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{C 000}	Initial Comments The Adult Care Licensure Section and the Edgecombe County Department of Social Services conducted a follow-up survey February 7, 2023 to February 8, 2023 with an exit conference via telephone on February 8, 2023.	{C 000}		
{C 131}	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) who was administering medications had completed the medication skills validation checklist and medication aide training hours or medication aide employment verification form prior to administering medications independently.	{C 131}		

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{C 131}	Continued From page 1 The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A completed the 15-hour medication aide training on 01/12/23. -Staff A had taken and passed the medication aide exam on 10/11/19. -Staff A's medication aide clinical skills checklist was completed on 01/12/23. -There was no documentation of Staff A having a medication aide employment verification form. Interview with the Administrator on 02/07/23 at 9:05am revealed Staff A's hire date was 01/01/23. Review of residents December 2022 medication administration records (MAR) revealed Staff A documented administration of medications beginning 12/27/22 through 12/31/22. Review of residents January 2023 MAR revealed Staff A documented administration of medications 01/01/23 through 01/31/23. Interview with a resident on 02/07/23 at 9:45am revealed: -Staff A administered the residents their medications since she had been living at the house. -He could not remember when she started at the facility. -Staff A tried to administer him a double dose of medication once and he had to stop her because he knew what his medication looked like. Interview with Staff A on 02/07/23 at 1:45pm revealed: -She started at the facility on 01/01/23.	{C 131}		

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{C 131}	Continued From page 2 -She was responsible for resident care including administering medications to the residents. -She lived and worked at the facility every day. -She was a MA previously, so she was familiar with the process of administering medications. -She began administering medications independently when she first arrived at the facility prior to her training on 01/12/23. Interview with the Administrator on 02/07/23 at 2:00pm revealed: -He was with Staff A administering medications when she was hired on 01/01/23 until the training nurse completed her training on 01/12/23. -He stayed at the facility "all hours of the day" to be with Staff A and administer medications to the residents until she completed her training on 01/12/23. Telephone interview with the facility's training Registered Nurse on 02/08/23 at 8:45am revealed: -She completed the medication aide clinical skills checklist and medication aide 15 hour training on 01/12/23 at the facility. -She was not sure if Staff A was administering medications independently prior to 01/12/23. Refer to Tag C 330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation). Refer to Tag C 342 10A NCAC 13G .1004(j) Medication Administration. _____ The facility failed to ensure Staff A, a medication aide, had an employment verification form or completed the medication skills checklist and medication aide training prior to passing medications independently. The facility's failure to ensure Staff A was properly trained prior to	{C 131}		

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{C 131}	Continued From page 3 administering medications independently was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/07/23 for this violation.	{C 131}		
{C 171}	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled staff (Staff A) was competency validated for Licensed Health Professional Support (LHPS) tasks by return demonstration including obtaining fingerstick blood sugar (FSBS) checks prior to performing these tasks on a diabetic resident (#3). The findings are: Review of Staff A, medication aide (MA) personnel record on 02/07/23 revealed there was no documentation of a Licensed Health Professional Support (LHPS) tasks checklist	{C 171}		

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{C 171}	Continued From page 4	{C 171}		

being completed.

Interview with the Administrator on 02/07/23 at 9:05am revealed Staff A's hire date was 01/01/23.

Review of Resident #3's current FL-2 dated 02/08/23 revealed diagnoses included type 2 diabetes.

Review of Resident #3's January 2023 medication administration record (MAR) revealed:
-There was an entry for check FSBS before breakfast daily scheduled at 8:00am.
-FSBS was documented as performed by Staff A at 8:00am 01/01/23 to 01/12/23.

Interview with Staff A on 02/07/23 at 1:50pm revealed:
-She checked Resident #3's FSBS every day before breakfast.
-She had an idea of how to perform FSBS because she had seen it done before.
-Resident #3 needed his FSBS checked so she did it.

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

Interview with the Administrator on 02/07/23 at 1:45pm revealed:
-Resident #1 received his intramuscular Haldol injection at the local hospital.
-He was responsible for ensuring that a LHPS competency checklist was completed for staff performing FSBS.
-He was not sure what the LHPS competency checklist looked like, but he was sure that the facility's training registered nurse filled out the checklist for Staff A when she was on-site earlier

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{C 171}	Continued From page 5 today (02/07/23). Review of a LHPS competency check off signed by the facility's Registered Nurse revealed: -The facility's training Registered Nurse initialed all of the tasks. -There was no staff name or date on the competency check off. -The facility's traning Registered Nurse signed the LHPS competency check off at the end of the document. Telephone interview with the facility's training Registered Nurse on 02/08/23 at 8:45am revealed: -She thought that she had signed off the LHPS competency check off when she was on-site yesterday (02/07/23). -This was her first facility that she was completing staff training so she was not familiar with all of the paperwork. -She went over FSBS with Staff A during her medication aide skills checklist on 01/13/23.	{C 171}		
{C 185}	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter.	{C 185}		

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{C 185}	Continued From page 6 The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in death, serious physical harm, abuse, neglect or exploitation. THIS IS A TYPE A1 VIOLATION Based on observations, interviews, and record reviews the Administrator failed to ensure the total operation of the home, to meet and maintain the rules in areas of Qualifications of Medication Staff, Health Care, Medication Administration, Competency Validation for Licensed Health, Tuberculosis Test and Medical Examination, Resident Care Plan, Licensed Health Professional Support, Medication Orders, Self-Administration of Medications, Medication Disposition, and Reporting of Accidents and Incidents. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 5 ambulatory residents. Interview with the Administrator on 02/07/23 at 8:45am revealed: -The facility had a current census of 4 residents. -One of the residents (#4) was out of the facility. Review of the facility's records on 02/07/23 at	{C 185}		

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{C 185}	Continued From page 7 9:06am revealed there were no FL-2s for any of the residents. Review of Resident #1's current FL-2 dated 02/08/23 revealed diagnoses included recurrent major depressive disorder and schizophrenia disorder. Review of Resident #2's current FL-2 dated 02/08/23 revealed diagnoses included essential hypertension, atrial fibrillation, and memory loss. Review of Resident #3 current FL-2 dated 02/08/23 revealed diagnoses included schizophrenia and type 2 diabetes. Review of Resident #4's current FL-2 dated 02/08/23 revealed diagnoses included type 2 diabetes mellitus, long term current use of insulin, and schizophrenia. Telephone interview with the facility's contracted primary care provider (PCP) on 02/08/23 at 3:08pm revealed: -The Administrator was "hurried" to get the residents seen at the physician's office and brought 8 residents to the office on 01/18/23. -The office visit on 01/18/23 was to establish care with the PCP's office. -The staff member that brought the resident's to the PCP's office "knew very little about the residents" and handed him a file folder with each of the resident's records. -The main purpose of the visit on 01/18/23 was to ensure that resident's had their medications. -He was not told by the staff accompanying the residents on 01/18/23 that any of the residents were out of their medication refills. -If he was told by the staff accompanying the residents on 01/18/23 that any of the residents	{C 185}		

