STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025037	A. BUILDING: _____ B. WING _____	R 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROATAN VILLAGE	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

(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 Craven County Department of Social Services conducted an annual survey, a follow-up survey and complaint investigations from February 22, 2023 to February 24, 2023. The complaint investigations were initiated by the Craven County Department of Social Services on December 21, 2022, December 29, 2022, and February 17, 2023.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 5 of 6 exit doors that were accessible to five residents who were intermittently disoriented and ambulatory (#6, #11, #12, #13, and #15) and one resident who was constantly disoriented and ambulatory (#16) had audible alarms activated when the exit doors were opened to alert staff.	D 067		

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D 067	Continued From page 1 The findings are: Review of the facility's Assisted Living (AL) roster on 02/22/23 revealed there was a census of 36 residents on the AL unit. Review of Resident #6's current FL-2 dated 06/28/22 revealed: -Diagnoses included unspecified dementia. -Resident #6's recommended level of care was assisted living facility. -Resident #6 was intermittently disoriented. -Resident #6 was semi-ambulatory. Review of Resident #11's current FL-2 dated 08/15/22 revealed: -Diagnoses included dementia. -Resident #11's recommended level of care was assisted living facility. -Resident #11 was intermittently disoriented. -Resident #11 was ambulatory. Review of Resident #12's current FL-2 dated 06/03/22 revealed: -Diagnoses included hyperlipidemia, iron deficiency anemia, hypertension, and muscle weakness. -Resident #12's recommended level of care was assisted living facility. -Resident #12 was intermittently disoriented. -Resident #12 was semi-ambulatory. Review of Resident #13's current FL-2 dated 01/12/23 revealed: -Diagnoses included mixed Alzheimer's disease and vascular dementia. -Resident #13's recommended level of care was assisted living facility. -Resident #13 was intermittently disoriented.	D 067		

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D 067	Continued From page 2 -Resident #13 was ambulatory. Review of Resident #15's current FL-2 dated 01/12/23 revealed: -Diagnoses included dementia. -Resident #15's recommended level of care was assisted living facility. -Resident #15 was intermittently disoriented. -Resident #15 was ambulatory. Review of Resident #16's current FL-2 dated 07/21/22 revealed: -Diagnoses included Alzheimer's disease and dementia. -Resident #16's recommended level of care was assisted living facility. -Resident #16 was constantly disoriented. -Resident #15 was ambulatory. Observation of the facility's main entrance on 02/22/23 at 7:57am revealed: -The front door to the facility was not locked and did not alarm. -The Business Office Manager's (BOM) office and the Administrator's office were located beside the front door of the facility. -There were no facility staff members present in the offices by the front door. Second observation of the facility's main entrance door on 02/22/23 at 1:15pm the door was not locked and did not have an audible alarm. Third observation of the facility's main entrance door on 02/23/23 at 8:25am revealed the door was not locked and did not have an audible alarm. Observation of the door at the end of the 100 hall on 02/22/23 at 8:05am revealed: -The door was not locked and there was no	D 067		

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audible alarm.
-The door led out to the front of the building and the front parking lot which led to a main road.
-To the right of the door was a hill which led to a gravel road.

Observation of the side door on the 300 hall on 02/22/23 at 8:10am revealed:
-The door was not locked and did not have an audible alarm.
-The door led out to the front of the facility and a parking lot which led to a main road.
-There was another parking lot to the left of the door.

Observation of the door at the end of the 300 hall on 02/22/23 at 9:19am revealed:
-The door was not locked and did not have an audible alarm.
-The door led to a parking lot at the side of the building.

Observation of the side door near the laundry entrance off of 300 hall on 02/22/23 at 9:29am revealed:
-The door was not locked and did not have an audible alarm.
-The door led to a parking lot at the side of the building.

Observation of the parlor door on 02/22/23 at 8:43am revealed:
-The door was not locked and did not have an audible alarm.
-The door led out to the front parking lot which led to a main road.

Second observation of the parlor door on 02/22/23 at 11:55am revealed the door was not locked and did not have an audible alarm.

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D 067	Continued From page 4 Third observation of the parlor door on 02/23/23 at 9:42am revealed: -The door was not locked. -There was an audible alarm which stopped as soon as the door was closed. Fourth observation of the parlor door on 02/23/23 at 2:55pm revealed: -The door was opened by a resident. -There was an audible alarm. -The resident ambulated outside of the facility using a rollator. -When the door closed behind the resident the audible alarm stopped. -No facility staff came to see if a resident had left the building. Telephone interview with the previous maintenance director on 02/23/23 at 11:14am revealed: -All exit doors on the assisted living (AL) side of the facility should alarm. -Many of the exit door on the AL side of the facility did not alarm because staff turned the alarms off. Interview with the BOM on 02/24/23 at 3:51pm revealed: -The front door to the facility was locked around 8:00pm. -The front door to the facility was unlocked when she arrived between 7:00am to 8:00am. -She was not always in her office because she helped in the kitchen at times, made beds for residents, and went into the Special Care Unit (SCU). -The Administrator was not at the facility every day. -There were times when there was no one at the front entrance of the building.	D 067		

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D 067	Continued From page 5 Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 3:02pm revealed: -She was not aware that all doors on the AL unit should be alarmed. -There were several residents on the AL unit that were confused. -Sometimes facility staff disengaged the alarms on the doors on assisted living to take out trash. -It was important for facility staff to reengage the alarms on the doors when they reentered the facility so the residents would be safe. Interview with the Administrator on 02/22/23 at 11:47am revealed the assisted living doors had alarms in place which should be turned on at all times. Telephone interview with the facility's contracted mental health provider on 02/24/23 at 8:36am revealed she expected all exit doors in the facility to alarm and be secured to ensure the safety of the residents. Telephone interview with the facility's contracted primary care provider (PCP) on 02/24/23 at 2:37pm revealed: -There were confused residents who resided on the assisted living side of the facility. -She expected assisted living doors to have audible alarms so confused residents could not leave the facility and get lost. The facility failed to ensure 5 of 6 exit doors were equipped with a sounding device alerting staff when activated with six residents who were identified by their physician's to be intermittently or constantly disoriented and ambulatory This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type	D 067		

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D 067	Continued From page 6 B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/22/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 8, 2023.	D 067		
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: Based on observations, interviews, and record reviews, the facility failed to ensure the facility remained free of hazards including shaving razors, personal care items, and cleaning supplies found on the Special Care Unit (SCU) and an unsecured oxygen cylinder on the Assisted Living (AL) unit. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 72 residents with an Assisted Living (AL) capacity of 54 and a Special Care Unit (SCU) capacity of 18 residents.	D 079		

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1. Review of the facility's resident roster on 02/22/23 revealed the facility's SCU census was 18.

a. Observation of resident room #207 on 02/23/23 at 12:10pm revealed a personal care aide (PCA) walked two residents out of the resident room #207 and into the dining room.

A second observation of resident room #207 on 02/23/23 at 12:12pm revealed:
-There were three bottles of cleaning solution on top of a resident dresser including an all-purpose disinfectant cleaner, fabric spray, and air freshener.
-There were no staff or residents in the room.

Interview with the PCA on 02/23/23 at 3:10pm revealed:
-She walked the two residents to the dining room out of room #207 for lunch around 12:10pm.
-She planned on returning to resident room #207 after she got the residents to the dining room to eat lunch.

Observation of the dining room from 12:10pm until 12:25pm revealed the PCA remained with the residents in the dining room to assist with their lunch meals.

Interview with the Administrator on 02/24/23 at 4:15pm revealed she expected staff to not leave cleaning supplies unattended on the SCU for resident safety.

Telephone interview with the facility's mental health provider (MHP) on 02/24/23 at 8:40am revealed:
-On the SCU, it was important to ensure that cleaning supplies were locked based on the

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resident population.
-Residents on the SCU have periods of confusion and memory loss which was why it was important to keep cleaning supplies locked when not in use.

b. Review of Resident #9's current FL-2 dated 12/13/22 revealed:
-Diagnoses included vascular dementia.
-The requested level of care was a secure memory unit.

Observation of the bathroom in resident room #206 on 02/22/23 at 8:37am revealed:
-There was a storage cabinet in the bathroom.
-There was a disposable razor on top of the storage cabinet.
-There was a package of three replacement razors on top of the storage cabinet.
-There were no residents or staff members in the bathroom.

Observation of room #206 on 02/22/23 at 8:45am revealed:
-Two residents reside in the room (Resident #9 and his roommate) and share the adjoining bathroom. .
-Resident #9 entered the room after breakfast.
-A personal care aide (PCA) came into the room and informed Resident #9 that today was his shower day.
-This surveyor informed the PCA of the razors in the bathroom and the PCA took the razors out of the bathroom.

Interview with the PCA on 02/22/23 at 8:50am revealed:
-Resident's personal care items including razors should be kept locked in the storage room.
-She was not sure how the razor was left but confirmed that the Resident #9 was going to have

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a shower today.
-Resident #9 usually just required standby assistance when showering and shaving.

A second observation of the bathroom in resident room #206 on 02/23/23 at 12:02pm revealed:
-There was a disposable razor blade without a handle on top of the storage cabinet.
-There were no residents or staff members in the bathroom.

Interview with a second PCA on 02/23/23 at 3:05pm revealed:
-There were at least 2 residents on the SCU that wandered.
-Bathroom items such as razors should be kept in the resident's specific personal care item bins, locked in the storage room.

Interview with a medication aide (MA) on 02/23/23 at 2:40pm revealed it was the responsibility of the PCAs to ensure that after providing personal care to residents that their items including razors would be locked back in the storage room.

