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BROOKDALE DURHAM	4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from November 29, 2022-December 2, 2022 with an exit conference via telephone on December 2, 2022.	{D 000}	The following is a summary of the Plan of Correction for Brookdale Durham. This Plan of Correction is in regards to the follow-up survey completed on December 02, 2022. This Plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.	
{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 substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there were no substantiated findings on the Health Care Personnel Registry (HCPR) for 3 of 6 sampled staff (Staff A, D, E) prior to hire. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 01/03/22. -There was no documentation a HCPR check was completed upon hire. -There was documentation a HCPR check was completed on 12/01/22 with no substantiated findings. Attempted telephone interview with Staff A on 12/02/22 at 9:29am was unsuccessful. Refer to the interview with the Administrator on 12/01/22 at 6:16pm.	{D 137}	10A NCAC 13F .0407 Other Staff Qualifications The Executive Director or designee will conduct an audit of current associates HCPR verification to verify that a HCPR review is completed for each active associate. To assist with ongoing compliance, the Business Office Manager or designee will review new associate files quarterly for six (6) months. Plan of correction completed by 1/16/23.	

Reviewed and acknowledged 02/07/23.
With addendums on page 82 and 85. kg

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{D 137}	Continued From page 1 2. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff D was hired on 12/19/19. -There was no documentation a HCPR check was completed upon hire. -There was documentation a HCPR check was completed on 12/01/22 with no substantiated findings. Telephone interview with Staff D on 12/02/22 at 11:32am revealed: -When she applied and interviewed for the MA position she was told a HCPR would be checked. -She did not know if the HCPR had been checked. Refer to the interview with the Administrator on 12/01/22 at 6:16pm. 3. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E was hired on 01/03/22. -There was no documentation a HCPR check was completed upon hire. -There was documentation a HCPR check was completed on 12/01/22 with no substantiated findings. Attempted telephone interview with Staff E on 12/02/22 at 8:51am was unsuccessful. Refer to the interview with the Administrator on 12/01/22 at 6:16pm. ______________________ Interview with the Administrator on 12/01/22 at 6:16pm revealed: -The Business Office Manager (BOM) was responsible for making sure all personnel records were complete.	{D 137}		

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{D 137}	Continued From page 2 -The previous BOM was no longer employed by the facility and there was no current BOM, so she was responsible. -She had started auditing the staff records and knew there was missing information. -The record audits were initiated on 11/16/22. -She expected the HCPR checks to be completed before employment to ensure there were no issues with the employee in other facilities and that without verification there could be concerns.	{D 137}		
{D 234}	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) had completed two-step tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #4's current FL-2 dated 10/25/22 revealed: -Diagnoses included hypertension, paroxysmal	{D 234}	10A NCAC 13F .0703 Tuberculosis Test, Medical Exam & Immunizations The Health & Wellness Director or designee will conduct an audit of current residents' charts to verify completion of tuberculosis testing. All resident who have not received a two-step tuberculosis test will receive this testing by 1/16/23. To assist with ongoing compliance, the Health & Wellness Director will review new resident charts weekly for four (4) weeks.	

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{D 234}	Continued From page 3 atrial fibrillation, and history of cardiovascular disease. -The FL-2 was completed by the skilled nursing facility (SNF) where the resident was admitted on 09/09/22. Review of Resident #4's Resident Register revealed an admission date of 05/02/22. Review of Resident #4's record on 11/30/22 revealed there was no documentation of a tuberculosis (TB) skin test. Review of Resident #4's TB skin test results obtained from the SNF on 12/01/22 revealed: -The TB skin test was administered on 09/10/22. -The results were negative. -The results were read by the nurse at the SNF on 12/23/22. Interview with Resident #4 on 11/30/22 at 11:23am revealed she did not know what a TB skin test was or if she had ever had one. Interview with the Administrator on 12/01/22 at 6:16pm revealed: -She was not aware Resident #4 did not have a record of a TB skin test prior to 12/01/22. -All residents should have a record of a TB skin test placed and read prior to admission. -She was concerned without a TB skin test you would not be able to confirm the resident was free of TB which put everyone at risk.	{D 234}		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	{D 269}	10A NCAC 13F .0901 Personal Care & Supervision The Health and Wellness Director or designee provided retraining to direct care associates regarding the provision of personal care on 1/12/23. The Health & Wellness Director or designee will conducts rounds	

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{D 269}	Continued From page 4 (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 5 sampled residents (#3, #4) had personal care provided by staff including incontinence care and getting the resident out of bed (#3); and showers for a resident (#4). The findings are: 1. Review of Resident #3's current FL-2 dated 02/22/22 revealed: -Diagnoses included coronary artery disease, cerebral infarction, acute raspatory failure with hypoxia, hypertension, and neuropathic pain. -The resident was intermittently disoriented. -The resident was semi-ambulatory and used a wheelchair. -The resident was incontinent of bowel and bladder. -The resident was total care. Review of Resident #3's care plan dated 11/02/22 revealed: -He required assistance with pulling pants up and down when in the bathroom. -He required assistance with putting on and taking off clothing when dressing and bathing. -He required physical assistance related to the inability to stand independently during bathroom task, dressing or grooming task.	{D 269}	on current residents to verify personal care provided as outlined in the residents care plan. To assist with ongoing compliance, the Health & Wellness Director or designee will review five (5) resident chart weekly for four (4) weeks to verify compliance with the personal care plan. The Health & Wellness Director or designee will complete the Plan of correction by 1/16/23.	

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-He used a wheelchair and required assistance to and from the dining room and around the facility.
-He required a two person assist for all transfers.

Observations of Resident #3 on 11/29/22 at various times revealed:
-Resident #3 shared his room with a family member.
-At 10:51am Resident #3 was in his bed in his room.
-At 12:00pm Resident #3 was in the dining room eating lunch.
-At 2:00pm Resident #3 was in his recliner in his room.
-At 4:42pm Resident #3 was in his bed.

Observation of Resident #3 on 11/30/22 at various times revealed:
-At 10:06am Resident #3 was in his bed.
-At 11:00am Resident #3 was in his bed.
-At 12:03pm Resident #3 was in the dining room eating his lunch.
-At 2:32pm Resident #3 was in his recliner.
-At 5:48pm Resident #3 was in the bed.

Observations of Resident #3 on 12/01/22 at various times revealed:
-At 9:05am Resident #3 was awake but sitting in his bed.
-At 1:43pm Resident #3 was in his bed eating lunch.
-At 6:18pm Resident #3 was in his bed.

Interview with Resident #3 on 11/29/22 at 10:51am revealed:
-He had a stroke about a year ago and could not use the right side of his body.
-He stayed in the bed all day yesterday because there was no one to lift him.
-The last time he was out of the bed was the day

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before yesterday, Sunday, 11/27/22.
-He only got out of bed on the days there was a named male staff working who could lift him.
-He stayed in the bed on most days.
-He would like to get out of the bed and sit in his reclining chair and to eat in the dining room.
-He was told staff could only get him up once daily and then back to bed once daily.
-On the days he was moved out of his bed he would be left in his wheelchair all day.
-He had constant pain on his right side.
-He did not like to sit in his wheelchair all day because it would become too painful.
-He was incontinent and used adult incontinent briefs.
-He could not change his own adult incontinent briefs and needed the staff to change them.
-He could not assist staff with changing his adult incontinent briefs because he could not use his right side.
-His family member would use the call bell to ring for help when he needed it.

Interview with Resident #3 on 11/30/22 at 11:00am revealed:
-Staff changed his adult incontinent brief that morning and applied barrier cream and powder to his sacral and groin area.
-He did not have any pressure ulcers or areas of tenderness.
-He reminded the staff to apply the cream and the powder because he would stay in his adult incontinent brief for "so long".

Interview with Resident #3 on 12/01/22 at 1:43pm and 6:20pm revealed:
-He had been in the bed all day and no one had offered or asked if he wanted to get out of the bed.
-He was very uncomfortable and wanted to be

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repositioned in the bed.
-He also requested pain medication because of pain on his right side.
-He wanted to get out of the bed and sit in his recliner, but no one asked him or checked on him.
-He would use the call bell, but his family member would dismiss the staff if they came to the room.
-Staff had changed his adult incontinent brief in the morning would not him again until bedtime.
-He could not change his adult incontinent briefs or roll over or lift his bottom to assist staff when changing him.
-The staff had placed him in two adult incontinent briefs that morning when they changed him; he still had the two adult incontinent briefs on.
-Staff would put three adult incontinent briefs on him at night and not change him until he woke up the next day.
-Most days he had wet bed sheets and clothes when he woke up.
-He slept later in the mornings and his back would be wet.

Interview with Resident #3's family member on 11/29/22 at 10:51am revealed:
-She family member shared the room with Resident #3.
-Staff did not get Resident #3 out of bed every day because he was "too hard to lift".
-There was a named staff that could lift Resident #3 out of the bed and into the wheelchair or recliner.
-Staff changed Resident #3's adult incontinent brief when he woke up in the morning and did not change it again until bed time.

Interview with Resident #3's family member on 12/01/22 1:43pm and 6:20pm revealed:
-Resident #3 had not been out of the bed all day

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{D 269}	Continued From page 8 today, 12/01/22. -Staff did not offer to get him out of bed. -A named staff was not working today, 12/01/22 so Resident #3 stayed in bed all day. -The named staff was the only one who could lift and transfer Resident #3. -Staff had not come into check on Resident #3 or offer to reposition him. -She used the call bell for assistance, but the staff would not transfer or reposition Resident #3 when they came to the room. -Staff would place three adult incontinent briefs on Resident #3 at bedtime. -Staff did not check on Resident #3 at night to see if he was wet. -Resident #3 would have "soaking" wet sheets and clothes in the morning when he woke up. -The staff would place two adult incontinent briefs on Resident #3 when they changed him in the mornings. -Staff did not check Resident #3's adult incontinent briefs during the day. Telephone interview with Resident #3's primary care provider (PCP) on 11/30/22 at 3:58pm revealed: -Resident #3's family member used to assist him with transferring from the bed to his chair, but he had a stroke and had declined. -Resident #3 required 2 to 3 staff to assist him out of bed and to transfer him. -He did not realize Resident #3 required 2 to 3 staff to transfer him until the facility's Registered Nurse (RN) brought it to his attention on 11/29/22. -Resident #3 had complained about wanting to sit in his recliner and not stay in the bed. -He did not have any immediate concerns but Resident #3 would need to eventually be turned every 2 to 3 hours because he could not physically reposition himself in the bed.	{D 269}		

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-If Resident #3 was left in the bed for too long without repositioning he could develop pressure ulcers.
-It was difficult for staff to care for Resident #3 because he could not physically turn or reposition himself in the bed.
-If Resident #3 was not changed often enough he could have skin break down and pressure ulcers.
-Resident #3 depended on the staff to change him when he got wet.
-He expected the staff to change the resident when he was wet and not leave him in wet adult briefs for hours.

Interview with a personal care aide (PCA) on 11/29/22 at 1:46pm revealed:
-Resident #3 did not get up out of the bed because he needed assistance.
-He would help Resident #3 out of the bed on the days he worked.
-He worked five days a week and every other weekend.
-Resident #3 did not get up every day because the other PCAs could not lift him; even with two PCAs.
-Resident #3 told him before that he did not get up on the days he did not work because the other PCAs could not lift him.
-He was not assigned to work on Resident #3's floor today, 11/29/22, but he was called to assist him out of the bed and into his wheelchair.
-Resident #3 wanted to get out of bed to eat in the dining room and then go to his room and sit in his recliner.
-He would move Resident #3 back to his bed before his shift was over or at the end of the day someone else would move him back to bed.
-He would move Resident #3 from the bed to the wheelchair, from the wheelchair to the recliner, from the recliner back to the wheelchair, and then

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back to the bed; it was a lot of lifting for the PCAs.
-Resident #3 did not bear his own weight so he would lift and turn him to get him into his chair.
-He tried to encourage Resident #3 to support some of his own weight, but the resident would not try.

Interview with a second PCA on 11/29/22 at 9:23am revealed:
-Resident #3 required total care and was "bed bound".
-Staff only checked on him once per shift.
-He required a two person assist to lift but, because he was "too heavy to lift" he stayed in the bed.
-He required complete assistance with bathing, dressing, and incontinent care.

Interview with a third PCA on 12/01/22 at 3:29pm revealed:
-Two staff could not assist Resident #3 with a transfer; he required up to three staff to transfer him.
-Resident #3 could not pivot or assist with his own transfer.
-Resident #3 would ask to get out of bed, but some days he was told he would have to stay in bed.
-She was told by the RN not to get Resident #3 out of the bed today, 12/01/22, because he was too hard to transfer, and a named staff was not there to assist.
-The RN said staff could get hurt or hurt Resident #3 when he was being transferred.
-She was told by the previous Administrator that the facility did not use hoyer lifts because they were not a skilled nursing facility.
-Resident #3 was unable to roll over in the bed.
-She changed him between 10:30am and 11:00am because he slept in.