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{C 185}	Continued From page 8 were out of their medications he would have called in refills for the medications. Interview with the Administrator on 02/07/23 at 1:45pm revealed: -He did not have FL-2s for the residents because he was waiting for the PCP to complete them. -He was not familiar with what the Licensed Health Professional Support (LHPS) competency checklist looked like. -He was not aware if he could discontinue a medication for a resident that was not able to afford it without contacting the PCP. -He did not complete audits of the medication carts, orders, or medications administration records (MAR) currently, but he was going to have the facility's training registered nurse complete them twice a month starting with her next visit. -He did not complete audits of the residents records, medication carts, orders or MAR because he was waiting for the facility's training Registered Nurse to start. Telephone interview with the facility's training Registered Nurse on 02/08/23 at 8:45am revealed: -She was responsible for training the facility staff on medication administration and Licensed Health Professional Support (LHPS) tasks. -Her first visit to the facility was in January of 2023 to perform medication aide training to Staff A. -This was her first facility providing oversight for LHPS tasks for residents and competency training. -She utilized her critical thinking skills as a nurse to assess resident's needs. -She was not familiar with the LHPS tasks that required review.	{C 185}		

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{C 185}	Continued From page 9 Telephone interview with the Administrator on 02/08/23 at 11:15am revealed: -He was responsible for the total operations of the facility. -He was on-site at the facility every day. -Staff A, medication aide (MA), "covers" for the Administrator when he was not on-site. -In September of 2022 he received notice from the facility's contracted primary care provider (PCP) that their last day providing medical services to the facility would be 11/22/22. -He reached out to another provider in November of 2022 to see if they would be willing to accept the residents as patients and they had a first appointment in the middle of January 2023. -The residents were without a physician provider from 11/22/22 until 01/18/23 when they established care at the PCP's office. -If a resident was sick and needed medical attention he would take them to the emergency department (ED). -He was not aware when a resident was discharged from the facility that there a medication disposition must be completed and he was previously cited on 11/22/22 for failing to complete a medication disposition on a discharged resident. -He was not familiar with the LHPS tasks that required review for the residents quarterly and he was previously cited on 11/22/22 for failing to meet the requirements for LHPS review. A second telephone interview with the Administrator on 02/08/23 at 5:52pm revealed he took the resident's to their appointment with the PCP on 01/18/23. Non-compliance was identified in the following rule areas:	{C 185}		

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{C 185}	Continued From page 10 1. Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) who was administering medications had completed the medication skills validation checklist and medication aide training hours or medication aide employment verification form prior to administering medications independently [Refer to Tag C0131 10A NCAC 13G .0403(a) Qualifications of Medication Staff (Unabated Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure health care referral and follow up for 1 of 3 residents sampled related to mental health services (#1) [Refer to Tag C0246 10A NCAC 13G .0902(b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure that medications were administered according to physician orders for 2 of 3 residents sampled for medications including blood pressure (#2), a medication used to manage schizophrenia (#3) and chronic obstructive pulmonary disease (#3) [Refer to Tag C0330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)]. 4. Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled staff (Staff A) was competency validated for Licensed Health Professional Support (LHPS) tasks by return demonstration including obtaining fingerstick blood sugar (FSBS) checks prior to performing these tasks on a diabetic resident (#3) [Refer to Tag C0171 10A NCAC 13G .0504(a) Competency Evaluation and Validation For Licensed Health Professional Support Tasks].	{C 185}		

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{C 185}	Continued From page 11 5. Based on record reviews and interviews, the facility failed to ensure 1 of 3 residents sampled (#1) had been tested for tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag C0202 10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination]. 6. Based on record reviews and interviews the facility failed to ensure an annual FL-2 was completed for 3 of 3 sampled residents (#1, #2, #3) [Refer to Tag C0203 10A NCAC 13G .0702(b) Tuberculosis Test and Medical Examination]. 7. Based on record reviews and interviews the facility failed to ensure 3 of 3 residents sampled (#1, #2, #3) had a completed FL-2 in their records [Refer to Tag C0208 10A NCAC 13G .0702(c)(5) Tuberculosis Test and Medical Examination]. 8. Based on interviews and record reviews, the facility failed to ensure that 3 of 3 residents sampled (#1, #2, #3) had an individualized care plan completed with written program of personal care for each resident [Refer to Tag C0236 10A NCAC 13G .0802(a) Resident Care Plan]. 9. Based on record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 2 of 2 sampled residents (#1, #2) to include the identified tasks of fingerstick blood sugars (FSBS) (#3) and administering medication by injection (#1). [Refer to Tag C0254 10A NCAC 13G .0903(c) Licensed Health Professional Support]. 10. Based on observations, interviews, and record reviews, the facility failed to clarify	{C 185}		

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{C 185}	Continued From page 12	{C 185}		

medication orders for 1 of 3 sampled residents (#3) for an inhaler, a medication used to treat skin conditions, a medication used for pain or to thin the blood, a diabetes medication, a blood pressure medication, a supplement, a medication used to treat schizophrenia, a medication used to treat acid reflux, and a medication used to treat constipation [Refer to Tag C0315 10A NCAC 13G .1002(a) Medication Orders].

11. Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were complete and accurate for 3 of 3 residents sampled (#1, #2, #3) [Refer to Tag C0342 10A NCAC 13G .1004(j) Medication Administration].

12. Based on observations, interviews, and record reviews, the facility failed to ensure that 1 of 1 residents sampled (#4) that was self-administering their own insulin injections had an order to self-administer from a prescribing practioner [Refer to Tag C0350 10A NCAC 13G .1005(a and b) Self-Administration of Medications].

13. Based on record review and interview the facility failed to ensure that physician-prescribed medications were released with the resident upon discharge for 1 of 1 sampled resident (#5) [Refer to Tag C0361 10A NCAC 13G .1007(a) Medication Disposition].

14. Based on observations, interviews, and record reviews, the facility failed to notify the local county Department of Social Services (DSS) of an incidents resulting in medical evaluation for 1 of 3 residents sampled (#1) [Refer to Tag C0444 10A NCAC 13G .1213(a) Reporting of Accidents and Incidents].