Interview with the Special Care Coordinator (SCC) on 02/24/23 at 3:30pm revealed:
-Hazardous items such as razors should be locked in individual resident bins in the storage rooms.
-She completed a walk through of the unit every morning to ensure that hazardous items such as razors were locked up.
-It was "dangerous" to leave items such as razors out on the SCU.
-No residents had any history of harming themselves or any other resident or staff with dangerous items like a razor that she was aware of.

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D 079	Continued From page 10 Interview with the Administrator on 02/24/23 at 4:15pm revealed it was important that staff placed hazardous items such as razors back into the storage room. Telephone interview with the facility's mental health provider (MHP) on 02/24/23 at 8:40am revealed it was important to keep hazardous items such as a razor secured when not in direct supervision of a staff member for resident safety. c. Observation of resident room #212 on 02/22/23 at 8:34am revealed: -There was one resident present in the room. -There were no staff present in the room. -In the bathroom there were two bottles of shampoo and two bottles of body wash on a stand next to the sink. Observation of resident room #210 on 02/22/23 at 8:35am revealed: -There were no residents or staff in the room. -There was a dresser in the bathroom that with the top drawer left opened. -There was toothpaste and a bottle of petroleum jelly in the dresser drawer that was opened in the bathroom. Observation of resident room #206 on 02/22/23 at 8:37am revealed: -There was a storage cabinet in the bathroom. -There were no residents or staff members in the bathroom. -There were two bottles of shaving cream, a bottle of aftershave, and deodorant on top of the storage cabinet. A second observation of the bathroom in resident room #206 on 02/23/23 at 12:02pm revealed:	D 079		

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-There was a bottle of body wash on top of the storage cabinet.
-There were no residents or staff members in the bathroom.

Interview with a personal care aide (PCA) on 02/23/23 at 3:05pm revealed:
-All resident's shower supplies were to be kept locked in the storage room when they finished giving a resident their shower.
-Each resident had a labeled bin in the locked storage room to keep their items.

Interview with a medication aide (MA) on 02/23/23 at 2:40pm revealed it was the PCA's responsibility to ensure that personal care items such as body wash, shampoo and shaving creams were put away after shower and not left out.

Interview with the Special Care Coordinator (SCC) on 02/24/23 at 3:30pm revealed there were some things in place to prevent personal care items being left out such as rounding on the unit when she arrived in the morning.

Interview with the Administrator on 02/24/23 at 4:15pm revealed she expected staff to keep personal care items including shampoos and body wash secure when not in use to keep the residents safe.

Telephone interview with the facility's mental health provider (MHP) on 02/24/23 at 8:40am revealed:
-On the SCU, it was important to ensure that personal care items such as shampoos, body wash, and shaving cream were locked based on the resident population.
-Residents on the SCU had periods of confusion

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and memory loss which is why it is important to keep personal items locked when not in use with staff supervision.

2. Review of the facility's resident roster on 02/22/23 revealed the facility's assisted living (AL) census was 36.

Observation of resident room #306 on the AL unit on 02/22/23 at 9:39am revealed:
-There was an oxygen cylinder in front of the resident's dresser.
-The oxygen canister was not in a container or transport stand.
-The resident was in her recliner across the room from her dresser.

Interview with the resident in room #306 on 02/22/23 at 9:40am revealed her oxygen cylinder was usually in a transport stand and she noticed this morning it was not in the stand.

Observation of the Administrator on 02/22/23 at 11:27am revealed she removed the unsecured oxygen canister from room #306 and placed it in a secure container in the medication room.

Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 2:33pm revealed:
-Oxygen cylinders should be secured in a container or a transport stand.
-The unsecured oxygen cylinder in Room #306 could have exploded or caused the resident to fall or trip.

Interview with the Administrator on 02/22/23 at 11:25am revealed:
-The oxygen cylinder should be secured in a container or transport stand.
-The oxygen cylinder should have been stored in

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D 079	Continued From page 13 the medication room behind the nurse's station on the 300 hall. Telephone interview with the facility's contracted primary care provider (PCP) on 02/24/23 at 2:37pm revealed: -All oxygen cylinders should be secured in a container or a transport stand. -Oxygen cylinders that were not properly secured could be a hazard by exploding and/or causing a fire and causing injury to residents.	D 079		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a resident's FL-2 included complete information and was clarified by the primary care provider (PCP) for 1 of 5 sampled residents (#5) which had incorrect medication dosages and omitted medications.	D 238		

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D 238	Continued From page 14 The findings are: Review of Resident #5's current FL-2 dated 01/26/23 revealed diagnosis included hypertension, diabetes, and depression. Review of Resident #5's physician order sheet dated 12/30/22 revealed: -There was an order for Eliquis (a blood thinner) 5mg twice day. -There was an order for Trulicity (used to treat high blood sugars) 1.5mg weekly. -There was an order for Lantus (used to treat high blood sugar) 13 units twice a day. Review of Resident #5's physician order sheet dated 01/19/23 revealed: -There was an order to increase Trulicity to 3mg weekly. -There was an order to increase Lantus to 30 units every day for 1 week, then 35 units every day for 1 week, then 40 units every day. Review of Resident #5's current FL-2 dated 01/26/23 revealed: -There was no order for Eliquis. -There was no order for Trulicity. -There was an order for Lantus 13 units twice a day. Review of Resident #5's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 5mg twice a day scheduled for administration at 8:00am and 8:00pm. -Eliquis 5mg was documented as administered at 8:00am on 02/01/23 to 02/22/23 and at 8:00pm on 02/01/23 to 02/21/23.	D 238		

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D 238	Continued From page 15 -There was an entry for Trulicity 3mg weekly scheduled for administration at 8:00am. -Trulicity was documented as administered to at 8:00am on 02/06/23, 02/13/23, and 02/20/23. -There was an entry for Lantus 35 units scheduled for administration at 8:00am with an effective date of 01/28/23 and an end date of 02/03/23. -Lantus 35 units was documented as administered at 8:00am on 02/01/23 to 02/03/23. -There was an entry for Lantus 40 units scheduled for administration at 8:00am with an effective date of 02/04/23. -Lantus 40 units was documented as administered at 8:00am on 02/04/23 to 02/22/23. Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 3:02pm revealed: -She put Resident #5's medications on her FL-2 dated 01/26/23 and sent it to the primary care provider (PCP) for him to sign. -She missed putting Eliquis and Trulicity on Resident #5's FL-2 as well as the most current order for Lantus. -She should have caught the error before she sent the FL-2 to the PCP. -When she received Resident #5's signed FL-2 from the PCP she should have compared it to the resident's current medication orders. -If she had compared the FL-2 to Resident #5's current medication orders she would have caught the error and clarified the orders for Eliquis, Trulicity, and Lantus with the PCP. Interview with the Administrator on 02/24/23 at 4:11pm revealed: -The RCC put Resident #5's medications on the FL-2 for the PCP to review and sign. -The RCC should have used the most current medication orders to put on Resident #5's FL-2.	D 238		

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D 238	Continued From page 16 -If the medication orders on the signed FL-2 did not match Resident #5's most current medication orders the RCC should have contacted the PCP to clarify the medication orders. Telephone interview with Resident #5's PCP's nurse on 02/23/23 at 11:36am revealed she would speak to the PCP about clarifying the medications on her FL-2 and have the PCP call back. Second telephone interview with Resident #5's PCP's nurse on 02/23/23 at 3:13pm revealed: -She had spoken to Resident #5's PCP and he had provided answers to questions about clarifying the medications on the resident's FL-2. -The PCP overlooked the fact that Trulicity and Eliquis were not listed on Resident #5's FL-2 and also that the wrong dose of Lantus was listed on the FL-2. -He expected Resident #5 to continue with her Trulicity and Eliquis as well as the most recent dose of Lantus. -He expected the facility to clarify any medication omissions or dosage differences with him to make sure they were administering the right medications and dosages to Resident #5.	D 238		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Information On Home And Resident Register (b) The administrator or administrator-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the facility and revise the	D 248		

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information on the form as needed. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register.

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to revise emergency contact information as needed on the Resident Register for 1 of 5 residents (#1).

The findings are:

Review of Resident #1's current FL-2 dated 10/28/23 revealed:
-Diagnoses included Alzheimer's disease, essential hypertension, and fall/nasal fracture.
-The recommended level of care was Special Care Unit (SCU).
-The resident was intermittently disoriented.

Review of Resident #1's Resident Register revealed:
-Resident #1 was admitted to the facility on 10/12/20.
-The Resident Register was dated 10/12/20.
-The phone number for the Healthcare Power of Attorney (HPOA) was not in service.
-There was no Power of Attorney listed.
-The last time Resident #1 saw the attending physician listed on the Resident Register was June 2020.

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Review of Resident #1's progress note dated 01/03/23 revealed at 9:37am the HPOA contacted the facility to verify that emergency contact numbers were correct.

Interview with Resident #1's HPOA on 02/23/23 at 3:10pm revealed:
-He updated the facility with his new phone number over a year ago and in January 2023.
-The resident was sent to the local emergency room (ER) in December 2022 after a fall.
-Another family member was Resident #1's the Durable Power of Attorney (POA).

Interview with the Business Office Manager (BOM) on 02/24/23 at 3:51pm revealed:
-When there was a change of information, whoever was in charge of the department put it in the facility's computer system.
-Resident Register were only completed on residents upon admission to the facility.
-She did not know the Resident Register needed to be changed or updated after that.