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{D 269}	Continued From page 11 -His clothes and sheets would be wet sometimes when she changed him. -She would change his sheets and clothes when there was a named PCA working and could help her or when he was really wet. -He always had three adult incontinent briefs on when she changed him in the morning. -She always put two adult incontinent briefs on him when she changed him in the morning; she was trained by other staff to "double brief" him. -She was told by other staff when they trained her to only change him once a day because he was so difficult to change. Telephone interview with a fourth PCA on 12/02/22 at 11:16am revealed: -She was told by other staff when she was hired to put three adult incontinent briefs on Resident #3 in the evenings. -She would put the adult briefs on him around 6:00pm. -She did not check his adult incontinent briefs during the night or do incontinent care while Resident #3 slept. -Resident #3's roommate was a family member and complained to the staff about waking her up. -His roommate told the staff not to bother him while he slept. Interview with a medication aide (MA) on 12/01/22 at 2:41pm revealed: -Resident #3 wanted to get up out of bed and he would ask staff to assist him. -Resident #3 was always a two person assist to transfer but he used to be able to support his own weight and pivot during the transfer, but that had changed around August 2022. -Now Resident #3 had no upper body strength and could not roll over, sit up or reposition himself in the bed.	{D 269}		

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-It felt like she was going to fall over backwards with him when she tried to assist other staff with his transfers.
-There were days the staff would leave Resident #3 in the bed because they could not lift him, even with three people.
-Sometime in November 2022 the RN watched the staff transfer Resident #3.
-After that, the RN told the staff not to get him up any more because it was too hard to transfer him.
-The RN was afraid the staff would get hurt or hurt Resident #3 during a transfer.
-The transfer to Resident #3's wheelchair would not be the only transfer for the shift because he would need to be transferred back to his bed or into his recliner because he could not sit in his wheelchair for long periods of time.
-He could not assist when staff changed his adult incontinent brief.
-She came into work in the mornings and found Resident #3 in three adult incontinent briefs at a time and in a wet bed.
-He was so wet his shirt was wet up the back between his shoulder blades and his sheets were soaked.
-She had marked his adult incontinent briefs once at 5:00pm before she left for the day and when she returned the next morning at 10:00am he still had on the same adult incontinent briefs.
-She told the Administrator about Resident #3 around September 2022, but nothing was done.
-The last time she had found Resident #3 in wet bed sheets and clothes was a couple of weeks ago.
-He always had on two adult briefs during the day.

Telephone interview with the RN on 12/02/22 at 9:44am revealed:
-He required two to three staff to transfer him.
-He was listed as a two person assist with

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{D 269}	Continued From page 13 transfer on his current care plan. -He was not able to pivot or stand to help support some of his weight. -He could not sit on the side of the bed. -She had tried to use different lifting and transferring techniques that she knew of and could not transfer him either. -A named PCA could lift him for transfer but still required another two staff to assist. -She was concerned about the safety of the staff and Resident #3 during a transfer. -She was afraid Resident #3 could fall during a transfer. -Resident #3 needed to be transferred with the use of a mechanical lift and the facility did not have one. -On 11/29/22, she instructed the staff to leave Resident #3 in the bed and not try to transfer him. -All of Resident #3's care was to be done from the bed. -Staff were required to round on residents every four to six hours. -There were supposed to look in on the resident to see if any thing needed to be done for the resident. -Staff were instructed to round on Resident #3 every two to four hours because of his needs. -Rounded included checking to see if his adult incontinent brief was wet and needed to be changed. -Personal care checks or rounding was not documented and was not in the resident's care plan. -Increased rounds were discussed between staff from shift to shift. -Because Resident #3 was bed bound and incontinent, staff should check his adult incontinent brief every two to four hours. -If Resident #3 had a soiled or wet adult brief during an incontinent check, then his adult	{D 269}		

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{D 269}	Continued From page 14 incontinent brief should be changed. -Placing two or more adult incontinent briefs on a resident was not acceptable and she was not aware any residents were being "double briefed". -She was not aware staff were placing three adult incontinent briefs on Resident #3 in the evening. -She was not aware staff were not checking on him or providing incontinent care during the night. -She was not aware Resident #3's roommate had told staff not to check on him during the night. -It did not matter that his roommate had requested staff not to come into the room at night because Resident #3 still needed personal care. -Staff were required to provide personal care for Resident #3, even if he was bed bound. -Resident #3 needed to be changed every time his adult incontinent brief, his clothes, or his bed sheets were wet. -She was concerned Resident #3 could experience skin breakdown if he was left wet. Interview with Administrator on 12/01/22 at 5:36pm revealed: -Depending on the residents' needs, staff should round from room to room every 4 to 6 hours during their shift. -The staff should check on the residents to see if their needs were being met, to see if they were just "okay" or need anything. -Resident #3 seemed to have had a change in condition and was declining. -Staff were doing the best they could for Resident #3, but he required two staff to transfer him or reposition him. -It was a challenge to get Resident #3 out of the bed when a named PCA was not working. -Staff were told to use a gait belt to assist with transfers and were told to partner with someone when transferring him. -She did not want the staff or Resident #3 to get	{D 269}		

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injured while attempting to transfer him, so the decision was made on 11/28/22 not to transfer him if it was not possible.
-Staff were instructed to round on Resident #3 every two hours or more often if they could not get him out of the bed.
-Residents should never have more than one adult incontinent brief on at a time.
-The best practice was for residents to be toileted or have incontinent care every two hours if the resident required assistance.
-She was not aware the staff were placing two to three adult incontinent briefs on Resident #3 at a time.
-It was not acceptable to place Resident #3 in two or three adult briefs at a time.
-Resident #3 should never have been left in a wet bed.
-Resident #3 should have been changed more often, even if his roommate was not happy about being disturbed while she slept.
-She expected the staff to check on Resident #3 as often as needed to keep him dry and to change his adult incontinent brief as needed.
-She was "mortified" Resident #3 was not changed more often.

2. Review of Resident #4's current FL-2 dated 10/25/22 revealed:
-Diagnoses included hypertension, paroxysmal atrial fibrillation, and a history of cardiovascular disease.
-Resident #3 required assistance with bathing.

Review of Resident #3's Licensed Health Professional Support (LHPS) form completed on 06/02/22 revealed Resident #4 required assistance with her personal care.

Review of Resident #4's care plan dated 10/25/22

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revealed:
-Resident #4 preferred showering/bathing on Sundays and Thursdays.
-Resident #4 was able to perform showering tasks of shampooing hair, washing upper body, and lower body with staff attention and/or verbal prompts and physical assistance as needed.

Review of the facility's shower binder on the third floor revealed:
-There was documentation to complete a shower form after each resident shower and turn it into the Health and Wellness Director (HWD).
-If a resident refused a shower after two attempts, the medication aide (MA) must be notified so they could make a third attempt.
If the 3rd attempt was unsuccessful, the power of attorney (POA) must be notified of the refusal, and a note entered into the computer.
-There were shower forms in the binder with spaces for name, date, time, and notes.
-There were no shower forms for Resident #4.
-The last shower form for any resident completed in the shower binder was in July 2022.
-There was no shower form for Resident #4.

Interview with Resident #4 on 11/30/22 at 3:02pm revealed:
-She had a doctor's appointment tomorrow, 12/01/22, and was concerned she had not had a shower in 2-3 weeks.
-She asked a staff member, (she did not know the staff member's name), last Wednesday, 11/23/22, to help her with a shower.
-The staff member told her she would and never showed up to assist her.
-She liked to get her showers in the morning.
-Not getting a shower happened all the time.

Interview with a personal care aide (PCA) on

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{D 269}	Continued From page 17 12/01/22 at 3:01pm revealed: -There were times she did not have time to help residents with showers, but she would try to get the shower on another day. -Resident #4 was assisted with a shower on Tuesday of last week, 11/22/22. -She had not had time to assist Resident #4 with a shower since last Tuesday, because she had been busy. -Resident #4 had not complained to her about not getting a shower. -They did not document showers or refusals anywhere; they just told the MAs. -She recalled telling another staff member she had not had time to assist Resident #4 with a shower, but she did not recall who she told. -She did not follow up and ask if anyone else had assisted Resident #4 with a shower. -She was going to assist Resident #4 with a shower on 12/01/22, but someone had helped the resident with a shower on 11/30/22. Interview with a MA on 12/01/22 at 2:27pm revealed: -Resident #4 needed assistance with a shower. -Resident #4 would remember if she had a shower or not. -The PCAs were responsible for assisting residents with showers. -The PCAs used to document when a resident had a shower or not, but now they are just relaying the information verbally. -She could not remember what she had been told about Resident #4's shower. Interview with the facility's Registered Nurse RN on 11/30/22 at 3:02pm revealed: -The facility did not have shower sheets on residents, and the completion of these forms had been discontinued.	{D 269}		

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{D 269}	Continued From page 18 -She was not aware Resident #4 had not had a shower until it was brought to her attention, today, 11/30/22. Interview with the Administrator on 12/01/22 at 6:16pm revealed: -She was not aware Resident #4 had not had a shower until it was brought to her attention, on 11/30/22. -She expected showers to be given as scheduled. -If a resident refused a shower she expected she or the RN to be notified of the refusal. -She was concerned about the resident's hygiene and overall skin integrity if showers were not being given as scheduled.	{D 269}		
{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 notify the physician for 2 of 5 sampled residents (#2, #5) related to a resident with orders for scheduled eyedrops who had multiple refusals (#2), and a resident with a recent bone fracture who had an order for a calcium suppliement and multiple refusals (#5). The findings are: 1. Review of Resident #2's current FL2 dated 09/29/22 revealed: -Diagnoses included major depression, anxiety, some loss of vision, and hearing loss. -There was an order for polymyxin B-trimethoprim	{D 273}	10A NCAC 13F .0902 Health Care All medication technicians will be reeducated on or before 1/16/23 by the Health & Wellness Director (HWD) or designee on referral and follow up and physician notification. The Health & Wellness Director or designee will complete a chart audit to verify referral and follow-up has been completed for current residents. To assist with ongoing compliance, all residents returning from an appointment or readmission will be audited by HWD or designee to verify orders, follow up appointments, other medical recommendations will be implemented as ordered by physician for four (4) weeks. Plan of correction completed by 1/16/23.	

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ophthalmic solution 4 times a day.

Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) from 10/05/2022 to 10/31/2022 revealed:
-There was an entry for polymyxin B-trimethoprim scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There were 24 refusals out of 106 total opportunities documented for polymyxin B-trimethoprim.

Review of Resident #2's October 2022 progress notes revealed there was no documentation the ordering provider was notified regarding Resident #2's refusals.

Review of Resident #2's November 2022 eMAR from 11/01/22 to 11/28/22 revealed:
-There was an entry for polymyxin B-trimethoprim scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There were 14 refusals out of 113 total opportunities documented for polymyxin B-trimethoprim.

Review of Resident #2's November 2022 progress notes revealed there was no documentation the ordering provider was notified regarding Resident #2's refusals.

Interview with a medication aide (MA) on 11/30/22 at 2:10pm revealed:
-She mostly worked second shift when she worked at the facility.
-Resident #2 had multiple orders for different eyedrops.
-Resident #2 told the MAs which eyedrops she wanted them to administer prior to Resident #2's eye doctor appointment which was 11/21/22.

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{D 273}	Continued From page 20 -Resident #2 always refused polymyxin B-trimethoprim when the MA tried to administer it to Resident #2 prior to Resident #2's eye doctor appointment on 11/21/22. -Resident #2 said that she had too many eyedrops. -She did not think any of the staff notified the provider about Resident #2's refusals of polymyxin B-trimethoprim. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/22 at 3:20pm revealed: -There was an active order on file for polymyxin B-trimethoprim instill four times a day in both eyes. -There was a bottle of polymyxin B-trimethoprim dispensed to the facility on 11/16/22. -Polymyxin B-trimethoprim was not dispensed to the facility prior to 11/16/22. -She thought Resident #2 brought polymyxin B-trimethoprim that was dispensed from another pharmacy with her when Resident #2 was admitted to the facility in October 2022. -One bottle of polymyxin B-trimethoprim would last approximately 50 days if it was administered as ordered. Interview with Resident #2 on 11/30/22 at 5:00pm revealed: -She gave facility staff her bottles of eyedrops that were dispensed from a different pharmacy when she moved into the facility in October 2022. -She was blind in her right eye and had glaucoma in her left eye. -She refused polymyxin B-trimethoprim before her eye doctor appointment on 11/21/22 because she was not taking it at home prior to moving into the facility. -She was administered different types of	{D 273}		

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{D 273}	Continued From page 21 eyedrops 4 times a day. Interview with another MA on 11/30/22 at 5:25pm revealed: -Resident #2 refused polymyxin B-trimethoprim "all the time" when she tried to administer it. -She had not notified anyone, including the ordering provider, about Resident #2 refusing polymyxin B-trimethoprim. -She would have documented in the progress notes if she had notified a provider about the refusals. -She was not sure if the facility had a policy for notifying the provider about medication refusals. Interview with the Health and Wellness Coordinator (HWC) on 12/01/22 at 8:55am revealed: -She was not aware that Resident #2 had multiple refusals of polymyxin B-trimethoprim in October 2022 and November 2022. -She expected MAs to contact the ordering provider regarding medication refusals or let her know about refusals so that she could contact the provider. -She expected MAs to contact the provider or let her know about medication refusals after 3 consecutive refusals. Interview with the Registered Nurse (RN) on 12/01/22 at 9:05am revealed: -She thought that Resident #2's Primary Care Provider (PCP) was aware of the polymyxin B-trimethoprim refusals. -She was not aware the ordering provider was not notified of the polymyxin B-trimethoprim refusals and there was no documentation that the provider was notified of the refusals. -MAs were responsible to notify the provider regarding medciation refusals.	{D 273}		

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-She expected the MAs to notify the provider after "several" medication refusals.

Interview with the Administrator on 12/01/22 at 11:55am revealed:
-She was not aware that Resident #2 refused polymyxin B-trimethoprim multiple times in October 2022 and November 2022.
-She was not aware there was no documentation the provider was notified about Resident #2's polymyxin B-trimethoprim refusals.
-MAs were responsible to follow up with the provider regarding medication refusals.
-She expected MAs to let the HWC or RN know if the MAs did not receive a response from the provider regarding medication refusals.
-If a resident was consistently refusing a medication, the HWC or RN were expected to notify the resident's family and speak with the resident to understand why they were refusing a medication.
-She expected staff to notify the ordering provider after 3 consecutive medication refusals.