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{C 185}	Continued From page 13 The Administrator failed to ensure that the management and operations of the facility were implemented to ensure services necessary to maintain the residents' physical and mental health were provided as evidenced by the failure to maintain compliance with the rules and statutes governing adult care homes, which is the responsibility of the Administrator. Residents at the facility went without a primary care provider for 11 weeks and there was no process in place for a resident who had an inpatient psychiatric hospitalization for referral and follow-up. There were multiple errors with medications not being available for administration including blood pressure medication. The facility's failure resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/08/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 11, 2023.	{C 185}		
{C 202}	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family 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	{C 202}		

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{C 202}	Continued From page 14 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 3 residents sampled (#1) had been tested for tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #1's current FL-2 dated 02/08/23 revealed diagnoses included recurrent major depressive disorder and schizophrenia disorder. Review of Resident #1's Resident Register revealed an admission dated of 08/31/22. Review of Resident #1's facility record on 02/07/23 revealed there was no tuberculosis (TB) skin test documentation. Interview with Resident #1 on 02/07/23 at 9:45am revealed: -He went with the rest of the residents on 01/04/23 to get a TB skin test placed at the local health department (LHD). -He did not remember returning to the LHD to have his TB skin test read. Interview with the Administrator on 02/07/23 at 2:20pm revealed: -Resident #1 did have his TB test placed on 01/04/23 at the LHD. -Resident #1 did not return to the LHD on 01/06/23 with the rest of the residents to have his TB test read because he was hospitalized.	{C 202}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 202}	Continued From page 15 -He did not think to ask the hospital to read Resident #1's TB test while he was admitted. -He did not take Resident #1 back to the LHD to have another TB test placed. -He was responsible for ensuring that residents had their TB tests completed. Telephone interview with the facility's primary care provider (PCP) on 02/08/23 at 2:40pm revealed it was important for residents to have TB skin tests in a facility setting because the residents were in close contact with others and were potentially compromised because of their comorbidities.	{C 202}		
{C 203}	10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination (b) Each resident shall have a medical examination prior to admission to the home and annually thereafter. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an annual FL-2 was completed for 3 of 3 sampled residents (#1, #2, #3). The findings are: 1. Review of Resident #3 current FL-2 dated 02/08/23 revealed diagnoses included schizophrenia and type 2 diabetes. Review of Resident #3's Resident Register	{C 203}		

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{C 203}	Continued From page 16 revealed he was admitted on 02/16/21. Review of Resident #3's facility's record on 02/07/23 revealed there was not a FL-2 for Resident #3. Refer to interview with the Administrator on 02/07/23 at 9:06am. Refer to second interview with the Administrator on 02/07/23 at 9:49am. 2. Review of Resident #1's current FL-2 dated 02/08/23 revealed diagnoses included recurrent major depressive disorder and schizophrenia disorder. Review of Resident #1's Resident Register revealed he was admitted on 08/31/22. Review of Resident #1's facility record on 02/07/23 revealed there was not a FL-2 for Resident #1. Refer to interview with the Administrator on 02/07/23 at 9:06am. Refer to second interview with the Administrator on 02/07/23 at 9:49am. 3. Review of Resident #2's current FL-2 dated 02/08/23 revealed diagnoses included essential hypertension, atrial fibrillation, and memory loss. Review of Resident #2's Resident Register revealed he was admitted on 10/31/22. Review of Resident #2's facility record on 02/07/23 revealed there was not a FL-2 for Resident #2.	{C 203}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 203}	Continued From page 17 Refer to interview with the Administrator on 02/07/23 at 9:06am. Refer to second interview with the Administrator on 02/07/23 at 9:49am. _____ Interview with the Administrator on 02/07/23 at 9:06am revealed: -Resident #1, #2, and #3 did not have a current or previous FL-2 in their facility record. -The residents did not have a FL-2 because he was waiting for the primary care provider's (PCP) office to complete them. -He took the residents to the PCP's office 01/18/23 to establish care. -When he took the residents to the appointment on 01/18/23 he provided the office with blank FL-2s. -He would go to the PCP's office today (02/07/23) to check on the status of the FL-2s. Second interview with the Administrator on 02/07/23 at 9:49am revealed that the PCP was out of the office today (02/07/23) and he would sign the FL-2s tomorrow (02/08/23).	{C 203}		
C 208	10A NCAC 13G .0702 (c-5) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:	C 208		

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C 208	Continued From page 18 (5) The completed FL-2 or MR-2 shall be filed in the resident's record in the home. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 3 of 3 residents sampled (#1, #2, #3) had a completed FL-2 in their records. The findings are: 1. Review of Resident #3's facility's record on 02/07/23 revealed there was not a FL-2 for Resident #3. Review of Resident #3's Resident Register revealed he was admitted on 02/16/21. Refer to interview with the Administrator on 02/07/23 at 9:06am. Refer to second interview with the Administrator on 02/07/23 at 9:49am. 2. Review of Resident #1's facility record on 02/07/23 revealed there was not a FL-2 for Resident #1. Review of Resident #1's Resident Register revealed he was admitted on 08/31/22. Refer to interview with the Administrator on 02/07/23 at 9:06am. Refer to second interview with the Administrator on 02/07/23 at 9:49am. 3. Review of Resident #2's facility record on	C 208		

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C 208	Continued From page 19 02/07/23 revealed there was not a FL-2 for Resident #2. Review of Resident #2's Resident Register revealed he was admitted on 10/31/22. Refer to interview with the Administrator on 02/07/23 at 9:06am. Refer to second interview with the Administrator on 02/07/23 at 9:49am. _____ Interview with the Administrator on 02/07/23 at 9:06am revealed: -Resident #1, #2, and #3 did not have a FL-2 in their facility record. -The residents did not have a FL-2 because he was waiting for the primary care provider's (PCP) office to complete them. -He took the residents to the PCP's office 01/18/23 to establish care. -When he took the residents to the appointment on 01/18/23 he provided the office with blank FL-2s. -He would go to the PCP's office today (02/07/23) to check on the status of FL-2s. Second interview with the Administrator on 02/07/23 at 9:49am revealed that the PCP was out of the office today (02/07/23) and he would sign the FL-2s tomorrow (02/08/23).	C 208		
{C 236}	10A NCAC 13G .0802 (a) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plans (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule	{C 236}		

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{C 236}	Continued From page 20 .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 3 of 3 residents sampled (#1, #2, #3) had an individualized care plan completed with written program of personal care for each resident. The findings are: 1.Review of Resident #1's current FL-2 dated 02/08/23 revealed diagnoses included recurrent major depressive disorder remission status and schizoaffective disorder. Review of Resident #1's Resident Register revealed he was admitted on 08/31/22. Review of Resident #1's care plan on 02/07/23 revealed: -The most recent care plan was completed by the Administrator on 01/01/23. -The activities of daily living were not completed on the care plan for Resident #1. -There was no physician signature on the care plan. -The facility's training Registered Nurse signed the care plan under the physician authorization statement with a date of 02/07/23. Refer to telephone interview with the Administrator on 02/08/23 at 11:15am. 2. Review of Resident #2's current FL-2 dated 02/07/23 revealed diagnoses included essential hypertension, atrial fibrillation (irregular heart rhythm), and memory loss.	{C 236}		

