardian informed the facility he could not travel to his family member's home alone or ride public transportation alone. He could go outside by himself, but he could not not leave the property alone.
-Resident #3's therapists reported that he was not confused.
-Staff acted fast regarding Resident #3's last fall.

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D 270	Continued From page 15 -Resident #3 was outside and fell; another resident was outside noticed it and informed the MA. -Staff got Resident #3's wheelchair and placed him in it with the help of a resident. -EMS was called and Resident #3 was taken to the ER. -Resident #3 was not lost on 01/16/23 because, staff noticed he was not in the facility when they did their checks and another resident was outside with Resident #3 and informed staff he had fallen. Interview with Resident #3's Mental Health Therapist on 01/19/23 at 3:40 pm revealed: -Resident #3 was not at all disoriented constantly. -Resident #3 became confused when he was sick. -Resident #3 had mild dementia but he oriented to person, place, and recognized her when she visited. -Resident #3 was very educated and discussed literature with her during their sessions. -Resident #3 was attention seeking and had a lot of health issues. -Resident #3 had complicated health issues and she did not agree with the most recent FL-2 diagnosis of constantly disoriented. Interview with the RCC on 01/19/23 at 4:40 pm revealed: -Resident #3 got confused when his hemoglobin was low. -He was currently going through treatments for low hemoglobin. -He was not confused constantly that was a diagnosis from the hospital when he was a patient there. -His PCP did not agree with that diagnosis. _____	D 270		

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D 270	Continued From page 16 The facility failed to provide supervision to Resident #3, who had a history of dementia, confusion, and falls. The facility's failure resulted in the resident falling down a slope beside the residence and landing in the parking lot of a building neighboring the facility. Resident #3 was found lying in a fetal position in the dark parking lot in 47 degree Fahrenheit temperature weather for fourty-five minutes . This failure resulted in substantial risk of death or serious injury to a resident (#3) and constitues a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-34 on 01/19/23. for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBURARY 18, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 1 of 1 sampled resident (#4) related to elevated blood sugar readings and the physician was not notified. The findings are: Review of Resident #4's current FL-2 dated	D 273		

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09/02/2022 revealed:
-Diagnoses included diabetes mellitus type 1 and a history of diabetes ketoacidosis.
-There was an order to check Resident #4's fingerstick blood sugar (FSBS) before meals and at bedtime and administer insulin based on a sliding scale.
-There was an order to notify the Primary Care Provider (PCP) for FSBS reading greater than 400.

Review of Resident #4's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS checks four times a day with a scheduled time of 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Resident #4's FSBS was 410 on 11/27/22 at 8:00am and 404 at 12:00pm.
-There was no documentation that the PCP had been notified of the elevated FSBS readings on 11/27/22.

Review of Resident #4's December 2022 eMAR revealed:
-There was an entry for FSBS checks four times a day with a scheduled time of 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Resident #4's FSBS was 410 on 11/27/22 at 8:00am and 404 at 12:00pm.
-There was no documentation that the PCP had been notified of the elevated FSBS readings.

Review of Resident #4's January 2023 eMAR from 01/01/23-01/17/23 revealed:
-There was an entry for FSBS checks four times a day with a scheduled time of 8:00am, 12:00pm, 4:00pm and 8:00pm.

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-There was documentation Resident #4's FSBS was 441 on 01/06/23 at 8:00am.
-There was no documentation that the PCP had been notified of the elevated FSBS reading.

Review of Resident #4's progress notes on 01/17/23 revealed documentation from 08/23/22-12/12/2022 and there was no documentation from the staff that Resident #4's PCP had been notified of FSBS readings greater than 400 for the dates and times documented above.

Telephone interview with Resident #4's PCP's medical assistant on 01/18/23 at 11:26am revealed:
-There was documentation of a low FSBS on 12/06/22 and an elevated FSBS on 12/14/22 on 12/15/22 but there were no other calls documented in Resident #4's record related to FSBS.
-All incoming calls were documented in the resident's record.

Telephone interview with Resident #4's PCP on 01/18/23 at 1:39pm revealed:
-Resident #4 was a brittle diabetic.
-She would like to be notified when Resident #4's FSBS was low or high so she could make changes if needed.
-She expected to be called when Resident #4's FSBS was outside of the parameters.

Interview with Resident #4 on 01/18/23 at 3:05pm revealed:
-His FSBS had been going up and down a lot as long as he had been diagnosed as a diabetic.
-He did not know if his PCP was to be notified when his FSBS was high.
-He knew there were times his FSBS was "real

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high" because he would throw up when his FSBS was too high.

Telephone interview with a nurse at Resident #4's Endocrinologists office on 01/18/23 at 4:11pm revealed there was no documentation their office staff had been notified of Resident #4's having high or low FSBS.

Telephone interview with Resident #4's Endocrinologist on 01/19/23 at 3:06pm revealed:
-The purpose of FSBS parameters was so adjustments could be made if needed to avoid an emergency.
-He expected a provider to be notified when Resident #4's FSBS were outside of the ordered parameters.

Interview with the Resident Care Coordinator (RCC) on 01/19/23 at 9:50am revealed:
-If there was an order with parameters, she expected the medication aides (MA) to do follow the order.
-She knew she had called Resident #4's PCP was called a lot because the resident's FSBS "were all over the place."
-Without documentation she would not know if the PCP was notified, and the MAs documentation was not "the best in the world."
-She expected the MAs to document when the PCP was notified.

Interview with the Administrator on 01/19/23 at 11:51am revealed:
-She would expect the MA to follow the order as written and document calls to the PCP.
-She was concerned the MAs had not called Resident #4's PCP per the order.

Attempted telephone interview with a MA on

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D 273	Continued From page 20 01/18/23 at 4:37pm was unsuccessful. Attempted telephone interview with another MA on 01/19/23 at 2:36pm was unsuccessful.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure implementation of orders for 1 of 1 sampled resident (#4) related to fingerstick blood sugar (FSBS) daily before meals and at bedtime. The findings are: Review of Resident #4's current FL-2 dated 09/02/2022 revealed: -Diagnoses included diabetes mellitus type1 and a history of diabetes ketoacidosis. -There was an order to check Resident #4's fingerstick blood sugar (FSBS) before meals and at bedtime and administer insulin based on a sliding scale. Review of Resident #4's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks four times	D 276		

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a day with a scheduled time of 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was no documentation Resident #4's FSBS was checked on 11/24/22 and 11/26/22 at 8:00pm.
-There were no exceptions documented for the 8:00pm FSBS for 11/24/22 and 11/26/22.