Attempted telephone interview with Resident #2's ophthalmologist on 12/01/22 at 9:42am unsuccessful.

2. Review of Resident #5's current FL-2 dated 10/20/22 revealed:
-Diagnoses included closed fracture of left femur and pressure ulcers.
-There was an order for calcium-vitamin D3 600 -400iu (a calcium supplement) two tablets once daily.

Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for calcium-Vitamin D3 600

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-400iu two tablets once daily scheduled at 9:00am.
-There was documentation Resident #5 had self-administered the calcium-Vitamin D3 from 10/01/22 to 10/13/22.
-There was documentation facility staff began to administer Resident #5 the calcium-vitamin D3 beginning on 10/14/22.
-There was documentation Resident #5 refused the calcium-vitamin D3 seven of eighteen total opportunities from 10/14/22 to 10/31/22.

Review of Resident #5's November 2022 eMAR revealed:
-There was an entry for calcium-Vitamin D3 600 -400iu two tablets once daily scheduled at 9:00am.
-There was documentation Resident #5 refused the calcium-vitamin D3 twenty five of thirty total opportunities.

Review of Resident #5's progress notes revealed:
-There were no progress notes for October 2022.
-There was no documentation that the primary care provider (PCP) or the hospice nurse were notified of the refusals of calcium-vitamin D3 in November 2022.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 12/01/22 at 3:12pm revealed:
-There was a current order for Resident #5 for calcium-vitamin D3 600-400iu two tablets once daily dated 06/02/22.
-Two cards each with thirty tablets of calcium-vitamin D3 600-400iu had been dispensed on 06/02/22; there were no other dispense dates.
-Calcium-Vitamin D3 was used to treat for fragile bones to increase the bone strength.

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-An outcome of not administering the calcium-vitamin D3 as ordered could be a broken bone if there was a fall.

Telephone interview with Resident #5's Power of Attorney on 11/30/22 at 2:28pm revealed:
-Resident #5 had a fall and broke her leg on 09/18/22; the calcium-vitamin D3 was ordered after the fall.
-She did not recall Resident #5 having an order for calcium-vitamin D3 prior to the fall.
-Resident #5 administered her own medication prior to the fall but when she returned from the hospital the facility began to administer the medications.
-She was aware Resident #5 was refusing her medications because the facility staff told her.

Telephone interview with Resident #5's hospice nurse on 12/01/22 at 3:47pm revealed:
-There was no documentation in Resident #5's notes about notification of refusals of medications.
-She was in the facility three times a week and staff had not notified her of any refusals.
-She would want to be notified if Resident #5 was refusing her medications including calcium-vitamin D3.
-She would like to know specifics when notified of refusals; she would want to know if the resident was lethargic or if she was having difficulty swallowing the tablets.
-Resident #5 was ordered the calcium-vitamin D3 because she had a bone fracture in September 2022.

Telephone interview with a representative from Resident #5's PCP's office on 12/01/22 at 4:02pm revealed:
-Any notification from the facility about refusals of

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mediation was usually documented.
-There was nothing documented in Resident #5's record about notification of refusals.

Interviews with a medication aide (MA) on 12/01/22 at 10:18am and 1:53pm revealed:
-Resident #5 used to self-administer her medications but the facility began to administer them sometime in the middle of October 2022.
-Resident #5 would refuse to take her calcium-vitamin D3 all the time.
-She would document the refusals on the eMAR.
-After so many days of refusals she would contact the PCP.
-She did not have a set number of refusals before contacting the PCP.
-If the resident was on hospice the hospice agency would also need to be contacted about refusals.
-She had contacted the PCP once and left a message, but she did not know if she documented the call.
-She had not contacted the hospice agency, but she had let the previous Administrator know about the refusals.

Interview with the facility's Registered Nurse (RN) on 12/01/22 at 11:04am revealed:
-Resident #5 had self-administered her medications at one time but she had been assessed in October 2022 and the facility began to administer the medications to her.
-Resident #5 would routinely refuse her medications.
-The facility did not have a policy for the number of times a resident could refuse medication before notifying the PCP.
-Best practice was when a resident refused medications for three consecutive days, the MA should notify the PCP about the refusals.

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{D 273}	Continued From page 26 -Documentation of the refusals were done on the eMAR and documentation of the notification to the PCP was documented on the progress notes. -There should also be documentation in the progress notes of instructions from the PCP once they were contacted. -She contacted the hospice nurse and notified her of Resident #5's refusals today, 12/01/22. -She did not know if the PCP had been notified of the refusals prior to today, 12/01/22. -The hospice nurse had not been notified of the refusals before 12/01/22. -The hospice nurse discontinued Resident #5's calcium-vitamin D3 when she notified them of the refusals. Interview with the Administrator on 12/01/22 at 5:02pm revealed: -When a resident refused medications more than three times in a row, the practice was for the MA to notify the PCP and to make the RN aware. -The MA would document the call to the PCP in the progress notes. -She expected the MAs to follow the process for refusals. -The PCP needed to be made aware of the refusals so they could either discontinue the medication or tell the staff what to do. Based on observations, interviews and record reviews, it was determinded Resident #5 was not interviewable.	{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	{D 276}		

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{D 276}	Continued From page 27 a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to implement physician orders for 1 of 5 sampled residents (#5) related to weekly blood pressure checks and repositioning every hour. The findings are: Review of Resident #5's current FL-2 dated 10/20/22 revealed diagnoses included closed fracture of left femur and pressure ulcers. a. Review of Resident #5's current FL-2 dated 10/20/22 revealed there was an order to check blood pressure weekly. Review of Resident #5's October 2022 and November 2022 electronic medication administration records (eMARs) revealed: -There was no entry for weekly blood pressure checks. -There was no weekly blood pressure documented. Telephone interview with a Registered Nurse (RN) from Resident #5's primary care provider's (PCP) office on 4:02pm revealed: -The weekly blood pressures were ordered to monitor her blood pressure because her metoprolol (used to treat hight blood pressure) had been discontinued due to low blood pressure results. -Outcomes of not monitoring blood pressures	{D 276}	10A NCAC 13F .0902 Health Care All medication technicians will be reeducated on or before 1/16/23 by the HWD or designee, on referral and follow up and physician notification. The Health & Wellness Director or designee will complete a chart audit to verify referral and follow-up has been completed for current residents. To assist with ongoing compliance, all residents returning from an appointment or readmission will be audited by HWD or designee for four (4) weeks to verify orders, follow up appointments, other medical recommendations will be implemented as ordered by physician. Plan of correction completed by 1/16/23.	

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could be they would continue to drop without indications.
-The PCP expected the orders to be followed as written.

Interview with a medication aide (MA) on 12/0122 at 2:03pm revealed:
-When a resident had an order for blood pressure checks, it would be on the eMAR.
-There would be documentation for standing verses sitting, which arm the blood pressure was taken, and a box for the results.
-Blood pressures were taken once a month unless there was an order to do them more often.
-Resident #5 did not have an order to have blood pressure checks done weekly.
-The MAs were responsible for entering new orders on the eMAR, including blood pressure checks.

Telephone interview with the Registered Nurse (RN) on 12/02/22 at 9:26am revealed:
-If a resident had an order for weekly blood pressure checks, the entry would be on the eMAR.
-The Health and Wellness Director (HWD) or the RN reviewed the FL-2 after it was signed by the PCP.
-The MAs were responsible for reviewing orders and entering them on the eMAR.
-She was not aware Resident #5 had an order for weekly blood pressure checks.
-The previous RN or the MAs should have caught the order when they reviewed the FL-2.
-She expected the staff to follow the PCP's orders.

Interview with the Administrator on 12/01/22 at 6:03pm revealed:
-The MAs were responsible for reviewing new

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orders, order changes, and the FL-2s.
-The MAs were responsible for entering any new orders into the eMAR.
-The HWD and the RN were responsible for making sure the orders were being followed.
-She was not aware Resident #5 had orders to have her blood pressures taken weekly.
-The MAs should have monitored Resident #5's blood pressures weekly because she had an order.
-The MAs should have been documenting the results on the eMAR.
-She expected the staff to implement orders as written.

b. Review of Resident #5's current FL-2 dated 10/20/22 revealed there was an order to reposition every hour to aide in pressure ulcer healing.

Review of Resident #5's progress notes for October 2022 and November 2022 revealed there was nothing documented about repositioning Resident #5.

Review of Resident #5's October 2022 and November 2022 electronic medication administration records (eMARs) revealed:
-There was no entry for repositioning of Resident #5.
-There was nothing documented about repositioning Resident #5 every hour.

Telephone interview with Resident #5's hospice nurse on 12/01/22 at 3:47pm revealed:
-Resident #5 had multiple stage III pressure ulcers in September 2022.
-Her pressure ulcers were healing and were currently at a stage II.

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-The order to reposition her was an attempt to help her ulcers heal.
-She did not know if the resident was being turned or repositioned.
-She would ask the staff and they would say they repositioned her, but she did not know how often.
-She would expect the repositioning order to be followed as written.

Interview with a personal care aide (PCA) on 12/01/22 at 3:42pm revealed:
-She did not know about an order to reposition Resident #5 every hour.
-She was told to not put Resident #5 in the recliner because it made her pressure ulcers worse.
-She would reposition Resident #5 every hour if there was an order.

Interview with a medication aide (MA) on 12/0122 at 2:03pm revealed:
-She was told by the previous Administrator and management that the facility did not reposition residents because they were in an assisted living facility and that was a task for a skilled facility.
-She did not know Resident #5 had an order for repositioning every hour.
-If she had known Resident #5 had the order to reposition her, she would have made sure it was done.
-The MAs were responsible for entering new orders on the eMAR.

Telephone interview with the Registered Nurse (RN) on 12/02/22 at 9:26am revealed:
-If a resident had an order for repositioning, it would be on the eMAR.
-The MAs were responsible for informing the PCAs about the repositioning order.
-The PCAs would do the repositioning and notify

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the MA when the task was completed so the MA could enter it on the eMAR.
-The Health and Wellness Director (HWD) or the RN reviewed the FL-2 after it was signed by the PCP.
-The MAs were responsible for reviewing orders and entering them on the eMAR.
-She was not aware Resident #5 had an order to be repositioned every hour.
-The previous RN or the MAs should have caught the order when they reviewed the FL-2.
-She did not know why the staff was told the facility did not reposition residents.
-She expected the staff to follow orders the PCP gave.

Interview with the Administrator on 12/01/22 at 6:03pm revealed:
-The MAs were responsible for reviewing new orders, order changes, and the FL-2s.
-The MAs were responsible for entering any new orders into the eMAR.
-The HWD and the RN were responsible for making sure the orders are being followed.
-She was not aware Resident #5 had an order for repositioning every hour.
-The staff should have been told the facility could carry out the order for repositioning.
-There should have been documentation on the eMAR about the repositioning being done.
-She expected the staff to implement orders as written.

{D 282} 10A NCAC 13F .0904(a)(1) Nutrition and Food Service {D 282}

10A NCAC 13F .0904 Nutrition and Food Service
(a) Food Procurement and Safety in Adult Care Homes:

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{D 282}	Continued From page 32 (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure the kitchen and food storage areas were clean and free from contamination including the walk-in cooler, the freezer, the dry food pantry, and the oven. The findings are: Observation of the kitchen on 11/30/22 at 11:26am revealed: -There was a long narrow pan at the side of the flat top griddle that was full of black chunks and a black liquid; the pan was above the oven door and was leaking. -There was a thick brown and black liquid on the top of the oven door that ran down inside the oven. -There was a brown sticky substance on the door to the walk-in cooler that was easily scrapped off with a fingernail. -There were debris and dried liquids on the floor to the walk-in cooler including various pieces of food and trash. -There were dried liquid drips, and large areas of black and white build-up that could be removed when touched on the shelves of the walk-in cooler. -There was a build-up of black and brown substances on the shelves in the freezer. -There were pieces of paper and food crumbs on the floor in the freezer. -There were pieces of torn boxes, food crumbs, a utensil, and small packages of food on the floor	{D 282}	10A NCAC 13F .0904 Nutrition & Food Service The Dining Services Manager or designee will conduct an audit to identify areas requiring follow up. A shift cleaning schedule will be implemented and the Dining Services Manager or designee will review daily schedules to verify completion for four (4) weeks. The Dining Services Manager or designee will audit current residents' diet orders to verify current therapeutic diet orders are in place as ordered by the physician. To assist with ongoing compliance, the Dining Services Manager or designee will review diet orders weekly for four (4) weeks to verify that residents are receiving the therapeutic diet order per physicians' order(s). Plan of correction to be completed by 1/16/23.	

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under the shelves in the dry food pantry area.
-There was a brown sticky substance on the shelves in the dry food pantry.

Review of the daily and weekly kitchen cleaning schedule dated 11/28/22 to 12/03/22 revealed:
-The ovens were to be cleaned once weekly.
-The shelving was to be wiped clean on Mondays and Thursdays.
-The floor to the freezer, walk-in cooler, and the dry food pantry were to be swept daily.
-The walk-in cooler and the dry food pantry were to be mopped daily.
-Doors and walls were scheduled to be cleaned on Mondays and Thursdays.
-There were names assigned to the task on the cleaning schedule.

Interview with the cook on 12/01/22 at 9:20am revealed:
-He was assigned to clean something different each week.
-He tried to clean as he went and when he saw something that needed to be cleaned, he cleaned it.
-There was always something that needed to be cleaned.
-The brown liquid that had dripped down the stove into the oven was from a drip pan for the griddle that was stuck and could not be removed and would drip down into the oven.
-He did not think about cleaning the oven because he did not use it, but it was scheduled to be cleaned once a week.
-The cooks were responsible for sweeping the walk-in cooler and the freezer floor once a day.
-The walk-in cooler was supposed to be mopped once daily at the end of the day and the freezer floor was never mopped.

