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	HAL008042	A. BUILDING: _____ B. WING _____	R-C 01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted an annual, follow-up and complaint investigation on 01/11/23 to 01/13/23. The complaint investigation was initiated by the Bertie County Department of Social Services on 12/05/22.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that cleaning agents, bleaches and other substances which may be hazardous if ingested were kept in a separate locked area and that cleaning supplies were monitored while in use. The findings are: Observation of the resident's common bathroom cabinet on 01/11/23 at 9:11am revealed: -There was a partial can of polyurethane protectant in the cabinet next to the sink. -There were two partial cans of paint in the	D 056		

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D 056	Continued From page 1 cabinet next to the sink. Observation of the cleaning closet on 01/11/23 at 9:20am revealed: -The door was shut but unlocked. -There were four 2-gallon containers of bleach on the shelf. -There was a 2-gallon container of tile and grout sealer on the floor. -There was a can of lubricant and degreaser above the sink. Observation of the hallway outside of the resident's rooms on 01/11/23 12:50pm revealed: -There was an unattended cleaning cart left in the hallway. -There were cleaning supplies on the cart including window cleaner and bleach. -There were no staff or residents in the hallway. Observation of the activity room on 01/12/23 at 7:40am revealed: -A resident was seated at one of the tables. -The cleaning cart was positioned next to the resident. -The cleaning cart was unattended by staff and there was no staff in the room. Observation of the hallway on 01/12/23 at 8:58am revealed: -A resident was pushing the cleaning cart down the hallway. -The resident asked the medication aide (MA) who was passing medications at the medication cart if she should put the cleaning cart in the laundry room. -The MA told the resident to put the cleaning cart in the laundry room and the resident proceeded to push the cart into the laundry room.	D 056		

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D 056	Continued From page 2 Observation of the cleaning closet on 01/13/23 at 10:05am revealed a resident attempting to get into the closet but the closet was locked. Interview with the resident that was attempting to get into the cleaning closet on 01/13/23 at 10:06am revealed the cleaning closet was normally left unlocked and residents could get supplies out of the closet such as paper towels. Interview with the MA on 01/11/23 at 1:30pm revealed: -The cleaning cart should be left in the laundry closet when not in use. -Residents should not have access to the cleaning closet because of the chemicals that were stored in the closet. -It was important to keep it locked so that residents did not accidentally drink the chemicals. -They had residents with dementia and memory issues so it was important for resident safety that all chemicals remain locked. Interview with the lead MA on 01/13/23 at 3:30pm revealed: -Chemicals should remain locked in the cleaning closet and inaccessible to residents. -She was not aware until yesterday (01/12/23) that there were chemicals in the residents bathroom and that staff was leaving the cleaning closet unlocked. -It was important that chemicals and cleaning agents remain locked for resident safety. -She was not aware of any residents ingesting any cleaning chemicals or using them independently without staff supervision. Interview with the Administrator on 01/11/23 at 4:22pm revealed: -She expected staff to ensure that chemical and	D 056		

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D 056	Continued From page 3 cleaning supplies were locked when not in use. -It was everyone's responsibility to ensure that chemicals and cleaning supplies are locked when not in use. -It was important with the resident population that they had in the facility which included residents with impaired memory to keep chemicals locked for their safety. Interview with the facility's primary care provider (PCP) on 01/12/23 at 2:00pm revealed he expected the facility to keep cleaning agents and chemicals to be locked for resident safety. Request for the facility's policy on storage of chemicals was done on 01/12/23 and 01/13/23. No policy or procedure on the storage of chemicals was provided prior to exit.	D 056		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that it was kept in good repair to include damage to a door, peeling paint on walls, and composite build up on a bathtub/shower used by residents.	D 074		

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D 074	Continued From page 4 The findings are: 1. Observation of the facility's laundry room door on 01/11/23 at 9:25am revealed: -The door was closed and unlocked to the laundry room. -There was a hole approximately 4 inches in circumference next to the door handle. Interview with the medication aide (MA) on 01/11/23 at 1:30pm revealed: -The hole had been there for a couple of weeks. -A staff member that no longer worked at the facility locked the keys in the laundry room and attempted to get into the laundry room by putting the hole in the door. -She was not sure if management was aware of the hole. Interview with the Administrator on 01/12/23 at 4:22pm revealed: -She was not aware of the hole in the laundry room until it was brought to her attention by staff today (01/12/23). -The facility was currently without a maintenance person but was working on obtaining one so that the hole in the door could be repaired. 2. Observation of the facility's laundry room on 01/11/23 at 9:26am revealed: -There was peeling paint above the above the sink underneath the window. -There was peeling paint on the left wall above the washer and dryer. -There was peeling paint on the right wall of the laundry room. Interview with the medication aide (MA) on 01/11/23 at 1:30pm revealed:	D 074		

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-The paint was peeling in the laundry room since before December of 2022.
-The previous Administrator, who left at the end of December 2022 used a family member to do repairs to the facility but she was not sure what the current Administrator's plan was for repair and maintenance.
-She was not sure if management was aware of peeling paint in the laundry room.

Interview with the Administrator on 01/12/23 at 4:22pm revealed:
-She was not aware of the peeling paint in the laundry room until it was brought to her attention by staff today (01/12/23).
-The facility was currently without a maintenance person but was working on obtaining one so that the paint in the laundry room could be sanded and repainted.

3. Observation of a bathroom shared by room 2 and room 4 on 01/11/23 at 9:33am revealed:
-The bathtub had composite buildup around the faucet, faucet handles and drain.
-There was black around the faucet and the drain.
-There were black specked areas and brown discoloration from the faucet, faucet handles that led down to the drain.

Interview with a resident that resided in Room 4 on 01/11/23 at 9:37am revealed:
-The bathtub looked gross and she did not understand why staff had not cleaned it.
-She took showers because she did not want to sit in the discolored bathtub.

Interview with a MA on 01/11/23 at 1:30pm revealed:
-The facility did not have anyone for maintenance

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D 074	Continued From page 6 staff. -She had tried to clean bathtub, but she was unable to remove the discoloration. Interview with the Administrator on 01/13/23 at 1:02pm revealed: -She was not aware of the discoloration of the bathtub shared by residents in room 2 and room 4. -She needed to contact someone that could remove the discoloration in the bathtub. -The bathtub needed to be repaired or replaced so the residents would feel more comfortable using the bathtub.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that the facility was kept clean and orderly related to an infestation of active cockroaches and lack of cleanliness throughout the facility including resident's rooms and activity areas. The findings are:	D 079		

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D 079	Continued From page 7 Review of the facility's environmental sanitation report revealed the facility had a score of 96.0 on 12/02/22. 1. Observations of the facility's activity room: -There were 6 two person tables and 12 chairs on the outside perimeter of the room. -11 residents ate meals in the activity room. -There was a door that led to a resident's bathroom. a. On 01/11/23 at 11:24am there was a cockroach that was crawling on the wall of the activity room. b. On 01/11/23 at 1:55pm there was a cockroach that was crawling across the floor of the activity room. c. On 01/11/23 at 2:32pm there was a cockroach that crawled out from under the door of the resident's bathroom that connected to the activity room. d. On 01/12/23 at 9:26am revealed there was a cockroach that crawled up the back of a surveyor who was seated on a chair and then the cockroach retreated back into the cushion of the seat. e. On 01/12/23 at 10:00am revealed there was a cockroach crawling below the window on the wall. f. On 01/13/23 at 11:50am revealed there was a cockroach on the wall next to the window that ran into the heating element below the window. g. On 01/13/23 at 2:50pm revealed there was a cockroach crawling on the floor that ran under the door that connected to the resident's bathroom.	D 079		

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D 079	Continued From page 8 h. On 01/13/23 at 4:29pm during the exit conference with the facility team including the Administrator, lead medication aide (MA) and MA there was a cockroach that ran across the floor and was killed by the MA. Observation of the activity supply closet in the main lobby next to the kitchen on 01/12/23 at 10:37am revealed there were five dead roaches at the front of the closet on the floor. Interview with a resident on 01/12/23 at 4:45pm revealed: -The facility had a "problem with bugs". -She saw bugs in her room and in the common rooms including the room where she ate meals. -The facility had an exterminator come out, but she could not remember when. -There was not much improvement, if any since the exterminator was there. -It was "gross and disgusting" to have bugs crawling on the wall, floors, and everywhere. Interview with a second resident on 01/13/23 at 8:55am revealed: -She saw cockroaches every day in the facility. -They were in the common room, the activity room, bathroom, and her room. -She was not sure what the facility were doing to take care of the bug problem. -The facility staff was aware of the problem because they were seeing them. Interview with a personal care aide (PCA) on 01/12/23 at 4:12pm revealed: -She saw roaches in the facility a lot. -She had recently observed roaches in the dining room and family room.	D 079		

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Telephone interview with the previous Administrator on 01/12/23 at 10:50am revealed:
-There were cockroaches in the kitchen and the resident's rooms.
-The previous facility owners had an exterminator that would come to the facility, and she thought the last time they were there was in October of 2022.
-The facility staff noticed cockroach activity and she notified the new owner of the problem around November 2022.
-The new owner approved her calling a new terminator company because she did not want to renew the contract with the current company that ended in October of 2022.
-She called a new exterminator company, and they came to give the facility a quote at the end of December 2022.

Interview with the Administrator on 01/12/23 at 10:35am revealed:
-She was not sure why the new exterminator company was called to do a second treatment.
-She thought that maybe the owner was notified that staff were still seeing bugs and that might be why they were called.

Telephone interview with the facility's pest management control company secretary on 01/12/23 at 10:00am revealed:
-The facility contacted the company in December to come do a quote for pest management.
-The first time the exterminator company came to spray the facility was on 12/30/22.
-The facility was scheduled for a "re-service" spray tomorrow 01/13/23.

Telephone interview with the exterminator at the facility's current pest management control company on 01/12/23 at 10:20am revealed:

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-He was the technician that sprayed the facility on 12/30/22.
-There was an infestation of cockroaches in the facility.
-There was a large number of cockroaches found in the activity closet near the kitchen.
-It would take several service visits to get the facility pest free.
-He instructed the previous Administrator that if they still had active cockroaches 7-10 days after the initial treatment on 12/30/22 to call them to schedule a re-service.
-It was important that the facility was kept clean to ensure that they could control the infestation.
-There should be no food particles on the floor.

Interview with the facility's primary care provider (PCP) on 01/12/23 at 2:00pm revealed:
-He did not recall seeing cockroaches in the facility, but he did notice flies throughout the facility.
-He expected the facility to provide the residents with a home that was free of cockroaches.
-It was important for the facility to be free of cockroaches to reduce the risk of contamination.

2. Observation of the facility's activity room off of the common area on 01/12/23 at 11:59am revealed there were particles of food and debris on the ground around the tables.

Observation of a bathroom suite for resident rooms 2 and 4 on 01/11/23 at 9:32am revealed:
-There was a 6 quart trashcan to the left of the sink that was full.
-There was a one gallon bucket to the left of the sink that was full.
-There was an empty toilet paper roll behind the door.
-There was a wet towel on the floor beside the

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D 079	Continued From page 11	D 079		

bathtub and to the right of the toilet.
-There were two used blue vinyl gloves in the windowsill to the left of the sink; one to the far left of the window sill and the second glove in the middle of the window sill.
-There was a purple shower loofah mesh netting hanging from the hot water bathtub faucet that had black stains on the bottom.

Observation of the laundry room on 01/11/23 at 9:24am revealed:
-There was a dark gray wet mop leaning against the wall with the mop head on the floor by the washing machine.
-There was a mop bucket on a housekeeping cart that had dark gray water in the mop bucket.
-There was a mop in the dirty water in the mop bucket; the mop head was dark gray.

Observation of the laundry room on 01/12/23 at 10:32am revealed:
-There was a dark gray wet mop leaning against the wall with the mop head on the floor by the washing machine.
-There was a mop bucket on a housekeeping cart that had dark gray water in the mop bucket.
-There was a mop in the dirty water in the mop bucket; the mop head was dark gray.