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{C 236}	Continued From page 21 Review of Resident #2's Resident Register revealed he was admitted on 10/31/22. Review of Resident #2's care plan on 02/07/23 revealed: -The most recent care plan was completed by the Administrator on 01/01/23. -The activities of daily living were not completed on the care plan for Resident #2. -There was no physician signature on the care plan. -The facility's training Registered Nurse signed the care plan under the physician authorization statement with a date of 02/07/23. Refer to telephone interview with the Administrator on 02/08/23 at 11:15am. 3. Review of Resident #3's current FL-2 dated 02/07/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes, essential hypertension, dementia, and schizophrenia. . Review of Resident #3's Resident Register revealed he was admitted on 02/16/21. Review of Resident #3's care plan on 02/07/23 revealed: -The most recent care plan was completed by the Administrator on 01/01/23. -The activities of daily living were not completed on the care plan for Resident #3. -There was no physician signature on the care plan. -The facility's training Registered Nurse signed the care plan under the physician authorization statement with a date of 02/07/23.	{C 236}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 236}	Continued From page 22 Refer to telephone interview with the Administrator on 02/08/23 at 11:15am. _____ Interview with the Administrator on 11/22/22 at 2:20pm revealed: -He was responsible for ensuring that residents had care plans completed. -He completed the resident's care plans but did not complete all sections of the care plan including activities of daily living and the amount of assistance each resident required. -He was not aware that the care plans needed to be signed by the physician; he thought the facility's training Registered Nurse could sign the care plans.	{C 236}		
{C 246}	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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 interviews and record reviews, the facility failed to ensure health care referral and follow up for 1 of 3 residents sampled related to mental health services (#1). The findings are: Review of Resident #1's current FL-2 dated 02/08/23 revealed diagnoses included alcoholism, recurrent major depressive disorder remission status, and schizoaffective disorder depressive type. Review or Resident #1's Resident Register revealed he was admitted to the facility on	{C 246}		

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{C 246}	Continued From page 23 08/31/22. Review of Resident #1's emergency department (ED) record dated 01/04/23 revealed: -Resident #1 was brought into the ED by Emergency Management Services (EMS) at 9:23pm on 01/03/23. -The police department (PD) called EMS stating that the resident had been smoking spices. -EMS was called by the police to check out Resident #1 who stated he had been high for the past week. -Resident #1 also stated that he had been hallucinating. -Resident #1 asked for a drug screen because he reported that he thought the facility had poisoned him because he cooked with a lot of spices, and he felt high every time he ate food. -A drug screen was obtained on Resident #1 which was negative. -Resident #1 was discharged back to the facility on 01/04/23 at 12:47am. Review of Resident #1's second ED record also dated 01/04/23 revealed: -Resident #1 had attempted suicide and had a neck laceration which was sutured in the ED. -Resident #1 reported that he was hearing voices telling him to cut off his genitalia. -Resident #1 was also hearing voices saying, "You raped me." and "We're married." -Resident #1 also reported seeing a small white and tan puppy out of the corner of his eye at times. -Resident #1 was recently hospitalized in a psychiatric facility from 11/14/22 to 11/23/22. -Resident #1 stated that right after discharge on 11/23/22 he was doing well but within a day or two he began to hear voices again. -Resident #1 was discharged from the ED on	{C 246}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 246}	Continued From page 24 01/07/23 and was admitted to a psychiatric hospital for auditory command hallucinations and medication stabilization. Review of Resident #1's incident/accident report dated 01/05/23 revealed: -Resident #1 "called the police without notice". -Resident #1 "gave himself a cut after bedtime". Review of Resident #1's record revealed he was discharged from the psychiatric hospital on 01/13/23. Telephone interview with the Administrator on 02/08/23 at 11:15am revealed: -In September of 2022 he received notice from the facility's contracted primary care provider (PCP) that the last day providing medical services to the facility would be 11/22/22. -That same agency provided mental health services to the residents as well. -He reached out to another provider in November of 2022 to see if they would be willing to accept the residents as patients and they had a first appointment in the middle of January 2023. -The residents were without a primary care physician or mental health provider from 11/22/22 until 01/18/23 when they established care at the PCP's office. -Resident #1 was supposed to follow up with a psychiatric provider but that did not happen after he was discharged from the psychiatric hospital in November 2022 because there was no psychiatric doctor with which he could follow up. -It was important for Resident #1 to follow up with a mental health provider so they could analyze what was happening with the resident and to look at his medications. -On 01/04/23 Resident #1 was shaving and tried to harm himself with a razor.	{C 246}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 246}	Continued From page 25 -He attended Resident #1's PCP appointment with him on 01/18/23. -He was not sure if he told the PCP about Resident #1's recent suicide attempt or not. -The new PCP's office did not provide mental health services. -He had contacted another PCP's office who provided mental health services and Resident #1 had an appointment there on 02/22/23. Telephone interview with Resident #1's PCP on 02/08/23 at 3:07pm revealed: -He had only seen Resident #1 once at an appointment on 01/18/23. -Resident #1 made him aware of a recent suicide attempt. -Resident #1 told him that he was receiving psychiatric services. -The person who attended the appointment with Resident #1 did not seem to know anything about the resident and only provided information to him in a folder. -The PCP's office also provided mental health services and if he had been made aware that Resident #1 did not have a mental health provider on 01/18/23 he would have made sure the resident saw someone that day about his mental health. _____ The facility failed to follow up with a mental health provider after a resident was discharged from a psychiatric facility in which the resident went without mental health services for an 11-week timeframe during which the resident had hallucinations and had a suicide attempt where he cut his neck which required sutures and a 7 day stay at a psychiatric hospital. The failure of the facility resulted in serious injury and neglect and constitutes a Type A1 Violation. _____	{C 246}		

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{C 246}	Continued From page 26 The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 02/08/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 10, 2023.	{C 246}		
{C 254}	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a Licensed Health	{C 254}		

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{C 254}	Continued From page 27	{C 254}		

Professional Support (LHPS) evaluation was completed on 2 of 2 sampled residents (#1, #2) to include the identified tasks of fingerstick blood sugars (FSBS) (#3) and administering medication by injection (#1).

The findings are:

1. Review of Resident #3's current FL-2 dated 02/08/23 revealed diagnoses included type 2 diabetes.

Review of Resident #3's physician order sheet dated 05/09/22 revealed there was an order to start blood sugar checks twice daily before breakfast and before dinner.

Review of Resident #3's medication administration record (MAR) revealed there was an entry for fingerstick blood sugars (FSBS) scheduled daily at 8:00am.

Review of Resident #3's record on 02/07/23 revealed there was no licensed health professional support (LHPS) evaluation.

Interview with a medication aide (MA) on 02/07/23 at 1:50pm revealed she performed FSBSs on Resident #3.

Refer to telephone interview with the Administrator on 02/08/23 at 11:17am.

Refer to telephone interview with the facility's training Registered Nurse on 02/08/23 at 8:45am.

2. Review of Resident #1's current FL-2 dated 02/08/23 revealed:
-Diagnoses included major depressive disorder and schizoaffective disorder.