Review of Resident #4's December 2022 eMAR revealed:
-There was an entry for FSBS checks four times a day with a scheduled time of 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was no documentation Resident #4's FSBS was checked on 12/0122 at 4:00pm, 12/08/22, 12/09/22, 12/13/22, 12/14/22 at 8:00pm and 12/17/22 at 12:00pm and 8:00pm.
-There were no exceptions documented for the missed FSBS.

Review of Resident #4's January 2023 eMAR from 01/01/23-01/17/23 revealed:
-There was an entry for FSBS checks four times a day with a scheduled time of 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was no documentation Resident #4's FSBS was checked on 01/04/23 and 01/05/23 at 8:00pm.
-There were no exceptions documented for the missed FSBS.

Review of Resident #4's glucometer readings by the Resident Care Coordinator (RCC) on 01/19/23 at 9:50am revealed:
-The RCC went through Resident #4's glucometer readings and the readings were compared to the FSBS documented on the eMAR.
-There was only one FSBS reading in Resident #4's glucometer, that was not recorded on the

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eMAR for November 2022, December 2022, and January 2023.

Interview with the RCC on 01/19/23 at 9:50am revealed:
-She expected Resident #4's FSBS to be checked at meals and bedtime per the order.
-If Resident #4's FSBS was not checked the MA would not know whether the resident needed insulin based on his sliding scale.
-She was concerned Resident #4's orders had not been followed.

Telephone interview with Resident #4's PCP on 01/18/23 at 1:39pm revealed:
-Resident #4 was a brittle diabetic.
-She expected Resident #4's FSBS to be checked as ordered and if needed, insulin administered, based on the sliding scale.
-If Resident #4's FSBS not checked and he needed insulin, he was at risk for ketoacidosis (a serious diabetes complication that occurs when there is not enough insulin in the body).

Interview with Resident #4 on 01/18/23 at 3:05pm revealed:
-The staff normally checked his FSBS.
-He could not recall if he had missed any FSBS checks over the past 3 months.

Telephone interview with Resident #4's Endocrinologist on 01/19/23 at 3:06pm revealed:
-He expected Resident #4's FSBS to be checked and insulin ad ministered based on the sliding scale.
-There should be no reason why Resident #4's FSBS would not be checked, but if there was the reason should be documented.
-He adjusted Resident #4's insulin based on his FSBS and if the FSBS were not done he would

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D 276	Continued From page 23 not know how to adjust. Interview with the Administrator on 01/19/23 at 11:51am revealed: -She would expect the MA to follow the order as written and check Resident #4's FSBS. -She was concerned Resident #4's FSBS had not been checked because if his FSBS was high and insulin was no administered he would be at risk for ketoacidosis. Attempted telephone interview with a MA on 01/18/23 at 4:37pm was unsuccessful. Attempted telephone interview with another MA on 01/19/23 at 2:36pm was unsuccessful.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure there was a matching therapeutic diet menu for 2 of 5 sampled residents (#5, and #9) who had physician ordered therapeutic diets. The findings are: Observation of the kitchen on 01/17/23 at 8:31am	D 296		

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revealed:
-There were no therapeutic diet menus being referenced for meal preparation.
-The cook could not locate the therapeutic diet menus.
-A list of resident therapeutic diets was posted for staff reference.
-Therapeutic diets on the diet list included mechanical soft diet, and 2gm sodium restricted (2gm Na) diet.

Observation of the facility's therapeutic diet menus on 01/17/23 revealed there were no matching therapeutic diet menus for a 2gm Na diet and a mechanical soft diet for the staff to reference as guidance when preparing meals.

1. Review of Resident #5's current FL2 dated 10/28/22 revealed:
-Diagnoses included encephalopathy, ascites, polysubstance use disorder, chronic anemia, alcoholic hepatitis, and depressed mood.
-There was an order for a 2gm Na diet.

Review of the facility's therapeutic diet list on 01/17/23 revealed Resident #5 was documented as having a 2gm Na diet.

Refer to the interview with the cook/Kitchen Manager on 01/17/23 at 12:33pm.

Refer to the interview with the Maintenance Director on 01/19/23 at 10:05am.

Refer to the interview the Administrator on 01/19/23 at 2:44pm.

2. Review of Resident #9's current FL2 dated 04/05/22 revealed: diagnoses included gastroesophageal reflux disease (GERD),

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D 296	Continued From page 25 hyperlipidemia, history of seizures, schizophrenia and hypertension. Review of Resident #9's record revealed there was an order dated 11/07/22 to change Resident #9's diet to mechanical soft. Review of the facility's therapeutic diet list on 01/17/23 revealed Resident #9 was documented as having a mechanical soft diet. Refer to the interview with the cook/Kitchen Manager on 01/17/23 at 12:33pm. Refer to the interview with the Maintenance Director on 01/19/23 at 10:05am. Refer to the interview the Administrator on 01/19/23 at 2:44pm. _____ Interview with the cook/Kitchen Manager on 01/17/23 at 12:33pm revealed: -He prepared the food and served the residents the same food except for the residents who were ordered a diabetic diet. -He used the weekly menu for a reference when preparing the meals because he had the therapeutic diets memorized and knew what to prepare. -The only therapeutic diets the facility offered was a diabetic diet, a mechanical soft diet and double portions. -He did not need to reference a therapeutic diet menu for those diets because he had them memorized. -He did not know Resident #5 had a diet order for a 2gm Na therapeutic diet and he was not sure what the diet required. -He thought a mechanical soft diet was cut up meats and soft food.	D 296		