Observation of the utility closet on 01/12/23 at 10:29am revealed there were 5 new mop heads that were in the original packaging.

Interview with a medication aide (MA) on 01/11/23 at 1:30pm revealed:
-She always changed the mop bucket water after she mopped.
-She was not sure why the water in the mop bucket was so dirty.
-The mop bucket should have been emptied after

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D 079	Continued From page 12 staff mopped the floors. Interview with a medication aide (MA) on 01/11/23 at 1:30pm revealed: -There was no housekeeper for the facility. -There was no specific schedule for cleaning of resident rooms or any common areas. -Staff just "helped out by cleaning" when they had extra time. -The facility had been without a housekeeper for approximately 2 months. -MAs and personal care aides (PCAs) tried to clean the resident rooms as time allowed. Interview with a resident on 01/12/23 at 4:45pm revealed: -There was no housekeeper at the facility. -The facility had been without a housekeeper since December of 2022. -She had to take out the trash in her room and dump it in the trash can next to the kitchen. Interview with a cook on 01/13/23 at 10:30am revealed: -She was responsible for wiping down the tables in the activity room and common room where the residents ate after meals. -She was not sure who was responsible for mopping the floor. -She was not sure if there was a housekeeper or not currently, but she had not seen one. Interview with the Administrator on 01/13/23 at 2:20pm revealed: -There were in the process of hiring a full time housekeeper for the facility. -Until then, she expected the facility staff to maintain a clean environment for the residents. The facility failed to ensure the facility was clean	D 079		

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D 079	Continued From page 13 and protected from pests including cockroaches in resident's rooms and common areas resulting in active infestation in the facility. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2023.	D 079		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide the residents with soap, hand towels and toilet paper. The findings are: Observation of the resident's common bathroom on 01/11/23 at 9:11am revealed: -There were three toilet stalls in the bathroom. -There was no toilet paper in the toilet stall closet	D 080		

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D 080	Continued From page 14	D 080		

to the door.
-There was no toilet paper in the middle toilet stall.
-There was a partial roll of toilet paper on the windowsill in the far toilet stall.
-There was a hand soap dispenser above the sink that was empty.

Observation of the hallway sink on 01/11/23 at 9:15am revealed there were no paper towels in the paper towel dispenser.

Interview with a resident on 01/11/23 at 10:10am revealed:
-She did not have a bathroom in her room, so she used the common bathroom.
-There was never any soap to wash her hands at the sink.
-She had hand sanitizer in her room to use.
-It was "hit or miss" if there was toilet paper in the bathroom.
-She would tell staff that they did not have any toilet paper in the bathroom and sometimes staff would give her a roll to keep with her.

Interview with a second resident on 01/11/23 at 4:45pm revealed:
-She shared a bathroom with her roommate and the resident's next door.
-She had her own soap supply for her bathroom and would ask for toilet paper to put in their bathroom when they needed it.
-She did not like using the common bathroom when their personal bathroom was being used because there was never any toilet paper or soap there.
-She would take down some of her own toilet paper to use if she had to go to the common bathroom.

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D 080	Continued From page 15 Interview with a personal care aide (PCA) on 01/11/23 at 9:35am revealed: -The hallway sink was mainly used to wash hands. -She was not sure who was responsible for making sure that the resident's common bathroom and hallway sink were stocked with soap and paper towels. -She had residents ask about getting toilet paper and she would give them a roll when they needed. -She did not know who was responsible for making sure that the resident's bathrooms, including the common bathroom, were stocked with toilet paper. Interview with a medication aide (MA) on 01/11/23 at 1:30pm revealed: -It was everyone's duty to make sure that resident's bathrooms were stocked with soap, toilet paper and paper towels. -There were currently without a housekeeper and had been for about 3 months. -Housekeeping was normally responsible for making sure that there was soap in the dispensers at the sink. -It would be important to have soap in the bathroom so the residents could wash their hands and have access to toilet paper when they were using the bathroom. Interview with the Administrator on 01/11/23 at 4:22pm revealed: -She was not aware that there was not any toilet paper in 2 of the 3 common bathroom stalls. -Staff was all responsible for ensuring that when they noticed there was no toilet paper or soap that it should be restocked immediately. -There was a supply of toilet paper, paper towels, and soap at the facility that the staff has access	D 080		

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D 080	Continued From page 16 to. Interview with the facility's primary care provider (PCP) on 01/12/23 at 2:00pm revealed: -He expected the residents to have toilet paper available next to the commode in all of their bathrooms. -He expected the residents to have soap available at the bathroom sink to wash their hands to prevent spread of infection and bacteria. -He expected the residents to have towels available to dry their hands in the bathroom. -He expected residents to have necessities including toilet paper, soap, and paper towels available to them at all times.	D 080		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that hot water temperatures were maintained at 100 to 116 degrees Fahrenheit (F) for 20 residents. The findings are:	D 113		

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D 113	Continued From page 17 Review of the inspection report that was completed on 12/02/22 from the local health department (LHD) revealed: -The hot water temperature for all resident's rooms was 64 degrees F. -The hot water temperature for the sink in the hallway was 63 degrees F. -The hot water temperature for the resident's common bathroom was 64 degrees F. Interview with the facility manager on 12/06/22 at 1:00pm revealed: -The sink in the kitchen operated on a different gas line. -The gas company reported that the facility needed a new gas water heater tank. -She had contacted a plumber and was waiting for the new gas water heater tank to be delivered to the plumbing company. -The water heater had been out since 11/18/22. -She could not locate the monthly water log for the residents' rooms. Review of an invoice from the plumbing company on 12/06/22 at 2:00pm revealed: -The facility ordered a new gas water heater tank on 11/30/22. -The due date to complete the sale was 12/15/22. Interview with the inspector from the LHD on 12/07/22 at 9:32am revealed: -The sink in the kitchen had hot water. -He was informed by the facility manger that the gas water heater tank was not working. -The facility was waiting to receive the new gas water heater tank. -He reported a scheduled follow-up appointment on 12/09/22. Interview with the inspector from the LHD on	D 113		

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D 113	Continued From page 18 12/13/22 at 9:16am revealed: -He completed a follow-up. -He tested the hot water in the all the resident's rooms, the sink in the hallway and the sink in the resident's common bathroom. -He reported 107.5 degrees F for the hot water in the resident 's rooms. -He reported 108 degrees F for hot water in the hallway and for the resident common bathroom. Observation of resident room #6 on 01/11/23 at 9:15am revealed the hot water temperature at the sink was 90.8 degrees F. Observation of resident room #4 on 01/11/23 at 9:17am revealed the hot water temperature at the sink was 95 degrees F. Observation of handwashing sink in the hallway on 01/11/23 at 12:51pm revealed the hot water temperature at the sink was 89 degrees F. Observation of resident room #7 on 01/11/23 at 12:55pm revealed the hot water temperature at the sink was 82 degrees F. Observation of resident room #5 on 01/11/23 at 12:59am revealed the hot water temperature at the sink was 79 degrees F. Interview with a resident on 01/12/23 at 4:45pm revealed: -There was a time when there was no hot water in her bathroom for 3 weeks. -There was hot water available in the kitchen but not in the resident's common bathroom or personal bathrooms. -She brought it to management's attention and was told to take the hot water from the kitchen to her room in a basin to take a bath.	D 113		

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-After 3 weeks, the resident contacted the local ombudsman to get help with getting hot water around the end of November 2022.
-Shortly after she contacted the ombudsman, the new owners bought a new water heater for the residents bathrooms.

Interview with the medication aide (MA) on 01/11/23 at 1:30pm revealed:
-She was not sure who was currently responsible for checking the water temperatures at the facility.
-She and other staff members were doing them daily up until November of 2022.
-When she was checking water temperatures in November of 2022 they ranged between 110-117 degrees F.

Telephone interview with the previous Administrator on 01/12/23 at 10:50am revealed:
-The residents bathrooms were on a different water heater than the kitchen.
-The kitchen water heater was electric and the rest of the facility was on a gas heater.
-She was told by the new owners to shut off the water heater for the residents because "it smelled like gas".
-The residents' bathrooms were without water for 3 weeks.
-In order for the residents to get hot water for personal care, they would have to get water from the kitchen.

Interview with the Administrator on 01/12/23 at 4:22pm revealed:
-She spot checked the water temperatures at the facility whenever she came to the facility.
-She did not keep a log of the water temperature checks that she performed.
-She was not sure when she checked the water temperature last but every time she checked the

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D 113	Continued From page 20 water temperature it was between 110-115 degrees F. -She was not aware that there were any current issues with low water temperature. -No staff or residents made her aware of any issues with the new water heater. A second interview with the Administrator on 01/13/23 at 2:20pm revealed she reached out to the water heater manufacturer for information on adjusting the water temperature at the facility. Interview with the facility's primary care provider on 01/12/23 at 2:00pm revealed he expected the residents to have hot water at the facility for purposes of personal care and infection control.	D 113		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care based on resident's needs for 1 of 4 residents sampled (#6) related to fingernail care. The findings are:	D 269		

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D 269	Continued From page 21 Review of Resident #6's current FL-2 dated 11/09/22 revealed: -Diagnoses of diabetes, hypertension, and lower left leg amputee. -He was ambulatory with his wheelchair. Review of Resident #6's care plan dated 11/09/22 revealed: -He required total assistance with bathing, grooming, dressing and toileting. -He required limited assistance with ambulating and transferring. Observation of Resident #6 on 01/12/23 at 11:44am revealed: -He was in the community room waiting for lunch to be served. -He was in a wheelchair and self-propelled to his table. -His fingernails were dirty, overgrown and had a brown substance at his cuticles. -The left thumb was 1/2 inch long extended from his fingertip with dark yellow discoloration. -The first and second finger was ¼ inch long extended from his fingertip with a black substance under the nail. -The third and fourth fingers were 1/2 inch long extended from his fingertip with a black substance built up underneath them. -The fifth finger was ¼ inch long extended from his fingertip with a black substance under the nail. -The right thumb was 1/2 inch long extended from his fingertip with a black substance under the nail. -The first finger had a sticky substance on top of the nail with a black substance underneath the nail. -The second, third and fifth fingers were ¼ inch long extended from his fingertip with a black substance under the nail.	D 269		

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D 269	Continued From page 22 Interview with Resident #6 on 01/12/23 at 11:44am revealed: -He could not remember the last time he washed his hands. -He could not remember a time that staff had cleaned and trimmed his fingernails. -The personal care aide (PCA) bathed him three times a week but did not scrub under his fingernails. Interview with a personal care aide (PCA) on 01/12/23 at 4:12pm revealed: -Resident #6 had food underneath his fingernails often. -She did not know why his fingernails had a black substance built up underneath his nails. -The 2nd shift PCA was responsible for bathing Resident #6. -She tried to provide all residents with hand sanitizer prior to their meal. Interview with the lead medication aide (MA) on 01/13/23 at 3:33pm revealed: -PCAs were responsible for cleaning resident's fingernails during personal care. -She was not aware that Resident #6 's fingernails were so dirty. -PCAs had a nail brush to clean under residents fingernails to ensure they were clean. -She was concerned that the resident could become sick from unclean fingernails and was concerned that if the fingernails were not clean that the rest of their body may not be clean. Interview with the Administrator on 01/13/23 at 3:00pm revealed: -Facility staff provided manicures to all residents at least once a month during activities. -PCAs were expected to clean resident's fingernails during their regular shower days.	D 269		

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D 269	Continued From page 23 -She was not aware that Resident #6's fingernails were so dirty. -She expected staff to ensure all residents fingernails were clean to prevent infection. Interview with Resident #6's primary care provider (PCP) on 01/12/22 at 2:00pm revealed: -He expected staff to keep residents' fingernails clean and trimmed. -Resident #6 was totally dependent on staff for assistance with bathing. -He was concerned that Resident #6's fingernails had an excessive amount of a black substance built up under his fingernails. -It was important for staff to properly clean the residents' fingernails when they were bathed to help reduce infection.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision for 3 of 6 residents (#2, #5, and #6) related to a resident who had multiple falls resulting in injuries including a closed head injury and fractured nose (#5); a resident who had two falls, one of which	D 270		

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required the resident to be sent to the emergency room(#6); and a resident with two unwitnessed falls (#2).