Interview with the Special Care Coordinator (SCC) on 02/24/23 at 3:32pm revealed:
-The Resident Register was only checked when residents were admitted to the facility so the staff could get to know the residents.
-The Resident Registers were not updated, and staff did not look at the Resident Register when they needed to contact families.
-The facility used the electronic resident record platform for medications, to manage changes, and to get contact information.
-The electronic resident record was not updated with the emergency contact information.
-The SCC or Administrator were responsible for updating the Resident Register.

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D 248	Continued From page 19 Interview with the Administrator on 02/24/23 at 4:11pm revealed: -The facility only had the signed Resident Register upon admission. -She did not know that the Resident Register needed to be changed or updated to reflect updated emergency contact information.	D 248		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#3) resulting in Resident #3 eloping from the Special Care Unit (SCU) of the facility, without staffs' knowledge, to the facility parking lot where he was found by a staff member arriving to work. The findings are: Review of the facility's Elopement Policy, dated 07/27/22, revealed: -Staff will make routine rounds during their assigned shift to validate that all residents are accounted for and present.	D 270		

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D 270	Continued From page 20 -An investigation is conducted, and staff are interviewed to determine the last time the resident was observed present in the facility. -An incident report is completed, and an entry is made into the resident's medical record describing the event. -All exit door alarms and other devices such as window alarms are checked to validate that they are in working order. -When the resident is located and returned to the facility the resident's physician, authorities, Department of Health, responsible party, and staff are notified. -The resident is examined for any signs or symptoms of injury, the physician is notified, and the resident is sent to the emergency room for evaluation if indicated. -The resident is placed on frequent checks which is minimally 15-minute checks. -The timing of the checks is incrementally increased based on the residents behavior until checks are no longer required. -Notation of the resident's return are made in the shift report. -Monitoring and observation of the resident are documented in the clinical record every shift for 72 hours. -Staff in-service education is provided to review the elopement policy and procedure. Review of the facility's Supervision Policy, dated 08/15/22, revealed: -15-minute checks are an advanced level of supervision and require documentation. -Facility staff are providing a safety check approximately every 15 minutes to ensure the resident's overall safety and well-being. -Typically, 15-minute checks are conducted for a 72-hour period or once the resident's behavior has been reassessed.	D 270		

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D 270	Continued From page 21 Review of Resident #3's current FL-2 dated 04/07/22 revealed: -Diagnoses include late onset Alzheimer's disease, hypertension, chronic atrial fibrillation, depression, diabetes mellitus, and hyperlipidemia. -He was ambulatory. -He was constantly disoriented. -His level of care was SCU. Review of Resident #3's Resident Register dated 04/08/22 revealed: -He was admitted to the facility on 04/12/22. -He required assistance with orientation to time and place, scheduling appointments and dressing. -He had significant memory loss and required redirection. Review of Resident #3's initial psychiatric assessment completed by the facility's Mental Health Provider (MHP) dated 04/28/22 revealed: -Resident #3's psychiatric diagnoses included Alzheimer's disease and depression. -Staff reported that upon admission Resident #3 had exit seeking behaviors. -Resident #3 continuously pushed on doors and windows to the point that he had skin tears on his arms. -Staff reported that Resident #3 spent most of the day constantly looking and asking for ways to get out of the SCU. Review of Resident #3's Special Care Unit Admission Criteria Review dated 04/05/22 revealed: -He habitually wandered, would wander out of the building and would not be able to find his way back.	D 270		

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D 270	Continued From page 22 -Resident #3 met the facility's criteria for placement in the SCU. Review of Resident #3's initial SCU Resident Profile dated 05/26/22 revealed: -Resident #3 had wandering behaviors. -Resident #3 was verbally abusive and agitated at times. -Resident #3 was independent with toileting and ambulation. -Resident #3 required cueing and redirecting for dressing, grooming, bathing and eating. -Resident #3's was alert to person but not place or time. -Resident #3 had short term and long-term memory loss. -Resident #3 ambulated without any assistive devices. Review of Resident #3's most recent SCU Resident Profile dated 02/03/23 revealed: -Resident #3 had wandering behaviors. -Resident #3 was verbally abusive at times, agitated and displayed sundowning behaviors. -Resident #3 was independent with toileting and ambulation. -Resident #3 required cueing and redirecting for dressing, grooming, bathing and eating. -Resident #3's was alert to person but not place or time. -Resident #3 had short term and long-term memory loss. -Resident #3 was able to ambulate. Review of Resident #3's most recent care plan dated 01/25/23 revealed: -Resident #3's mental health history included wandering behaviors, verbal abuse, resisting care, disruptive behaviors, and social inappropriateness.	D 270		

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D 270	Continued From page 23 -Resident #3 received mental health services and was seen by a mental health provider (MHP). -The resident had a history of aggressive behavior with agitation and frequent exit seeking behaviors. -Resident #3 had a previous elopement on 05/23/22. -Resident #3 "responded to redirection fairly". -Resident #3 required "frequent monitoring due to exit seeking and previous elopement". -Resident #3 was always disoriented, and had significant memory loss that required redirection. -Resident #3 was independent with ambulating. --Resident #3's care plan was signed by his primary care provider (PCP) on 01/31/23. Review of Resident #3's most recent Elopement Risk assessment completed on 01/29/23 revealed: -He received 2 points for having one or more predisposing diseases including Alzheimer's disease and a mental illness. -He received 1 point for being ambulatory. -He received 2 points for being confused at times. -He received 2 points for taking more than 2 medications. -He received 0 points for being greater than 120 days since his last elopement. -He received 3 points for history of elopement within the last 6 months. -Resident #3's elopement risk assessment score was 10. -An elopement risk assessment score of 10 or higher places the resident at risk for elopement. -Resident #3 was to be placed on the elopement risk list and an appropriate system should be put in place to prevent elopement. Review of Resident #3's previous Elopement Risk assessment on 07/26/22 revealed a score of 11.	D 270		

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D 270	Continued From page 24 Review of Resident #3's Incident Report dated 02/17/23 revealed: -Resident #3 eloped on from the SCU 02/17/23 at approximately 8:50am. -He was located outside on the facility's property. -He did not have any apparent injuries. -Resident #3 stated "I don't know" when he was asked how he got out to the parking lot. -The Activities Director (AD) stated that as she drove into the parking lot, she observed Resident #3 walking around outside. -Resident #3's family was notified at 9:20am. -Resident #3's PCP was notified at 9:26am. -The incident report was completed by the facility's Registered Nurse (RN). Review of Resident #3's facility progress note dated 02/17/23 at 1:40pm revealed: -The progress note was completed by the Resident Care Coordinator (RCC). -She documented that the courtyard door was open in the SCU and due to the wind, the door from the SCU that lead onto the Assisted Living (AL) did not close tightly. -The AD drove up in parking lot and found Resident #3 outside walking around. -The resident's PCP, family and Administrator were notified of the elopement. -An Incident Report was completed and sent to the local county Department of Social Services (DSS). -A "Do Not Leave Door Open" sign was placed on the courtyard door for "future safety precautions". Review of Resident #3's provider notification dated 02/17/23 revealed: -The provider notification was completed by the RCC and sent to Resident #3's PCP. -The door to the facility's courtyard was open	D 270		

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because the weather was nice.
-Due to the breeze, the door to the AL did not tightly close.
-Resident #3 "went outside of the building per himself".
-Staff brought Resident #3 back inside in a timely manner.

Review of Resident #3's PCP order dated 02/17/23 revealed staff should perform 30 minute checks on Resident #3 for 72 hours and place in resident's chart.

Review of Resident #3's "15 Minute Checks" form dated 02/17/23 revealed:
-Resident #3 was on 15- minute check for his behaviors including exit seeking.
-At 7:00am, his location was documented as dining room by a personal care aide (PCA).
-At 7:15am, his location was documented as bedroom by a PCA.
-At 7:30am, his location was documented as hallway by a PCA.
-At 7:45am, his location was documented as nurses' station by a PCA.
-At 8:00am, his location was documented as nurses' station by a PCA.
-At 8:15am, his location was documented as dining room by a PCA.
-At 8:30am, his location was documented as dining room by a PCA.
-At 8:45am, his location was documented as "? Out of facility" by a PCA.
-At 9:00am, his location was documented as nurses' station by a PCA.

Interview with the AD on 02/23/23 at 8:35am revealed:
-She usually arrived to work around 8:00am, but on the morning of 02/17/23 she arrived around

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8:30am.
-She noticed Resident #3 was walking up the grassy slope hill on the side of the facility by the activity bus.
-Resident #3 had a cup of water in his hand when she approached him.
-Resident #3 did not appear to have any visible injuries.
-She asked Resident #3 to get into her car with her and when he did, she drove around to the front entrance and called the Administrator.

Observation of the location where Resident #3 was found by the AD on 02/24/23 from 8:15am to 8:30am revealed:
-The location was approximately 500 feet from the front door of the building on the AL side of the facility.
-There was a hill next to the facility's bus that led to a gravel road with residential properties.
-The gravel road led to the main road, which was a two-lane highway with a speed limit of 45 miles per hour and was parallel to the facility.
-There was no sidewalk up the hill to the gravel road.

Interview with a PCA on 02/23/23 at 3:05pm revealed:
-She was one of the two PCAs working on the SCU the morning of 02/17/23.
-Resident #3 was on 15-minute checks since his last elopement in May of 2022 because of his behaviors including exit seeking.
-She completed the 15-minute checks for Resident #3 until 8:30am.
-At 8:30am, she took a resident into the shower room and notified the other PCA working that she would be in there with the resident.
-When she was done with the other resident's shower that was when she was told that Resident

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#3 had eloped.
-She was not aware that Resident #3 was out of the facility.
-The last time she saw Resident #3 was when he was in the dining room around 8:30am.