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D 296	Continued From page 26 Interview with the Maintenance Director on 01/19/23 at 10:05am revealed: -He was responsible for overseeing the kitchen and the Kitchen Manager. -The wholesale food supplier provided the weekly menu and the therapeutic diet menus that were used in the kitchen by the staff. -The therapeutic diet menus were in a book for the cook to reference. -He thought all the therapeutic diets the facility offered were included in the therapeutic menus the facility had. -He was responsible for ensuring the kitchen staff were following the therapeutic menus. -The kitchen staff had not informed him they did not have a mechanical soft diet menu or a 2gm Na diet menu. -The kitchen staff should have let him know if there was a diet on the diet list that did not have a therapeutic diet menu for. -He expected the kitchen staff to use the therapeutic diet menu that was provided and to notify him if they did not have a therapeutic diet menu to match physician's orders for therapeutic diets. Interview the Administrator on 01/19/23 at 2:44pm revealed: -About a month ago the facility contracted a provider to write new therapeutic diet menus. -At that time the facility converted residents on a 2gm Na diet to a no added salt diet (NAS). -The only diets offered were the diets that were on the new therapeutic diet menu. -She did not know a resident still had an order for a 2gm Na therapeutic diet. -The mechanical soft diet should have been on the therapeutic diet menu because it was one of the diets the facility continued to offer.	D 296		

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D 296	Continued From page 27 -The kitchen staff had not informed her that they did not have a therapeutic diet menu for a mechanical soft diet as a guide when preparing the meals.	D 296		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medication aides observed residents taking their medication for 7 of 7 residents sampled (#8, #10, #11, #12, #13, #14 and #15) including observation of one resident with a cup of pills left on his dresser and with a tablet on his nightstand (#10) six residents who were given medication in the dining room and the medication aide did not observe the residents take the medication (#8, #11, #12, #13, #14 and #15). The findings are: 1. Review of Resident #10's current FL-2 dated 09/01/22 revealed diagnoses included chronic kidney disease, chronic pain, type two diabetes,	D 366		

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hyperglycemia, hypertension, hypokalemia and hyperlipidemia.

a. Review of Resident #10's current FL-2 dated 09/01/22 revealed:
-There was an order for pregabalin (used to treat nerve pain) 25mg four times daily.
-There was an order for hydralazine (used to treat high blood pressure) 100mg every eight hours.
-There was an order for amlodipine (used to treat high blood pressure) 10mg once daily.
-There was an order for oxycodone (used to treat pain) 10mg three times daily.

Observation of Resident #10's room on 01/17/23 at 8:33am revealed:
-There was a small white paper cup on Resident #10's dresser.
-The cup contained three tablets and a capsule.

Observation of Resident #10's room on 01/17/23 at 9:05am revealed:
-Another resident went into Resident #10's room with him and closed the door.
-The resident left and Resident #10 was in his room alone.
-The cup of medications was still on the dresser.
-The cup contained three tablets and a capsule.

Review of Resident #10's January 2023 electronic medication administration record (eMAR) on 01/18/23 revealed:
-There was an entry for pregabalin 25mg take every six hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation the pregabalin 25mg was administered four times on 01/17/23.
-There was an entry for hydralazine 100mg take every eight hours scheduled at 6:00am, 2:00pm and 10:00pm.

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-There was documentation the hydralazine 100mg was administered three times on 01/17/23.
-There was an entry for amlodipine 10mg take once daily scheduled at 8:00am.
-There was documentation the amlodipine 10mg was administered at 8:00am on 01/17/23.
-There was an entry for oxycodone 10mg take three times daily scheduled at 6:00am, 2:00pm and 10:00pm.
-There was documentation the oxycodone 10mg was administered three times on 01/17/23.

Interview with Resident #10 on 01/17/23 at 8:33am revealed:
-The medication aide (MA) left his medication in his room because he was sleeping.
-He would take his medication later when he woke up.
-The MA knew he would take them because he told her he would.
-He took his medication before breakfast and sometimes after breakfast.
-No one ever came back and asked him if he took his morning medications.

Interview with a MA on 01/18/22 at 3:01pm revealed:
-Some of the residents did not eat in the dining room for breakfast so he would take the medication to them in their room or they would come to the medication cart.
-Resident #10 usually came to the dining room to eat so he administered his medication to him in the dining room.
-He did not administer Resident #10 his 6:00am medications; the evening MA administered them.
-He had not noticed medication in Resident #10's room before and Resident #10 had not told him the evening MA left medication for him to take

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later.

Interview with the Resident Care Coordinator (RCC) on 01/18/23 at 5:02pm revealed:
-Resident #10's medications should have never been left in his room.
-The MA had no way of knowing if Resident #10 even took his medication if he was not observed.
-She was concerned another resident could come into Resident #10's room and take his medication and have a reaction to one or all of them.
-Amlodipine and hydralazine were used to lower blood pressure and could cause blood pressures to drop too low and pregabalin and oxycodone were controlled medications.

Attempted telephone interview with the evening MA on 01/18/23 at 4:36pm was unsuccessful.

b. Review of Resident #10's physician ordered dated 11/21/22 revealed an order for sertraline (used to treat depression) 25mg once daily.

Observation of Resident #10's room on 01/18/23 at 8:24am revealed:
-Resident #10 was not in his room.
-There was a tablet on his night stand.

Review of Resident #10's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for sertraline 50mg take once daily scheduled at 8:00am.
-Sertraline had been documented as administered on 01/18/23.

Interview with Resident #10 on 01/19/23 at 9:18am revealed:
-He did not know what the tablet was that was on his night stand on 01/18/23.

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-He thought he took all his morning medications.
-He did not know why it was on the night stand.
-No one said anything to him about the tablet on the night stand.

Interview with a MA on 01/18/22 at 3:01pm revealed:
-He did not administer Resident #10's medications in his room.
-He came to the dining room for meals, so he administered his medications to him then.

Attempted telephone interview with the evening MA on 01/18/23 at 4:36pm was unsuccessful.

Refer to the interview with the MA on 01/18/23 at 3:40pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 3:45pm.

2. Review of Resident #15's current FL-2 dated 12/01/22 revealed diagnoses included systematic lupus, major depressive disorder, muscle weakness, chronic pain, contracture of the left hand, muscle weakness, and a history of cerebral infarction.

Review of Resident #15's care plan dated 12/01/22 revealed Resident #15 was forgetful and needed reminders.

Observation of the facility's dining room on 01/17/23 between 8:10am-8:15am revealed:
-At 8:10am, Resident #15 was asleep at the dining room table.
-On the table in front of Resident #15 was a

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medication cup that contained six tablets.
-At 8:12am, Resident #15 woke up, picked up the medication cup, and fell back asleep holding the cup.
-At 8:15am, Resident #15 woke up for a second time and took the medication.