The findings are:

A facility policy on Fall Prevention was requested on 01/11/23 at 3:49pm, 01/12/23 at 4:24pm, and 01/13/23 at 12:42pm, and it was not received prior to exit.

1. Review of Resident #5's current FL-2 dated 11/09/22 revealed:
-Diagnoses included schizophrenia and anxiety.
-The resident was ambulatory.

Review of Resident #5's care plan dated 11/09/22 revealed the resident was independent with ambulation, transferring, dressing, bathing, toileting, and grooming.

a. Review of Resident #5's incident and accident report dated 11/17/22 at 7:45pm revealed:
-Resident #5 was observed by a medication aide (MA) walking toward the front door and noticed the resident's balance was "off."
-The MA called out to the resident to see if he was okay.
-The resident fell on the floor and hit his head and back on the floor.
-The MA documented that the resident's communication was unclear.
-The MA called for Emergency Medical Services (EMS) and the resident was transported to a local emergency room (ER).

Review of Resident #5's hospital discharge summary dated 11/17/22 revealed:
-He had a discharge diagnosis of an accidental fall.

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-The resident was to follow up with the ER if symptoms worsen.

Review of Resident #5's resident record on 01/12/23 revealed there were no progress notes available on his fall on 11/17/22; and there was no documentation of interventions put in place to ensure the resident's safety.

Interview with a medication aide (MA) on 01/11/23 at 1:49pm revealed:
-She observed Resident #5 fall on 11/17/22.
-The resident was walking toward the front door of the lobby, his legs became weak, and he appeared to have difficulty walking.
-She contacted EMS, and the resident was transported to the local ER.

b. Review of Resident #5's incident and accident report dated 11/21/22 at 3:00pm revealed:
-Resident #5 was found by a medication aide (MA) in his bathroom on the floor.
-The MA notified the Administrator and called EMS.
-The MA administered first aid to stop the bleeding; however, there was no documentation on the incident and accident report of what injuries the resident sustained.
-The resident returned from the ER to the facility on 11/21/22.
-The resident would be monitored every hour and the MA would inform the next shift MA to monitor the resident.

Review of Resident #5's hospital discharge summary dated 11/21/22 revealed he had a discharge diagnosis of an accidental fall with a closed head injury and broken nose.

Review of Resident #5's resident record on

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01/12/23 revealed there were no progress notes available on his fall on 11/21/22; and there was no documentation of interventions put in place to ensure the resident's safety.

Interview with a medication aide (MA) on 01/11/23 at 1:49pm revealed:
-MAs documented updates on residents on a shift report form that was kept in a binder in the medication room.
-The facility did not have a log where staff documented increased checks on residents.
-The shift report binder was used as a communication tool to ensure the MA that was coming on duty was updated and any resident changes.

c. Review of Resident #5's incident and accident report dated 12/04/22 at 12:45pm revealed:
-Resident #5 was found by a personal care aide (PCA) on the floor in his bedroom.
-A MA documented that numerous times the resident was laying on his bed with his feet on the floor and attempted to get out of his bed.
-The MA observed the resident almost sliding out of the bed.
-The MA called EMS and the Administrator; the resident was transported to the hospital.

Review of Resident #5's hospital discharge summary dated 12/07/22 revealed he had a discharge diagnoses of acute kidney failure and sepsis.

Review of Resident #5's resident record on 01/12/23 revealed there were no progress notes available documenting he fell on 12/07/22; and there was no documentation of interventions put in place to ensure the resident's safety.

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Attempted interview with Resident #5 on 01/11/23 at 1:20pm and on 01/13/23 at 2:00pm were unsuccessful.

Interview with a MA on 01/12/23 at 3:35pm revealed:
-Resident #5 would become weak at times and had a history of falls.
-Staff checked on him at least every hour.

Refer to interview with a PCA on 01/12/23 at 4:12pm.

Refer to interview with a medication aide (MA) on 01/12/23 at 3:55pm.

Refer to interview with the Lead MA on 01/12/23 at 10:10am.

Refer to interview with the Administrator on 01/13/23 at 3:00pm.

Refer to interview with the primary care provider (PCP) on 01/12/23 at 2:00pm.

2. Review of Resident #6's current FL-2 dated 11/09/22 revealed:
-Diagnoses included diabetes, hypertension, and lower left leg amputee.
-He was ambulatory with his wheelchair.

Review of Resident #6's care plan dated 11/09/22 revealed:
-He required total assistance with bathing, grooming, dressing and toileting.
-He required limited assistance with ambulating and transferring.

a. Review of Resident #6's progress note dated 12/01/22 revealed:

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-The 3rd shift medication aide (MA) documented that Resident #6 was very unbalanced and could not stand to transfer to his wheelchair.
-Resident #6 fell backwards while trying to get into his wheelchair.
-There was no documentation of any intervention provided by facility staff to prevent his fall.

Review of Resident #6's resident record revealed there was no incident and accident report for 12/01/22 or documentation of interventions implemented to ensure the resident's safety after he fell on 12/01/22.

b. Review of Resident #6's progress note dated 12/04/22 revealed:
-The 1st shift MA documented that the resident kept falling on the floor because he was transferring from his wheelchair without locking the wheels.
-There was no documentation of any intervention provided by facility staff to prevent the falls.
-The 3rd shift MA documented that the resident was sent to the hospital.

Review of Resident #6's resident record revealed there was no incident and accident report for 12/04/22 or documentation of interventions implemented to ensure the resident's safety after he fell on 12/04/22.

Refer to interview with a PCA on 01/12/23 at 4:12pm.

Refer to interview with a medication aide (MA) on 01/12/23 at 3:55pm.

Refer to interview with the Lead MA on 01/12/23 at 10:10am.

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D 270	Continued From page 29 Refer to interview with the Administrator on 01/13/23 at 3:00pm. Refer to interview with the primary care provider (PCP) on 01/12/23 at 2:00pm. _____ Interview with a personal care aide (PCA) on 01/12/23 at 4:12pm revealed: -She checked on residents every 2 hours; unless they had a fall, she would check on the resident every hour. -The MA would let her know if a resident was on hourly checks or monitoring instead of every 2 hours. -She had never had a time that she needed to check on a resident every 15 minutes or 30 minutes. Interview with a MA on revealed 01/12/23 at 3:35pm revealed: -Resident #5 would become weak at times and had a history of falls. -Staff checked on him at least every hour. -Staff used to keep a record of increased supervision; however, they had not kept a log of increased supervision for any residents for the past two months. -She checked on all residents every 2 hours; however the PCA would check on residents every hour if they had a fall. Interview with the Lead MA on 01/12/23 at 10:10am revealed: -She had worked at the facility since 12/22/22. -She thought that the facility needed two PCAs on first and second shift to help with supervision. -She was not aware of any residents that had been on increased supervision since she had started working at the facility.	D 270		

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-She was not aware of a fall log or an increased supervision list for residents that had falls.

Interview with the Administrator 01/13/23 at 3:00pm revealed:
-There was not currently a policy in place to increase supervision for residents that had frequent falls.
-The facility did not have a way to inform PCAs and MAs that a resident was at risk of a fall.
-She was concerned that staff had not provided increased supervision for residents at risk of falls due to the risk of additional falls.
-She was concerned that increased supervision for falls had not been immediately addressed by MAs and PCAs to ensure the residents safety.

Interview with the primary care provider (PCP) on 01/12/23 at 2:00pm revealed:
-He expected staff to notify him when a resident had a fall so he could be aware of any unmet needs and order physical therapy.
-He expected staff to increase supervision of residents that had a fall to ensure their safety and prevent future falls.
-He was not aware that the facility did not have a procedure in place to monitor residents for increased falls.

3. Review of Resident #2's current FL-2 dated 11/09/22 revealed:
-Diagnoses included muscle weakness, epilepsy, hypokalemia, cirrhosis of liver, and emphysema.
-Resident #2 used a rollator walker to assist with mobility.

Review of Resident #2's assessment and care plan dated on 11/09/22 revealed:
-Resident #2 required supervision with ambulation seven days a week.

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D 270	Continued From page 31 -Resident #2 had significant deficits in self-care and mobility. Observation on 01/13/23 at 12:15pm revealed he ambulated in his wheelchair and was able to eat independently. Interview with Resident #2 on 01/13/23 at 12:30pm revealed: -A personal care aide (PCA) assisted him with bathing and dressing. -He used a bell to request assistance. Review of Resident #2's personal care services report for the month of December 2022 revealed Resident #2 required limited assistance with toileting, bathing, dressing and ambulating. Review of Resident #2's fall log on 01/13/23 revealed: -Resident #2 was found on the floor by the trash can on 12/10/22. -Resident #2 was found on the floor in the sitting area when reaching for an apple from another resident on 12/10/22. -Resident #2 was getting out of the bed and he slipped and fell when reaching for the wheelchair on 12/27/22. Review of Resident #2's resident record revealed there was no incident and accident report for 12/10/22 or 12/27/22; or documentation of interventions implemented to ensure the resident's safety after he fell on 12/10/22 and 12/27/22. Review of Resident #2's record on 01/12/23 revealed: -There were no progress notes available regarding his fall on 12/10/22 and 12/27/22.	D 270		

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D 270	Continued From page 32 -There was no documentation of interventions put in place to ensure the resident's safety. Interview with first shift PCA on 01/13/23 at 2:00pm revealed: -She assisted Resident #2 with self-care and toileting. -She denied having to assist with ambulation. -She checked on Resident #2 every 2 hours. Interview with the lead medication aide (MA) on 01/13/23 at 12:30pm revealed: -The PCA was responsible for supervising the residents. -The PCA was required to assist Resident #2 with ambulation. -Resident #2 did not use the bell to request assistance. Interview with the Administrator on 1/13/23 at 3:27pm revealed: -She expected the PCA to assist Resident #2 with ambulation. -She expected the PCA to complete 2 hour monitoring checks. _____ The facility failed to provide supervision for a resident which resulted in a resident sustaining 3 falls from 11/17/22 to 12/04/22, one resulting in a closed head injury and a fractured nose (#5), and the primary care provider (PCP) expected staff to increase supervision to prevent additional falls. This failure of the facility placed the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/12/23 for this violation.	D 270		

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D 270	Continued From page 33 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 12, 2023.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to initiate Cardio-Pulmonary Resuscitation (CPR) in accordance with facility policy and procedure for a resident (#4) who was unresponsive, without a pulse and not breathing and pronounced dead on arrival (DOA) by the local emergency medical service (EMS). The findings are: Review of Resident #1's current FL-2 dated 10/26/22 revealed diagnoses included coronary obstructive pulmonary disease (COPD), hypertension, heart failure, neuropathy, bilateral	D 271		

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below knee amputee (BKA), phantom limb syndrome, depressive disorder, and peripheral vascular disease.

Review of Resident #1's Resident Register, no date, revealed an admission date of 10/21/22.

Review of the facility's Cardio-Pulmonary Resuscitation Policy (CPR) (no date) revealed :
-The first staff member on the scene assumes control of the facility's response.
-Approach the victim and gently shake them while asking, "Are you all right?"
-If the victim does not response Call for HELP.
-If you are alone, call for help first, then start CPR if needed.
-Dial 911 immediately.
-All residents are considered to be a full code unless the resident has a Do NOT Resuscitate (DNR) order or is under hospice care.

Review of the Department of Health and Human Services (DHHS) Death Report dated for Resident #4 revealed:
-A death report dated 12/29/22 was submitted to the Department of Health Service Regulation (DHSR) Complaint Intake Unit by the former Administrator.
-The resident was discovered dead by the facility on 12/24/22 at 5:00pm.
-The resident was lying in his bed in his room.
-The first person to discover the resident dead was the cook.
-The cook notified the former Administrator that she could not wake Resident #4.
-The Administrator assessed the resident determined he was dead and called Emergency Medical Service (EMS) and the local police department.
-The county department of social services was

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notified of the death.
-The cause of the resident's death was unknown.