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{C 254}	Continued From page 28 -There was an order for Haldol 50mg intramuscularly every 30 days. Review of Resident #1's medication administration record (MAR) revealed there was an entry for Haldol 50mg intramuscularly every 30 days. Review of Resident #1's record on 02/07/23 revealed there was no licensed health professional support (LHPS) evaluation. Refer to telephone interview with the Administrator on 02/08/23 at 11:17am. Refer to telephone interview with the facility's training Registered Nurse on 02/08/23 at 8:45am. _____ Telephone interview with the Administrator on 02/08/23 at 11:17am revealed he was not familiar with the licensed health professional support (LHPS) tasks that required review for the residents quarterly. Telephone interview with the facility's training Registered Nurse on 02/08/23 at 8:45am revealed: -This was her first facility providing oversight for LHPS tasks for residents and competency training. -Yesterday (02/07/23) was her first visit to the facility to look over the resident records. -She utilized her critical thinking skills as a nurse to assess resident's needs. -She was not familiar with the LHPS tasks that required review.	{C 254}		
C 315	10A NCAC 13G .1002(a) Medication Orders	C 315		

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C 315	Continued From page 29 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (#3) for an inhaler, a medication used to treat skin conditions, a medication used for pain or to thin the blood, a diabetes medication, a blood pressure medication, a supplement, a medication used to treat schizophrenia, a medication used to treat acid reflux, and a medication used to treat constipation. The findings are: Review of Resident #3's current FL-2 dated 02/08/23 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes, hypertension, and schizophrenia. -All medications listed on the FL-2 did not have instructions on how often to administer the medications.	C 315		

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C 315	Continued From page 30 Review of Resident #3's physician visit note dated 01/18/23 revealed: -There was an order for Proair HFA (used to treat shortness of breath). -There were no instructions on a dosage or how often to administer Proair HFA. -There was an order for Kenalog (a cream used to treat skin conditions). -There were no instructions on a dosage or how often to administer Kenalog. -There was an order for aspirin 81mg (used as a pain reliever or to thin the blood). -There were no instructions for how often to administer aspirin. -There was an order for Januvia 100mg as directed (used to lower blood sugars). -There were no instructions for how often to administer Januvia. -There was an order for lisinopril 10mg (used to treat high blood pressure). -There were no instructions on how often to administer lisinopril. -There was an order for magnesium oxide 400mg (a supplement) as needed. -There were no instructions for how often to administer magnesium oxide. -There was an order for olanzapine 10mg (used to treat schizophrenia). -There were no instructions on how often to administer olanzapine. -There was an order for Protonix 40mg (used to treat acid reflux). -There were no instructions on how often to administer Protonix. -There was an order for Miralax 17gm packet as directed (used to treat constipation). -There were no instructions on how often to administer Miralax.	C 315		

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C 315	Continued From page 31 Telephone interview with the Administrator on 02/08/23 at 11:17am revealed: -If there was a medication order in a resident's record without all the needed information, he would check with the primary care provider (PCP) who prescribed it to get the information and check with the pharmacy to see if they had complete orders from the PCP. -He did not check with the PCP or pharmacy about Resident #3's incomplete medication orders.	C 315		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION. Based on observations, interviews, and record reviews, the facility failed to ensure that medications were administered according to physician orders for 2 of 3 residents sampled for medications including blood pressure (#2), a	{C 330}		

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{C 330}	Continued From page 32	{C 330}		

medication used to manage schizophrenia (#3) and chronic obstructive pulmonary disease (#3).

The findings are:

1. Review of Resident #2's physician visit note dated 01/18/23 revealed there was an order for Lisinopril 10mg daily.

Review of Resident #2's current FL-2 dated 02/08/23 revealed:
-Diagnoses include hypertension and cerebral vascular accident (CVA).
-There was an order for Lisinopril 10mg daily (Lisinopril is a medication used to treat hypertension).

Review of Resident #2's December 2022 medication administration record (MAR) revealed:
-There was an entry for Lisinopril 10mg once a day, scheduled for administration at 8:00am.
-Lisinopril 10mg was documented as administered from 12/01/22 to 12/31/22 at 8:00am.

Review of Resident #2's January 2023 MAR revealed:
-There was an entry for Lisinopril 10mg once a day, scheduled for administration at 8:00am.
-Lisinopril 10mg was documented as administered from 01/01/23 to 01/31/23 at 8:00am.
-Example of Resident #2's daily's blood pressures that were above target range were 189/104, 184/77, and 183/100 (normal blood pressure range should not exceed 120/80).
-There was a handwritten note on the back of the January 2023 MAR by the medication aide (MA) dated 01/02/23 that stated, "all drugs are administered except Lisinopril which was being

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{C 330}	Continued From page 33 sent to the pharmacy today". Review of Resident #2's February 2023 MAR revealed: -There was an entry for Lisinopril 10mg once a day, scheduled for administration at 8:00am. -Lisinopril 10mg was not documented as administered from 02/01/23 to 02/07/23. Observation of Resident #2's medications on hand on 02/07/23 at 9:42am revealed there was no Lisinopril 10mg available for administration. Interview with the MA on 02/07/23 at 9:45am revealed: -Resident #2 was out of Lisinopril but she could not recall for how long. -She told the Administrator that Resident #2 was out of the Lisinopril, and he was responsible for calling the pharmacy. Telephone interview with a pharmacist at the facility's contract pharmacy at 02/07/23 at 12:06pm revealed: -The facility faxed the pharmacy an order for Lisinopril 10mg daily on 10/31/22. -The facility dispensed a 7-day supply (7 tablets) of Lisinopril to the facility on 10/31/22. -The pharmacy had not dispensed any Lisinopril to Resident #2 since 10/31/22. -The facility was aware that the pharmacy needed a refill prescription in order to dispense Resident #2 more Lisinopril. -Lisinopril was used to treat high blood pressure. -If a resident did not receive their ordered Lisinopril, they could be at increased risk for elevated blood pressure which could potentially lead to a stroke. Interview with the Administrator on 02/07/23 at	{C 330}		

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{C 330}	Continued From page 34 12:45pm revealed: -Resident #2 came to the facility with some medications but he was not sure how many. -He did not have documentation of what medications the resident brought or how many pills of each medication, but he was sure the Lisinopril was with him when he arrived. -He contacted the local county Department of Social Services (DSS) who was supposed to be paying for Resident #2's medication but they were not willing to pay for his medications. -He did not contact Resident #2's primary care provider (PCP) to let them know that he was without Lisinopril because the facility was without a PCP from 11/23/22 to 01/18/23. -When Resident #2 went to new PCP appointment on 01/18/23, the Administrator did not inform the PCP that the resident needed a refill for Lisinopril. -The facility did not have a back-up pharmacy or alternative pharmacy that they used to obtain medications. Telephone interview with the facility's PCP on 02/08/23 at 2:30pm revealed: -Resident #2 was ordered Lisinopril for treatment of high blood pressure. -If Resident #2 was without Lisinopril, he was at risk for increased blood pressure and risk for stroke. -He was under the impression that Resident #2 was receiving his Lisinopril because it was on the medication list provided by the facility on the 01/18/23 visit. -He expected to be notified if the resident was out of a medication and needed a refill. -Resident #2's blood pressure at the 01/18/23 visit was 130/70. Based on observations, interviews, and record	{C 330}		

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{C 330}	Continued From page 35	{C 330}		

reviews it was determined that Resident #2 was not interviewable.