Review of Resident #15's January 2023 electronic medication administration record (eMAR) for 01/17/23 revealed there was documentation all 8:00am medications were administered.

Interview with Resident #15 on 01/18/23 at 10:22am revealed:
-She usually took her morning medications "much later" and that was why she fell asleep at the dining room table.
-When she took her medications later, she would have taken them as soon as the medication aide (MA) gave them to her.
-It was not her "norm" to leave the medication sitting on the table.

Interview with a MA on 01/18/23 at 3:40pm revealed:
-Resident #15 was not asleep when he put the medications on the table for her to take on 01/17/23.
-He did not observe her take the medication because she usually took the medication when he gave it to her.
-He did not know Resident #15 fell asleep without taking the medication.

Interview with the Resident Care Coordinator (RCC) on 01/18/23 at 4:45pm revealed:
-She was concerned Resident #15's medication was left on the table.
-If the medication was left on the table other

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people would have access to the medication and could take the medication.

Refer to the interview with the MA on 01/18/23 at 3:40pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 3:45pm.

3. Review of Resident #8's current FL-2 dated 01/05/23 revealed:
-Diagnoses included toxic metabolic encephalopathy, thrombocytopenia, hepatic steatosis with elevated aspartate aminotransferase (AST), and hypertension.
-Resident #8 was intermittently disoriented.

Observation of the facility's dining room on 01/17/23 between 8:55am-8:57am revealed:
-At 8:55am, the medication aide (MA) was at the medication cart and poured Lactulose (used in the treatment of hepatic encephalopathy) into a medication cup.
-The liquid medication was placed on the table in front of Resident #8 and the MA walked away from the table.
-At 8:56am, Resident #8 poured the liquid medication onto his plate of food and pushed the plate away.

Review of Resident #8's January 2023 electronic medication administration record (eMAR) for 01/17/23 revealed Lactulose was documented as administered.

Interview with Resident #8 on 01/18/23 at 10:37am revealed:

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-He was administered Lactulose twice a day.
-Sometimes he took it and sometimes he did not.
-He did not like the taste of the Lactulose and it would make him sick.

Interview with a MA on 01/18/23 at 3:40pm revealed:
-He did not watch Resident #8 take his Lactulose on 01/17/23.
-He did not know Resident #8 poured the lactulose out on his plate.
-He had never had a problem with Resident #8 taking his medications.
-Resident #8 had told him he did not like taking the Lactulose because it made him go to the bathroom.
-Resident #8 had never refused to take his Lactulose.

Interview with the Resident Care Coordinator (RCC) on 01/18/23 at 4:45pm revealed she was concerned Resident #8 did not take his Lactulose because he was recently diagnosed with an infectious disease.

Refer to the interview with the MA on 01/18/23 at 3:40pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 3:45pm.

4. Review of Resident #12's current FL-2 dated 08/31/22 revealed diagnoses included paranoid schizophrenia, diabetes, and hypertension.

Review of Resident #12's care plan dated 07/19/22 revealed Resident #12 was forgetful and

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needed reminders.

Observation of the facility's dining room on 01/17/23 between 9:09am-9:11am revealed:
-At 9:09am, the medication aide (MA) was at the medication cart, prepared medication into a cup, and handed the cup to Resident #12.
-Resident #12 took the cup across the dining room and sat down at a table.
-Resident #12 was observed looking at the cup of medication and then he took the medication in the cup at 9:11am.

Review of Resident #12's January 2023 electronic medication administration record (eMAR) for 01/17/23 revealed there was documentation all 8:00am medications were documented as administered.

Interview with Resident #12 on 01/18/23 at 10:37am revealed:
-He usually got his medication from the MA at the medication cart and went back to his table to take the medication.
-No one watched him take his medication; they trusted him to take it because he knew how important it was to take the medications.

Interview with a MA on 01/18/23 at 3:40pm revealed:
-Resident #12 usually came to the medication cart to get his medication.
-Some residents insisted they had to have food to take their medication and it could be as simple as that as why Resident #12 took the medication back to the table.
-Resident #12 had never told the MA he needed to eat before taking his medications.

Interview with the Resident Care Coordinator

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(RCC) on 01/18/23 at 4:45pm revealed:
-The MA should not have allowed Resident #12 to leave the medication cart without taking the medication.
-If the resident started to walk away, he should have been called back to the medication cart.

Refer to the interview with the MA on 01/18/23 at 3:40pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 3:45pm.

5. Review of Resident #11's current FL-2 dated 08/16/22 revealed diagnoses included major depressive disorder, history of cerebral vascular accident, and type two diabetes mellitus.

Observation of the facility's dining room on 01/17/23 between 9:19am-9:21am revealed:
-At 9:19am, the medication aide (MA) was at the medication cart, prepared medication into a cup, and handed the cup to Resident #11.
-Resident #11 took the medication cup, approached another resident, and asked, "do you want some pills?"
-Resident #11 laughed and then took the medication at 9:21am.

Review of Resident #11's January 2023 electronic medication administration record (eMAR) for 01/17/23 revealed there was documentation all 8:00am medications were documented as administered.

Interview with Resident #11 on 01/18/23 at 10:16am revealed:

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-He usually got his medication from the MA at the medication cart and got out of the way because there were a lot of residents trying to get their medications.
-A named MA did not watch him take his medication, but another named MA always watched him take his medication.
-No one needed to watch him take his medication because he always took his medications.
-A lot of residents did not take their medications, but he did.

Interview with a MA on 01/18/23 at 3:40pm revealed:
-He "just did not watch Resident #11 take his medications."
-He did not know why he did not watch Resident #11 take his medication.

Interview with the Resident Care Coordinator (RCC) on 01/18/23 at 4:45pm revealed:
-The MA should not have allowed Resident #12 to leave the medication cart without taking the medication.
-If the resident started to walk away, he should have been called back to the medication cart.

Refer to the interview with the MA on 01/18/23 at 3:40pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 3:45pm.

6. Review of Resident #13's current FL-2 dated 05/23/22 revealed diagnoses included neurocognitive disorder and alcohol withdrawal seizure.