Review of the local EMS report dated 12/24/22 revealed:
-The EMS was called to the facility on 12/24/22 at 5:07pm and arrived at 5:13pm due to male patient unresponsive, not breathing and cold to touch.
-The police department was dispatched to the facility on 12/24/22 at 5:09pm and arrived at 5:18pm.
-Resident #4 was found lying in bed, unresponsive, not breathing, cold to touch, eyes open and dry, and skin color pale.
-Resident #4 had not been seen by facility staff since 6 hours prior to being found unresponsive.
-The initial clinical impression was Resident #4 was dead without resuscitation efforts.
-Resident #4 was assessed to be asystole (heart not beating) and time of death was declared at 5:16pm.
-Resident #4's body was transported to the hospital morgue.

Review of Resident #4's death certicate dated 01/30/23 revealed:
-The date of death was 12/24/22.
-The immediate cause of death was cardiopulmonary failure.

Review of the former Administrator's CPR certification revealed she was trained in CPR and her certification was active when Resident #4 was found unresponsive on 12/24/22.

Interview with the Cook on 01/12/22 at 4:40pm revealed:
-She worked at the facility on 12/24/22 from 4:00pm to 6:00pm.

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-Resident #4 told her he did not feel well that day.
-He did not eat breakfast or lunch on 12/24/22, which was unusual for him.
-She noticed he had not come to the dining area for dinner.
-She went to his room around 5:00pm to inform him that dinner was ready.
-She called out his name and gently touched him but could not arouse him.
-She immediately went to inform the former Administrator that she could not arouse Resident #4.
-The former Administrator determined he was dead because he was cold to touch, pale, and not breathing.
-Cardio-Pulmonary Resuscitation (CPR) was not initiated.
-The former Administrator called 911.

Telephone interview with the former Administrator on 01/11/23 at 10:50am revealed:
-She worked at the facility on 12/24/22 on the 2nd shift (3:00pm-11pm).
-She was in the office when the cook notified her that Resident #4 could not be aroused.
-She went to the resident's room and found him lying in bed, skin cold to touch, eyes set, and he had no pulse (heart beat).
-It was around 5:00pm.
-She immediately called 911 and the police.
-Resident #4 was a full code.
-She did not initiate CPR because the resident was obviously dead because he was cold to touch and had no pulse.
-She did not tell the EMS Resident #4 was a full code.

Telephone interview with an EMS personnel on 01/13/23 at 12:54pm revealed:
-The facility should first follow their policy

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regarding CPR.
-Chest compressions should be initiated until EMS arrive, if the resident was a full code, unresponsive and not breathing, even though they may think the resident was dead.
-Only authorized personnel could pronounce a resident deceased.

Interview with the medication aide (MA) on 01/22/23 at 1:30pm revealed:
-She worked on 12/24/22 on the 2nd shift (3:00pm to 11:00pm).
-She checked on Resident #4 at about 4:00pm on 12/24/22.
-She observed the resident lying in bed with his eyes closed and breathing.
-She was out of the facility around 4:30pm on 12/24/22 to run an errand for the facility.
-The former Administrator texted her around 5:00pm with the message to call her as soon as possible.
-The former Administrator asked her when was the last time she had checked on Resident #4 because he was found to be unresponsive, cold to touch, and not breathing.
-She told the Administrator she had checked on Resident #4 around 4:00pm and he was lying in bed with eyes closed, but breathing.
-The outgoing 1st shift MA told her that Resident #4 had not been feeling well that day.
-She did not know if CPR was administered, but he was a full code.
-When she got back to the facility, the EMS had arrived.

Interview with the Lead MA on 01/13/23 at 3:30pm revealed:
-She did not work on 12/24/22 on the 2nd shift when Resident #4 passed.
-If the resident was not DNR (Do not resuscitate),

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D 271	Continued From page 38 she would expect CPR to be administered per facility policy. -Staff should have administered CPR to Resident #4 until EMS arrived. Interview with the Administrator on 01/13/23 at 2:50pm revealed: -Staff should follow facility policy and procedure regarding CPR. -Facility policy was to start CPR when a resident was a full code and found to be unresponsive and not breathing. -She expected all facilty staff to be CPR trained. -Staff should have initiated CPR to Resident #4. Interview with the Registered Nurse Consultant on 01/13/23 at 12:05pm revealed: -She provided clinical education and training to facilty staff. -Staff should follow facility policy and procedure and CPR guidelines. -She expected CPR to have been initiated to Resident #4 until EMS arrived. _____ The facility failed to ensure Cardio-Pulmonary Resuscitation (CPR) efforts were initiated in accordance with facility policy and procedure to a resident who was a full code and was found unresponsive and not breathing by facility staff. The resident was pronounced dead upon arrival by the emergency medical service (EMS) (#4). This failure resulted in neglect to the resident and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY	D 271		

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D 271	Continued From page 39 12, 2023.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure physician notification and referral for 3 of 5 sampled residents (#2, #3, #4), including a resident who complained of not feeling well and complained of chest pain, and was not sent to the emergency department for evaluation and management and was later found unresponsive, and not breathing and pronounced dead upon the arrival of the emergency medical service (#4); a resident who was admitted to the Emergency Room (ER) for a seizure and had a referral to a neurologist that was not scheduled (#2); and a resident who was ordered fingerstick blood sugars but failed to ensure that the resident had a glucometer (#3). The findings are: 1. Review of Resident #4's current FL-2 dated 10/26/22 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, heart failure, neuropathy, bilateral below knee amputee (BKA), phantom limb syndrome, depressive disorder, and peripheral vascular disease. Review of Resident #1's Resident Register, no	D 273		

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D 273	Continued From page 40 date, revealed an admission date of 10/21/22. Review of a shift communication report revealed: -The medication aide (MA) and personal care aide (PCA) documented on 12/24/22, lst shift (7:00am-3:00pm) that Resident #4 had complained of a "stiff neck." -There was no documentation of physician notification. Interview with the Cook on 01/12/23 at 4:40pm revealed: -Resident #4 had complained of not feeling well for about a week leading up to Christmas. -She noticed he constantly held his head down while sitting in his wheel chair in the dining room or on the front porch. -She worked at the facility on 12/24/22 from 7:00am to 9:00am, from 10:00am to 1:30pm and from 4:00pm to 6:00pm. -The resident complained of chest, neck, and shoulder pain and told her he did not feel well on 12/24/22. -She notified the MA on the 7:00am-3:00pm shift that the resident was not feeling well. -The MA asked the resident if he wanted to go out to the ER, he said no. -He did not eat breakfast or lunch on 12/24/22, which was unusual for him. -She noticed he had not come to the dining area for dinner. -She went to his room around 5:00pm to inform him that dinner was ready. -She called out his name and gently touched him but could not arouse him. -She immediately went to inform the former Administrator that she could not arouse Resident #4. -The former Administrator determined he was deceased because he was cold to touch, pale,	D 273		

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and not breathing.
-The former Administrator called 911.

Telephone interview with the former Administrator on 01/11/22 at 10:50am revealed:
-She worked at the facility on 12/24/22 on the 2nd shift (3:00pm-11:00pm).
-She was informed by the 1st shift (7:00am-3:00pm) MA that Resident #4 was not feeling well that day.
-She did not recall any staff notifying her before that day on 12/24/22 that Resident #4 had not felt well and complained of chest pain.

Interview with Resident #4's roommate on 01/13/23 at 10:39am revealed:
-Resident #4 told him that he was not feeling well on 12/24/22 and was going to bed.
-The resident complained he had a "cramp" in his neck.
-He noticed the resident had a difficult time getting out of his wheelchair and into his bed.
-Resident #4 got in his bed around mid-day on 12/24/22.
-He did not know if the resident told anyone he was not feeling well.

Interview with a personal care aide (PCA) on 01/12/23 at 8:10am revealed:
-She was not working on the evening of 12/24/22 when Resident #4 died.
-She worked on the day before he died on 12/23/22 on the 3rd shift (11pm 7:00am).
-On 12/23/22 during the 3rd shift he complained of his chest not feeling "right."
-The Lead MA was in the room because it was time to administer his inhaler medication.
-The time was between 12:00am and 12:30am.
-She thought the Lead MA asked him if he wanted to go out to the emergency room and the

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D 273	Continued From page 42 resident said "no." Interview with the MA on 01/12/23 at 4:45pm revealed: -She worked on 12/24/22 lst shift (7:00am to 3:00pm). -Resident #4 was up when she got to work. -He was holding his head down and sitting in his wheelchair and said he had a "stiff neck." -He asked for some Acetaminophen. -He was administered his scheduled Acetaminophen. -He went to lie down because he said he felt tired. -She put a note in the shift communication book and informed the incoming 2nd shift staff, which was the former Administrator and the MA, that Resident #4 had not been feeling well and complained of a "stiff neck.". Interview with the Lead MA on 01/13/23 at 3:30pm revealed: -She started employment at the facility around 12/21/22 and was still in training and was not familiar with Resident #4 and his medications. -On 12/22/22 or 12/23/22 she remembered Resident #4 complaining about not feeling well and said he was experiencing chest pain. -She told him he really needed to go to the emergency if he had chest pain. -He said he did not want to go. -She notified the former Administrator who was working with her that evening that Resident #4 was not feeling well and was experiencing chest pain. -To her knowledge the PCP was not notified. -The former Administrator did not address Resident #4's complaints of not feeling well and experiencing chest pain. -He was not sent to the ER.	D 273		

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Interview with the Administrator on 01/13/23 at 2:50pm revealed:
-She expected the PCA to notify the MA if Resident #4 was not feeling well and complained of chest pain.
-She expected the MA to evaluate Resident #4's complaints and notify the Administrator.
-She expected Resident #4 to be sent to the ER immediately if he was experiencing chest pain.

Interview with Resident #4's primary care provider (PCP) on 01/12/23 at 2:00pm revealed:
-Resident #4 had a lot of health issues including coronary artery disease.
-He expected Resident #4 to be sent to the ER if he was not feeling well and experiencing chest pain.

Review of the Department of Health and Human Services (DHHS) Death Report of Resident #4 revealed:
-A death report dated 12/29/22 was submitted to the Department of Health Service Regulation (DHSR) Complaint Intake Unit by the former Administrator.
-The resident was discovered deceased by the facility on 12/24/22 at 5:00pm.
-The resident was lying in his bed in his room.
-The first person to discover the resident deceased was the cook.
-The cook notified the former Administrator that she could not wake Resident #4.
-The Administrator assessed the resident as deceased and called Emergency Medical Service (EMS) and the local police department.
-The county department of social services was notified of the death.
-The cause of the resident's death was unknown.

Review of the local EMS report dated 12/24/22

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revealed:
-The EMS was called to the facility on 12/24/22 at 5:07pm and arrived at 5:13pm due to male patient unresponsive, not breathing and cold to touch.
-The police department was dispatched to the facility on 12/24/22 at 5:09pm and arrived at 5:18pm.
-Resident #4 was found lying in bed, unresponsive, not breathing, cold to touch, eyes open and dry, and skin color pale.
-Resident #4 had not been seen by facility staff since 6 hours prior to being found unresponsive.
-The initial clinical impression was Resident #4 was deceased without resuscitation efforts.
-Resident #4 was assessed to be asystole (heart not beating) and time of death was declared at 5:16pm.
-Resident #4's body was transported to the hospital morgue.

Review of Resident #4's death certificate dated 01/30/23 revealed:
-The date of death was 12/24/22.
-The immediate cause of death was cardiopulmonary failure.

2. Review of Resident #2's current FL-2 dated 11/09/22 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), muscle weakness, gastro-esophageal regurgitation disease (GERD), epilepsy, hypokalemia, cirrhosis of the liver, and emphysema.
-There was a medication order for Keppra 500mg daily. (Keppra is a medication used to treat seizures).
-There was a medication order for Dilantin 100mg, 3 tablets daily. (Dilantin a medication used to treat and prevent seizures).