2. Review of Resident #3's current FL-2 dated 02/08/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD) and schizophrenia.

a. Review of Resident #3's current FL-2 dated 02/08/23 revealed there was an order for olanzapine 10mg (Olanzapine is used to treat schizophrenia).

Review of Resident #3's January 2023 medication administration record (MAR) revealed:
-There was an entry for olanzapine 10mg dissolve 1 tablet every morning for mood scheduled for administration at 8:00am.
-Olanzapine 10mg was documented as administered 01/01/23 to 01/31/23.

Review of Resident #3's February 2023 MAR revealed:
-There was an entry for olanzapine 10mg dissolve 1 tablet every morning for mood scheduled for administration at 8:00am.
-Olanzapine 10mg was documented as administered 02/01/23 to 02/07/23.

Observation of Resident #3's medications on hand on 02/07/23 at 9:55am revealed there was no olanzapine 10mg on the cart.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/07/23 at 12:06pm revealed:
-Twenty-eight tablets of olanzapine 10mg was last dispensed for Resident #3 on 12/15/22.
-When a resident needed refills, the pharmacy reached out to the facility and the primary care

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provider (PCP) to make them aware.
-Refills for Resident #3's olanzapine were denied by the PCP in December 2022.
-The pharmacy did not place medications on the MAR based on what was on the resident's FL-2.
-The pharmacy used the most recent signed copy of medications orders to enter resident's medications on the MAR.

Interview with the medication aide (MA) on 02/07/23 at 1:50pm revealed:
-If a resident was out of medication she would make the Administrator aware immediately so he could call the pharmacy for refills on the medication.
-She did not know Resident #3 was out of olanzapine.

Telephone interview with the Administrator on 02/07/23 at 11:17am revealed:
-The facility did not have a PCP in December 2022.
-When the pharmacy notified him that Resident #3 needed refills on his olanzapine in December 2022 he reached out to the former PCP and did not hear back from her.
-Resident #3 saw his new PCP on 01/18/23 and the Administrator made the PCP aware that the resident needed medication refills.
-He was not sure how the new PCP handled refills and was not sure if the PCP would send the refill request to the pharmacy or not.

Telephone interview with a PCP at Resident #3's PCP office on 02/08/23 at 2:28pm revealed:
-Facility staff should have made Resident #3's PCP aware at his visit on 01/18/23 if he needed refills on any medications.
-Residents were usually weaned off olanzapine.
-Not weaning a resident off olanzapine could

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cause withdrawals or rebound issues that would increase any symptoms that were being treated.

Interview with Resident #3's PCP on 02/08/23 at 3:07pm revealed:
-He had only seen Resident #3 once and did not know much of his history.
-He was not aware that Resident #3 needed refills on his olanzapine.
-Resident #3 should have been weaned off his olanzapine.
-If Resident #3 was taking olanzapine for psychosis it could cause it to worsen if he stopped olanzapine suddenly.

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

b. Review of Resident #3's primary care provider (PCP) progress notes dated 01/18/23 revealed there was an order for Serevent Diskus 50mcg 1 puff twice a day [Serevent Diskus is used to treat chronic obstructive pulmonary disease (COPD)].

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/07/23 at 12:06pm revealed:
-The pharmacy did not place medications on the MAR based on what was on the resident's FL-2.
-The pharmacy used the most recent signed copy of medications orders to enter resident's medications on the MAR.
-Resident #3's Serevent Diskus was last dispensed on 02/23/22.
-Serevent Diskus was not on a cycle refill and the facility would have to request a refill for Resident #3's Serevent Diskus.

Review of Resident #3's January 2023

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medication administration record (MAR) revealed:
-There was an entry for Serevent Diskus inhale 1 puff 2 times a day for COPD scheduled for administration at 8:00am and 8:00pm.
-Serevent Diskus was documented as administered at 8:00am on 01/01/23 to 01/06/23.
-Serevent Diskus was documented as administered at 8:00pm on 01/01/23 to 01/05/23.
-Serevent Diskus was not documented as administered at 8:00am on 01/07/23 to 01/31/23 and at 8:00pm on 01/06/23 to 01/31/23 with no documentation as to why it was not administered.

Review of Resident #3's February 2023 MAR revealed:
-There was an entry for Serevent Diskus inhale 1 puff 2 times a day for COPD scheduled for administration at 8:00am and 8:00pm.
-Serevent Diskus was documented as administered at 8:00am on 02/01/23 to 02/07/23.
-Serevent Diskus was documented as administered at 8:00pm on 02/01/23 to 02/05/23.
-Serevent Diskus was not documented as administered at 8:00pm on 02/06/23 with no documentation as to why it was not administered.

Observation of Resident #3's medications on hand on 02/07/23 at 9:55am revealed there was no Serevent Diskus on the cart for Resident #3.

Observation of a Servant Diskus inhaler on 02/07/23 at 1:45pm revealed:
-The Administrator was holding a Serevent Diskus inhaler in his hand.
-The Serevent Diskus inhaler was not labeled with a pharmacy label or with a resident's name.
-The Serevent Diskus inhaler had 37 doses left.

Interview with the medication aide (MA) on 02/07/23 at 1:50pm revealed:

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{C 330}	Continued From page 39 -Resident #3's Serevent Diskus inhaler was empty. -She had made the Administrator aware that Resident #3 needed a refill on his Serevent Diskus. -She thought the last time she administered Resident #3's Serevent Diskus was sometime in December 2022. Interview with the Administrator on 02/07/23 at 12:51pm revealed: -He knew Resident #3 had a Serevent Diskus inhaler because he requested the refill himself. -Resident #3 was currently at a day program and sometimes he kept his inhaler in his pocket. -Resident #3 would return to the facility today sometime between 2:00pm and 3:00pm. Second interview with the Administrator on 02/07/23 at 1:45pm revealed: -He had found Resident #3's Serevent Diskus inhaler on the medication cart. -It was not labeled with Resident #3's name because he threw away the package that the Serevent Diskus came in when he received it from the pharmacy. Telephone interview with the Administrator on 02/08/23 at 11:17am revealed sometimes Resident #3 coughed uncontrollably. Telephone interview with a PCP at Resident #3's PCP office on 02/08/23 at 2:28pm revealed Resident #3 not receiving his Serevent Diskus inhaler as ordered could cause him to have an exacerbation of his COPD which could cause the resident to have shortness of breath and increased coughing. Based on observations, interviews, and record	{C 330}		

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reviews it was determined Resident #3 was not interviewable.

c. Review of Resident #3's primary care provider's (PCP) progress notes dated 01/18/23 revealed:
-There was an order for Proair HFA (an inhaler used to treat wheezing and shortness of breath).
-There were no instructions on how often to administer Proair HFA.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/07/23 at 12:06pm revealed:
-The pharmacy did not place medications on the MAR based on what was on the resident's FL-2.
-The pharmacy used the most recent signed copy of medications orders to enter resident's medications on the MAR.