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Observation of the morning medication pass on 01/18/23 at 7:51am revealed:
-The medication aide (MA) prepared 7 tablets for Resident #13.
-Resident #13 was sitting at a table in the dining room.
-The MA took the medications in a pill cup to Resident #13.
-He sat the pill cup in front of Resident #13 on the table and walked away.
-Resident #13 slowly picked up the pill cup and took the pills.
-The MA was standing at the medication cart on the other side of the dining room with his back to Resident #13.

Review of Resident #13's January 2023 electronic medication administration record (eMAR) for 01/18/23 revealed there was documentation all 8:00am medications were documented as administered.

Interview with Resident #13 on 01/19/23 at 3:05pm revealed:
-His medications were sometimes placed on his bedside table and left for him to take once he got out of bed.
-The MA did not always stay and watch him while he took his medications.
-He took his medications when they were placed in front of him at the dining room table.
-If the MAs were busy they did not stay to watch him take medications.

Interview with the MA who conducted the morning medication pass on 01/18/23 at 3:43pm revealed:
-He knew he did not observe Resident #13 take his morning medications.
-Resident #13 never gave him problems with

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taking medications.
-He trusted that Resident #13 would take his medications.

Interview with the Resident Care Coordinator (RCC) on 01/18/23 at 4:45pm revealed:
-She was obtaining fingerstick blood sugar readings during the 01/18/23 medication pass.
-She had not observed the MA walk away after placing Resident #13's pill cup on the dining room table.
-She expected the MAs to administer medications as ordered and observe residents taking the medications.

Refer to the interview with the MA on 01/18/23 at 3:40pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 3:45pm.

7. Review of Resident #14's current FL-2 dated 09/19/22 revealed diagnoses included visual disturbance/cataract, history of falling, myasthenia gravis, hypertension, cerebrovascular accident, and history of seizures.

Observation of the morning medication pass on 01/18/23 at 7:56am revealed:
-The medication aide (MA) prepared 6 tablets for Resident #14.
-Resident #14 was sitting at a dining room table.
-The MA took and placed the pill cup in front of Resident #14 and walked away.
-Resident #14 picked up the pill cup and took the pills after the MA walked away.
-The MA was standing at the medication cart with

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his back to Resident #14.

Review of Resident #14's January 2023 electronic medication administration record (eMAR) for 01/18/23 revealed there was documentation all 8:00am medications were documented as administered.

Interview with Resident #14 on 01/19/23 at 3:10pm revealed:
-The MAs gave him medications.
-Most of the time the MAs watched as he took his medications.
-He thought the MA did not watch him take his morning medications on 01/18/23 because the MA was busy and had to keep working.

Interview with the MA who conducted the morning medication pass on 01/18/23 at 3:43pm revealed:
-He knew he had left Resident #14's medications on the dining room table and walked away.
-He should have observed Resident #14 taking the medications.
-He was taught to observe residents taking their medications during his training to be a MA.

Interview with the Resident Care Coordinator (RCC) on 01/18/23 at 4:45pm revealed:
-She had not observed the MA leave Resident #14's medications on the dining room table.
-She had told the MAs daily to administer medications as ordered, observe residents taking the medication and document accurately.
-She did not know what else to do because these instructions were repeated to the MAs.
-The MA should have slowed down and observed Resident #14 taking his medications.

Interview with the Administrator on 01/19/23 at 4:06pm revealed:

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D 366	Continued From page 41 -She knew Resident #14's morning medications on 01/18/23 were not observed by the MA when the resident took them. -She was administering medications on the other medication cart and she saw the error when the MA walked away from Resident #14. -She expected the MA to observe residents when they took their medications. -She did not know why the MA did not observe Resident #14 despite the recent training with the pharmacy's Registered Nurse (RN). Refer to the interview with the MA on 01/18/23 at 3:40pm. Refer to the interview with the RCC on 01/18/23 at 4:45pm. Refer to the interview with the Administrator on 01/19/23 at 3:45pm. _____ Interview with a medication aide (MA) on 01/18/23 at 3:40pm revealed: -He needed to pay better attention to the residents taking their medications. -He was trained to watch the residents take their medication. Interview with the RCC on 01/18/23 at 4:45pm revealed: -She expected the MA to prepare the medication and ensure the resident takes all the medication. -If the resident said, "you do not have to watch me" she would tell them she had to. -The only time staff would not have to watch a resident take their medication was if the resident had a self-administer order. Interview with the Administrator on 01/19/23 at 3:45pm revealed:	D 366		

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D 366	Continued From page 42 -She expected the MA to watch the resident take their medication to ensure the resident took all the medication. -The MA should not put the medication in a resident's hand and walk away. -She had told staff to not leave medication in a resident's room. -She saw the MA walking away from a table after giving the resident medication and reminded the MA he could not walk away. -The MA walking away was not the MA's usual behavior. -If the resident came to the medication cart to get medication, she expected the MA to observe the resident take the medication before going onto the next resident. -If the resident started to walk away she expected the MA to stop the resident. -If a resident was asleep, the MA would not leave the medication; the MA would take the medication back to the cart. -Medications should not be left for a resident to take. -She was aware medications were being left in resident rooms. -The MAs had been told not to leave medications in resident rooms. -She was concerned the residents were not getting their medications. -She was concerned someone else could get the medications that were left unattended. Second interview with the Administrator on 01/19/23 at 4:06pm revealed: -She had arranged training for the MAs with the Registered Nurse (RN) at the facility's contracted pharmacy. -She expected the MAs to watch as residents took medications. -Medications should not be placed in front of a	D 366		

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D 366	Continued From page 43 resident if the MA could not observe the resident taking the medications. -She saw the MA who administered medications during the morning medication pass on 01/18/23. -She prompted the MA to not leave the medications on the table, but he did not follow her prompt. _____ The facility failed to ensure the medication aides observed residents taking their medications which resulted in medication being left on the dining room table accessible to other residents and multiple medications including controlled substances being left in medication cups in resident rooms which were easily accessible to other residents. The facility's failure 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 on 01/18/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 5, 2023.	D 366		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and	D 375		

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documented in the resident's record; and
(2) specific instructions for administration of prescription medications are printed on the medication label.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure 1 of 1 sampled resident (#7) had physicians' orders to self-administer medications for a skin cleanser and a moisturizing skin cream.