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D 273	Continued From page 45 Review of Resident #2's Resident Register revealed that he was admitted to the facility on 11/09/22. Review of Resident #2's emergency room (ER) visit report dated 12/22/22 revealed: -Resident #2 was seen today for having a seizure. -Resident #2 had a prior history of seizures. -Resident #2 received a dose of IV Keppra as well as IV Dilantin. -Resident #2 Dilantin level was extremely low. -Resident #2 may need an increase in Dilantin. -Resident #2 was referred to a neurologist to determine if an increase of Dilantin was appropriate. Telephone interview with the former Administrator on 01/12/23 at 11:30am revealed: -She was unsure if an appointment was scheduled with the neurologist for Resident #2. -She recalled rescheduling follow-up medical appointments for other residents because of not having a transporter. Telephone interview with the patient access services representative at the neurologist on 01/12/23 at 12:00pm revealed: -She received the referral for Resident #2 from the hospital. -The facility had not scheduled Resident #2 an appointment with the neurologist.. Interview with the Lead medication aide (MA) on 01/12/23 at 12:15pm revealed: -She was not aware that Resident #2 had a referral with a neurologist. -The MAs were responsible for scheduling follow-up medical appointments.	D 273		

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D 273	Continued From page 46 Interview with the facility's contracted primary care provider (PCP) on 01/12/23 at 2:00pm revealed: -He did not need to be contacted when Resident #2 went to the Emergency Room (ER). -He expected to be informed of the neurologist referral. -He expected the facility to follow-up with the referral. Interview with the Administrator on 01/12/23 at 5:00pm revealed: -The MAs scheduled follow-up medical appointments. -She expected the MAs to schedule follow-up medical appointments. 3. Review of the facility's policy and procedure on Procedure for New Orders for Blood Sugar Monitoring, undated, revealed: -Current residents who get new orders for blood sugar monitoring will have an individual glucometer and testing supplies available for their use. -If glucometer is not immediately available upon receipt of new orders, the lead medication aide (MA) will notify physician and documented referral and follow up on any new order given. Review of Resident #3's current FL-2 dated 11/09/22 revealed diagnoses included hyperlipidemia and hypertension. Review of Resident #3's emergency room (ER) discharge summary dated 01/11/23 revealed: -The resident was seen for hypertension and hyperglycemia. -The resident was prescribed Metformin to help control his blood sugar.	D 273		

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D 273	Continued From page 47 -The resident was to follow up with his primary care provider (PCP). Review of Resident #3's physician's orders dated 01/12/23 revealed there was an order for fingerstick blood sugar (FSBS) checks twice a day. Interview with Resident #3 on 01/13/23 at 2:11pm revealed: -He did not know that he had high blood pressure or blood sugar issues until he went to the ER earlier this week. -The medication aide (MA) checked his blood sugar this morning before he ate breakfast. Interview with the MA on 01/13/23 at 10:40am revealed: -The PCP ordered FSBS checks twice a day for Resident #3 yesterday. -Resident #3 did not have his own glucometer. -It was the responsibility of the person who reviewed the resident's new orders to ensure that a glucometer was ordered for the resident. -She was not sure who reviewed Resident #3's orders yesterday. Interview with the Administrator on 01/13/23 at 11:10am revealed: -The PCP sent his orders to the pharmacy for Resident #3 yesterday (01/13/23) and then the pharmacy entered the orders into the computer for the facility to review. -The lead MA and the Administrator had access to review orders. -When the order came in yesterday for Resident #3 to have FSBS, whoever reviewed the order should have ensured that Resident #3 had a glucometer or have ordered one.	D 273		

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D 273	Continued From page 48 Attempted interview with the facility's primary care provider (PCP) on 01/13/23 at 10:56am and 01/13/23 at 2:50pm were not successful. _____ The facility failed to ensure the referral and follow-up to meet the routine and acute health care needs of sampled residents, including a resident who complained to staff of not feeling well and had chest pain and was not sent to the emergency room for evaluation and management and was later found unresponsive and not breathing and pronounced dead upon the arrival of the emergency medical service (#4); and a resident who was admitted to the emergency room (ER) for a seizure and had a referral to a neurologist that was not scheduled to evaluate the appropriate dose of a medication used to treat and prevent seizures (#2). This failure resulted in serious physical harm and neglect to the residents and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 12, 2023.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.	D 283		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to expired food that had molded and improper storage of food items in the refrigerator.

The findings are:

Observation of the kitchen pantry on 01/12/23 at 7:59am revealed:
-There were 3 packages that contained 6 hoagie rolls stored on the pantry shelf.
-There were small green circles which were surrounded by fuzzy white circles of mold scattered on all hoagie rolls in all 3 packages.

Observation of the refrigerator on 01/12/23 at 8:09am revealed:
-There was a one pound margarine wrapper with half of the margarine left that was not sealed or dated.
-There was a 32 ounce (oz) container of ricotta cheese with an expiration date of 10/01/22.
-There were small black spots of mold on the inner rim of the 32 oz container and green mold on the ricotta cheese.
-There were approximately 32 slices of cheese that were not individually wrapped and were not sealed properly.
-There was no date on the sliced cheese that had plastic wrap around it but the top was not covered.

Interview with the Dietary Manager (DM) on 01/12/23 at 8:40am revealed:
-She checked the expiration date of all food items

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D 283	Continued From page 50 all the time. -She labeled all foods on the day they were delivered and when they were opened. -She was not aware that the hoagie rolls in the pantry had mold and should have discarded the bread prior to it molding. -She never used ricotta cheese but should have discarded it since it was expired and molded. Interview with the Administrator on 01/13/23 at 3:00pm revealed: -The DM was responsible for discarding any foods that had expired or molded. -She expected the DM to check for any expired food at least once a week. Interview with the primary care provider (PCP) 01/12/23 at 2:00pm revealed he expected staff to ensure there were no expired or molded foods served to residents.	D 283		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water was served with meals to all residents.	D 306		

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D 306	Continued From page 51 The findings are: Review of the facility's census on 01/11/23 revealed there were 19 residents at the facility. Observation of the breakfast meal service on 01/12/23 revealed: -Breakfast was served by a personal care aide (PCA) to the residents at 8:18am. -There were 0 of 17 residents observed to be served or offered water as a beverage. -Residents were served orange juice and coffee. Observation of the lunch meal service 01/12/23 revealed: -Lunch was served by a PCA to the residents at 12:15pm. -There were 11 residents in the dining room that were served tea to drink, but no water. -There were 6 residents in the common area that were served tea to drink. -There was one resident that had water and one resident had milk. Interview with a resident on 01/12/23 at 12:26pm revealed he asked for water at each meal and was served water for each meal. Interview with a PCA on 01/12/23 at 12:30pm revealed she only served residents water if they asked for it. Interview with the dietary manager on 01/12/23 at 12:40pm revealed: -She usually prepared water for each meal but made a mistake at breakfast and lunch and forgot to prepare the resident water glasses. -She knew she was supposed to serve water but forgot.	D 306		

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D 306	Continued From page 52 Interview with the Administrator on 01/13/23 at 3:00pm revealed: -She was not aware that residents were not served water at breakfast and lunch yesterday. -She expected all residents to be served water. -The facility had a 5 gallon water dispenser in the community room that residents could access anytime. Interview with the facility's primary care provider (PCP) on 01/12/23 at 2:00pm revealed: -He expected the facility to serve water to residents at all meals. -It was important for residents to be served water even if they did not drink it to encourage hydration. -He was not aware that the facility was not serving water to residents at each meal.	D 306		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered per policy and physician's	D 358		

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orders for 3 of 4 residents observed during medication pass including medications omitted including a renal supplement (#8), an inhaler (#7) and insulin not being administered per manufacturer's recommendations (#1); and for 2 of 4 residents sampled for record review including not administering a vasodilator medication for a resident in active chest pain (#4), and running out of medication ordered including a blood pressure medication (#3).

The findings are:

Review of the facility's Medication Administration policy and procedure, undated revealed:
-Medications that are within seven days of being complete shall be called into pharmacy to be refilled.
-Administration of insulin pens shall follow the manufacturer's directions to prepare or prime your particular pen and perform the injection using the manufacturer's recommended technique.

1. The medication error rate was 10% as evidenced by 3 errors out of 28 opportunities during the 8:00am medication pass on 01/12/23.

a. Review of Resident #8's current FL-2 dated 11/09/22 revealed diagnoses include end stage renal disease.

Observation of the morning medication pass on 01/12/23 revealed:
-The medication aide (MA) prepared Resident #8's medications.
-The medications did not include Prorenal with Vitamin D (Prorenal with Vitamin D is a supplement to support kidney health).
-Resident #8 swallowed 7 tablets of medications

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D 358	Continued From page 54 at 7:50am. -Upon returning to the medication cart, the MA showed the surveyor a bottle of Prorenal with Vitamin D capsules and said that they were not administering that medication because there was no order for the medication and it was not on the electronic medication administration record (eMAR). Review of Resident #8's hospital discharge summary dated 12/25/22 revealed there was an order for ProRenal with Vitamin D oral tablet, with instructions to take one tablet by mouth once a day. Review of Resident #8's January 2023 eMAR revealed there was no entry for ProRenal with Vitamin D. Interview with the lead MA on 01/12/23 at 11:30am revealed: -It was the responsibility of the MA who was working when the discharge orders came in to ensure that the residents orders were faxed to the pharmacy. -The pharmacy placed orders on the eMAR. -Resident #8 received her Prorenal with Vitamin D from another pharmacy and that may have been why it was not placed on the eMAR. -She was working as the MA on 12/25/22 but was new to the facility and was not sure of the process for orders at the time. Interview with Resident #8's primary care provider (PCP) on 01/12/23 at 2:00pm revealed: -Resident #8 was a dialysis patient and received dialysis three times a week. -It was important for the resident to receive all of her ordered medication to help support her kidney function.	D 358		

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D 358	Continued From page 55 -Dialysis patients needed additional supplements to help kidney function. Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable. b. Review of Resident #7's current FL-2 dated 11/09/22 revealed: -Diagnoses included acute respiratory failure and chronic obstructive pulmonary disease (COPD) exacerbation. -There was an order for Incruse Ellipta 62.5mcg, inhale one puff by mouth daily for COPD (Incruse Ellipta is an inhaler used to relieve the symptoms of COPD). Observation of the morning medication pass on 01/12/23 at 8:04am revealed: -The medication aide (MA) administered Resident #7's morning medications including 7 pills. -The MA did not offer Resident #7 her Incruse Ellipta 62.5mcg inhaler. Review of Resident #7's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Incruse Ellipta 62.5mcg, with instructions to inhale one puff by mouth daily for COPD, scheduled for administration at 8:00am. -Incruse Ellipta 62.5mcg 1 puff was documented as administered on 01/12/23 at 8:00am. Interview with the MA on 01/12/23 at 8:08am revealed there were no more medications scheduled for Resident #7 during her morning medication pass. Interview with Resident #7 on 01/12/23 at 9:45am	D 358		

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revealed:
-She took a daily inhaler that helped with her breathing, but she could not recall the name of the inhaler.
-She did not get her inhaler this morning.

A second interview with the MA on 01/12/23 at 3:35pm revealed:
-She should not have documented the inhaler as administered on the eMAR unless Resident #7 took the inhaler.
-She thought that she gave Resident #7 her inhaler during the morning medication pass on 01/12/23 but might have forgotten.

Observation of Resident #7's medication on hand on 01/12/23 at 4:25pm revealed there was an Incruse Ellipta 62.5 mcg available for administration, with 20 doses remaining.

Interview with the lead MA on 01/12/23 at 11:30am revealed:
-She expected the MA to administer Resident #7's Incruse Ellipta inhaler or at least offer the medication to the resident.
-She had never known Resident #7 to refuse her inhaler.
-Resident #7 did not report any shortness of breath or difficulty breathing to her.