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-The dry food pantry was supposed to be swept and mopped once daily at the end of the day.
-Sometimes he would start work in the mornings and he could see the floors were not swept or mopped the night before because they would still be dirty.
-The shelves in the walk-in cooler, freezer, and dry food pantry were scheduled to be wiped down a couple of times a week.
-The shelves in the walk-in cooler, freezer, and dry food pantry were scheduled to be removed and deep cleaned by hand a couple of times a year.
-He had scrubbed the door to the walk-in cooler, but he could not remove the sticky brown build-up.
-The kitchen had been short staffed for a long time and it had been difficult to deep clean everything on the cleaning schedule.

Interview with the Kitchen Manager (KM) on 12/01/22 at 9:55am revealed:
-She was responsible for assigning the cleaning, posting the cleaning schedule, and ensuring the cleaning was being completed.
-She looked at the cleaning schedule to monitor if cleaning was being done.
-Staff signed off on the cleaning schedule once they had completed the cleaning task.
-Sometimes she checked the equipment or areas to be sure they had been properly cleaned.
-She had not been checking on the assigned cleaning like she should because she was short staff and had to cook.
-The floor in the dry food pantry was scheduled to be swept twice daily and mopped at the end of the day.
-The floor in the dry food pantry was always clean when she came to work in the mornings.
-She did not see anything under the shelves

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when she saw the floor in the dry food pantry.
-The floors in the freezer and the walk-in cooler were scheduled to be swept once a day.
-The freezer floor was mopped once a month with a special cleaner that did not freeze, and the walk-in cooler was mopped every day.
-She could not recall the last time the shelves in the dry food pantry were removed and deep cleaned.
-One of shelves in the walk-in cooler was removed and cleaned a while ago.
-There were still shelves in the walk-in cooler and the freezer that still needed to be deep cleaned.
-She did not think any cleaning of the shelving was on the cleaning schedule.
-The pan that was full of food and liquid was stuck in the grill and could not be removed.
-She did not know how to clean it out and asked maintenance about removing the pan.
-The pan dripped into the oven and the oven should have been cleaned once a week.
-The door to the walk-in cooler was wiped down every day but it needed to be deep cleaned to remove the sticky brown build-up.
-She knew there was potential for cross contamination because there was equipment in the kitchen that needed to be cleaned.
-She focused on getting the meals to the residents every day.
-She would have to monitor the equipment and not just the cleaning schedule to make sure the staff were doing the cleaning assignments.

Interview with the Administrator on 12/01/22 at 5:02pm revealed:
-She had been in the kitchen, but it had been a minimal amount of times.
-She had spent more time in the dining room getting to know the residents.
-The KM had given her a tour of items that

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{D 282}	Continued From page 36 needed to be cleaned and repaired. -The KM said the cleaning was not done due to staffing challenges. -Some staff had been recently hired. -She expected the KM to review the cleaning schedule and address any concerns with the staff.	{D 282}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 5 sampled residents, (#8) who had an order for a 2 gram (gm) sodium diet. The findings are: Review of Resident #8's current FL-2 revealed: -Diagnosis included cirrhosis of the liver, hypothyroidism, and edema. -She was ordered a 2gm sodium diet. Review of Resident #8's diet order dated 01/05/22 revealed she was ordered a 2gm sodium diet.	{D 310}	10A NCAC 13F .0904 Nutrition & Food Service The Dining Services Manager or designee will conduct an audit to identify areas requiring follow up. The Dining Services Manager or designee will implement a shift cleaning schedule and the Dining Services Manager or designee will review daily schedules for four (4) weeks to verify completion. The Dining Services Manager or designee will audit current residents' diet orders to verify current therapeutic diet orders are followed as ordered by the physician. To assist with ongoing compliance, the Dining Services Manager or designee will monitor diet orders weekly for four (4) weeks to verify that residents are receiving the therapeutic diet order per physicians' order(s). Plan of correction to be completed by 1/16/23.	

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Review of Resident #8's physicians order dated 05/11/22 revealed she was ordered a 2gm sodium diet.

Review of the therapeutic diet menu for breakfast and lunch on 11/30/22 revealed:
-The 2gm sodium diet menu listed breakfast as 4.75 ounces of low sodium scrambled eggs, a beef patty, low sodium buttered toast and beverages were to be served.
-The 2gm sodium diet menu listed lunch as chicken tenders, white rice in place of the corn bread stuffing, baked potato, steamed spinach, low sodium margarine and assorted beverages were to be served.

Observation of the breakfast meal on 11/30/22 at 8:10am revealed:
-Resident #8 was served approximately one and a half cups or 12 ounces of scrambled eggs, one piece of toast with jelly, and orange juice.
-She ate 100 percent of her breakfast meal.

Observation of the lunch meal on 11/30/22 at 12:03pm revealed:
-The table was preset with a salt shaker and packed portions of regular margarine in a bowl.
-Resident #8 was served two chicken tenders, a baked potato, 1 cup of cornbread stuffing, and iced tea.
-Resident #8 spread a portion of the regular margarine and sprinkled table salt on her baked potato.
-Resident #8 ate 100 percent of her meal.

Interview with Resident #8 on 12/01/22 at 4:54pm revealed:
-Her doctor had ordered her to be on a no salt diet several months ago.

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{D 310}	Continued From page 38 -She was on a no salt diet because she had cirrhosis of the liver and edema. -Too much salt made her ankles swell. -Her ankles were not swollen now. -She was told by her doctor what she could and could not eat. -She did not use the salt shaker that was on the table. -The Kitchen Manager (KM) told her what she could and could not eat at the meals. -She was okay with what the KM told her she could not eat. Telephone with Resident #8's primary care provider (PCP) on 12/02/22 at 10:55am revealed: -Resident #8 was ordered a 2gm sodium diet because she had a diagnosis of cirrhosis of the liver. -Resident #8 would retain fluid due to her underlying liver disease. -She had attempted to educate Resident #8 on her diet. -Resident #8 had a long history of not being compliant with her diet order. -She depended on the facility to provide the appropriate diet. -She expected the facility to follow the 2gm sodium diet as she had ordered it. Interview with a dietary aide on 11/30/22 at 12:32pm revealed: -She referenced the diet list on the wall in the kitchen when she served meals. -She referenced the diet menu before she served the residents their meals. -The cook knew the residents and their diet orders. -She would tell the cook the resident's name and what they wanted to be served. -She was not aware Resident #8 was on a 2gm	{D 310}		

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sodium diet.
-Resident #8 liked scrambled eggs.
-She thought the serving was a little bit big that morning, 11/30/22, when she served Resident #8.
-She did not know to give Resident #8 the low sodium margarine with her meals.
-She thought it was okay for Resident #8 to have the cornbread stuffing for lunch.
-She was not aware anyone on the 2gm sodium diet was supposed to have the rice and not the stuffing.
-Resident #8 ate the cornbread stuffing all the time.

Interview with a cook on 11/30/22 at 12:20pm revealed:
-He prepared the plates of foods for the residents.
-He knew all the residents' diets by heart.
-The staff told him the resident's name and he would reference the diet menu and then prepare the plate of food based on the diet menu.
-He did not know which residents were ordered a 2gm sodium diet; he did not know Resident #8 was on a 2gm sodium diet.
-He prepared the scrambled eggs without salt, butter or milk so they were low sodium; he was not aware of the portion size.
-He did not know he served Resident #8 too large a portion of scrambled eggs.
-Resident #8 usually got double portions of scrambled eggs because she loved them.
-He made rice for lunch because he knew the residents on the 2gm sodium diet were not supposed to be served cornbread stuffing.
-He was not aware he served Resident #8 the cornbread stuffing.

Interview with the KM on 12/01/22 at 9:37am revealed:

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-The kitchen staff and personal care aides (PCAs) served the residents in the dining room.
-The staff serving the meals were supposed to reference the board in the kitchen with the residents' diets.
-The staff would ask the resident what they wanted and then tell the cook the resident's name and what they wanted.
-She and the cook knew all the residents' diets.
-The cook looked at the diet menu and plated the food according to the diet menu.
-The cooks could also see the board with the diet list from the serving line if they were not sure of a diet.
-The scrambled eggs were made following the low sodium recipe; nothing was added to the scrambled eggs.
-She was not aware the low sodium eggs were a 4.75 ounce portion.
-Resident #8 usually only ate the scrambled eggs for breakfast so she thought it was okay to give her double portions.
-She must have made the mistake and allowed Resident #8 to have the cornbread stuffing when she served meals.
-There should have been low sodium margarine and a salt substitute on Resident #8's table.
-Resident #8 told her she did not use the salt shaker on the table.
-She was going to start providing the residents on special diets individual menus based on their diets to make sure their diets are followed.

Interview with the Administrator on 12/01/22 at 5:02pm revealed:
-She was a little familiar with a 2gm sodium diet.
-She knew there were restrictions on salt and food that had salt in it.
-She knew there was a menu for the diet in the kitchen.

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{D 310}	Continued From page 41 -She had not had the opportunity to discuss diet orders with anyone. -She walked around the dining room during meals to talk to residents and assisted them. -She expected the meals to be prepared according to the diet menu. -She expected the cooks, the kitchen staff and the KM to be familiar with the residents' diets and serve them as ordered.	{D 310}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Follow-Up to Type B Violation. Based on these findings the Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents (#1, #2, #4, and #5) including a resident whose blood pressure was not taken before administering a blood pressure medication, a medication used to treat atrial fibrillation, a medication used to treat high cholesterol, and a pain patch (#4); an antibiotic (#1); a medication to treat mood (#2); and a medication used to treat high blood pressure (#5).	{D 358}	10A NCAC 13F. 1004 Medication Administration Medication aides received retraining by the Health & Wellness Director or designee on medication administration as ordered by the physician, as well as on the utilization of the new order tracking form. The new order tracking form is submitted to the Health & Wellness Director of designee, to verify accuracy and implementation of all new orders. Current residents' charts have been audited by the Health & Wellness Director or designee, to verify orders are correctly entered into MAR and administered. All orders provided in FL2, discharge summary will be entered into MAR upon receipt by the Health & Wellness Director or designee. Health & Wellness Director or designee will monitor all new orders at least weekly for three weeks and monthly for two months to verify compliance and to verify that pre-charting isn't occurring. To assist with ongoing compliance, the Health & Wellness Director or designee will observe medication aides administer medications during one med pass, twice weekly for two weeks. Plan of correction by 1/16/23.	

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The findings are:

1. Review of Resident #4's current FL-2 dated 10/25/22 revealed diagnoses included hypertension, paroxysmal atrial fibrillation, and history of cardiovascular disease.

a. Review of Resident #4's physician's order dated 10/25/22 revealed an order for Amlodipine Besylate (used to treat elevated blood pressure) 5mg tablet daily; hold if systolic blood pressure (BP) was less than 110.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) for 10/27/22-10/31/22 revealed:
-There was an entry for Amlodipine 5mg daily with a scheduled administration time of 8:00am; hold if systolic blood pressure is less than 110.
-There was documentation Amlodipine 5mg was administered from 10/28/22-10/31/22 with no recorded blood pressure readings.

Review of Resident #4's November 2022 eMAR revealed:
-There was an entry for Amlodipine 5mg daily with a scheduled administration time of 8:00am; hold if systolic blood pressure is less than 110.
-There was documentation Amlodipine 5mg was administered from 11/01/22-11/30/22 with no recorded blood pressure readings.

Review of Resident #4's December 2022 eMAR for 12/01/22 revealed:
-There was an entry for Amlodipine 5mg daily with a scheduled administration time of 8:00am; hold if systolic blood pressure is less than 110.
-There was documentation Amlodipine 5mg was administered on 12/01/22 with no recorded blood pressure readings.

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Observation of Resident #4's medication on hand on 12/01/22 at 10:30am revealed there was a bubble pack dispensed on 11/17/22 for Amlodipine 5mg; there were 25 tablets of 30 tablets remaining in the bubble pack.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 12/01/22 at 11:26am revealed:
-Resident #4's medications were not cycle-filled and had to be requested for a refill.
-The pharmacy had an order for Resident #4's Amlodipine Besylate 5mg tablet daily; hold if systolic blood pressure is less than 110 dated 10/25/22.
-The pharmacy dispensed 30 tablets for a one-month supply on 11/16/22.
-The pharmacy dispensed 30 tablets for a one-month supply on 08/19/22; he did not see a hold related to blood pressure readings on that dispensing.
-If Resident #4's BP was low, and Amlodipine was administered, the resident's BP could bottom out and the resident could experience dizziness, fainting, and headaches.

Interview with a medication aide (MA) on 12/01/22 at 10:44am revealed:
-She only checked Resident #4's BP when requested and the routine once-a-month BP checks.
-She did not check Resident #4's BP before administering the Amlodipine because she did not know she was supposed to.
-After reviewing the order on the eMAR with a parameter she stated she had "missed it."
-Usually for orders with a parameter, a "pop-up" box would require you to enter information before you could proceed.

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-There were times when Resident #4 complained of dizziness in the morning.

Observation of Resident #4's blood pressure on 12/01/22 at 10:59am revealed a reading of 109/70.

Interview with Resident #4 on 12/01/22 at 11:01am revealed:
-She had dizziness sometimes in the mornings.
-Staff did not check her BP often.
-Staff did not check her BP daily.
-She did not recall when her BP had been checked prior to today, 12/01/22.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 12/01/22 at 3:48pm revealed:
-Resident #4 had been taking Amlodipine 5mg since May 2022.
-Resident #4 did not have a hold order for the Amlodipine before a recent hospital discharge (he did not have the date).
-Resident #4's current Amlodipine 5mg order included a blood pressure check to ensure the resident's BP was not too low to administer the medication.
-He expected Resident #4's BP to be checked before administering the medication.
-If Resident #4 was administered the Amlodipine when her BP was low, it could cause her to have syncope episodes (fainting and temporary loss of unconsciousness) and shock-like symptoms.

b. Review of Resident #4's physician's order dated 10/25/22 revealed an order for Amiodarone (used to treat irregular heartbeat) 20mg tablet daily.