Review of Resident #3's January 2023 medication administration record (MAR) revealed:
-There was an entry for albuterol HFA 90mcg (the same as Proair HFA) use 2 puffs by mouth every 6 hours as needed for severe coughing, wheezing, or shortness of breath.
-Albuterol HFA was documented as administered three times a day on 01/01/23 to 01/10/23.
-Albuterol HFA was not documented as administered 01/11/23 to 01/31/23.

Review of Resident #3's 2023 February medication administration record (MAR) revealed:
-There was an entry for albuterol HFA 90mcg use 2 puffs by mouth every 6 hours as needed for severe coughing, wheezing, or shortness of breath.
-Albuterol HFA was documented as administered once a day on 02/01/23 to 02/07/23.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 330}	Continued From page 41 Observation of Resident #3's medications on hand on 02/07/23 at 9:55am revealed there was an albuterol inhaler on the cart for Resident #3. Interview with the medication aide (MA) on 02/07/23 at 1:50pm revealed she administered albuterol HFA to Resident #3 every day because she thought he needed it. Telephone interview with the Administrator on 02/08/23 at 11:17am revealed: -He knew Resident #3's albuterol inhaler was ordered to be given as needed but Resident #3 coughed uncontrollably sometimes so he was given his albuterol every day. -Resident #3 received his albuterol inhaler every morning and every evening. Telephone interview with Resident #3's primary care provider (PCP) on 02/08/23 at 3:07pm revealed albuterol HFA should only be administered as needed if Resident #3 was having shortness of breath. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. _____ The facility failed to ensure residents had their medications available for administration including a resident (#2) that had a history of hypertension and stroke, who was ordered a blood pressure medication to help manage his blood pressure and experienced hypertension in the absence of this medication which placed the resident at increased risk for stroke. Additionally, the facility did not administer a resident's (#3) inhalers as ordered and failed to ensure that a resident (#3) with chronic obstructive pulmonary disease (COPD) had his inhaler available for	{C 330}		

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{C 330}	Continued From page 42 administration which was used to help manage his symptoms. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/07/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 25, 2023.	{C 330}		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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).	{C 342}		

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{C 342}	Continued From page 43 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were complete and accurate for 3 of 3 residents sampled (#1, #2, #3). The findings are: 1. Review of Resident #3's current FL-2 dated 02/08/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD) and schizophrenia. a. Review of Resident #3's current FL-2 dated 02/08/23 revealed there was an order for olanzapine 10mg (Olanzapine is used to treat schizophrenia). Review of Resident #3's January 2023 medication administration record (MAR) revealed: -There was an entry for olanzapine 10mg dissolve 1 tablet by mouth every morning for mood scheduled for administration at 8:00am. -Olanzapine 10mg was documented as administered 01/01/23 to 01/31/23. Review of Resident #3's February 2023 MAR revealed: -There was an entry for olanzapine 10mg dissolve 1 tablet by mouth every morning for mood scheduled for administration at 8:00am. -Olanzapine 10mg was documented as administered 02/01/23 to 02/07/23. Observation of Resident #3's medications on hand on 02/07/23 at 9:55am revealed there was no olanzapine 10mg on the cart. Telephone interview with a pharmacy technician	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 342}	Continued From page 44 at the facility's contracted pharmacy on 02/07/23 at 12:06pm revealed 28 tablets of olanzapine 10mg was last dispensed for Resident #3 on 12/15/22. Interview with the medication aide (MA) on 02/07/23 at 1:50pm revealed she did not know Resident #3 was out of olanzapine. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to interview with the MA on 02/07/23 at 1:50pm. Refer to telephone interview with the Administrator on 02/08/23 at 11:17am. b. Review of Resident #3's primary care provider (PCP) progress notes dated 01/18/23 revealed there was an order for Serevent Diskus 50mcg 1 puff twice a day [Serevent Diskus is used to treat chronic obstructive pulmonary disease (COPD)]. Observation of Resident #3's medications on hand on 02/07/23 at 9:55am revealed there was no Serevent Diskus on the cart for Resident #3. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/07/23 at 12:06pm revealed: -Resident #3's Serevent Diskus was last dispensed on 02/23/22. -Serevent Diskus was not on a cycle refill and the facility would have to request a refill for Resident #3's Serevent Diskus. Review of Resident #3's January 2023 medication administration record (MAR) revealed:	{C 342}		

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{C 342}	Continued From page 45 -There was an entry for Serevent Diskus inhale 1 puff 2 times a day for COPD scheduled for administration at 8:00am and 8:00pm. -Serevent Diskus was documented as administered at 8:00am on 01/01/23 to 01/06/23. -Serevent Diskus was documented as administered at 8:00pm on 01/01/23 to 01/05/23. -Serevent Diskus was not documented as administered at 8:00am on 01/07/23 to 01/31/23 and at 8:00pm on 01/06/23 to 01/31/23. Review of Resident #3's February 2023 MAR revealed: -There was an entry for Serevent Diskus inhale 1 puff 2 times a day for COPD scheduled for administration at 8:00am and 8:00pm. -Serevent Diskus was documented as administered at 8:00am on 02/01/23 to 02/07/23. -Serevent Diskus was documented as administered at 8:00pm on 02/01/23 to 02/05/23. Interview with the medication aide (MA) on 02/07/23 at 1:50pm revealed: -Resident #3's Serevent Diskus inhaler was empty. -She thought the last time she administered Resident #3's Serevent Diskus was sometime in December 2022. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to interview with the MA on 02/07/23 at 1:50pm. Refer to telephone interview with the Administrator on 02/08/23 at 11:17am. 2. Review of Resident #1's current FL-2 dated	{C 342}		

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{C 342}	Continued From page 46	{C 342}		

02/08/23 revealed:
-Diagnoses included major depressive disorder and schizoaffective disorder.
-There was an order for Haldol 50mg intramuscularly every 30 days (Haldol is an antipsychotic medication used to treat schizophrenia).

Review of Resident #1's December 2022 medication administration record (MAR) revealed:
-There was an entry for Haldol 50mg, with instructions to inject 1mL intramuscularly every 30 days.
-It was documented that Resident #1 was out of the facility from 12/01/22 to 12/05/22.
-Haldol 50mg, inject 1 mL intramuscularly every 30 days was documented as administered by the Administrator from 12/06/22 to 12/25/22 at 8am.

Observation of Resident #1's medications on hand on 02/07/23 at 9:38am revealed there was no Haldol liquid medication available for administration.