Interview with a second PCA on 02/24/23 at 8:40am revealed:
-She was the second PCA working on the SCU the morning of 02/17/23.
-After breakfast was served, around 8:30am she pushed the meal cart from the hallway in the SCU out of the front entrance to the AL, down the hallway and to the kitchen.
-The side door to the secure courtyard was opened because the weather was nice.
-It was noisy and she did not hear if the door to the SCU latched all the way after she pushed the cart out of the door.
-She was aware that when the SCU courtyard door was propped open that the SCU entrance door to the AL did not always latch properly.
-When she returned to the SCU, she was told that Resident #3 had eloped.
-She documented "? out of facility" on Resident #3's 15 minute checks at 8:45am because when she came back on the unit she was told that he eloped.

Interview with the medication aide (MA) on 02/23/23 at 2:40am revealed:
-She was working on the SCU on 02/17/23.
-She was administering medications to residents on the SCU between 7:45am and 8:45am.
-The PCAs were responsible for completing the 15-minute checks for Resident #3.
-Resident #3 had wandering behaviors and constantly tried to get out of the SCU.

Interview with the RCC on 02/24/23 at 2:50pm

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revealed:
-She was working when Resident #3 eloped from the facility on 02/17/23.
-She was told that when the courtyard door was open it created a crosswind or draft that caused the SCU exit door to not close completely.
-Resident #3 exited the SCU door that connected to the AL side of the facility and then out one of the unalarmed doors on the AL.
-It was important for resident's safety on the SCU for them to be supervised and it was "scary" that he made it to the parking lot before a staff member saw him.
-She was not aware of anyone in the facility that knew that Resident #3 was missing.

Interview with the Special Care Coordinator (SCC) on 02/24/23 at 3:30pm revealed:
-She was not at work when Resident #3 eloped on 02/17/23.
-Residents on the SCU required constant supervision because "that was why they were on the SCU".
-If a resident on the SCU was left unattended they could get injured because they "are not all the way there cognitively".
-If a resident on the SCU was outside there should be a staff member with them so they did not get injured.
-She expected staff to ensure that the door was shut properly and pulled closed on the SCU so that residents could not elope.

Telephone interview with Resident #3's family member on 02/24/23 at 10:47am revealed:
-She was notified of the incident on 02/17/23 when Resident #3 made it to the parking lot from the SCU.
-She knew that Resident #3 "actively looked for any opportunity" to exit the SCU.

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-Resident #3 eloped in May of 2022, shortly after he was admitted to the facility.
-He eloped and was found down the road so she was glad that he was found closer this time.

Telephone interview with the facility's Maintenance Director (MD) on 02/23/23 at 11:15am revealed:
-The entrance door from the AL to the SCU did not always shut completely.
-When the exit door to the secured courtyard was open on the SCU, it created a draft and caused the entrance door from the SCU on the AL to not close securely.
-He mentioned the issue of the SCU door not closing completely to a medication aide (MA) in passing.

Interview with the Administrator on 02/24/23 at 4:15pm revealed:
-The facility's RN, who completed the Incident Report on 02/17/23 for Resident #3, was no longer employed at the facility.
-There were no audible alarms on the front door or parlor door from the AL to the front of the facility where it was believed that the resident went out of the building.
-The facility had camera monitors in their hallways, but they are not functioning.
-She was at the facility on 02/17/23 when the AD called her that she had Resident #3 in her car.
-She expected staff to ensure that the doors were properly closed when leaving the SCU to prevent elopements from occurring.

Telephone interview with Resident #3's PCP on 02/24/23 at 2:50pm revealed:
-She was notified by the facility on 02/17/23 of Resident #3's elopement.
-Resident #3 required constant supervision

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because of his diagnoses including Alzheimer's and depression.
-If Resident #3 made it out of the facility on his own he was at risk of injury especially because he would not know where he was.
-Resident #3 had wandering behaviors.
-Resident #3 could have fallen and injured himself or ran out into the road when he eloped from the facility on 02/17/23.
-SCU doors should be locked at all times for the safety of residents and to prevent elopements.

Telephone interview with Resident #3's MHP on 02/24/23 at 8:42am revealed:
-Resident #3 had wandering behaviors and a history of elopement.
-She was not notified of the resident's elopement on 02/17/23 but assumed the facility notified Resident #3's PCP.
-She expected Resident #3 to be monitored more frequently based on his behavior pattern including elopement history and exit seeking behavior.
-It was important for residents on the SCU to be supervised at all times because of their cognitive status including disorientation and forgetfulness.
-If a resident on the SCU was not supervised appropriately there was risk for resident injury.

Attempted interview with Resident #3 on 02/22/23, 02/23/23, and 02/24/23 were unsuccessful.

_____

The facility failed to ensure that Resident #3 was supervised based on his needs and diagnoses including a previous elopement in May of 2022, short term and long term memory loss, disorientation, wandering tendencies and exit seeking behaviors. The lack of supervision resulted in Resident #3 eloping from the facility's Special Care Unit, without staff's knowledge

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D 270	Continued From page 31 where he was at risk for injuries including falls or being hit by a vehicle. The facility's failure resulted in substantial risk for serious harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/17/23 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 26, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#1) related to failing to schedule a podiatry appointment (#1). The findings are: 1. Review of Resident #1's current FL-2 dated 10/28/23 revealed: -Diagnoses included Alzheimer's disease, essential hypertension, fall/nasal fracture, and elevated troponin. -The recommended level of care was Special Care Unit (SCU). -The resident was intermittently disoriented and ambulatory.	D 273		

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Review of the facility's contracted podiatrist visit note for Resident #1 dated 10/03/22 revealed:
-The resident was seen for a regular podiatry visit at the facility.
-The resident complained of painful toenails.
-The resident had thick, elongated toenails that were yellow, brittle, painful nails, ingrown toenails, keratotic lesions (corns and calluses), and dry scaling skin.
-The resident required treatment of her toenails and keratotic lesions to relieve pain in her feet.
-There was documentation that the resident should be seen for a follow up visit in 30 days due to systemic conditions or sooner if needed.

Review of a faxed physician order for Resident #1 dated 10/11/22 revealed the resident was scheduled to see outside podiatrist on 10/19/22 per her healthcare power of attorney (HCPOA).

Observations of Resident #1's right foot on 02/15/23 at 10:05am revealed:
-There was nail discoloration of the big toe with a reddened area surrounding the nail bed.
-The second toenail was ¼ inch long.
-The third nail had jagged edges.

Interview with Resident #1 on 02/15/23 at 10:05am revealed she was experiencing pain in her right big toe.

Interview with Resident #1's HPOA on 02/23/23 at 3:10pm revealed:
-Resident #1 complained of foot pain in November 2022.
-She observed the resident's toenails in November 2022, and they were long, dirty, discolored, smelled, and had a nail fungus.
-Resident #1 was seen by a podiatrist at the facility in October 2022.

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D 273	Continued From page 33 -The resident needed and had spoken to staff regarding the resident's toenails. -The resident needed to get her toenails trimmed because she had foot pain and nail fungus. Interview with the receptionist at facility's contracted podiatrist on 02/23/23 at 2:55pm revealed: -Resident #1 was seen by the podiatrist at the facility on 10/03/22. -The podiatrist was scheduled to visit the resident at the facility in December 2022, but the providers were out. -The podiatrist was scheduled to see residents at the facility in March 2023 or April 2023. Interview with an outside podiatrist on 02/24/23 at 3:01pm revealed that Resident #1 was seen by the provider at their office 10/20/14. Interview with the Special Care Coordinator (SCC) on 02/24/23 at 3:32pm revealed the SCC had not spoken to the podiatrist. Interview with the Business Office Manager (BOM) on 02/24/23 at 3:51pm revealed: -The facility's contracted podiatrist was scheduled to come in December 2022, but they were short providers and there was COVID in the facility. -The Resident Care Coordinator (RCC) or SCC would usually schedule resident podiatry visits. Interview with the Administrator on 02/24/23 at 4:11pm revealed: -The last time Resident #1 was seen by a podiatrist was in October 2022 at the facility. -Resident #1 had not seen the outside podiatrist since 2014. -The Administrator was not aware that Resident #1 had been referred to an outside podiatrist by	D 273		

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D 273	Continued From page 34 her PCP. Interview with the PCP on 02/24/23 at 2:36pm revealed: -The facility's contracted podiatrist came to the facility every 3 months. -She observed Resident #1's toenails a few months ago and her toenails had discoloration and bruising. -The PCP was concerned the resident had not been seen by an outside podiatrist because it caused difficulty with walking, fungal infections, and poor hygiene. -She expected the resident to be seen by an outside podiatrist. -Staff should have informed her that the resident was not referred to an outside podiatrist as ordered. -Resident #1 should be seen by a podiatrist as soon as possible.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#4) related to weekly weights.	D 276		

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D 276	Continued From page 35 The findings are: Review of Resident #4's current FL-2 dated 11/15/22 revealed diagnoses included myocardial infarction (heart attack). Review of Resident #4's physician order sheet dated 01/17/23 revealed there was an order for check weight once weekly, inform primary care provider (PCP) if weight has increased by 5 pounds in a week. Review of Resident #4's January 2023 electronic medication administration record (eMAR) revealed: -Resident #4's weight was 187 pounds on 01/02/23 and 187 pounds on 01/09/23. -There was no entry for check weight weekly beginning on 01/17/23. -There were no other weights documented in January 2023. Review of Resident #4's February 2023 eMAR revealed there was no entry for check weight once weekly. Review of Resident #4's medication passing detail report of the weekly weights revealed: -Resident #4 had a weight of 186 recorded on 02/01/23. -There were no other weights recorded for Resident #4. Interview with the medication aide (MA) on 02/24/23 at 11:50am revealed: -MAs were responsible for checking weights on residents. -MAs knew to check a weight on a resident because it would pop up on the eMAR. -Orders to check resident weights were put on the	D 276		