Review of Resident #4's October 2022 electronic

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medication administration record (eMAR) for 10/28/22-10/31/22 revealed:
-There was an entry for Amiodarone 20mg daily with a scheduled administration time of 8:00am; the entry had a start date of 05/19/22.
-There was documentation Amiodarone 5mg was self-administered from 10/28/22-10/31/22.

Review of Resident #4's November 2022 eMAR revealed:
-There was an entry for Amiodarone 20mg daily with documentation the medication was self-administered.
-There was documentation Amiodarone 5mg was self-administered from 11/01/22-11/30/22.

Review of Resident #4's 12/01/22 eMAR revealed:
-There was an entry for Amiodarone 20mg daily with a scheduled administration time of 8:00am.
-There was documentation Amiodarone 5mg was administered on 12/01/22.

Observation of Resident #4's medication on hand on 11/30/22 at 3:00pm and 12/01/22 at 10:30am revealed:
-There was a bubble pack dispensed on 10/14/22 for Amiodarone 20mg; there were 4 of 14 tablets remaining in the bubble pack.
-There was a bubble pack dispensed on 11/17/22 for Amiodarone 20mg; there were 30 of 30 tablets remaining in the bubble pack.

Interview with Resident #4 on 11/30/22 at 11:07am revealed:
-She did not have any pills in her room to self-administer.
-She did not self-administer Amiodarone.
-She did not know what medications the medication aide (MA) gave her in the mornings.

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-She took a lot of medication.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/22 at 2:19pm revealed:
-The pharmacy did not have a self-administer order for Resident #4's Amiodarone 20mg tablet daily.
-Orders were entered into the eMAR system by pharmacy staff, but the facility staff could make changes to the eMAR.
-The pharmacy dispensed 30 tablets of Amiodarone 20mg for a one-month supply on 11/16/22 and 05/20/22.
-She was unclear as to why there were no other dispensed dates showing in the computer system for Resident #4's Amiodarone.
-If Resident #4 did not receive her Amiodarone 20mg as ordered she would be at risk for her heart not being in rhythm.
-The facility was not cycle filled and medication needed to be requested for a refill by the facility staff.

Interview with a MA on 11/30/22 at 2:42pm revealed:
-She did not administer Resident #4's Amiodarone; it did not pop up for her to administer.
-The Amiodarone showed up green in the facility's eMAR system which meant it was not a medication to be administered during her medication pass.
-She thought the medication might be administered on the night medication pass.

Interview with another MA on 12/01/22 at 10:44am revealed:
-She did not administer Resident #4's Amiodarone today, 12/01/22.

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-Resident #4's Amiodarone was administered by the night shift at 6:00am.
-She had not administered Resident #4's Amiodarone because the medication was already checked off when she did her medication pass.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/30/22 at 3:58pm revealed:
-Resident #4 had a history of atrial fibrillation.
-Resident #4 should be administered Amiodarone 20mg daily; "the order had not changed."
-Resident #4 did not have an order to self-administer Amiodarone 20mg.
-He expected Resident #4's Amiodarone to be administered daily.
-If Resident #4's Amiodarone was not administered as ordered, it could worsen her atrial fibrillation and she could feel more fatigued.

c. Review of Resident #4's physician's order dated 10/25/22 revealed an order for Atorvastatin (used to treat high cholesterol) 20mg tablet daily.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) for 10/27/22-10/30/22 revealed:
-There was an entry for Atorvastatin 20mg daily with a scheduled administration time of 8:00pm.
-There was documentation Atorvastatin 20mg was administered at 8:00pm from 10/27/22-10/30/22.
-There were no exceptions documented.

Review of Resident #4's November 2022 eMAR revealed:
-There was an entry for Atorvastatin 20mg daily with a scheduled administration time of 8:00pm.
-There was documentation Atorvastatin 20mg was administered at 8:00pm from

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{D 358}	Continued From page 48 11/01/22-11/09/22 and 11/11/22-11/30/22. -There were no exceptions documented. Observation of Resident #4's medication on hand on 11/30/22 at 2:27pm revealed: -There was a bubble pack dispensed on 05/20/22 for Atorvastatin 20mg; there were 9 tablets of 30 tablets remaining in the bubble pack. -There was a bubble pack dispensed on 11/17/22 for Atorvastatin 20mg; there were 29 tablets of 30 tablets remaining in the bubble pack. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/22 at 2:19pm revealed: -The pharmacy dispensed 30 tablets of Atorvastatin 20mg for a one-month supply on 11/16/22. -The pharmacy dispensed 30 tablets of Atorvastatin 20mg for a one-month supply on 05/20/22. -The facility was not cycle filled and medication needed to be requested for a refill by the facility staff. Interview with a medication aide (MA) on 12/01/22 at 10:38am revealed: -She administered Resident #4's Atorvastatin. -She did not know why there were too many Atorvastatin tablets on hand to have been administered daily as ordered. Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/30/22 at 3:58pm revealed: -Resident #4's Atorvastatin was ordered to treat high cholesterol. -Resident #4 could be at risk for stroke or heart attack if her Atorvastatin was not administered as ordered.	{D 358}		

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-He expected Resident #4's Atorvastatin to be administered daily.

d. Review of Resident #4's physician's order dated 10/25/22 revealed an order for Lidocaine Patch 4% (used to relieve pain) apply to the most painful area, one time a day.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) for 10/17/222-10/31/22 revealed:
-There was an entry for Lidocaine Patch 4% daily with a scheduled administration time of 8:00am.
-There was documentation the Lidocaine Patch was administered at 8:00am on 10/29/22.
-There were exceptions documented for 10/28/22 as pharmacy action required, 10/30/22 as other, and 10/31/22 as resident refused.

Review of Resident #4's November 2022 eMAR revealed:
-There was an entry for Lidocaine Patch 4% daily with a scheduled administration time of 8:00am.
-There was documentation the Lidocaine Patch was administered at 8:00am from 11/02/22-11/08/22, 11/12/22-11/16/22, and 11/18/22-11/24/22.
-There were exceptions documented from 11/09/22-11/11/22 as pharmacy action required and 11/17/22 as resident refused.
-There was documentation the medication was discontinued on 11/24/22.

Observation of Resident #4's medication on hand on 11/30/22 at 2:27pm revealed:
-There was a plastic storage bag with a pharmacy label that contained 10 individually sealed Lidocaine Patches; 30 were dispensed on 08/12/22.
-There was a plastic storage bag with a pharmacy

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label that contained 29 individually sealed Lidocaine Patches; 30 were dispensed on 10/27/22.

Interview with Resident #4 on 11/30/22 at 11:07am revealed:
-She had a lot of pain in her lower right back/hip area.
-She used a roll-on pain reliever on the area daily that she self-administered.
-She was scheduled to get an injection in her back later this week that was supposed to help with her back pain.

Interview with Resident #4 on 12/01/22 at 5:49pm revealed:
-She had just returned from an appointment where she received an injection to her lower back.
-The Lidocaine Patches relieved her pain "for a little while" when the patches were applied; the patches were rarely applied.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 12/01/22 at 11:26am revealed:
-The pharmacy dispensed 30 Lidocaine Patches for a one-month supply on 08/12/22 and 10/27/22.
-The facility was not cycle filled and medication needed to be requested for a refill by the facility staff.
-The Lidocaine patch order was still active and had not been discontinued.

Interview with a medication aide (MA) on 12/01/22 at 10:38am revealed:
-She had applied Resident #4's Lidocaine Patch before, but had not applied the patch today, 12/01/22.

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-She did not recall when she had last applied Resident #4's Lidocaine Patch.
-Resident #4's Lidocaine Patch was not scheduled but was to be used as needed (PRN).
-She did not know why Resident #4's Lidocaine Patch had been discontinued in the eMAR on 11/24/22.
-Resident #4 had not complained of back/hip pain to her.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/30/22 at 3:58pm revealed:
-Resident #4's Lidocaine Patch was ordered for pain in her back/hip area.
-Resident #4 could have worsened back pain if the Lidocaine patch was not administered as ordered.

Interview with the facility's Registered Nurse (RN) on 12/01/22 at 4:39pm revealed:
-She was not aware Resident #4's medications had not been administered correctly.
-She was concerned if the medications were not administered correctly it could affect Resident #4's physical health and safety.

Interview with the Administrator on 12/01/22 at 6:16pm revealed:
-She was not aware Resident #4 had not been administered her medications as ordered.
-She was concerned Resident #4's medications had not been administered correctly.

Refer to interview with a medication aide (MA) on 11/30/22 at 5:21pm.

Refer to interview with another MA on 12/01/22 at 2:27pm.

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Refer to interview with the Health and Wellness Coordinator (HWC) on 12/01/22 at 8:51am.

Refer to interview with the Registered Nurse (RN) on 12/01/22 at 9:01am.

Refer to interview with the Administrator on 12/01/22 at 11:51am.

2. Review of Resident #1's current FL-2 dated 06/07/22 revealed diagnoses included hypertension, atrial fibrillation, edema, anxiety, depression, and a history of cerebrovascular disease.

Review of Resident #1's hospital discharge summary dated 11/07/22 revealed:
-Resident #1 was treated for a skin infection.
-Resident #1 was diagnosed with cellulitis (bacterial skin infection).
-There was an order to start taking Cephalexin (an antibiotic) 500mg and take one tablet every six hours for five days.

Observation of Resident #1 on 11/29/22 at 9:30am revealed:
-Resident #1 was sitting in a chair in her room holding a container with 11 miscellaneous tablets/capsules.
-She identified a green capsule with the imprint of 219 as an antibiotic she was taking for an infection in her leg.

Review of Resident #1's November 2022 electronic medication administration record (eMAR) for 11/07/22-11/3022 revealed:
-There was an entry for Cephalexin 500mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm; the entry had a start date of 11/22/22 and an end date of

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{D 358}	Continued From page 53 11/26/22. -There was documentation Cephalexin 500mg was administered at 2:00pm and 8:00pm on 11/22/22, and three times daily from 11/23/22-11/25/22, and at 8:00am and 8:00pm on 11/26/22. -There was no other documentation Cephalexin 500mg had been administered to Resident #1. -There was no entry for 11/08/22 when the medication was ordered and dispensed. -There were no exceptions documented for Resident #1's Cephalexin 500mg. Observation of Resident #4's medication on hand on 11/29/22 at 11:39am revealed there was no Cephalexin 500mg available to be administered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/22 at 9:40am revealed: -Resident #1's Cephalexin 500mg was dispensed on 11/08/22 for a 5-day supply. -Cephalexin 500mg was ordered to be administered one tablet every 6 hours for five days. -She did not see an order for Cephalexin 500mg for 11/22/22 or any dispensing of Cephalexin for Resident #1 on or around the date of 11/22/22. Interview with a medication aide (MA) on 12/01/22 at 10:38am revealed: -She saw Resident #1's Cephalexin on the medication cart but did not see an order for the medication. -She did not recall the date but it was "around" when the medication was first delivered to the facility. -She told the previous Registered Nurse (RN) and the Previous Administrator the medication was in the medication cart and needed an order.	{D 358}		

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-The current RN put Resident #1's Cephalexin order in the eMAR.
-She did not notify Resident #1's Primary Care Provider (PCP) there had been a delay in administering Resident #1's Cephalexin.
-She administered Resident #1's last Cephalexin on 11/29/22.
-She did not know why any Cephalexin had been left to be administered after 11/26/22.

Telephone interview with Resident #4's PCP on 11/30/22 at 3:58pm revealed:
-Resident #1 was ordered Cephalexin 500mg for cellulitis of the leg.
-There was no reason why Resident #1's Cephalexin should have been delayed in starting the medication.
-Resident #1's Cephalexin should have been started when the medication was ordered.
-Resident #1 could have a worsening of her infection because the medication was not administered as ordered.

Telephone interview with an RN with Resident #1's home health agency on 12/02/22 at 8:37am revealed Resident #1 was seen on 11/15/22, 11/22/22, and 11/29/22 and her leg wound had improved each visit and had no sign or symptoms of an infection.

Interview with the facility's RN on 12/01/22 at 4:39pm revealed:
-She was not aware Resident #1 had an order for Cephalexin on 11/09/22 that was not started until 11/22/22.
-It was not acceptable for Resident #1's medication to not have been administered as ordered.

Interview with the Administrator on 12/01/22 at

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6:16pm revealed:
-Resident #1's order for Cephalexin should have been entered into the eMAR and faxed to the pharmacy when the resident returned from the hospital.
-If the medication did not come in, the order should have been sent to the backup pharmacy, so the medication could be started immediately.
-She did not know the medication had been available and was not started because there was no order.
-The MA should have asked for assistance with the order.
-She was not aware the MA had asked the previous RN and previous Administrator about the order.

Refer to interview with a medication aide (MA) on 11/30/22 at 5:21pm.

Refer to interview with another MA on 12/01/22 at 2:27pm.

Refer to interview with the Health and Wellness Coordinator (HWC) on 12/01/22 at 8:51am.

Refer to interview with the Registered Nurse (RN) on 12/01/22 at 9:01am.

Refer to interview with the Administrator on 12/01/22 at 11:51am.

3. Review of Resident #2's current FL2 dated 09/29/22 revealed:
-Diagnoses included major depression, anxiety, some loss of vision, and hearing loss.
-There was an order for clonazepam (used to treat anxiety) 1mg take one tablet at bedtime.