Interview with Resident #7's primary care provider (PCP) on 01/12/22 at 2:00pm revealed:
-Resident #7 was ordered Incruse Ellipta inhaler to help with her COPD.
-The inhaler would help Resident #7 with shortness of breath and difficulty breathing.
-Resident #7 not receiving her Incruse Ellipta inhaler would increase her risk for COPD exacerbation.
-Resident #7 was on supplemental oxygen and if

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she was administered her inhaler as ordered that would potentially decrease the amount of time the resident needed to use her oxygen.

c. Review of Resident #1's current FL-2 dated 11/09/22 revealed:
-Diagnoses include type 2 diabetes.
-There was an order for Lantus 26 units, to be administered once a day (Lantus is a long-acting insulin).

Observation of the morning medication pass on 01/12/23 revealed:
-Resident #1's finger stick blood sugar was 87 at 8:10am.
-The medication aide (MA) administered 26 units of Lantus Flex-Touch Pen insulin into Resident #1's right abdomen at 8:12am.
-The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle and that the resident received the full dose of insulin.
-The MA did not hold the insulin pen at the injection site after injection for 7-10 seconds and there was visible clear liquid on the resident's abdomen.

Review of Resident #1's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus 26u with instructions to administer once a day, scheduled for administration at 8:00am.
-Lantus 26u was documented as administered on 01/12/23 at 8:00am, with injection site documented as abdomen.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/12/23 at

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2:34pm revealed:
-The Lantus manufacturer recommended priming the insulin pen with two units prior to administration of the medication to ensure that the needle was primed so that the resident would receive the full ordered dose of medication.
-The Lantus manufacturer recommended holding the injection at the injection site for 7-10 seconds so that the ordered dose had time to be injected into the patients subcutaneous tissue.

Interview with the MA on 01/12/23 revealed:
-She was trained to prime the Lantus insulin pen with two units prior to dialing up the ordered dose but she was nervous this morning during medication pass and forgot.
-She was trained to hold the Lantus insulin pen after injection at the injection site for 10 seconds but she was nervous this morning during medication pass and forgot.

Interview with the lead MA on 01/12/23 at 11:30am revealed:
-The MAs were trained to prime the insulin pens and hold them at the injection site for at least 10 seconds during training.
-She expected the MA to administer Resident #1's insulin as she was trained.

Interview with the Administrator on 01/12/23 at 4:22pm revealed she expected the MA to administer Resident #1's Lantus as ordered and as she was trained to do.

Interview with Resident #1's primary care provider (PCP) on 01/12/22 at 2:00pm revealed:
-It was concerning that the MA did not administer the Lantus injection as she was trained to by following the manufacturer's recommendations.
-If there was visible liquid on the resident's

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abdomen it was likely that the resident did not receive the full ordered dose of Lantus.
-Resident #1 was a diabetic and was on long-acting insulin to help control her blood sugars throughout the day.
-If Resident #1 did not receive the full ordered dose of Lantus she might be at risk for uncontrolled blood sugars that could cause risk for falls or kidney damage.

2. Review of Resident #4's current FL-2 dated 10/26/22 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, heart failure, neuropathy, bilateral below knee amputee (BKA), phantom limb syndrome, depressive disorder, and peripheral vascular disease.

Review of Resident #4's Resident Register revealed an admission date of 10/21/22.

Review of Resident #4's physician medication report dated 10/21/22 revealed an order for Nitroglycerin 0.4mg, 1 tablet every 5 minutes as needed up to 3 doses, call 911 if no relief. (Nitroglycerin is a medication used to treat angina (chest pain) in people who have coronary artery disease (narrowing of the blood vessels that supply blood to the heart).

Review of Resident #4's physician medication order dated 10/26/22 revealed an order tor Acetaminophen 650mg, 1 tablet every 6 hours.

Review of Resident #4's death certicate signed 01/30/23 revealed:
-The resident's date of death was 12/24/22.
-The immediate cause of Resident #4's death was cardiopulmonary failure.
-The underlying cause of Resident #4's death

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was complications of atherosclerotic cardiovascular disease.

Review of a shift communication report revealed:
-The medication aide (MA) and the personal care aide (PCA) documented on 12/24/22, lst shift (7:00am-3:00pm) that Resident #4 had complained of a "stiff neck."
-There was no documentation of an intervention.

Review of Resident #4's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Nitroglycerin 0.4mg, dissolve 1 tablet under tongue every 5 minutes times 3 doses as needed for chest pain, then call 911 if no result.
-There was no documentation that Nitroglycerin 0.4mg, 1 tablet was administered from 12/01/22 to 12/24/22.
-There was an entry for Acetaminophen for 650mg,1 tablet every 6 hours.
-There was documentation that Acetaminophen 650mg, 1 tablet was last administered on 12/24/22 at 6:00am by the lead MA.

Telephone interview with the former Administrator on 01/11/22 at 10:50am revealed:
-She worked at the facility on 12/24/22 on the 2nd shift (3:00pm-11pm).
-She was in the office when the cook notified her that Resident #4 could not be aroused.
-She went to the resident's room and found him lying in bed, skin cold to touch, eyes set, and he had no pulse (heart beat).
-She had been notified that Resident #4 had not felt well on 12/24/22 by the outgoing MA and the PCA on the previous shift (1st shift).
-Shs did not recall any staff notifying her before 12/24/22 that Resident #4 had not felt well.

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D 358	Continued From page 61 Interview with a PCA on 01/12/23 at 8:10am revealed: -She was not working on the evening of 12/24/22 when Resident #4 passed. -She worked on the day before he passed on 12/23/22 on the 3rd shift (11:00pm 7:00am). -On 12/23/22 during the 3rd shift he complained of his chest not feeling "right." -The Lead MA was in the room because it was time to adminimister his inhaler medication. -The time was between 12:00am and 12:30am. -She thought the Lead MA asked him if he wanted to go out to the emergency room and the resident said "no." Interview with the MA on 01/12/23 at 4:45pm revealed: -She worked on 12/24/22 lst shift (7am-3:00pm). -Resident #4 was up when she got to work. -He was holding his head down and sitting in his wheelchair and said he had a "stiff neck." -He asked for some Acetaminophen. -His scheduled Acetaminophen was administered. -He went to lie down because he felt tired. -She put a note in the shift communication book and informed the incoming staff on 2nd shift that Resident #4 had not been feeling well and complained of a "stiff neck." Interview with the Lead MA on 01/13/223 at 3:30pm revealed: -She started employment at the facility around 12/21/22 and was still in the process of training and was not yet familiar with Resident #4 and his medications. -She was in training for about two days. -On 12/22/22 or 12/23/22 she remembered Resident #4 complaining about not feeling well	D 358		

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and said he was experiencing chest pain.
-She told the resident if he was experiencing chest pain it was best to go to the ER.
-He said he did not want to go.
-She notified the former Administrator who was working with her that evening that Resident #4 was not feeling well and was experiencing chest pain.
-She was still in training on the medication cart.
-She came off training on 12/24/22 and worked independently on the medication cart beginning 12/25/22.
-To her knowledge the PCP was not notified.
-The former Administrator did not address Resident #4's complaint of not feeling well and chest pain.
-Nitroglycerin was not administered.
-He was not sent to the ER.

Interview with the Administrator on 01/13/23 at 2:50pm revealed:
-She had been at the facility for about two and a half weeks.
-She expected the MAs to be familiar with Resident #4's medications and to see if there was anything prescribed for chest pain.
-If Nitroglycerin was prescribed for chest pain, she expected the medication to be administered and to follow instructions provided by the PCP.
-She expected Resident #4 to be sent to the ER immediately if he was experiencing chest pain.

Interview with Resident #4's primary care provider (PCP) on 01/12/22 at 2:00pm revealed:
-Resident #4 had a lot of health issues including coronary artery disease.
-Resident #4 was prescribed Nitroglycerin to relieve any chest pain he might be experiencing.
-He expected Resident #4 to be administered Nitroglycerin when he informed staff he was

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D 358	Continued From page 63 having chest pain. 3. Review of Resident #3's current FL-2 dated 11/09/22 revealed: -Diagnoses include hypertension. -There was an order for Valsartan 320mg, take one tablet daily (Valsartan is a medication used to treat hypertension). Review of Resident #3's hospital discharge summary dated 01/11/23 revealed: -He was treated in the emergency room (ER) for hypertension and hyperglycemia. -There was an order to continue Valsartan 320mg with instructions to take one tablet daily. Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Valsartan 320mg take one tablet daily, scheduled for administration at 8:00am. -Valsartan 320mg was documented as administered on 01/11/23 at 8:00am. Observation of Resident #3's medications on hand on 01/12/23 revealed: -There was no Valsartan 320mg available for administration. -One month supply (31 tablets) of Valsartan 320mg was dispensed on 12/17/22. -There was an empty bubble pack with a pharmacy label for Valsartan 320mg with instructions to take one table daily. Interview with the medication aide (MA) on 01/12/23 at 4:03pm revealed: -Resident #3's Valsartan 320mg had been ordered from the pharmacy and would be delivered tonight (01/12/23).	D 358		

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D 358	Continued From page 64 -She or the other MA contacted the pharmacy when a medication was needed. -Resident #3's Valsartan 320mg would be available to administer to him tomorrow morning. A second observation of Resident #3's medications on hand on 01/13/23 revealed there was no Valsartan 320mg available for administration. A second interview with the MA on 01/13/23 at 11:10am revealed: -The pharmacy delivery came last night which included Resident #3's Valsartan 320mg but she could not start that packet until 01/16/23 because that was when the batch medications were supposed to start. -Resident #3 would have to wait until 01/16/23 to get his Valsartan 320mg. Interview with the lead MA on 01/13/23 at 11:12am revealed: -She was not aware that Resident #3 was out of his Valsartan 320mg. -She expected the MA to make her aware that he was out of his medication so that she could contact the pharmacy to get the order filled. -Resident #3 should not go without his Valsartan because he had high blood pressure and was taken to the ER multiple times for high blood pressure. Interview with the Administrator on 01/13/23 at 11:15am revealed she expected the MA to notify the lead MA or the Administrator if a resident did not have their medications. Attempted telephone interview with the facility's primary care provider (PCP) on 01/13/22 at 10:56am and 01/13/23 at 2:50pm were not	D 358		

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D 358	Continued From page 65 successful. _____ The facility failed to ensure that medications were administered as ordered observed during medication pass. Resident #8 who has end-stage renal disease was not administered and Resident #7 who had chronic obstructive pulmonary disease was not administered her inhaler that was prescribed to help manage her COPD symptoms. Resident #1 was a diabetic who required long-acting insulin and the medication aide (MA) did not administer the resident her insulin per manufacturers recommendations, placing her at risk for uncontrolled or elevated blood sugars which could lead such things as falls or kidney damage. The facility did not administer a vasodilator medication to a resident (#4) that was complaining of active chest pain as ordered and the resident was later found deceased by staff. The facility failed to have blood pressure medication on hand for a resident (#3) that had been hospitalized multiple times for elevated blood pressure. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/05/23 and an addendum on 01/13/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 66 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, interviews, and record reviews, the facility failed to ensure the electronic medication administration record (eMAR) for 2 of 3 residents sampled (#1, #7) were complete and accurate. The findings are: Review of the facility's Medication Administration Policy, undated revealed: -The medication administration record (MAR) will include the follow information: -Resident's Name -Name of medication and/or treatment performed. -Strength and dosage or quantity of medication.	D 367		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 67 -Instructions for administering the medication or performing the treatment. -Date and time of administration, or date and time when treatment was performed. -Name and initials of the person administering the medication or performing the treatment. A signature equivalent to those initials will appear on the MAR. -Omissions and refusals of medications or treatments and the reason for omissions will be documented on MAR. Follow the code on the MAR. 1. Review of Resident #7's current FL-2 dated 11/09/22 revealed: -Diagnoses included acute respiratory failure and chronic obstructive pulmonary disease (COPD) exacerbation. -There was an order for Incruse Ellipta 62.5mcg, inhale one puff by mouth daily for COPD (Incruse Ellipta is an inhaler used to relieve the symptoms of COPD). Observation of the morning medication pass on 01/12/23 at 8:04am revealed: -The medication aide (MA) administered Resident #7's morning medications including 7 pills. -The MA did not offer Resident #7 her Incruse Ellipta 62.5mcg inhaler. Review of Resident #7's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Incruse Ellipta 62.5mcg, with instructions to inhale one puff by mouth daily for COPD, scheduled for administration at 8:00am. -Incruse Ellipta 62.5mcg 1 puff was documented as administered on 01/12/23 at 8:00am.	D 367		

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Interview with the MA on 01/12/23 at 8:08am revealed there were no more medications scheduled for Resident #7 during her morning medication pass.