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D 276	Continued From page 36 eMAR by the Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC). Interview with the RCC on 02/24/23 at 3:02pm revealed: -MAs knew to obtain weights on residents because it would pop up on the eMAR. -The prior SCC put weights on the eMAR. -She did not know how to put weights on the eMAR. Interview with the Administrator on 02/24/23 at 4:11pm revealed: -The RCC should have put weekly weights on the eMAR for Resident #4. -The RCC had been trained how to put weights on the eMAR for residents. Interview with Resident #4's primary care provider (PCP) on 02/24/23 at 2:37pm revealed: -She ordered weekly weights on Resident #4 because he had cardiac issues and some swelling in his feet. -She ordered weekly weights on Resident #4 to assess for fluid buildup. -She expected to be notified by the facility if Resident #4 had a weight gain of 5 pounds. -If Resident #4 had a weight gain of 5 pounds it could mean he had fluid overload which would affect his cardiac output which could affect his breathing and cause him to decline quickly. Attempted interview with Resident #4 on 02/24/23 at 1:02pm was unsuccessful.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310		

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D 310	Continued From page 37 (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to serve a therapeutic diet to 1 of 4 sampled residents (#4) with a physicain order for a mechanical soft diet. The findings are: Review of Resident #4's current FL-2 dated 11/15/22 revealed diagnoses included vitamin D deficiency, hyperlipidemia (high cholesterol), and unspecified hearing loss. Review of Resident #4's diet order dated 11/15/22 revealed an order for mechanical soft diet. Review of the facility's assisted living diet chart on 02/23/23 revealed Resident #4 should be served a mechanical soft diet. Review of the facility's posted menu for lunch on 02/23/23 revealed it included green salad, fried chicken, red beans and rice, corn on the cob, ice cream, water, and tea. Review of the facility's diet extensions therapeutic diet menu for lunch dated 02/23/23 revealed there was a listing for mechanical soft diet with chopped meats which included green salad replaced with soft bite sized vegetable, fried	D 310		

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chicken should be soft and bite sized, corn on the cob should be replaced with a small bite sized vegetable, and garlic bread should be soaked.

Observation of Resident #4's lunch meal service on 02/23/23 from 12:30pm to 12:51pm revealed:
-The resident was served three chicken drumettes, corn on the cob, rice, and a roll.
-Surveyor intervened and asked staff to return the meal back to the kitchen because the chicken was not soft and bite sized, he was served corn on the cob and his bread was not soaked.
-The resident was then served chopped chicken, corn, bread that was cut up and soaked, and rice.

Based on observations, interviews, and record reviews it was determined that Resident #4 was not interviewable.

Interview with the Dietary Manager (DM) on 02/23/23 at 12:53pm revealed:
-Resident #4 was on a mechanical soft diet.
-Resident #4 should have been served chicken tenders cut in bite sized pieces, corn off the cob and a roll that was soaked and cut up for lunch today.
-Resident #4 was visually impaired and requested finger foods for his meals.
-Resident #4 did not have an order to be served finger foods.
-She should have prepared his meal per physician orders to ensure the resident did not choke.

A second interview with the DM on 02/24/23 at 1:04pm revealed:
-She received diet orders from the business office manager (BOM) or the Resident Care Coordinator (RCC).
-Resident #4 did not want a mechanical soft diet

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D 310	Continued From page 39 and had requested to receive finger foods. -Resident #4 reported to her several months ago that he did not have any problems with swallowing foods. -The resident did not like his chicken cut up yesterday and preferred to keep the chicken drumettes and corn on the cob. -She had not notified the RCC that the resident wanted finger foods and did not want to eat a mechanical soft diet. -She was responsible for following the diet order by the primary care provider (PCP) diet orders. -She should not have changed the resident's meal because it increased his risk of choking. Telephone interview with the resident's primary care physician (PCP) on 02/24/23 at 2:37pm revealed Resident #4 should be served a mechanical soft diet as ordered to prevent choking and aspiration. Interview with the Administrator on 02/24/23 at 4:15pm revealed Resident #4 should be served a mechanical soft diet as ordered by the PCP.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues.	D 338		

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D 338	Continued From page 40 THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure residents were treated with respect and dignity (#10, #12, #13, #18, #19) by Staff A and were free from theft of personal property (#5, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17). The findings are: Review of the facility's Grievance Policy, undated, revealed: -The following problem solving-grievance/complaint process will be followed for each grievance/complaint to ensure that all grievance/complaints are addressed in an effective and professional manner. -All department managers will determine the specific problem with the complainant and forward the grievance/complaint to the Administrator. -The department where the grievance and/or complaint is accepted will assess the problem and determine the cause and plan the appropriate action toward resolution. -The Administrator will accept and mediate the grievances and/or complaints and advise the department heads on the appropriate solutions. -The Administrator will review with the parties involved all unsatisfied grievances and or complaints and attempt to seek a satisfied resolution acceptable to all parties. -If after the meeting with the Administrator the grievance and/or complaint is still unresolved you may contact the managing company. 1. Review of Staff A's personnel record revealed he had a hire date of 06/23/22.	D 338		

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Interview with a housekeeping staff on 02/15/23 at 12:45pm revealed:
-Staff A did not have a good demeanor, "had a rough edge", and was not a good boss.
-Staff A cursed a lot in the halls, and she had addressed Staff A about it, but it did not change.
-Residents had complained of Staff A being rude to them.
-Staff A would try to be buddies with certain residents who were more alert, because staff A knew they would talk and he did not want the residents to say anything bad.

Interview with a medication aide (MA) on 02/15/23 at 10:20am revealed:
-Staff A would not let one of the residents sit in the cloth chairs or couches in the parlor.
-Staff A would get irritated with residents and was not friendly or approachable.
-Staff A had a "speech" on toilet paper like he owned it.
-Staff A's demeanor, approach, and stance were wrong, and had driven staff away.

Interview with the Activities Director (AD) on 02/23/23 at 8:35am revealed:
-She observed Staff A use an "abrupt, dismissive" tone with the residents.
-It was "his way or the highway".
-She reported the observations she made with residents and Staff A to the Administrator but could not recall when that was.
-Staff A was observed in Resident Council meetings stating, "This is the last place you are going to live".

a. Review of Resident #10's current FL-2 dated 04/13/22 revealed diagnoses included hypertension, reduced mobility, and muscle weakness.

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D 338	Continued From page 42 Interview with Resident #10 on 02/16/23 at 12:00pm revealed: -Resident #10 put in a work request to have her refrigerator and freezer defrosted. -Her freezer would not shut, and her family member came to assist her with it. -Staff A was in the next room and heard the family member working on the refrigerator and Staff A barged in and said, "What the [expletive] is going on here?" -She tried to stay away from Staff A after that incident and did not appreciate the way he spoke to her. -She felt uncomfortable around Staff A after that incident. -Resident #10 did not feel that her rights were being upheld. Second interview with Resident #10 on 02/24/23 at 1:04pm revealed: -Staff A used to be more friendly before the incident with the freezer. -After the incident with the freezer he hardly ever talked to her and only would say hi and that was it. -Staff A apologized to Resident #10's family member but did not apologize to Resident #10. Interview with Resident #10's family member on 02/24/23 at 8:10am revealed: -He came to visit the resident and saw ice covering the ice tray in her refrigerator. -The refrigerator had been iced over for 3 weeks, and Resident #10 put in a work order for it then. -He used a butter knife to chip away at the ice. -While he was chipping at the ice, Staff A walked into the room and yelled "What the [expletive] is going on in here?" -Staff A did not knock before walking into	D 338		

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D 338	Continued From page 43 Resident #10's room. -Staff A later apologized to him but did not apologize to Resident #10. -The family member was concerned because Staff A did not know he was in the room, and would have been yelling at Resident #10. Telephone interview with Staff A on 02/23/23 at 11:15am revealed: -He was the facility's Environmental Director, Safety Director, Maintenance Director, and Transporter. -Some of the residents who reported that he was mean to them were confused. -He felt that many of the female residents were jealous of the attention the others were getting when he would work on things in their apartment. -He felt like he was "being accused of a bunch of nonsense". -He had been suspended from the facility since 02/17/23. -He was in a room replacing a mattress when he heard "loud banging followed by a pounding noise next door in Resident #10's room". -He walked into the room and yelled "what the [expletive]!" -Resident #10's family member was breaking up ice from the resident's freezer and he asked him to stop. -Resident #10 had no patience and her family had told him that as well, so when she wanted her freezer defrosted, she would not wait until he could get it done. -After he completed the defrost on the freezer, he saw Resident #10 and her family member in the hallway, and they thanked him for working on the freezer. -Resident #10 was telling residents that he was "cussing at her".	D 338		

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D 338	Continued From page 44 Interview with the Administrator on 02/24/23 at 12:05pm revealed: -On 01/23/23 Resident #10 came to her and reported that Staff A had yelled at her on 01/22/23. -Resident #10 stated that Staff A came into her room and yelled "what the [expletive]!". -On 01/23/23 she spoke with Staff A and he gave her a written statement. -On 01/23/23, Resident #10 came to her and told her that "it was all good" and that Staff A apologized. -Prior to 01/23/23, she had never had any complaints about Staff A. -On 02/16/23, local county Department of Social Services (DSS) Adult Home Specialist (AHS) reported to her that a social worker observed Staff A throw a roll of toilet paper in the direction of a resident. -On 02/16/23, she started the investigation and completed the 24- hour report to the Health Care Personnel Registry (HCPR). -On 02/16/23 Staff A was put on a suspension until she completed the investigation. -At the conclusion of her investigation, she terminated Staff A by attempting to call him on the telephone on 02/23/23. -She was unable to reach Staff A on 02/23/23 so sent a certified letter to Staff A terminating employment. b. Review of Resident #13's current FL-2 dated 01/12/23 revealed diagnoses included hypertension, venous insufficiency, and recurrent major depressive disorder. Interview with Resident #13 on 02/16/23 at 12:10pm revealed: -When Resident #13 moved to the facility, Staff A stopped her and her dog and yelled "You can't	D 338		

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have dogs here".
-Resident #13 was driven to an appointment by Staff A and the resident left her jacket in the vehicle and asked Staff A if they would get it for her.
-Staff A argued with her about not putting her name on her clothes and stated, "Well you should have put your name on it".
-The resident did not feel she should have had an issue with Staff A getting her jacket for her.
-She did not feel comfortable asking for his assistance and felt it would lead to an argument.
-Staff A was very rude to other residents and always said, "It's my way or the highway".