Review of Resident #2's October 2022 electronic

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Medication Administration Record (eMAR) from 10/05/2022 to 10/31/2022 revealed:
-There was an entry for clonazepam 1mg take 1 tablet at bedtime scheduled for 8:00pm.
-There was no documentation that clonazepam was administered on 10/16/22.
-Clonazepam 1mg was not administered and there was documentation that there was "pharmacy action required" on 10/15/22 and from 10/17/22 to 10/19/22.
-Clonazepam 1mg was not administered and was documented as "Other/See nurse notes" on 10/23/22.

Review of Resident #2's October 2022 progress notes revealed:
-There was a progress note dated 10/17/22 for clonazepam 1mg that the "medication technician contacted primary physician to request escript be forwarded to pharmacy. Awaiting response as of 10/17."
-There was documentation that clonazepam 1mg "needs refill" on 10/18/22.
-There was documentation that clonazepam 1mg was "not on med cart" on 10/19/22.
-There was documentation that clonazepam 1mg was "on order" on 10/23/22.

Review of Resident #2's November 2022 eMAR from 11/01/22 to 11/28/22 revealed:
-There was an entry for clonazepam 1mg take 1 tablet at bedtime scheduled for 8:00pm.
-Clonazepam 1mg was not administered and was documented as "Other/See nurse notes" on 11/23/22.
-There was no documentation that clonazepam 1mg was administered on 11/25/22.
-Clonazepam 1mg was not administered and was documented as "pharmacy action required" on 11/26/22 and 11/27/22.

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Review of Resident #2's November 2022 progress notes revealed:
-There was documentation that clonazepam 1mg was "not in cart" on 11/23/22.
-There was documentation that clonazepam 1mg "needs refill" on 11/27/22.

Observation of Resident #2's medications on hand on 11/30/22 at 2:20pm revealed:
-There was a medication bubble pack with a medication label for clonazepam 1mg take one tablet at bedtime.
-There was a medication bubble pack with 29 of 30 clonazepam tablets remaining that was dispensed on 11/28/22.

Interview with a medication aide (MA) on 11/30/22 at 2:05pm revealed:
-Resident #2 was administered clonazepam at bedtime.
-Resident #2 did not bring a copy of a prescription for clonazepam when she was admitted to the facility.
-She thought Resident #2's primary care provider (PCP) had to send the prescription to the pharmacy because clonazepam was a controlled substance.
-She thought Resident #2's family brought in clonazepam to the facility for Resident #2 that was dispensed from another pharmacy.
-She thought Resident #2 was not administered clonazepam for 3 or 4 days in November 2022.
-Resident #2 was administered clonazepam on 11/28/22 and 11/29/22.
-Resident #2 never refused her clonazepam.
-She thought one of the other MAs notified Resident #2's PCP regarding Resident #2 needing a new prescription for clonazepam.

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Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/22 at 3:17pm revealed:
-The pharmacy had an active order on file for Resident #2 for clonazepam 1mg take one tablet at bedtime.
-She thought Resident #2 had some clonazepam that was filled at a different pharmacy when she moved into the facility.
-Clonazepam 1mg was dispensed from the pharmacy on 10/19/22 for a quantity of 3 tablets only because the prescription sent to the pharmacy by the PCP at the time was not complete and was only a medication order.
-Clonazepam 1mg was dispensed from the pharmacy on 11/28/22 for a quantity of 30 tablets.
-Potential side effects of Resident #2 missing a few scheduled doses of clonazepam 1mg included increased anxiety and trouble sleeping.

Telephone interview with Resident #2's PCP on 11/30/22 at 3:50pm revealed:
-He began the primary care of Resident #2 on 11/15/22.
-He sent a prescription for clonazepam to the facility's contracted pharmacy on 11/20/22.
-He was not aware Resident #2 was not administered clonazepam from 10/15/22 to 10/19/22 for 5 consecutive days and from 11/25/22 to 11/27/22 for 3 consecutive days.
-Side effects of missing scheduled doses of clonazepam included increased anxiety.
-He saw Resident #2 at the facility on 11/29/22 for a provider visit and Resident #2 told him that she was anxious.
-He expected the staff to administer medications as ordered and he also expected the staff to notify him of any missed doses of medications.

Interview with Resident #2 on 11/30/22 at 4:58pm

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revealed:
-There were times when she was not administered her scheduled dose of clonazepam.
-When she moved into the facility, she thought her prescription for clonazepam would be transferred to the facility's contracted pharmacy.
-She was not administered clonazepam for several days in October 2022 and several days in November 2022.
-She thought she had missed 4 or 5 scheduled doses of clonazepam in the past week.
-She felt more anxious, had trouble sleeping and sometimes felt nauseated when waking up in the morning when she was not administered clonazepam.

Interview with another MA on 11/30/22 at 5:20pm revealed:
-Resident #2 ran out of clonazepam in October 2022 and in November 2022 and it took a few days to receive her prescription each time.
-She thought it took a while for the clonazepam to arrive to the facility from the pharmacy.
-She had not notified Resident #2's PCP that Resident #2 missed several doses of clonazepam in November 2022 and she was not sure about the missed doses in October 2022.
-She thought one of the nurses at the facility had audited the medication cart within the past two weeks.
-The MAs were in the process of learning who to contact when there were issues with medications because the Health and Wellness Coordinator (HWC), Registered Nurse (RN) and the Administrator were all hired within the past few weeks.

Interview with the HWC on 12/01/22 at 8:50am revealed she was not aware Resident #2 was not administered clonazepam from 10/15/22 to

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10/19/22 for 5 consecutive days and from 11/25/22 to 11/27/22 for 3 consecutive days.

Interview with the facility's RN on 12/01/22 at 9:00am revealed she was not aware Resident #2 was not administered clonazepam from 10/15/22 to 10/19/22 for 5 consecutive days and from 11/25/22 to 11/27/22 for 3 consecutive days.

Interview with the Administrator on 12/01/22 at 11:50am revealed she was not aware Resident #2 was not administered clonazepam from 10/15/22 to 10/19/22 for 5 consecutive days and from 11/25/22 to 11/27/22 for 3 consecutive days.

Refer to interview with a medication aide (MA) on 11/30/22 at 5:21pm.

Refer to interview with another MA on 12/01/22 at 2:27pm.

Refer to interview with the Health and Wellness Coordinator (HWC) on 12/01/22 at 8:51am.

Refer to interview with the Registered Nurse (RN) on 12/01/22 at 9:01am.

Refer to interview with the Administrator on 12/01/22 at 11:51am.

4. Review of Resident #5's current FL-2 dated 10/20/22 revealed diagnoses included closed fracture of left femur and pressure ulcers.

Review of Resident #5's physician's order dated 10/20/22 revealed the primary care provider (PCP) discontinued metoprolol (used to treat hypertension) 25mg once daily.

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{D 358}	Continued From page 61 Review of Resident #5's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol succinate 25mg once daily; scheduled at 9:00am. -There was documentation metoprolol was self-administered from 10/01/22 to 10/13/22. -There was documentation a medication aide (MA) began to administer Resident #5 her medication on 10/14/22. -There was documentation Resident #5 refused her metoprolol 6 of 18 opportunities from 10/14/22 to 10/31/22. -There was documentation on 10/16/22 and 10/17/22 to see nurses' notes. -There was documentation on 10/25/22 and 10/29/22 to hold medication and to reference the nurses' notes. -There was documentation Resident #5 was administered metoprolol five times from 10/21/22 to 10/31/22. Review of Resident #5's nurses notes from October 2022 revealed there was nothing documented for October 2022 for metoprolol. Review of Resident #5's eMAR from 11/01/22 to 11/11/22 revealed: -There was an entry for metoprolol succinate 25mg once daily; scheduled at 9:00am. -There was documentation Resident #5 refused her metoprolol 9 of 11 opportunities from 11/01/22 to 11/11/22. -There was documentation Resident #5 was administered metoprolol 25mg on 11/02/22 and 11/07/22. Review of Resident #5's nurses notes from November 2022 revealed there was nothing documented for November 2022 for metoprolol.	{D 358}		

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{D 358}	Continued From page 62 Observation of Resident #5's medication on hand on 12/01/22 at 10:19am revealed thirty tables of metoprolol 25mg were dispensed on 06/01/22; 18 tablets of metoprolol remained in the package. Telephone interview with the pharmacist from the facility's contracted pharmacy on 12/01/22 at 3:12pm revealed: -Resident #5 had a current order for metoprolol 25mg once daily dated 06/01/22. -Thirty tablets of metoprolol 25mg were dispensed on 06/01/22 for Resident #5; there were no other dispense dates for metoprolol. -The pharmacy did not have an order to discontinue Resident #5's metoprolol. -Metoprolol was used to lower blood pressure. -Possible outcomes of administering metoprolol after it was discontinued due to low blood pressure could be lowered blood pressure which could increase risk for falls when going from sitting to standing, dizziness and possible fainting. Telephone interview with Resident #5's Power of Attorney (POA) on 11/30/22 at 2:28pm revealed: -She took Resident #5 to her PCP appointment sometime in the middle of October 2022; she was not sure of the exact date. -Resident #5 had on order from the PCP to discontinue her metoprolol 25mg because her blood pressure was low. -She handed the PCP order to discontinue Resident #5's metoprolol to a MA when she returned from the PCP visit in October 2022. -Resident #5 continued to be administered the metoprolol for approximately three weeks after it had been discontinued. -She visited Resident #5 daily and had witnessed the MA attempting to administer the metoprolol on several occasions after it had been discontinued.	{D 358}		

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{D 358}	Continued From page 63 -Resident #5 could recognize her medications so she told Resident #5 to refuse the metoprolol. -She asked the MA why the metoprolol had not been discontinued and the MA said it had not been changed in the "system". Telephone interview with a Registered Nurse (RN) from Resident #5's PCP's office on 12/01/22 at 4:02pm revealed: -Metoprolol was ordered for blood pressure control. -Resident #5's metoprolol was discontinued on 10/20/22 based on blood pressure results from Resident #5's hospice RN. -Resident #5's blood pressure results were documented as 110/64 on 10/20/22, 140/60 at 6:18pm on 10/24/22, and 154/49 at 7:30pm on 10/24/22. -If Resident #5's blood pressure was low, the recommendation would be to discontinue metoprolol to prevent falls due to low blood pressure. -If Resident #5 was still administered metoprolol after it was discontinued, her blood pressure could continue to drop and could go undetected. Telephone interview with Resident #5's hospice RN on 12/01/22 at 4:34pm revealed: -She only saw a recommendation to hold Resident #5's metoprolol due to low blood pressure results but the PCP could have discontinued the medication. -She did not have a note about discontinuing the metoprolol. -Resident #5's blood pressure results documented by the hospice nurses from 10/25/22 to 11/11/22 ranged from 100/50 to 132/74. Interview with a MA on 12/01/22 at 10:06am revealed:	{D 358}		

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-Resident #5's POA gave her an order from the PCP to discontinue the metoprolol sometime in October 2022.
-She gave the order to the Administrator at the time because she had never seen a discontinue order like that one before.
-The order was on a list with other medications, it had a line through the metoprolol, and someone had written discontinue with a signature to the side of the medication.
-She did not recall a second page with an additional signature and a date.
-She did not hear back from the Administrator about the discontinue order and thought the Administrator had spoken to the POA about the order.
-She forgot about the order and continued to administer Resident #5 the metoprolol until the POA saw her attempt to administer it one day.
-The POA told her not to administer the metoprolol because it had been discontinued.
-She told the POA it had not been discontinued because the order was not correct.
-The POA told Resident #5 to not take the metoprolol and to refuse it.
-The POA brought in a second copy of the discontinued order; she gave it to the Administrator again.
-She continued to attempt to administer Resident #5 the metoprolol.
-She was told by the previous Administrator to discontinue the metoprolol when Resident #5 finished another medication she was ordered for 10 days and was due to be finished on a Saturday in November 2022.
-She did not enter the discontinue order on the eMAR or send it to the pharmacy; she did not know who did it.

Interview with the Health and Wellness Director

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(HWD) on 12/01/22 at 10:56am revealed:
-If the POA had the discontinue orders then they handed them directly to the MA.
-The MAs were responsible for faxing discontinued medication orders to the pharmacy.
-The MAs were responsible for entering the discontinued order on the eMAR.

Interview with the facility's RN on 12/01/22 at 11:04pm revealed:
-When the PCP discontinued a medication, the MA who received the order was responsible for entering the discontinued medication on the eMAR and faxing the order to the pharmacy.
-She was told by the MAs Resident #5 refused her medications because the POA had instructed her to refuse them.
-She did not know about the discontinue order for the metoprolol.

Interview with the Administrator on 12/01/22 at 5:02pm revealed:
-When a PCP discontinued medication, the MA on the shift the order came in were responsible for notifying the pharmacy, discontinuing the medication on the eMAR, and returning the medication to the pharmacy.
-The discontinued medication should have been noted on the progress notes.
-The medication should not have been administered even once after it was discontinued.
-The PCP discontinued Resident #5's metoprolol for a reason and it was the facility's responsibility to follow the order.
-She expected the MAs to discontinue medications when they received the orders.

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

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Refer to interview with a medication aide (MA) on 11/30/22 at 5:21pm.

Refer to interview with another MA on 12/01/22 at 2:27pm.

Refer to interview with the Health and Wellness Coordinator (HWC) on 12/01/22 at 8:51am.

Refer to interview with the Registered Nurse (RN) on 12/01/22 at 9:01am.

Refer to interview with the Administrator on 12/01/22 at 11:51am.

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Interview with a medication aide (MA) on 11/30/22 at 5:21pm revealed:
-She thought that MAs were responsible to administer medications as ordered.
-She thought MAs, the HWC, and the RN were responsible to fax orders to the pharmacy and follow up on reordering medications.