Interview with Resident #7 on 01/12/23 at 9:45am revealed she did not receive her inhaler this morning.

A second interview with the MA on 01/12/23 at 3:35pm revealed:
-She should not have documented the inhaler as administered on the MAR unless Resident #7 took the inhaler.
-She thought that she gave Resident #7 her inhaler during the morning medication pass on 01/12/23 but might have forgotten.

Refer to the interview with the lead MA on 01/13/23 at 3:30pm.

Refer to the interview with the Administrator on 01/12/23 at 4:22pm.

Refer to the interview with the primary care provider (PCP) on 01/12/23 at 2:00pm.

2. Review of Resident #1's current FL-2 dated 11/09/22 revealed:
-Diagnoses included schizoaffective disorder and bipolar disorder.
-There was an order for Haldol 75mg intramuscular injection every four weeks (Haldol is an anti-psychotic medicine that is used to treat mood disorders).

Review of Resident #1's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Haldol 75mg,

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D 367	Continued From page 69 intramuscular injection every 4 weeks for psychosis. -Haldol 75mg was documented as administered on 01/11/23 during first shift (7:00am to 2:59pm). Interview with the medication aide (MA) on 01/11/23 at 1:30pm revealed: -She administered Resident #1's medications today (01/11/23). -She did not administer Resident #1's Haldol injection today even though she documented it was administered. -Resident #1 received her Haldol 75mg injection at the facility's primary care (PCP) office every four weeks. -She should have charted as not administered and written a comment on why it was not administered. Refer to the interview with the lead MA on 01/13/23 at 3:30pm. Refer to the interview with the Administrator on 01/12/23 at 4:22pm. Refer to the interview with the PCP on 01/12/23 at 2:00pm. _____ Interview with the lead medication aide (MA) on 01/13/23 at 3:30pm revealed: -MAs should only sign off a medication as administered on the electronic medication administration record (eMAR) when they administer the medication to the resident. -If a medication was not administered the MA should choose a comment as to why the resident did not receive the medication. -It was important for the eMAR to match what medication the resident received or did not receive and why.	D 367		

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D 367	Continued From page 70 Interview with the Administrator on 01/12/23 at 4:22pm revealed she expected MAs to accurately document medications administered on the eMAR based on the facility's medication administration policy. Interview with the primary care provider (PCP) on 01/12/23 at 2:00pm revealed: -He expected the eMAR to accurately reflect what medications the residents received. -He reviewed the eMAR as part of his assessment process when he visited the residents and used the eMAR to develop the plan of care for the residents.	D 367		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication cart was locked when left unattended. The findings are: Review of the facility's Storage of Medication policy, undated revealed: -All medications, prescription and non-prescription, administered by facility staff,	D 378		

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including those requiring refrigeration, will be kept locked in the medication closet except when staff are in close proximity and can see the medications.
-Accessibility to locked medication closet will be allowed only to persons responsible for medication administration, the Administrator, or person in charge.

1. Observation of the medication room on 01/12/23 at 12:10pm revealed:
-A medication aide (MA) left the medication room unlocked with the medication cart in the room.
-All drawers on the medication cart were unlocked, but the controlled substance drawers were locked.
-The MA returned to the medication cart at 12:15pm

Refer to the interview with the medication aide (MA) on 01/13/23 at 8:45am.

Refer to the interview with the lead MA on 01/13/23 at 3:30pm.

Refer to the interview with the Administrator on 01/13/23 at 2:20pm.

Refer to the interview with the facility's primary care provider (PCP) on 01/12/23 at 2:00pm.

2. Observation of the resident's hallway on 01/13/22 from 8:30am to 8:45am revealed:
-The medication cart was located in the hallway outside of resident room #7.
-The medication cart keys were located in the lock of the medication cart.
-There was no staff at the medication cart.
-At 8:40am the medication aide (MA) on duty came out of a resident's room and returned to the

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medication cart to prepare medications for the next resident.
-At 8:42am the MA went into another resident's room and administered medications, leaving the keys in the medication cart.
-The medication cart was not visible to the MA while in the resident's room.
-At 8:44am the personal care aide (PCA) pushed a resident in their wheelchair next to the unlocked medication cart to go to the dining room to wait for breakfast.
-At 8:45am the MA returned to the medication cart.

Refer to the interview with the medication aide (MA) on 01/13/23 at 8:45am.

Refer to the interview with the lead MA on 01/13/23 at 3:30pm.

Refer to the interview with the Administrator on 01/13/23 at 2:20pm.

Refer to the interview with the facility's primary care provider (PCP) on 01/12/23 at 2:00pm.

_____

Interview with the medication aide (MA) on 01/13/23 at 8:45am revealed:
-She was responsible for making sure the medication cart was locked when unattended.
-She had forgotten to lock the cart and take the keys with her during her medication pass because she was in a hurry to get the residents their medications.
-It was her responsibility to ensure that the medication cart was locked even when in the medication storage room because there were times when that door was unlocked.
-The medication cart should be locked when not in use, including when stored in the medication

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D 378	Continued From page 73 storage room. -She was the only staff member with a key to the medication storage room. Interview with the lead MA on 01/13/23 at 3:30pm revealed: -She expected that the medication cart would be locked when unattended by staff. -It was important to keep the medication cart locked for resident safety. -She was not aware of any residents that went into the medication cart on their own. Interview with the Administrator on 01/13/23 at 2:20pm revealed she expected staff to keep the medication cart locked when unattended for resident safety based on the facility policy. Interview with the facility's primary care provider (PCP) on 01/12/23 at 2:00pm revealed: -He expected staff to keep the medication cart locked when unattended for resident safety. -If a resident were to get into the cart and "take medication that was not prescribed to them that would not be good".	D 378		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult 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 medical evaluation, hospitalization, or medical treatment other than first aid.	D 451		

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D 451	Continued From page 74 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) of incidents resulting in injury requiring emergency medical evaluation and treatment for 2 of 8 sampled residents (#2 and #6). The findings are: Review of an undated accident and incident policy revealed: -The purpose of the policy was to ensure accidents and incidents are referred and followed up in a timely manner to meet the safety, behavior and medical needs of a resident. 1. All accidents and incidents should immediately be reported to the supervisor in charge; staff shall ensure the immediate needs of the resident are met. 2. The staff in charge shall ensure proper referral and follow up for all incidents and accidents to include notification of the physician and contacting 911 as necessary. -Anything that requires more than first aide treatment should be reported immediately to the on call physician for further guidance on steps to take. -Staff should follow all emergency procedures for cardiopulmonary resuscitation (CPR), choking and other emergency needs and shall follow standing orders as needed. 3. The supervisor in charge shall ensure that proper documentation and notification is completed. -The supervisor in charge shall notify the residents responsible party immediately for accidents/incidents that require emergency management calls. -Incidents that require more than first aide	D 451		

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treatment shall be faxed to the local county department of social services (DSS) within 48 hours of the incident.
4. Staff should be trained on the accident and incident policy upon hire and annually.

1. Review of Resident #6's current FL-2 dated 11/09/22 revealed:
-Diagnoses included diabetes, hypertension, and lower left leg amputee.
-He was ambulatory with his wheelchair.

Review of Resident #6's shift report dated 12/04/22 revealed:
-The 1st shift medication aide (MA) documented that the resident kept falling on the floor because he was transferring from his wheelchair without locking the wheels.
-The 3rd shift MA documented that the resident was sent to the hospital.

Review of the facility file revealed there was not an incident and accident report for Resident #6's fall on 12/04/22.

Interview with a MA on 01/12/23 at 3:35pm revealed she had completed all incident and accident reports on Resident #6 but was not sure where they were located.

Interview with the Adult Home Specialist (AHS) with the local DSS on 01/13/23 at 10:10am revealed she did not have an incident and accident report for Resident #6 on 12/04/23 when he fell and required transport to the local ER.

Refer to interview with a PCA on 01/12/23 at 4:12pm.

Refer to interview with a medication aide (MA) on

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01/12/23 at 3:55pm.

Refer to interview with the Lead MA on 01/12/23 at 10:10am.

Refer to interview with the Administrator on 01/13/23 at 3:00pm.

2. Review of Resident #2's current FL-2 dated on 11/09/22 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), muscle weakness, gastroesophageal reflux disease (GERD), Epilepsy, Hypokalemia, Cirrhosis of Liver, and Emphysema.
-Resident #2 used a rollator walker to assist with mobility.

Review of the Emergency Room (ER) report dated on 12/10/22 at 3:30pm revealed:
-Resident #2 was diagnosed with accidental fall and acute cystitis with hematuria.
-Resident #2 was to follow-up with Emergency Department or Primary Care Provider if symptoms worsen.

Review of the facility file revealed there was not an incident and accident report for Resident #2's fall on 12/10/22.

Interview with the Adult Home Specialist (AHS) with the local DSS on 01/13/23 at 10:10am revealed she did not have an incident and accident report for Resident #2 on 12/10/22 when he fell and required transport to the local ER.

Refer to interview with a PCA on 01/12/23 at 4:12pm.

Refer to interview with a medication aide (MA) on

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D 451	Continued From page 77 01/12/23 at 3:55pm. Refer to interview with the Lead MA on 01/12/23 at 10:10am. Refer to interview with the Administrator on 01/13/23 at 3:00pm. Interview with the AHS with the local DSS on 01/13/23 at 10:00am revealed: -She did not have an incident and accident report for Resident #6 on 12/04/23 when he fell and required transport to the local ER. -She did not have an incident and accident report for Resident #2 on 12/10/22 when he fell and required transport to the local ER. Interview with a personal care aide (PCA) on 01/12/23 at 4:12pm revealed: -She had completed one or two incident and accident reports on residents that were sent to the local emergency room (ER). -She thought the medication aide (MA) usually completed the incident and accident reports. Interview with a MA on 01/12/23 at 3:35pm revealed: -She had completed all incident and accident reports on Resident #6 but was not sure where they were located. -The past Administrator would send incident and accident reports to the local DSS. -There was new ownership of the facility and she did not know who was responsible for sending the reports to the local DSS. Interview with the Lead MA on 01/12/23 at 10:10am revealed: -She had worked at the facility since 12/22/22. -The medication aide (MA) was responsible for	D 451		

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D 451	Continued From page 78 completing the incident and accident reports. -The MA was to notify the responsible party and the primary care provider (PCP). -She was unaware that the local county Department of Social Services (DSS) was to be notified of the incident. Interview with the Administrator 01/13/23 at 3:00pm revealed she was not aware that the facility needed to contact the local county DSS of any accidents or incidents.	D 451		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease	D 611		

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D 611	Continued From page 79 case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed follow their infection control policy for related to diabetic testing by sharing a single-use glucometer for residents without cleaning (#3, #9) and failing to perform hand hygiene and administer insulin injections during the morning medication pass on 01/12/23. The findings are: Review of the facility's policy and procedure manual for Diabetic Testing, undated, revealed: -Sharing of glucometers is a violation of policy and is strictly prohibited. -Each individual resident will have their own glucometer and it will be labeled with their name.	D 611		