Telephone interview with Staff A on 02/23/23 at 11:15am revealed:
-He was instructed by the Administrator to notify Resident #13 about where her dog could use the bathroom on the facility grounds.
-Resident #13 was not happy with where the dog could use the bathroom and so she was "running her mouth about me hating animals to other residents".

c. Review of Resident #19's current FL-2 dated 01/03/23 revealed diagnoses included dementia with behaviors and hypertension.

Interview with Resident #19's guardian on 02/10/23 at 3:10pm revealed:
-On 12/13/22, the guardian was dropping off another resident at the facility when Resident #19 was coming down the hall by the nurse's station.
-Resident #19 had an empty toilet paper roll and went up to the guardian and asked for more.
-The guardian asked one of the staff sitting at the nurse's station if she could get more toilet paper for Resident #19.
-The staff got up and asked Staff A who was in

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their office, and Staff A responded "Again, I just gave her a roll 2 days ago".
-The staff member walked off, and Staff A threw the toilet paper in their direction, and it landed on the floor.
-The guardian was concerned with the treatment that was given to Resident #19, as it was a resident rights issue, as well as him throwing the toilet paper at a resident.
-The guardian did not report Staff A throwing toilet paper to the Administrator.
-The guardian reported the incident to the County Department of Social Services (DSS).

Telephone interview with Staff A on 02/23/23 at 11:15am revealed:
-There was no toilet paper shortage at the facility but Resident #19 on the SCU was confused and put the whole roll of toilet paper in the toilet.
-Resident #19 would request toilet paper but he would tell her he could not give it to her.
-He would go put the toilet paper on the holder for Resident #19 when she requested toilet paper.
-He never threw toilet paper at Resident #19.

Interview with the Administrator on 02/24/23 at 4:11pm revealed she was not aware of the toilet paper being thrown in the direction of Resident #19 prior to being made aware of the incident by the County DSS monitor on 02/16/23.

Based on observations, interviews, and record reviews, it was determined Resident #19 was not interviewable.

d. Review of Resident #18's current FL-2 dated 02/07/23 revealed diagnoses included diabetes and hypertension.

Interview with Resident #18 on 02/16/23 at

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D 338	Continued From page 47 11:40am revealed: -Staff A acted like he was the boss at the facility. -Resident #18 was speaking to the incoming resident's social worker about theft in the facility but did not know the date she did so. -Staff A yelled at Resident #18 after he was speaking with an incoming resident's social worker, stating "Don't be talking and telling people what's going on here". Second interview with Resident #18 on 02/22/23 at 10:30am revealed: -He had not seen Staff A in a few days. -He felt humiliated by Staff A and did not want to have interactions with him again. -He did not report the incident to the Administrator. e. Review of Resident #12's current FL-2 dated 06/03/22 revealed diagnoses included hypertension, hyperlipidemia (high cholesterol), and gastroesophageal reflux disease (GERD). Interview with Resident #12 on 02/24/23 at 8:36am revealed: -Staff A came into Resident #12's bedroom while she was doing a puzzle. -Staff A assisted her with the puzzle and they interacted with each other. -She and Staff A had a conversation regarding Resident #12 not having kids or ever being married, and Staff A stated "You mean you haven't had sex yet?" -Resident #12 could not recall when the interaction took place. -The Administrator and the Business Office Manager (BOM) were aware of the incident and Staff A later came back and apologized to Resident #12.	D 338		

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D 338	Continued From page 48 Interview with the facility Primary Care Provider (PCP) on 02/24/23 at 2:36pm revealed: -Residents should be free from verbal abuse. -She was not informed of any kind of abuse at the facility. 2. a. Review of Resident #5's current FL-2 dated 01/26/23 revealed: -Diagnoses included hypertension, diabetes, and depression. -Orientation status was not completed. Interview with Resident #5 on 02/23/23 at 9:22am revealed: -She had money and items that had been stolen from her room. -She was not sure of the exact date that the money and items went missing. -Someone had taken $60.00 out of her purse that she kept under her bed. -Someone had also taken a tube of lipstick, a decorative pillow, a white sweater, and a $60.00 bottle of perfume out of her room. -She now slept with her purse under her pillow for fear that someone would come in and take more money from her. -She felt like she had been "invaded". -She was having problems going to sleep at night because she was afraid that someone was going to come in while she was sleeping and take more items from her. -Sometimes she stayed awake as late at 4:30am or 5:00am because she was too afraid to go asleep and then she would fall asleep at random times throughout the day because she was not sleeping well at night. -She made the Administrator and Business Office Manager (BOM) aware of the items and money that was missing from her room, and they said they would investigate it.	D 338		

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D 338	Continued From page 49 b. Review of Resident #14's current FL-2 undated revealed: -Diagnoses included Type 2 diabetes, mood disorder, and hypertension. -She was intermittently disoriented. Review of Resident #14's Incident Report dated 02/17/23 at 11:30am revealed: -The type of incident was theft. -The location of the incident was in her apartment/bedroom. -The item missing was an undisclosed amount of money. -Resident #14's family was not notified of the incident. Interview with Resident #14 on 02/22/23 at 3:05pm revealed: -She was missing $150 total from 2 separate occasions. -She kept her money in her purse on the back of her wheelchair. c. Review of Resident #9's current FL-2 undated revealed: -Diagnoses included vascular dementia and hypertension. -Orientation status was not completed. Review of Resident #9's Incident Report dated 02/17/23 at 2:35pm revealed: -The type of incident was theft. -The location of the incident was in his apartment/bedroom. -The item missing was $50 from his bill fold when he moved to the Special Care Unit (SCU). -Resident #9's family was notified of the incident. Interview with Resident #9's Power of Attorney	D 338		

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(POA) on 02/24/23 at 2:13pm revealed:
-Resident #9 informed the POA that money was missing after moving to the Special Care Unit (SCU).
-The amount of money missing was either $50 or $100.
-It was unknown when the money went missing.
-It was brought to Administrator's attention.

d. Review of Resident #15's current FL-2 dated 09/28/22 revealed:
-Diagnoses included stoke, dementia, and syncope (loss of consciousness).
-He was intermittently disoriented.

Review of Resident #15's Incident Report dated 02/13/23 at 10:45am revealed:
-The type of incident was theft.
-The location of the incident was in his apartment/bedroom.
-The item missing was $300 from his shirt pocket.
-Resident #15 saw a big man and woman in his room the night the money went missing, but it was unknown what night it took place.
-Resident #15's family was notified of the incident.

Interview with Resident #15 on 02/24/23 at 8:18am revealed $300 went missing 1 week prior to reporting it to staff at the facility.

Telephone interview with Staff A on 02/23/23 at 11:15am revealed:
-He took Resident #15, along with 2 other residents, out every month to get money for their rent.
-Resident #15 took out extra $300 cash one month and he told the resident he needed to give it to the Business Office Manager (BOM) to keep in his account.

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-A month later, Resident #15 told him that he was missing the $300 cash and he told the resident to tell the BOM.

e. Review of Resident #17's current FL-2 dated 01/25/23 revealed:
-Diagnoses included hypertension, Alzheimer's dementia, and vitamin deficiency.
-She was constantly disoriented.

Review of Resident #17's Incident Report dated 02/17/23 at 2:42pm revealed:
-The type of incident was theft.
-The location of the incident was in her apartment/bedroom.
-The item missing was $300 taken out of a wallet.
-Resident #17 stated they did not carry a purse anymore because of the theft.
-Resident #17's family member reported that a hair dryer, hair band, and a few personal items were missing.
-Resident #17's family was notified.

Interview with the Resident #17's family member on 02/24/23 at 1:20pm revealed:
-They were not aware that anything was stolen.
-They were at the facility visiting and took Resident #17's pocketbook home for safekeeping.

f. Review of Resident #13's current FL-2 dated 01/12/23 revealed:
-Diagnoses included hypertension, venous insufficiency, and recurrent major depressive disorder.
-She was intermittently disoriented.

Review of Resident #13's Incident Report dated 02/11/23 at 2:00pm revealed:
-The type of incident was theft.

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-The location of the incident was in her apartment/bedroom.
-The items missing were 2 lipsticks and a pair of scissors.