Interview with another MA on 12/01/22 at 2:27pm revealed:
-The MAs completed cart audits sometime in early November 2022.
-Carts audits consisted of making sure medications were on hand, ordering medications that were low or missing.
-She did not compare orders to the eMAR or labels on packages to the eMAR.
-She mainly was looking to make sure there were medications on the cart available to be administered based on the eMAR.

Interview with the HWC on 12/01/22 at 8:51am revealed:
-She expected the MAs to reorder medications when the quantity that remained was 4 or 5

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doses, or within 5 days of the medication running out.
-MAs were responsible to administer medications as ordered.
-MAs were responsible to reorder medications and to ensure that medications were available for administration.
-She thought that no one was currently auditing the eMARs and the medication carts but she planned to start soon.
-She thought the pharmacy audited the medication carts but she was not sure how often.

Interview with the RN on 12/01/22 at 9:01am revealed:
-MAs were responsible to administer medications as ordered.
-She expected MAs to reorder medications when the amount that remained reached the blue section of the medication bubble packs, which was typically when there were 4 doses remaining.
-She had contacted the pharmacy to try to restart cycle fill medications at the facility
-None of the residents' current medications at the facility were on a cycle fill.
-She was not sure if anyone had audited the eMARs or medication carts prior to when she was hired.
-One of the MAs audited the medications carts on the 2nd and 3rd floor for medication expirations within the last few weeks.
-She expected the MAs to use the five rights of medication administration, make sure orders are entered correctly, make sure orders are active, and administer the medication.
-She was concerned if medications were not being administered as ordered the residents' physical health and safety could be effected.

Interview with the Administrator on 12/01/22 at

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11:51am revealed:
-MAs were responsible to administer medications as ordered.
-She expected MAs to reorder medications when the doses remaining in the medication card bubble packs reached the blue reorder portion, which was typically when there were 4 doses of medication remaining.
-She thought there had been eMAR and medication cart audits within the last couple of months but she was not sure how often.
-She was concerned residents' were not being administered their medications as ordered.

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The facility failed to ensure medications were administered as ordered including a resident who was administered a blood pressure medication 35 times out of 35 opportunities without obtaining the required blood pressure readings prior to administration of a medication that could lead to further decreasing the residents' blood pressure; two medications that could negatively affect the resident's heart who had a diagnosis of atrial fibrillation or apply a pain patch when the resident was experiencing pain daily (#4); a resident who was not administered a scheduled anti-anxiety medication for a period of 5 consecutive days and a second period of 3 consecutive days which caused increased anxiety and trouble sleeping (#2); and continued to administer a medication used to lower blood pressure to a resident 11 times after it had been discontinued due to low blood pressure results (#5). The facility's failure to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/30/22 for

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{D 358}	Continued From page 69 this violation.	{D 358}		
{D 366}	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a medication aide (MA) observed a resident take their medications (#1). The findings are: Review of the facility's policy for administering medications dated March 2022 revealed: -Residents should be observed taking the medication by offering water or other fluids. -Medications should not be left for the resident to consume at a later time. Review of Resident #1's current FL-2 dated 06/07/22 revealed diagnoses included hypertension, atrial fibrillation, edema, anxiety, depression, and a history of cerebrovascular disease. Review of Resident #1's personal service assessment (PSA) dated 06/01/22 revealed:	{D 366}	10A NCAC 13F. 1004 Medication Administration Medication aides received retraining by the Health and Wellness Director or designee on medication administration as ordered by the physician, as well as on the utilization of the new order tracking form. The new order tracking form is submitted to the Health & Wellness Director of designee, to verify accuracy and implementation of all new orders. The Health and Wellness Director or designee audited current residents' charts to verify orders are entered into MAR. All orders provided in FL2, discharge summary will be entered into MAR upon receipt. Health & Wellness Director or designee will monitor all new orders weekly for three (3) weeks and then monthly for two (2) months to verify compliance. The Health & Wellness Director or designee will audit MAR to verify that pre-charting has not occurred. To assist with ongoing compliance, the Health & Wellness Director or designee will observe medication aides administer medications during one med pass, twice weekly for two weeks. Plan of correction by 1/16/23.	

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-Resident #1 required assistance with managing medications.
-Resident #1 required assistance with the administration of medications.
-Resident #1 knew her medications and what time she took them. She stated she did not want to administer them to herself. She did not want to have to worry about them. She did have some medications she wanted to self-administer.

Review of Resident #1's Primary Care Provider's after-visit summary dated 07/26/22 revealed Resident #1 had mild to moderate cognitive impairment.

Review of Resident #1's November 2022 electronic medication administration record (eMAR) for 11/29/22-11/30/22 for 9:00am medications revealed there was documentation all 9:00am medications were administered on 11/29/22 and 11/30/22.

Review of Resident #1's signed physician's orders and FL-2 revealed there were no orders to self-administer any of the 11 medications that were observed in Resident #1' s room on 11/29/22.

Observation of Resident #1 during the initial tour on 11/29/22 at 9:30am revealed Resident #1 was sitting in a chair in her room holding a disposable container lid with 11 miscellaneous tablets/capsules.

Interview with Resident #1 on 11/29/22 at 9:30am revealed:
-She had dropped all of her medications when moving from one chair to another chair and could not fine one of the pills.
-She did not know which pill she dropped but she

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knew she took 11 tablets every morning and one was missing.
-One of the tablets in the container was an antibiotic and that did not count as one of her 11 tablets.
-A pill was located under her chair that was identified as the same tablet she already had, "I must have dropped that one another day."
-The medication aides (MA) always gave her medications to her and let her take them after she had finished breakfast.
-The MAs were supposed to watch her take her medication, but they did not.
-She did not need anyone to watch her take her medications, they knew she would take them.

Second interview with Resident #1 on 11/29/22 at 11:03am revealed the MA helped her locate the missing pill, which was a Vitamin B12 tablet, and she had taken all of her medications.

Observation of Resident #1 ' s room on 11/30/22 at 9:55am revealed:
-There was a medication cup with 11 tablets in it, sitting on the desk in the resident ' s room.
-Resident #1 was in the bathroom.

Interview with a MA on 11/30/22 at 11:39am revealed:
-When she administered medication, she matched the punch card to the eMAR, made sure she had the right medication and dosage, and popped the tablet into a medication cup.
-She administered the medication and then documented she had administered the medication.
-She had not observed Resident #1 take her medication today, 11/30/22.
-Resident #1 was in the bathroom and the resident told her to leave her medication on the

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table, so she did.
-She knew she was not supposed to leave medication in a resident's room.
-She knew Resident #1 took her medication because she left the empty medication cup.

Interview with another MA on 12/01/22 at 10:44am revealed:
-She administered Resident #1's medications on 11/29/22 at the 9:00am medication pass.
-She did not observe Resident #1 take her medications; she knew she was supposed to.
-Resident #1 liked to pour her medications out of the medication cup, onto a tray, separate the medication, count the tablets, count them again, and would eventually take the medication.
-Sometimes she stood by the door and waited for Resident #1 to take her medications.
-Sometimes she would have to leave, but always checked back by to make sure Resident #1 had taken her medications.
-She knew Resident #1 had dropped a Vitamin B12 tablet on 11/29/22, and she had found the tablet for her.

Interview with the facility ' s Registered Nurse on 12/01/22 at 4:39pm revealed:
-When medications were given to a resident the MA was supposed to watch the resident take every pill before leaving the room.
-The resident could not take the medication which could cause a lot of issues.
-She expected the MAs to watch Resident #1 take her medications before leaving the room.

Interview with the Administrator on 12/01/22 at 6:16pm revealed:
-The MA was supposed to visually watch Resident #1 swallow her medication before leaving the room.

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{D 366}	Continued From page 73 -The resident could potentially not be taking her medication. -She expected the MAs to not leave medication in a resident's room.	{D 366}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to accurately document the administration of medications on the electronic Medication Administration Record (eMAR) for 1 of 5 residents (#4). The findings are:	{D 367}	10A NCAC 13F. 1004 Medication Administration Medication aides received retraining by the Health and Wellness Director or designee on medication administration as ordered by the physician, as well as on the utilization of the new order tracking form. The new order tracking form is submitted to the Health & Wellness Director of designee, to verify accuracy and implementation of all new orders. The Health and Wellness Director or designee audited current residents' charts to verify orders are entered into MAR. All orders provided in FL2, discharge summary will be entered into MAR upon receipt. Health & Wellness Director or designee will monitor all new orders weekly for three (3) weeks and then monthly for two (2) months to verify compliance. The Health & Wellness Director or designee will audit MAR to verify that pre-charting has not occurred. To assist with ongoing compliance, the Health & Wellness Director or designee will observe medication aides administer medications during one med pass, twice weekly for two weeks. Plan of correction by 1/16/23.	

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{D 367}	Continued From page 74 Review of Resident #4's current FL-2 dated 10/25/22 revealed diagnoses included hypertension, paroxysmal atrial fibrillation, and a history of cardiovascular disease. Review of Resident #4's physician's order dated 11/01/22 revealed an order for Meclizine 12.5mg (used to treat dizziness) as needed for dizziness. Review of Resident #4's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Meclizine 12.5mg (used to treat dizziness) as needed for dizziness. -There was documentation Meclizine 12.5mg was administered on 11/02/22, 11/06/22, and 11/29/22. -There was no other documentation for Meclizine 12.5mg. Observation of Resident #4's medication on hand on 12/01/22 at 10:30am revealed: -There was a bubble pack dispensed on 11/01/22 for Meclizine 12.5mg; there were 17 tablets of 30 tablets remaining in the bubble pack. -Ten tablets were unaccounted for. Interview with a medication aide (MA) on 12/01/22 at 2:27pm revealed: -She recalled administering Resident #4's Meclizine after the resident complained of dizziness. -She knew there were times when she forgot to document administering the medication. -She would take Resident #4's medications to her room, the resident would ask for the Meclizine, she would get the medication, take it to Resident #4 and she would get busy and forget to document.	{D 367}		

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{D 367}	Continued From page 75 Interview with the facility's Registered Nurse on 12/01/22 at 4:39pm revealed: -She expected the MAs to document on the eMAR when medication was administered and if a medication was not administered. -Every pill punched should be documented whether it was administered or not. Interview with the Administrator on 12/01/22 at 6:16pm revealed: -She was concerned the MAs were not documenting medications that were administered. -Without documentation, you would not know if the medication was administered or not. She expected the MAs to pull up the resident's eMAR, cross reference the bubble pack, administer the medication, and sign off it was administered. -She expected the MAs to document what was administered every time.	{D 367}		
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 documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375	10A NCAC 13F .1005 Self-Administration of Medications All residents self-administering their own medications will be audited by the Health & Wellness Director or designee to verify order and documentation is in place in residents' charts. The Health & Wellness Director or designee will verify each resident who self-administers their own medication has medications on hand that match current physician orders. To assist with ongoing compliance, the Health & Wellness Director or designee will complete an evaluation quarterly for six (6) months, of residents who self-administer. Plan of correction by 1/16/23.	

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to assure compliance with the facility's policies and procedures for the self-administration of medications for 2 of 2 sampled residents (#8, #9) without orders to self-administer medications.

The findings are:

Review of the facility's policy for self-administered medications dated March 2022 revealed:
-Residents who desired to self-administer medication should be permitted to do so if the admitting physician verified it was appropriate, the nurse confirmed the resident's ability, and any applicable state requirements were met.
-An evaluation would be conducted by the nurse, of the resident's cognitive, physical, and visual ability to carry this out.
-The self-administration of medications review form would be completed initially, quarterly, or as per state regulation with change in the resident's condition.
-The nurse should print a list of current medications to use when evaluating the resident's ability to self-administer medications.
-The resident's ability to self-administer medication, including over-the-counter (OTC) medications, should be determined by means of a skills evaluation as follows. The resident should be able to identify the medication either by reading the label on the medication bottle or identifying the pill in a pill organizer. State what each medication was for. State what time the medication was to be taken. State the proper dosage and route of each medication. Verbalize

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the steps involved in medication administration for non-solid form
-If the resident passed the self-administration evaluation, an order should be obtained from the physician and should be reflected on the physician's plan of care.

1. Review of Resident #8's current FL-2 dated 11/18/21 revealed diagnoses included essential hypertension, type 2 diabetes, hypothyroidism, and age-related osteoporosis.

Observation of Resident #8's room on 11/30/22 at 10:55am revealed:
- There was a bottle of Hair, Skin, and Nails with Biotin 2500mcg gummies (supplement) sitting on the table beside the resident's chair.
- There was a bottle of Vitamin D3 bone and immune support 50mcg gummies (supplement) sitting on the table beside the resident's chair.
-There was a bottle of Tylenol 500mg (used to treat mild pain) sitting on the table beside the resident's chair.

Review of Resident #8's physician's orders dated 05/06/22 revealed there was no order for Resident #8 to self-administer a Biotin supplement, a Vitamin D3 supplement, or Tylenol.

Review of Resident #8's Primary Care Providers (PCP) after visit summary dated 10/25/22 revealed Resident #8 had mild to moderate cognitive impairment, particularly with short-term memory issues.

Interview with Resident #8 on 11/30/22 at 10:55am revealed:
-She took two biotin gummies daily.
-She took one Vitamin D3 gummy daily.
-She had been hurting a lot lately, so she was

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taking one Tylenol three times a day.
-She did not know she needed an order to self-administer these medications.

Telephone interview with Resident #8's PCP on 11/30/22 at 3:58pm revealed:
-Resident #8 had memory loss.
-He was not concerned Resident #8 was self-administering the Vitamin D3, Biotin or Tylenol.
-"It was the last bit of control" Resident #8 had left.

Interview with a medication aide (MA) on 12/01/22 at 2:27pm revealed:
-Resident #8 had an order to self-administer some of her medications.
-She had seen other medications in the resident's room and the resident's family member was supposed to take the medication home.