The findings are:

Review of Resident #7's current FL-2 dated 06/15/22 revealed:
-Diagnoses included hypertension, dementia, and self-care deficit.
-There was documentation that the resident was intermittently confused.

Review of Resident #7's physician's order dated 01/05/23 revealed:
-There was an order for Cetaphil (used for dry, sensitive skin) cleanser, use topically daily to cleanse the face with cool to warm water and pat dry.
-There was an order for Cetaphil moisturizer, use topically on the face daily after cleansing.
-There were instructions to avoid hot water and any other products on her face after cleansing.
-There was no order Resident #7 could self-administer the cleanser or moisturizer.

Observation of Resident #7's room on 01/17/23 at 8:40am revealed:
-There were two bottles in a basket on a table,

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and each bottle had a pharmacy label.
-The container had a pharmacy label but no documentation of an order for self-administration.

Review of Resident #7's record revealed there was no documentation of a self-administration assessment, order, or documentation to keep medication in his room.

Interview with Resident #7 on 01/18/23 at 10:43am revealed:
-She had a rash on her face and the primary care provider (PCP) was supposed to get her something for the rash.
-She did not think the PCP had given her anything for the rash, but it had cleared up.
-If there was something for the rash in her room someone must have taken it.
-She did not know why someone took the wash and cream for her rash.
-Someone had used "something" on her face "a little while ago."

Interview with the Resident Care Coordinator on 01/19/23 at 9:50am revealed:
If a resident wants to self-administer medication, she talked it over with the resident's primary care provider (PCP) and would obtain an order.
-Resident #7 did not have a self-administration order that she recalled.
-She thought Resident #7 could administer her Cetaphil.
-She had no concerns Resident #7's Cetaphil was in her room.
-Resident #7 had a rash on her face and the PCP ordered Cetaphil.
-When she worked the medication cart, Resident #7's Cetaphil was on the cart.
-She did not know who had left the Cetaphil or when the Cetaphil was left in Resident #7's room.

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D 375	Continued From page 46 -Resident #7's Cetaphil was on the medication cart on 01/18/23. -She did not know who had put the Cetaphil back on the medication cart. Interview with the Administrator on 01/19/23 at 11:51am revealed: -A self-administration form would be completed by the RCC and PCP. -Resident #7's Cetaphil had been left in the resident's room by mistake. -Resident #7 did not keep the Cetaphil in the room, it was a "one-time mistake." -Resident #7 could not use the Cetaphil without assistance. -Resident #7's Cetaphil could not be left in the room for the resident to use because she might not use it correctly. Telephone interview with Resident #7's PCP on 01/19/23 at 11:15am revealed: -When she wrote orders, she expected the orders to be followed. -She wrote an order for Resident #7's Cetaphil for a rash. -Resident #7 did not have an order to self-administer her Cetaphil. -She did not want Resident #7 to have anything in her room, because the resident may have put something on her face that caused the rash. Interview with a medication aide (MA) on 01/19/23 at 3:18pm revealed: -Resident #7 did her own Cetaphil. -Resident #7's Cetaphil was kept in the resident's room. -Resident #7's Cetaphil would pop up on the electronic medication administration record (eMAR) and Resident #7 would be reminded to use the Cetaphil.	D 375		

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D 375	Continued From page 47 -You would know Resident #7 had used the Cetaphil on her face because the resident would have cream on her face that could be seen.	D 375		
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 an anxiety medication, a medication used to treat attention deficit hyperactivity disorder (#1), another medication used to treat anxiety and a medication used to treat opioid dependency (#2). The findings are: 1. Review of Resident #1's current FL2 dated 05/04/22 revealed diagnoses included attention and concentration deficit and depression and benzodiazepine dependence. a. Review of Resident #1's psychiatric provider's orders dated 11/07/22 revealed there was an order for alprazolam 1mg one tablet at bedtime. Review of Resident #1's December 2022	D 392		

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electronic medication administration record (eMAR) revealed:
-There was an entry for alprazolam 1mg take one tablet daily at bedtime, scheduled for 8:00pm.
-There was documentation of administration of alprazolam from 12/01/22 to 12/31/22.

Review of Resident #1's December 2022 controlled substance count sheet (CSCS) for alprazolam 1mg revealed on 12/02/22, there was no documentation of removal of one alprazolam.

Review of Resident #1's eMAR 01/01/23-01/17/23 revealed:
-There was an entry for alprazolam 1mg take one tablet daily at bedtime, scheduled for 8:00pm.
-There was documentation alprazolam 1mg was administered from 01/01/23 to 01/02/23 and from 01/07/23 to 01/11/23 at 8:00pm.
-Alprazolam 1mg was documented as administered on 01/16/23 at 8:00pm.
-There was documentation that Resident #1 was out of the facility from 01/03/23 to 01/06/23 and from 01/12/23 to 01/15/23.

Review of Resident #1's January 2023 CSCS for alprazolam 1mg revealed on 01/02/23, there was no documentation of removal of one alprazolam.

Observation of Resident #1's medication on hand on 01/17/23 at 4:19pm revealed there were 11 of 30 alprazolam 1mg dispensed on 12/21/22.

Telephone interview with a representative at the facility's contracted pharmacy on 01/19/23 at 10:40am revealed:
-There was an order for alprazolam 1mg dated 11/07/22.
-Twenty-five tablets of alprazolam 1mg were dispensed on 11/07/22.

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-Thirty tablets of alprazolam 1mg were dispensed on 11/30/22 and 12/28/22.

Interview with Resident #1 on 01/19/23 at 10:00am revealed:
-She has anxiety and uses alprazolam to stay calm.
-She receives the alprazolam three times a day.

Attempted telephone interview with an evening/night shift MA on 01/18/23 at 3:55pm.

Attempted telephone interview with an evening shift MA on 01/18/23 at 4:37pm.

Attempted telephone interview with a day shift MA on 01/19/23 at 2:33pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 4:06pm.

b. Review of Resident #1's current FL2 dated 05/04/22 revealed there was an order for alprazolam (used to treat anxiety) 2mg two times daily as needed for anxiety.

Review of Resident #1's psychiatric practitioner's orders revealed:
-There was an order dated 05/12/22 for alprazolam 2mg one tablet every morning and every evening.
-There was an order dated 06/23/33 for alprazolam 2mg one table every noon and every evening.