Interview with Resident #13 on 02/23/23 at 10:05am revealed:
-She had items stolen from her room.
-She was afraid someone was going to break into her room again.

g. Review of Resident #10's current FL2 dated 04/13/22 revealed:
-Diagnoses included hypertension, reduced mobility, and muscle weakness.
-She was intermittently disoriented.

Interview with Resident #10's family member on 02/24/23 at 8:10am revealed:
-He was concerned with theft at the facility.
-Resident #10 had things missing and had to get a lock guard put on her closet door.

Interview with Resident #10's Power of Attorney (POA) on 02/20/23 at 9:05am revealed:
-Resident #10 had reported to them that money was stolen, and a lock had to be put on the closet door where only the resident had the key.
-Resident #10 had seen someone in their living room at night dressed in dark clothing and she did not feel safe but felt she could not lock her door in case she needed help.

Interview with Resident #10 on 02/16/23 at 12:00pm revealed:
-There was stealing going on in the facility and she felt she had to lock her doors.
-Money was missing from a bank envelope that was in her closet.
-She informed the Administrator of the missing

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CROATAN VILLAGE	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

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money.

h. Review of Resident #12's current FL-2 dated 06/03/22 revealed:
-Diagnoses included hypertension, hyperlipidemia (high cholesterol), and gastroesophageal reflux disease (GERD).
-She was intermittently disoriented.

Review of Resident #12's Incident Report dated 02/11/23 at 1:30pm revealed:
-The type of incident was theft.
-The location of the incident was in her apartment/bedroom.
-The item missing was Resident #12's virtual assistance speaker.

Interview with Resident #12 on 02/24/23 at 8:36am revealed someone in the facility took the cord to her virtual assistance speaker and then about a week later took the virtual assistance speaker itself.

i. Review of Resident #11's FL-2 dated 08/15/22 revealed:
-Diagnoses included hypertension and type 2 diabetes.
-She was intermittently disoriented.

Review of Resident #11's Incident Report dated 02/17/23 at 11:50pm revealed:
-The type of incident was theft.
-The location of the incident was in her apartment/bedroom.
-The item missing was a designer purse and a diamond ring.

Interview with Resident #11's family member on 02/24/23 at 1:32pm revealed:
-A designer purse, pants, and a diamond ring with

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3 diamonds was missing from Resident #11's room.
-The value of the items taken was at least $400.
-They searched the Resident's apartment and did not find the items.
-A few weeks ago, there was a person rummaging around in her room late one night, and Resident #11 pretended to be asleep.
-The family member was concerned because the diamond ring was given to Resident #11 by their deceased family member, and they could not replace it.
- The family member was also concerned with staff going through resident's personal property.
-The family member was going to call the police, but other people were having the same issue and the facility called the police.

j. Review of Resident #16's FL-2 dated 07/21/22 revealed:
-Diagnoses included Alzheimer's dementia and hyperlipidemia (high cholesterol).
-She was constantly disoriented.

Interview with Resident #16 on 02/22/23 at 10:10am revealed:
-She had shoes, a furry sweater, plaid pants, a blue shirt, and $145 stolen from her.
-She was unsure of when the items were taken but were taken on different dates.
-Resident #16 was concerned that someone was going through her things.

k. Review of Resident #7's current FL2 dated 11/11/22 revealed:
-Diagnoses included hypertension, chronic leg pain, and anxiety.
-Orientation status was not completed.

Interview with Resident #7's guardian on 02/20/23

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at 09:21am
-The guardian sent Resident #7 $40.
-They were concerned that some of the money that was sent to Resident #7 was missing or taken.

Interview with Resident #7 on 02/24/23 at 8:26am revealed:
-Resident #7 had a blue cloth pencil bag with money in it that his family gave him.
-About $8 was in the bag and was missing about 2 weeks prior.
-The bag was kept in a drawer under his underwear and lighters.
-Resident was unaware of the time the money went missing.

Interview with the Business Office Manager (BOM) on 02/24/23 at 3:51pm revealed:
-Resident #12 was the first to report theft to the facility.
-Around the same time Resident #11's family reported a ring and purse missing.
-She and the Administrator started an investigation.

Interview with the Activities Director (AD) on 02/23/23 at 8:35am revealed:
-Residents reported to her that they were missing items including money and personal items from their rooms.
-She could not remember when the residents first started to report missing items, but she immediately brought it to the Administrator's attention and the facility launched an investigation.
-She was part of the team that asked the residents about their missing items.

Interview with the Administrator on 02/24/23 at

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D 338	Continued From page 56 4:11pm revealed: -Resident #5 was the first to report anything missing. -The Administrator spoke with residents at the Resident Council meeting and found there were other residents who had items missing and started an investigation on 2/11/23 that ended on 2/17/23. -She started to interview residents and saw there were multiple residents who were missing items. -Cameras in the facility did not record video. -She contacted the police, completed incident reports, and a 24-hour Health Care Personnel Registry (HCPR) report on 02/17/23. -She completed a 5-day HCPR report on 02/23/23. Review of the 5-day HCPR report dated 02/17/23 revealed residents in the facility were interviewed about concerns of items going missing, if any facility staff had admitted taking items, and about the residents feeling safe at the facility. _____ The facility failed to ensure residents were treated with respect by Staff A. Staff A yelled at Resident #10 making her feel uncomfortable and her rights were not upheld; yelled at Resident #13 after being asked to assist her with her jacket; witnessed by a Guardian throwing toilet paper in the direction of Resident #19; causing Resident #18 to feel humiliated after being yelled at by Staff A. The facility's failure to respond to resident complaints against Staff A in January 2023 resulted in Staff A continuing to work with the residents for over three weeks. This failure placed the residents in substantial risk for abuse and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 received on	D 338		

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D 338	Continued From page 57 02/16/23 and amended on 02/22/23 for this violation. THE CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED March 26, 2023.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Non-compliance continues with increased severity resulting in death, serious physical harm, abuse, neglect, or exploitation. THIS IS A TYPE A1 VIOLATION Based on observations, record reviews and interviews the facility failed to administer medications as ordered for 3 of 5 sampled residents (#3, #4, #5, #7) including errors with not administering potassium and magnesium replacement medications and missed doses of a blood thinner (#3), not administering correct doses of insulin and missed doses of insulin (#5), receiving blood pressure medicine without blood pressure checks, missed doses of a supplement,	D 358		

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and receiving too many days of an ear medication (#4).

The findings are:

1. Review of Resident #3's current FL-2 dated 04/07/22 revealed diagnoses included late onset Alzheimer's disease, chronic atrial fibrillation (irregular heart rate), diabetes, and hyperlipidemia

a. Review of Resident #3's physician communication note dated 02/10/23 revealed there was an order to send the resident to the emergency room because his potassium level was 2.7 (Potassium helps muscles to contract, including cardiac muscles and the normal range is between 3.5 and 5.1).

Review of Resident #3's facility progress note dated 02/10/23 at 11:23am revealed:
-Resident #3 was being sent out to the emergency room due to having a critically low potassium level of 2.7.
-It was recommended by the on-call primary care provider (PCP) to send Resident #3 to the emergency room (ER) for treatment.
-Resident #3's family member was made aware, and emergency medical services (EMS) was called to transport the resident to the hospital.

Review of Resident #3's ER on 02/10/23 documentation revealed:
-Resident #3's arrived to the ER at 12:50pm.
-Resident #3's was being treating in the ER for low potassium levels.
-Resident #3's potassium level was 2.6 at 12:54pm.
-Resident #3's magnesium level was 1.5 (normal magnesium level is between 1.6 and 2.6).

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D 358	Continued From page 59 -Resident #3 was given potassium and magnesium intravenously while in the ER. Review of Resident #3's ER discharge summary dated 02/11/23 revealed: -Resident #3 was treated for hypokalemia (low potassium level) and hypomagnesaemia (low magnesium levels). -There was an order for the resident to start taking magnesium oxide 400mg tablets with instructions to take one tablet every day for 10 days (Magnesium oxide is a medication used to treat low levels of magnesium). -There was an order for the resident to start taking magnesium gluconate 500mg tablets with instructions to take ½ tablet every day (Magnesium gluconate is a medication used to treat low levels of magnesium). -There was an order for the resident to start taking potassium chloride 20mEq tablets with instructions to take one tablet every day (Potassium chloride is a medication used to treat low levels of potassium). Review of Resident #3's facility progress note dated 02/11/23 at 1:30am revealed Resident #3 returned to the facility from the ER "with no new orders just to schedule a follow-up in 2-3 days with PCP". Review of Resident #3's facility progress note dated 02/11/23 at 2:48am revealed: -The hospital called back to inform staff that Resident #3's folder including his discharge paperwork and DNR (do not resuscitate) form was left at the hospital and "would be dropped off". -The hospital staff notified the medication aide (MA) that the resident had new orders or magnesium gluconate, magnesium oxide, and	D 358		

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D 358	Continued From page 60 potassium chloride. Review of Resident #3's facility progress note dated 02/20/23 at 4:17pm revealed: -This was a late entry note from 02/11/23 at 3:00pm. -Resident was discharged from the hospital on 02/11/23 with two new orders for potassium and magnesium. -On 2/14/23, the PCP visited the facility and ordered the resident to continue the medications. -Upon discharge from the hospital the discharge paperwork was not faxed to the facility's contracted pharmacy. -The facility's contracted pharmacy contacted the Special Care Coordinator (SCC) for clarification because they did not have an original order for potassium and magnesium. -On 02/16/23 the SCC faxed the discharge paperwork for Resident #3's 02/11/23 hospitalization. -The medications were received the night of 02/17/23. Review of Resident #3's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for magnesium oxide 400mg with instructions to take one tablet every day for 10 days, scheduled for administration at 8:00am and documented as administered on 02/18/23 at 8:00am. -There was an entry for magnesium gluconate 500mg tablets with instructions to take ½ tablet every day, scheduled for administration at 8:00am and documented as administered on 02/18/23 at 8:00am. -There was an entry for potassium chloride 20mEq tablets with instructions to take one tablet every day, scheduled for administration at	D 358		

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8:00am and documented as administered on 02/18/23 at 8:00am.
-Magnesium oxide 400mg, magnesium gluconate 250mg, and potassium chloride 20mEq were not administered as ordered from 02/11/23 to 02/17/23.