Interview with the facility's Registered Nurse (RN) on 12/01/22 at 4:39pm revealed:
-She had not assessed Resident #8 to self-administer the Biotin, Vitamin D3, or Tylenol.
-Resident #8 should not have medications in her room without a self-administration order.

Refer to the interview with the facility's RN on 12/01/22 at 4:39pm.

Refer to the interview with the Administrator on 12/01/22 at 6:16pm.

2. Review of Resident #9's current FL-2 dated 04/29/21 revealed diagnoses included left-sided hemiplegia, hypothyroidism, hypertension, osteoporosis, and depression.

Observation of Resident #9's room on

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11/11/29/22 at 10:11am revealed:
-Resident #9 was asleep in her bed.
-Three medication bottles were sitting on a table in the resident's room.

Review of Resident #9's physician's orders dated 05/06/22 revealed there was no order for Resident #9 to self-administer any medications.

Interview with Resident #9 on 11/30/22 at 9:18am revealed:
-One bottle was Tylenol, another one was Tylenol she had put into another bottle, and the third medication was for cramps in her legs.
-She took Tylenol when she was hurting; she took two this morning.
-She took two pills for leg cramps every night, and they dissolved under her tongue.
-She did not know she needed an order from her Primary Care Provider (PCP) to self-administer medications.

Addendum 02/07/23: Date of correction 01/16/23

Interview with a medication aide (MA) on 12/01/22 at 2:27pm revealed:
-She had seen medication in Resident #9's room.
-She had told the previous Registered Nurse (RN) and the previous Administrator.
-The RN told her to take the medication out of the resident's room.
-The Administrator told her it was okay for the resident to have the medication.
-She knew the RN had to assess residents who wanted to self-administer their medication.

Interview with the current RN on 12/01/22 at 4:39pm revealed:
-She had not completed an assessment on Resident #9 to self-administer her medications.
-Resident #9 did not have an order to keep medications in her room.

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Attempted telephone interview with Resident #9's PCP on 12/01/22 at 3:33pm was unsuccessful.

Refer to the interview with the facility's RN on 12/01/22 at 4:39pm.

Refer to the interview with the Administrator on 12/01/22 at 6:16pm.

Interview with the facility's RN on 12/01/22 at 4:39pm revealed:
-The facility's RN was responsible for completing assessments on residents who wanted to self-administer medication.
-The PCP would need to write an order for the medication to be self-administered and she would then do an assessment.
-If anyone saw medication in a resident's room they should notify the MA.
-If the MA did not know if there was an order for the resident to self-administer the medication, she expected the MA to notify the RN or another clinical manager.

Interview with the Administrator on 12/01/22 at 6:16pm revealed:
-The MAs were responsible for verifying if a resident had an order for self-administration of medication.
-If there was no order for the medication to be self-administered, the medication should be removed from the resident's room, explain why the medication was being removed, communicate with the resident's PCP, and notify the RN and Administrator.
-She was concerned if any resident was self-administering medication without an order because you would not know if they are taking the medication correctly.

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{D 377}	10A NCAC 13F .1006(a) Medication Storage 10a NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that the residents' medications were stored in a safe and secure manner for 2 of 2 sampled residents (#8, #9). The findings are: Review of the facility's policy for self-administered medications dated March 2022 revealed: -The resident should be able to properly store medications and lock the apartment door upon departure from the apartment. -Locking the apartment door was considered the first level for securing medications in their apartment. -Residents who self-administered medications may store and secure their non-controlled medications in their apartment by locking the apartment door each time upon departure. 1. Review of Resident #8's current FL-2 dated 11/18/21 revealed diagnoses included essential hypertension, type 2 diabetes, hypothyroidism, and age-related osteoporosis. Observation of Resident #8's room on 11/30/22 at	{D 377}	10A NCAC 13F .1006 Medication Storage The Health & Wellness Director or designee will audit rooms of residents who self-administer medication at weekly for two weeks and monthly for two months thereafter. Residents' rooms not in compliance with medication storage will be corrected immediately and re-education will be provided to the resident by the Health & Wellness Director or designee. Addendum 02/07/23: Date of correction	01/16/23

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10:55am revealed:
- There was a bottle of Hair, Skin, and Nails with Biotin 2500mcg gummies (supplement) on the table beside the resident's chair.
- There was a bottle of Vitamin D3 bone and immune support 50mcg gummies (supplement) on the table beside the resident's chair.
-There was a bottle of Tylenol 500mg (used to treat mild pain) on the table beside the resident's chair.

Interview with Resident #8 on 11/30/22 at 10:55am revealed:
-She knew her medications were supposed to be locked but she did not think things like vitamins needed to be locked.
-She had a lock box provided by the facility to keep her prescribed medications in.
-She did not lock the door to her apartment when she left.
-She understood she should not leave medications out where they would be accessible to others and would all medications up.

Interview with a medication aide (MA) on 12/01/22 at 2:27pm revealed she had seen medications in the resident's room and the resident's family member was supposed to take the medication home.

Refer to the interview with the facility's Registered Nurse (RN) on 12/01/22 at 4:39pm.

Refer to the interview with the Administrator on 12/01/22 at 6:16pm.

2. Review of Resident #9's current FL-2 dated 04/29/21 revealed diagnoses included left-sided hemiplegia, hypothyroidism, hypertension, osteoporosis, and depression.

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Observation of Resident #9's room on 11/11/29/22 at 10:11am revealed:
-Resident #9 was asleep in her bed.
-Three medication bottles were on a table in the resident's room.

Interview with Resident #9 on 11/30/22 at 9:18am revealed:
-No one told her medications needed to be locked.
-She was concerned she would not be able to access the medication if it was locked.

Interview with a medication aide (MA) on 12/01/22 at 2:27pm revealed:
-She had seen medication in Resident #9's room.
-She had told the previous Registered Nurse (RN) and the previous Administrator.
-The RN told her to take the medication out of the resident's room.
-The Administrator told her it was okay for the resident to have the medication.
-She knew medications were supposed to be in a lockbox.

Refer to the interview with the facility's RN on 12/01/22 at 4:39pm.

Refer to the interview with the Administrator on 12/01/22 at 6:16pm.

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Interview with the facility's RN on 12/01/22 at 4:39pm revealed:
-If a resident had an order to self-administer medication, the medication should be in a lockbox.
-Medications not in a lock box should be reported to the MA.
-If the resident did not have an order to

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{D 377}	Continued From page 84 self-administer, the medications needed to be removed from the room by the MA. Interview with the Administrator on 12/01/22 at 6:16pm revealed: -If there was no order for the medication to be self-administered, the medication should be removed from the resident's room, explain why the medication was being removed, communicated with the resident's PCP, and notify the RN and Administrator. -If the resident had an order to self-administer medications, the staff member who saw the medication should remind them to use the lock box. -She was concerned medications that were not securely stored, would be accessible to other residents.	{D 377}		
D 156	10A NCAC 13F .0503 Medication Administration Competency 10A NCAC 13F .0503 Medication Administration Competency (a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration;	D 156	10A NCAC 13F .0503 Medication Administration Competency The Health & Wellness Director or designee will audit current medication aides' files to verify that the medication administration competency is on file. The Health & Wellness Director or designee will conduct the competency checklist for any medication aide identified through the audit process. The Business Office Manager or designee will audit medication aides files quarterly for six (6) months to verify that the medication administration competency is complete and in the medication aides file. Addendum 02/07/23: Date of correction 01/16/23	

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(7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions;
(8) medication storage and disposition;
(9) regulations pertaining to medication administration in adult care facilities; and
(10)the facility's medication administration policy and procedures
(b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.
(c) Verification of an individual's completion of the written examination and results can be obtained at no charge on the North Carolina Adult Care Medication Aide Testing website at https://mats.ncdhhs.gov/test-result.
(d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a licensed pharmacist who has a current unencumbered license in North Carolina. The registered nurse or licensed pharmacist shall conduct a clinical skills validation for each medication administration task or skill that will be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.
(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:
(1) name of the staff and adult care home;

Division of Health Service Regulation

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	HAL032065	A. BUILDING: ______ B. WING ______	R-C 12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DURHAM	4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704

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D 156	Continued From page 86 (2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature; (3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and (4) staff and instructor signatures and date after completion of tasks. Copies of this form and instructions for its use may be obtained at no cost on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 5 of 6 sampled staff, who administered medications, completed a medication clinical skills checklist, and completed the 5, 10, or 15-hour medication aide training course or or had verification of previous employment (employee verification form) as a medication aide (MA) before administering medication to residents (A, B, C, D and E). The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 01/03/22.	D 156		

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D 156	Continued From page 87 -There was no documentation Staff A had completed the medication clinical skills checklist. -There was no documentation Staff A completed the 5, 10, or 15-hour medication aide training. -There was no documentation of previous employment verifications Staff A had worked as a MA. Attempted telephone interview with Staff A on 12/02/22 at 9:29am was unsuccessful. Review of residents' October 2022 and November 2022 electronic medication administration records (eMAR) revealed: -There was documentation Staff A administered medications on 14 days from 10/01/22-10/31/22. -There was documentation Staff A administered medications on 15 days from 11/01/22-11/29/22. Refer to the interview with the Administrator on 12/01/22 at 6:16pm. 2. Review of Staff B's, medication aide (MA,) personnel record revealed: -Staff B was hired on 10/04/21. -There was no documentation Staff B had completed the medication clinical skills checklist. -There was no documentation Staff B completed the 5, 10, or 15-hour medication aide training. -There was no documentation of previous employment verifications Staff B had worked as a MA. Review of residents' October 2022 and November 2022 electronic medication administration records (eMAR) revealed: -There was documentation Staff A administered medications on 1 day from 10/01/22-10/31/22. -There was documentation Staff A administered medications on 1 day from 11/01/22-11/31/22.	D 156		

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Telephone interview with Staff B on 12/02/22 at 8:54am revealed:
-She was the Program Director for the Special Care Unit prior to resigning from the facility.
-She administered medications to the residents.
-She had her 15-hour medication aide training at another facility, but no other training had been provided since she began working at the facility.
-She gave a copy of her 15-hour training to staff at the facility (she did not recall who).
-No one watched her on the medication cart or had her demonstrate a medication pass.
-She would have been more comfortable on the medication cart had she been shadowed.

Refer to the interview with the Administrator on 12/01/22 at 6:16pm.

3. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff B was hired on 04/02/19.
-There was no documentation Staff C had completed the medication clinical skills checklist.
-There was no documentation Staff C completed the 5, 10, or 15-hour medication aide training.
-There was no documentation of employment verifications for Staff C.

Review of residents' October 2022 and November 2022 electronic medication administration records (eMAR) revealed:
-There was documentation Staff C administered medications on 2 days from 10/01/22-10/31/22.
-There was documentation Staff C administered medications on 5 days from 11/01/22-11/31/22.

Telephone interview with Staff C on 12/02/22 at 9:06am revealed:
-She completed her medication aide training

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while an employee at the facility.
-She was observed and checked off on the medication cart.
-She did not know why there were no copies of her training in her personnel record.

Refer to the interview with the Administrator on 12/01/22 at 6:16pm.

4. Review of Staff D's, medication aide (MA), personnel record revealed:
-Staff D was hired on 12/19/19.
-There was no documentation Staff D had completed the medication clinical skills checklist.
-There was no documentation Staff D completed the 5, 10, or 15-hour medication aide training.
-There was no documentation of employment verifications for Staff D.

Review of residents' October 2022 and November 2022 electronic medication administration records (eMAR) revealed:
-There was documentation Staff D administered medications on 1 day from 10/01/22-10/31/22.
-There was documentation Staff D administered medications on 1 day from 11/01/22-11/31/22.

Telephone interview with Staff D on 12/02/22 at 11:32am revealed:
-She was a MA prior to working at the facility.
-She shadowed a nurse at the facility and the nurse shadowed her.
-She did not recall a medication clinical skills check off being completed.
-She did not know if a staff member requested her MA training records or a verification form from her previous employer.

Refer to the interview with the Administrator on 12/01/22 at 6:16pm.

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4. Review of Staff E',s medication aide (MA), personnel record revealed:
-Staff E was hired on 01/03/22.
-There was no documentation Staff E had completed the medication clinical skills checklist.
-There was no documentation Staff E completed the 5, 10, or 15-hour medication aide training.
-There was no documentation of employment verifications for Staff E.

Review of residents' October 2022 and November 2022 electronic medication administration records (eMAR) revealed:
-There was documentation Staff E administered medications on 1 day from 10/01/22-10/31/22.
-There was documentation Staff E administered medications on 2 days from 11/01/22-11/31/22.

Attempted telephone interview with Staff E on 12/02/22 at 8:51am was unsuccessful.

Refer to the interview with the Administrator on 12/01/22 at 6:16pm.

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Interview with the Administrator on 12/01/22 at 6:16pm revealed:
-The Business Office Manager (BOM) was responsible for making sure all personnel records were complete.
-The previous BOM was no longer employed by the facility and there was no current BOM, so she was responsible.
-She had started auditing the personnel records and knew there was missing information.
-The record audits were initiated on 11/16/22.
-She did not know the personnel records that were reviewed had no documentation of the medication clinical skills checklist and that the 5, 10, or 15-hour medication aide training was

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completed before the staff administered medications.
-MA qualifications should have been verified on the front end of hiring and filed in the personnel records.
-Completion of MA training should have been filed in the personnel records.
-It was concerning there were MAs without the correct process and training for that role which could put the residents at risk.
-She expected all MA training to be completed and verified before the MA administered medication.

Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation).

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The facility failed to ensure five staff who worked as MAs and administered medications to residents had verification they had previously worked as a MA, or completed the medication aide training and competency evaluation before administering medications including the 5, 10, or 15-hour medication aide training course and the clinical skills checklist resulting in medication errors. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/02/22 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED January 16, 2023.