Review of Resident #1's signed physician's order dated 05/24/22 revealed there was an order for

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alprazolam 2mg every morning and every evening.

Review of Resident #1's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for alprazolam 2mg one tablet twice daily, scheduled for 12:00pm and 5:00pm.
-There was documentation alprazolam was administered from 12/01/22 to 12/31/22 at 12:00pm and 5:00pm.

Review of Resident #1 ' s control substance count sheet (CSCS) for alprazolam from 12/01/22 to 12/31/22 revealed on 12/16/22, there was no documentation of removal of one alprazolam 2mg for 5:00pm.

Review of Resident #1's eMAR 01/01/23-01/17/23 revealed:
-There was an entry for alprazolam 2mg one tablet twice daily, scheduled for 12:00pm and 5:00pm.
-There was documentation alprazolam was administered from 01/01/23 to 01/02/23 and from 01/08/23 to 01/11/23 at 12:00pm and 5:00pm.
-Alprazolam 2mg was documented as administered on 01/07/23 and 01/16/23 at 5:00pm.
-There was documentation that Resident #1 was out of the facility from 01/03/23 to 01/07/23 and from 01/12/23 to 01/16/23.

Review of Resident #1's CSCS for alprazolam from 01/01/23 to 01/17/23 revealed on 01/01/23, there was no documentation of removal of one alprazolam 2mg for 5:00pm.

Observation of Resident #1's medications on

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hand on 01/17/23 at 4:19pm revealed:
-There were two bubble packages of alprazolam 2mg.
-One bubble package of alprazolam 2mg dispensed on 12/21/22 contained 3 of 30 tablets.
-The other bubble package of alprazolam 2mg dispensed on 12/21/22 contained 30 of 30 tablets.

Telephone interview with a representative at the facility's contracted pharmacy on 01/19/23 at 10:40am revealed:
-There was an order dated 07/29/22 for alprazolam 2mg.
-Sixty tablets of alprazolam 2mg were dispensed on 11/02/22, 11/30/22 and 12/28/22.

Interview with Resident #1 on 01/19/23 at 10:00am revealed she had not had any problems receiving alprazolam from the MAs.

Attempted telephone interview with an evening/night shift MA on 01/18/23 at 3:55pm.

Attempted telephone interview with an evening shift MA on 01/18/23 at 4:37pm.

Attempted telephone interview with a day shift MA on 01/19/23 at 2:33pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 4:06pm.

c. Review of Resident #1's current FL2 dated 05/04/22 revealed there was an order for Adderall (used to treat attention deficit hyperactivity disorder) 30mg twice daily.

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D 392	Continued From page 52 Review of Resident #1's psychiatric practitioner's orders revealed: -There was an order dated 06/23/33 for Adderall 30mg one table every morning and every afternoon. -There was an order dated 08/25/22 for Adderall 30mg one tablet every morning and every afternoon. Review of Resident #1's signed physician's order dated 05/24/22 revealed there was an order for Adderall 30mg one tablet every morning and every afternoon. Review of Resident #1's December 2022 eMAR revealed: -There was an entry for Adderall 30mg one tablet every morning and every afternoon, scheduled for 8:00am and 2:00pm. -There was documentation Adderall was administered from 12/01/22 to 12/31/22 at 8:00am and 2:00pm. Review of Resident #1 ' s (CSCS) for alprazolam from 12/01/22 to 12/31/22 revealed on 12/12/22, there was no documentation of removal of one Adderall 30mg for 2:00pm. Observation of Resident #1's medications on hand on 01/17/23 at 4:19pm revealed there was one bubble package of Adderall 30mg dispensed on 12/27/22 that contained 27 of 30 tablets. Telephone interview with a representative at the facility's contracted pharmacy on 01/19/23 at 10:40am revealed: -Resident #1 had an order dated 11/12/27/22 for Adderall 30mg one tablet every morning and every afternoon.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068036	A. BUILDING: _____ B. WING _____	R 01/19/2023

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D 392	Continued From page 53 -Sixty tablets of Adderall were dispensed on 11/21/22 and 12/27/22. Interview with Resident #1 on 01/19/23 at 10:00am revealed she had no problems receiving her Adderall from staff. Attempted telephone interview with an evening/night shift MA on 01/18/23 at 3:55pm. Attempted telephone interview with an evening shift MA on 01/18/23 at 4:37pm. Attempted telephone interview with a day shift MA on 01/19/23 at 2:33pm. Refer to the interview with the RCC on 01/18/23 at 4:45pm. Refer to the interview with the Administrator on 01/19/23 at 4:06pm. 2. Review of Resident #2's current FL2 dated 05/31/22 revealed diagnoses included chronic obstructive pulmonary disease, heart failure, diabetes mellitus, and hypothyroidism. a. Review of Resident #2's current FL2 dated 05/31/22 revealed there was an order for clonazepam (used to treat panic disorders) 0.5mg twice daily as needed for anxiety. Review of Resident #2's psychiatric practitioner's order revealed there was an order dated 08/25/22 for clonazepam 0.5mg one tablet twice daily as needed for anxiety. Review of Resident #2's December 2022 electronic medication administration record (eMAR) revealed:	D 392		

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D 392	Continued From page 54 -There was an entry for clonazepam 0.5mg twice daily as needed for anxiety. -There was no documentation clonazepam was administered on 12/09/22 at 11:00am. -There was no documentation clonazepam was administered on 12/25/22 at 10:00pm. -There was no documentation clonazepam was administered on 12/29/22 at 8:07pm. Review of Resident #2's control substance count sheet (CSCS) for clonazepam for December 2022 revealed: -On 12/09/22 at 11:06am, there was documentation of removal of one clonazepam 0.5mg. -On 12/25/22 at 10:00pm, there was documentation of removal of one clonazepam 0.5mg. -On 12/29/22 at 8:07pm, there was documentation of removal of one clonazepam 0.5mg. Review of Resident #2's eMAR 01/01/23-01/17/23 revealed: -There was an entry for clonazepam 0.5mg twice daily as needed for anxiety. -There was no documentation clonazepam was administered on 01/06/23 at 10:15pm. -There was no documentation clonazepam was administered on 01/08/23 at 8:35am. -There was documentation clonazepam was administered on 01/11/23 at 7:53pm. Review of Resident #2's CSCS for clonazepam for 01/01/23-01/17/23 revealed: -On 01/06/22 at 10:15pm, there was documentation of removal of one clonazepam 0.5mg. -On 01/08/23 at 8:35am, there was documentation of removal of one clonazepam	D 392		

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D 392	Continued From page 55	D 392		

0.5mg.
-On 01/11/23 at 7:53pm, there was no documentation of removal of one clonazepam 0.5mg.