Interview with the MA on 02/07/23 at 9:45am revealed Resident #2 received his Haldol injections at the hospital.

Interview with Resident #1 on 02/07/23 at 2:40pm revealed he received his Haldol injections at the hospital.

Refer to the interview with the Administrator on 02/08/23 at 11:17am.

3. Review of Resident #2's current FL-2 dated 02/08/23 revealed:
-Diagnoses include hypertension and cerebral vascular accident (CVA).
-There was an order for Lisinopril 10mg daily

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{C 342}	Continued From page 47 (Lisinopril is a medication used to treat hypertension). Review of Resident #2's physician visit note dated 01/18/23 revealed there was an order for Lisinopril 10mg daily. Review of Resident #2's December 2022 medication administration record (MAR) revealed: -There was an entry for Lisinopril 10mg once a day, scheduled for administration at 8:00am. -Lisinopril 10mg was documented as administered from 12/01/22 to 12/31/22 at 8:00am. Review of Resident #2's January 2023 MAR revealed: -There was an entry for Lisinopril 10mg once a day, scheduled for administration at 8:00am. -Lisinopril 10mg was documented as administered from 01/01/23 to 01/31/23 at 8:00am. -Resident #2's daily's blood pressures ranged from 189/104 to 135/59. -There was a handwritten note on the back of the January 2023 MAR by the medication aide (MA) dated 01/02/23 that stated, "all drugs are administered except Lisinopril which was being sent to the pharmacy today". Observation of Resident #2's medications on hand on 02/07/23 at 9:42am revealed there was no Lisinopril available for administration. Interview with the MA on 02/07/23 at 9:45am revealed Resident #2 was out of Lisinopril but she could not recall for how long, at least since the beginning of January 2023. Telephone interview with a pharmacist at the	{C 342}		

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{C 342}	Continued From page 48 facility's contract pharmacy at 02/07/23 at 12:06pm revealed: -The facility faxed the pharmacy an order for Lisinopril 10mg daily on 10/31/22. -The facility dispensed a 7-day supply (7 tablets) of Lisinopril to the facility on 10/31/22. -The pharmacy had not dispensed any Lisinopril to Resident #2 since 10/31/22. Interview with the Administrator on 02/07/23 at 12:45pm revealed: -Resident #2 came to the facility with some medications but he was not sure how many. -He contacted the local Department of Social Services (DSS) to assist with paying for Resident #2's Lisinopril but they were not able to provide any assistance. Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable. Refer to the interview with the MA at 02/07/23 at 1:50pm. Refer to the interview with the Administrator on 02/08/23 at 11:17am. _____ Interview with the medication aide (MA) on 02/07/23 at 1:50pm revealed: -If a resident did not have a medication on the medication cart she would leave the medication entry blank on the medication administration record (MAR) or use a code on the back of the MAR to indicate why the medication was not administered. -She did not know why she documented that medications were administered to the sampled residents that were not at the facility to administer and it was an oversight.	{C 342}		

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{C 342}	Continued From page 49 Telephone interview with the Administrator on 02/08/23 at 11:17am revealed: -He expected the MA to use the correct code on the back of the medication administration record (MAR) if a medication was not administered. -If the MA documented that a medication was administered he assumed the medication was administered to the resident.	{C 342}		
{C 350}	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility 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. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.	{C 350}		

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{C 350}	Continued From page 50 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that 1 of 1 residents sampled (#4) that was self-administering their own insulin injections had an order to self-administer from a prescribing practioner. The findings are: Review of Resident #4's current FL-2 dated 02/08/23 revealed diagnoses included type 2 diabetes mellitus, long term current use of insulin, and schizophrenia. Review of Resident #4's physician progress note dated 01/18/23 revealed: -There was an order for Insulin determir, 15 units to be administered at bedtime (Insulin determir is a long-acting insulin used to manage symptoms of diabetes). -Resident #5's Hemoglobin-A1C was 10.5% (normal range is 4.8-5.6%). Review of Resident #4's facility record revealed there was no order for self-administration of Insulin determir. Observation of Resident #4's medications on hand on 02/07/23 revealed he had Insulin determir available for administration. Interview with the medication aide (MA) on 02/07/22 at 1:45pm revealed: -Resident #4 was ordered insulin daily. -Sometimes she would give Resident #4 his insulin and other times Resident #4 would self-administer the medication. -She was not aware if Resident #4 had an order	{C 350}		

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{C 350}	Continued From page 51 for self-administration of his insulin. Interview with the Administrator on 02/07/22 at 2:20pm revealed: -Resident #4 did not have a self-administration order for the Insulin determir because the MA was administering the medication to the resident. -He was not sure why the MA told the survey team that Resident #4 administered his own Insulin determir. -He thought that the MA may not have understood the question correctly. -He was aware that if Resident #4 was going to administer his own Insulin determir injection that he needed an order. Telephone interview with Resident #4's primary care provider (PCP) on 02/08/23 at 3:08pm revealed: -He was not aware that Resident #4 was self-administering his Insulin determir injections. -When he saw the resident for establishment of care on 01/18/23, he would have expected staff accompanying the resident to inform him that Resident #4 was self-administering the medication. -If he was aware that Resident #4 was self-administering the Insulin determir injections he would have had the resident demonstrate how he was administering the injection. -He was concerned that Resident #4 may not be administering the Insulin determir injection properly since he had an elevated Hemoglobin A1C level. Attempted interview with Resident #4 on 02/07/23 and 02/08/23 were unsuccessful.	{C 350}		

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C 444	Continued From page 52	C 444		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident resulting in medical evaluation for 1 of 3 residents sampled (#1). The findings are: Review of Resident #1's current FL-2 dated 02/08/23 revealed diagnoses included recurrent major depressive disorder remission status and schizoaffective disorder. Review of Resident #1's Accident/Incident Report dated 01/05/23 revealed: -The medication aide (MA) completed the report. -The report stated that Resident #1 called the police without notice. -The report stated that the nature of injury was "gave himself a cut after bedtime". -There was no signature at the bottom of the report where the Administrator was listed to sign.	C 444		

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C 444	Continued From page 53 Review of Resident #1's emergency department (ED) record dated 01/04/23 revealed Resident #1 had attempted suicide and had a neck laceration which required sutures. Interview with the local county Adult Home Specialist (AHS) on 02/07/23 at 2:20pm revealed she did not receive the Accident/Incident report from the facility Resident #1's incident on 01/05/23. Telephone interview with the Administrator on 02/08/23 at 11:15am revealed: -He was responsible for sending Accident/Incident Reports to the local county Department of Social Services (DSS) when a resident was taken to the hospital for medical evaluation. -He did not send the local county DSS Resident #1's Accident/Incident Report to the local county DSS for the 01/05/23 incident. -It was an oversight on his part not to send the report because he was aware that the local county DSS needed a copy of the report.	C 444		