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D 611	Continued From page 80 -Individual glucometers are kept inside the individual glucometer bag and should be labeled with the resident's name. -The glucometer bag should be stored inside a plastic bag also labeled with the resident's name. -Prior to checking a resident's blood sugar, ensure that the name on the glucometer, zippered bag and plastic bag match the resident who is having their sugar checked. -Notify the lead medication aide (MA) whenever you have a glucometer, glucometer bag or plastic bag that does not have a label with a resident's name. -What to do if a resident does not have a glucometer: notify by phone or in person, the lead MA or Administrator immediately if a new admission does not have a glucometer, a new order for blood sugar monitoring is given, or a resident's glucometer breaks. -Do not use another resident's glucometer in any of these cases. -Sharing of supplies is against policy and is strictly prohibited. -Wear gloves during blood glucose monitoring. -Change gloves between each resident contact. -Change gloves that have touched potentially blood-contaminated objects or fingerstick wounds before touching clean surfaces. -Appropriately, discard gloves after each use. -An alcohol based hand rub should be used between each resident fingerstick. -If hands are visibly dirty, become soiled or contaminated, proper hand hygiene should followed. -Procedure for emergency back-up glucometer use includes the facility will keep, in a secure location, a supply of extra individual glucometers available for use in emergency situations only. -Administrator, no other staff, will distribute the extra glucometer upon notification of emergency	D 611		

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D 611	Continued From page 81	D 611		

situation (broken glucometer, emergency admission, new order for diabetic testing).
-No other staff will have access to the extra glucometer.
-Once a glucometer from the extra supply inventory is assigned to a resident for their individual use in an emergency situation, the glucometer will be labeled for that residents individual use and only used for that resident.
-The Administrator will label the machine and bag.
-Once the resident's ordered meter is received the lead MA (medication aide) or Administrator (only) will ensure that the meter assigned for emergency use is pulled from the cart, disinfected by the lead MA according to manufacturer's instructions for disinfecting and will document that the disinfecting procedures were followed and completed.
-The disinfecting procedure will be documented.
-Once disinfected according to manufacturer's instructions and documented, the glucometer will be added to the secured glucometer inventory.
-Glucometers available for emergency only use will have manufacturer's instruction for disinfection.

Review of the facility's policy and procedure manual for Medication Administration, undated, revealed:
-General preparation for medication administration includes gathering appropriate materials and then cleansing hands. After medication administration the medication aide (MA) should cleanse hands.
-During insulin administration, choose an injection site and wipe the site with an alcohol pad.

Review of the facility's COVID-19 policy Cleaning Reusable Equipment, undated, revealed:

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D 611	Continued From page 82 -Reusable equipment will be clean by removing visible residue (i.e., blood and tissue) and other debris from client care equipment, and preparing it for safe handling and/or further decontamination. -Cleaning should be accomplished using water with detergents or enzymatic products that are capable of removing visible organic and inorganic residues. -In home cleaning is done manually with gloved hands using friction (i.e., rubbing or scrubbing the soiled item by hand with a cloth to remove soil and fluids). 1. Review of Resident #3's current FL-2 dated 11/09/22 revealed diagnoses include hypertension. Review of Resident #3's hospital discharge summary dated 01/11/23 revealed he was treated in the emergency room (ER) for hypertension and hyperglycemia. Review of Resident #3's physician's orders dated 01/12/23 revealed there was an order for fingerstick blood sugars (FSBS) twice a day. Observation of the medication cart in the hallway outside of room #7 on 01/13/23 revealed: -Another resident's labeled glucometer bag was opened on top of the unlocked medication cart. -The medication aide (MA) returned to the medication cart coming out of Resident #3's room. -The MA replaced the glucometer into another resident's glucometer bag and placed it back in the cart. -The MA replaced another resident's glucometer into Resident #9's labeled glucometer bag without cleaning it.	D 611		

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D 611	Continued From page 83 Review of Resident #9's current FL-2 dated 11/09/22 revealed diagnoses included schizoaffective disorder, diabetes mellitus, dyslipidemia, insomnia, hypertension, gastroesophageal reflux disease. Interview with the MA on 01/13/23 at 8:40am revealed: -The MA told the surveyor that Resident #3 was ordered FSBS twice a day now. -The surveyor asked the MA if she had checked Resident #9's blood sugar already this morning and she stated that she had. -The surveyor asked the MA if she cleaned the glucometer after taking Resident #9's blood sugar before using her glucometer to check Resident #3's FSBS and she said no. Review of Brand A glucometer's manufacturer's guidelines revealed: -Brand A glucometer was intended to be used by a single person and not to be shared. -Do not share Brand A glucometer with anyone, including family members. -Do not use Brand A glucometer on multiple patients. -All parts of Brand A glucometer could carry blood-borne pathogens after use, even after cleaning and disinfecting. -Cleaning and disinfecting the meter destroys most, but not necessarily all, blood-borne pathogens. Observation of the facility's medication cart on 01/13/23 at 8:59am revealed: -There were 9 glucometers in the medication cart that were labeled with resident's names. -Resident #3 did not have a labeled glucometer. -There were auto-retractable, disposable lancets	D 611		

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D 611	Continued From page 84 for all glucometers. Interview with the MA on 01/13/22 at 10:40am revealed: -There were no extra glucometers in the facility that she was aware of. -With previous Administration, the facility kept a spare glucometer for new orders or in case of emergency. -She did not know if the lead MA ordered a glucometer for Resident #3, but she called the pharmacy after her medication pass this morning around 10:00am to order Resident #3's glucometer. -Resident #3's glucometer would be arriving this afternoon from the pharmacy (01/13/22). -She did not clean Resident #9's glucometer prior to using it to check Resident #3's blood sugar. -There was not a process for how often to clean glucometers. -She cleaned the glucometers "when she had time" and just wiped them down with hand sanitizer. -She could not recall the last time that she cleaned the glucometers. -She "just didn't think about" cleaning Resident #9's glucometer before using it on Resident #3 because "she wanted to get her medication pass done". Interview with the lead MA on 01/13/23 at 3:30pm revealed: -She was not aware that the MA used Resident #9's glucometer to check Resident #3's FSBS without cleaning it before and after use. -She was not aware of the facility's policy on glucometer use because she was new and still learning the process of the facility. -She started at the facility on 12/22/2. -The MA should have notified her of the FSBS	D 611		

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D 611	Continued From page 85	D 611		

order for Resident #3 on 01/12/23 and then she could have contacted the pharmacy to get Resident #3 a glucometer.
-She did not think that the facility had an extra glucometer on site.
-She was concerned that the MA did not clean the glucometer prior to using it on another resident because there was risk for cross contamination of blood.

Interview with the facility's Registered Nurse consultant on 01/13/22 at 12:05pm revealed:
-The MAs should not have used another resident's glucometer on a newly diagnosed diabetic.
-Per the facility policy, each resident should have their own glucometer.
-She was not aware if the facility had an extra emergency glucometer on-site as the facility policy stated.
-The use of shared glucometers without cleaning presented the opportunity for exposures to bloodborne viruses through contaminated equipment and supplies.

Interview with the Administrator on 01/13/23 at 2:20pm revealed:
-It was not acceptable for the MA to use any resident specific assigned glucometer to check another resident's blood sugar.
-If there was an emergent situation where a blood sugar needs to be checked, the glucometer should be cleaned prior to use and after use.
-Every resident that as ordered a blood sugar check will should have their own glucometer.
-When Resident #3 was ordered fingerstick blood sugars yesterday (01/12/23), Resident #3 should have been ordered a glucometer.
-The facility did not have a back-up supply of glucometers.

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D 611	Continued From page 86 -She was not aware of any residents in the facility that had a blood borne pathogen communicable disease. -The MA using an individual's glucometer on a resident without cleaning it in between use places the resident at risk for infection and cross contamination and potentially blood pathogen transfer. Attempted interview with the facility's contracted primary care provider (PCP) on 01/13/23 at 10:56am and 2:50pm were unsuccessful. 2. Observation of the morning medication pass on 01/12/23 revealed: -There was hand sanitizer on the medication cart. -There were individual packets of alcohol wipes available on the medication cart. -The MA (medication aide) donned gloves at 7:45am and prepared medications for a resident. -The MA popped the medication from the bubble packets into her gloved hand and placed them in a medication cup. -The resident received 9 medications at 7:50am. -The resident was given an inhaler to perform at 7:51am. -The MA did not remove her gloves after administering medications to the first resident or perform hand hygiene. -The MA began preparing medications for the second resident. -The MA popped the medication from the bubble packets directly into her gloved hand and placed them in a medication cup. -The MA administered 7 oral medications to the second resident at 7:56am. -The MA did not remove her gloves after administering medications to the second resident or perform hand hygiene. -The MA began preparing medications for the	D 611		

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third resident.
-The MA popped the medication from the bubble packets directly into her gloved hand and placed them in a medication cup.
-The MA administered 7 oral medications to the third resident at 7:58am.
-The MA checked the third resident's fingerstick blood sugar (FSBS) at 8:00am.
-The MA did not cleanse the resident's finger with an alcohol swab prior to sticking her finger with the lancet.
-The MA removed her gloves but did not perform hand hygiene prior to preparing the third resident's insulin injections.
-The MA donned new gloves.
-At 8:02am the MA administered the third resident's first insulin injection in her right abdomen, but she did not prep the injection site with an alcohol swab prior to administration.
-At 8:04am the MA administered the third resident's second insulin injection in her left abdomen, but she did not prep the injection site with an alcohol swab prior to administration.
-At 8:10am a fourth resident came to the medication cart to have her blood sugar checked.
-The MA still had her gloves on from when she administered the third resident's insulin and was preparing to stick the fourth resident's finger for a FSBS.
-This surveyor stopped the MA and asked her if she was going to change gloves or perform hand hygiene, since she had the same gloves on.
-The MA stopped and changed gloves but did not perform hand hygiene prior to checking the fourth resident's blood sugar.

Interview with the MA on 01/12/22 at 3:35pm revealed:
-She was supposed to use hand sanitizer and change gloves in between administering

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medications to the residents.
-She was trained to use hand sanitizer and change gloves in between administering medications to the residents.
-She forgot to use the alcohol swab to clean the resident's finger prior to puncturing it for her FSBS.
-She was trained to clean the resident's finger before checking their FSBS.
-She was "in a rush this morning to get her medications passed" and just forgot to perform hand hygiene.

Interview with the lead MA on 01/13/23 at 3:30pm revealed:
-MAs were to change gloves and perform hand hygiene after each resident.
-It was important to perform hand hygiene to reduce the risk of infection.

Interview with the facility's Registered Nurse consultant on 01/13/23 at 12:05pm revealed:
-It was important to perform hand hygiene between residents when administering medication to prevent risk of spread of infection.
-Handwashing and hand hygiene was covered in the annual infection control training that was completed by the pharmacy training nurses.
-She expected staff to follow the facility's policy and procedure on administering medications which including washing hands before and after administration of medications to each resident.

Interview with the Administrator on 01/12/23 at 4:22pm revealed:
-She expected the MAs to perform hand hygiene in between each resident.
-She was surprised that the MA did not change gloves in between administering medications including FSBS and injections.

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D 611	Continued From page 89 -She thought that maybe the MA was nervous and that contributed to her not performing infection control measures as she normally would have. Interview with the facility's contracted primary care provider (PCP) on 01/12/23 at 2:00pm revealed: -He expected the MA to perform hand hygiene between administering medications to each resident. -It was important to prepare the insulin injection site with alcohol prep to prevent any risk for contamination. -If a MA did not change gloves after administering an injection there was a risk for transfer of any bloodborne pathogens to the next resident. _____ The facility failed to ensure that infection control procedures were followed by sharing glucometers and not performing hand hygiene while administering medications including fingerstick blood sugars and insulin administration. The medication aide (MA) used Resident #9's Brand A glucometer that was not intended for use on multiple residents on Resident #3 that was a newly diagnosed diabetic. The facility did not have an emergency use glucometer, which is part of the facility policy. Sharing of glucometers placed the residents at risk for bloodborne pathogen disease and risk of contamination. This failure of the facility placed the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/23 for this violation. CORRECTION DATE FOR THE TYPE A2	D 611		

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D 611	Continued From page 90 VIOLATION SHALL NOT EXCEED FEBRUARY 12, 2023.	D 611		