Observation of Resident #2's medications on hand on 01/19/23 at 10:15am revealed there was on bubble package of clonazepam 0.5mg dispensed on 12/30/22 that contained 22 of 30 tablets.

Telephone interview with a representative at the facility's contracted pharmacy on 01/19/23 at 10:40am revealed:
-Resident #2 had an order dated 08/25/22 for clonazepam 0.5mg one tablet twice daily as needed.
-Any as needed medication was refilled by request.
-Sixty tablets of clonazepam 0.5mg were dispensed on 10/13/22, 12/01/22, and 12/30/22.

Interview with Resident #2 on 01/19/23 at 10:28am revealed she had received clonazepam when she requested it from the MAs.

Attempted telephone interview with an evening/night shift MA on 01/18/23 at 3:55pm.

Attempted telephone interview with an evening shift MA on 01/18/23 at 4:37pm.

Attempted telephone interview with a day shift MA on 01/19/23 at 2:33pm.

Refer to the interview with the RCC on 01/18/23 at 4:45pm.

Refer to the interview with the Administrator on 01/19/23 at 4:06pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 56 b. Review of Resident #2's current FL2 dated 05/31/22 revealed there was an order for buprenorphine-naloxone (used to treat dependence of opioids) 2-0.5mg place one tablet under the tongue twice daily as needed. Review of Resident #2's Primary Care Provider's (PCP) order revealed there was an order dated 09/08/22 for buprenorphine 2mg one tablet sublingual twice daily as needed. Review of Resident #2's electronic medication administration record (eMAR) 11/25/22-11/30/22 revealed: -There was an entry for buprenorphine 2mg one tablet under the tongue twice daily as needed. -There was no documentation of administration of buprenorphine on 11/26/22 at 6:00am. Review of Resident #2's control substance count sheet (CSCS) for buprenorphine for November 2022 revealed on 11/26/22 at 6:00am, there was documentation of the removal of buprenorphine 2mg. Review of Resident #2's December 2022 eMAR revealed: -There was an entry for buprenorphine 2mg one tablet under the tongue twice daily as needed. -There was no documentation of administration of buprenorphine on 12/05/22 at 9:53am. -There was no documentation of administration of buprenorphine on 12/09/22 at 11:06am. -There was no documentation of administration of buprenorphine on 12/10/22 at 11:20pm. -There was no documentation of administration of buprenorphine on 12/25/22 at 10:00pm. -There was no documentation of administration of buprenorphine on 12/29/22 at 8:07pm.	D 392		

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D 392	Continued From page 57 Review of Resident #2's December 2022 CSCS for buprenorphine revealed: -On 12/05/22 at 9:53am, there was documentation of the removal of one buprenorphine 2mg. -On 12/09/22 at 11:06am, there was documentation of the removal of one buprenorphine 2mg. -On 12/10/22 at 11:20am, there was documentation of the removal of one buprenorphine 2mg. -On 12/25/22 at 10:00pm, there was documentation of the removal of one buprenorphine 2mg. -On 12/29/22 at 8:07pm, there was documentation of the removal of one buprenorphine 2mg. Review of Resident #2's eMAR for 01/01/23-01/17/23 revealed: -There was an entry for buprenorphine 2mg one tablet under the tongue twice daily as needed. -There was no documentation of administration of buprenorphine on 01/06/23 at 10:15pm. -There was no documentation of administration of buprenorphine on 01/08/23 at 8:35am. Review of Resident #2's January 2023 CSCS for buprenorphine revealed: -On 01/06/23 at 10:15pm, there was documentation of the removal of one buprenorphine 2mg. -On 01/08/23 at 8:35am, there was documentation of the removal of one buprenorphine 2mg. Observation of Resident #2's medications on hand on 01/19/23 at 10:15am revealed there was one bubble package of buprenorphine 2mg	D 392		

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D 392	Continued From page 58 dispensed on 01/18/23 that contained 29 of 30 tablets. Telephone interview with a representative at the facility's contracted pharmacy on 01/19/23 at 10:40am revealed: -Resident #2's most current order date for buprenorphine was 01/18/23. -Sixty tablets of buprenorphine were dispensed on 12/01/22 and 01/18/23. Interview with Resident #2 on 01/19/23 at 10:28am revealed: -She had no buprenorphine over the weekend. -The Resident Care Coordinator (RCC) worked yesterday to obtain a new order for her. -She received a dose of buprenorphine 2mg on 01/18/23. Attempted telephone interview with an evening/night shift MA on 01/18/23 at 3:55pm. Attempted telephone interview with an evening shift MA on 01/18/23 at 4:37pm. Attempted telephone interview with a day shift MA on 01/19/23 at 2:33pm. Refer to the interview with the RCC on 01/18/23 at 4:45pm. Refer to the interview with the Administrator on 01/19/23 at 4:06pm. _____ Interview with the RCC on 01/18/23 at 4:45pm revealed: -She expected the MAs to document on the CSCS when a controlled substance was removed. -After the MAs administered the medication, they	D 392		

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D 392	Continued From page 59 should document the administration on the eMAR. -She repeated to the MAs several times to document both on the eMAR and the CSCS. -She held the MAs responsible for ensuring they document on both the eMAR and the CSCS. -She completed audits of the CSCS, but she only looked at the balance to ensure the controlled substance deductions were accurate. -She did not compare the CSCS to the eMARs to ensure documentation was completed and accurate. Interview with the Administrator on 01/19/23 at 4:06pm revealed: -She thought staff forgot to document consistently on both the CSCS and the eMAR. -She thought that staff forgot because they became busy or were distracted by resident activities. -She did not think these issues were an excuse and that the MA should document the administration on both the CSCS and the eMAR. -She held all staff who administered medications responsible for ensuring controlled substances were documented on both the eMAR and the CSCS.	D 392		