Observation of Resident #3's medications on hand on 02/24/23 at 8:16am revealed:
-Resident #3 had a bubble package of magnesium oxide 400mg tablets with instructions to take one tablet every day for 10 days.
-There were 10 magnesium oxide 400mg tablets in the package.
-Ten 400mg tablets were dispensed on 02/16/23 and none were administered.
-Resident #3 had a bubble package of magnesium gluconate 500mg tablets with instructions to take ½ tablet every day.
-There were 11 magnesium gluconate ½ tablets in the package.
-Eleven magnesium gluconate 500mg ½ tablets were dispensed on 02/16/23 and none were administered.
-Resident #3 had a bubble package of potassium chloride 20mEq tablets with instructions to take one tablet every day.
-There were 11 potassium chloride 20mEq tablets in the package.
-Eleven potassium chloride 20mEq tablets were dispensed on 02/16/23 and none were administered.

Telephone interview with Resident #3's family member on 02/24/23 at 10:47am revealed:
-Resident #3 was admitted to the hospital on 02/18/23 and was still currently inpatient.
-Resident #3 had several falls on 02/18/23 and was sent to the ER where it was found that "his labwork was all wacky".

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-Resident #3 was admitted to get his "lab levels stable".
-She was not aware that Resident #3 had not received his potassium or magnesium replacement medications that were ordered on 02/11/23.
-The hospital was not aware that Resident #3 had not received his potassium or magnesium replacement medications that were ordered on 02/11/23 because they were listed on his current medications.

Review of Resident #3's facility progress note dated 02/18/23 at 6:37am revealed he was being sent to the ER because of a fall.

Review of Resident #3's ER discharge summary dated 02/18/23 revealed:
-Resident #3 was being evaluated for a fall and complaints of hip pain.
-Resident #3's potassium level on 02/18/23 at 10:00am was low at 2.9.
-Resident #3 received potassium replacement intravenously.
-Potassium chloride 20mEq once a day was noted as current on his medication list.
-Magnesium oxide 400mg once a day was noted as current on his medication list.
-Magnesium gluconate 250mg once a day was noted as current on his medication list.
-Resident #3 was discharged back to the facility with no new orders.

Review of Resident #3's facility progress note dated 02/18/23 at 6:23pm revealed:
-Resident was attempting to open his dresser drawer and fell to his knees.
-As staff was "picking him up, he complained of chest pain".
-EMS was called and resident was sent to the ER

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D 358	Continued From page 63 for evaluation. Review of Resident #3's ER physician note dated 02/18/23 revealed: -The resident was discharged from the ER less than 4 hours ago after an evaluation for a fall earlier in the day. -Facility staff found Resident #3 on his knees complaining of chest pain so he was sent back for evaluation. -Potassium chloride 20mEq once a day was noted as current on his medication list. -Magnesium oxide 400mg once a day was noted as current on his medication list. -Magnesium gluconate 250mg once a day was noted as current on his medication list. -Resident #3's potassium level on 02/18/23 at 7:07pm was low at 3.1. -Resident #3 was admitted to inpatient status for further evaluation and treatment. Review of Resident #3's hospitalization records from 02/18/23 to 02/23/23 revealed: -Resident #3 was still being treated in the hospital. -Resident #3's potassium level on 02/19/23 at 12:29pm was 3.6 after receiving additional potassium intravenously. -Resident #3's potassium level on 02/20/23 at 12:23am was 3.0. -Resident #3's potassium level on 02/23/23 at 4:14am was 3.8. -Resident #3's magnesium level on 02/20/23 at 12:23am was 1.8. -Resident #3 was receiving his oral medications that were listed as current including potassium chloride, magnesium oxide, and magnesium gluconate while hospitalized. Interview with the SCC on 02/24/23 at 3:30pm	D 358		

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revealed:
-Resident #3's discharge paperwork from 02/11/23 did not get faxed to the pharmacy when it was returned to the facility.
-When Resident #3's PCP evaluated the resident on 02/14/23 she wrote an order to continue the potassium chloride, magnesium oxide, and magnesium gluconate which was faxed to the pharmacy.
-The pharmacy called the facility to clarify because they did not have a current order for potassium chloride, magnesium oxide, and magnesium gluconate.
-The MA that received the discharge paperwork was to fax the new orders to the pharmacy but that did not happen.

Interview with the Administrator on 02/24/23 at 4:15pm revealed:
-When she was made aware that Resident #3 did not have his discharge orders from his 02/11/23 hospitalization faxed she notified the provider which was on 02/20/23.
-She thought that he received his ordered potassium chloride, magnesium oxide, and magnesium gluconate starting 02/17/23.
-She was not aware that none of the potassium chloride, magnesium oxide, and magnesium gluconate medications dispensed from the pharmacy were given to Resident #3.
-She expected staff to administer medications as ordered.

Telephone interview with Resident #3's PCP on 02/24/23 at 2:50pm revealed:
-Resident #3 was ordered laboratory work to monitor his blood levels including potassium because he was on an anti-diuretic that can sometimes lower electrolytes.
-Resident #3's laboratory work on 02/10/23

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showed his potassium level was critically low so he was sent to the ER for replacement therapy.
-When she visited the facility on 02/14/23 to conduct a follow-up visit on Resident #3 after his hospitalization she reviewed his discharge paperwork and saw that he was ordered potassium and magnesium replacement therapy.
-On 02/14/23, she wrote an order to continue the potassium and magnesium replacement that he was ordered on discharge.
-She was notified on 02/20/23 by electronic communication from the Administrator that Resident #3 did not start his potassium or magnesium until 02/17/23 but she was not aware that he never received any of the ordered medication.
-She expected the facility to administer medications as ordered upon discharge from the ER immediately.
-Low levels of potassium could cause chest pain and heart arrhythmias.
-Resident #3 was admitted to the hospital on 02/18/23 with chest pain.
-Low levels of potassium could also cause syncope which could be related to Resident #3's falls on 02/18/23.
-Low levels of magnesium could cause heart arrhythmias.

Attempted interview with Resident #3 on 02/22/23, 02/23/23, and 02/24/23 were unsuccessful.

b. Review of Resident #3's hospital discharge summary dated 01/01/23 revealed:
-The resident was treated in the hospital for concerns related to a fall.
-The resident's work up revealed that he had a deep vein thrombosis [(DVT) or blood clot].
-There was an order to start Eliquis 5mg, take

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two tablets (10mg) twice a day for 6 more days then 5mg twice a day (Eliquis is an anti-coagulant, blood thinner used to treat DVT).

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Eliquis 5 mg tablets, with instructions to take 2 tablets (=10mg) twice a day for 6 days, scheduled for administration at 8:00am and 8:00pm.
-Eliquis 10mg was documented as administered on 01/03/23 to 01/08/23 at 8:00am and 8:00pm.
-There was an entry for Eliquis 5mg twice a day, scheduled for administration at 8:00am and 8:00pm.
-Eliquis 5mg was documented as administered on 01/09/23 to 01/24/23 at 8:00am and 8:00pm, except on 01/11/23 at 8:00pm, 01/12/23 at 8:00am, 01/14/23 at 8:00am, 01/14/23 at 8:00pm, 01/15/23 at 8:00am, 01/16/23 at 8:00pm, 01/18/23 at 8:00pm, 01/19/23 at 8:00pm, and 01/24/23 at 8:00am when it was documented as not administered because of "awaiting medication delivery from pharmacy".

Telephone interview with pharmacist at the facility's contracted pharmacy on 02/23/23 at 3:35pm revealed:
-The pharmacy received the initial order for Resident #3's Eliquis on 01/01/23 and dispensed 24- 5mg tablets (which equaled 12 doses or 6 days medication).
-The pharmacy did not dispense any additional Eliquis until 01/24/23 when they dispensed 12-5mg tablets (which equaled 12 doses or 6 days of medication).

Interview with a medication aide (MA) on 02/23/23 at 3:45pm revealed:

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D 358	Continued From page 67 -He notified the facility's Registered Nurse (RN) and the Resident Care Coordinator (RCC) that Resident #3 was out of his Eliquis on multiple occasions. -He did not document that he notified the RN or RCC that Resident #3 was out of Eliquis. -He documented on the eMAR that the resident was out of the Eliquis. -He did not know why staff were documenting administered on Resident #3's Eliquis from 01/09/23 to 01/24/23 because there was none available on the medication cart to administer. Interview with the RCC on 02/24/23 at 2:40pm revealed: -She did not remember being told by any staff that Resident #3 was out of Eliquis in January of 2023. -Staff might have told the facility's previous RN who no longer worked at the facility. -If she was notified that Resident #3 was out of Eliquis she would have contacted the backup pharmacy for immediate delivery. -She was completing cart audits currently but didn't have a schedule as to how she was completing them and she did not remember if she completed any cart audits in January 2023. Interview with the Special Care Coordinator (SCC) on 02/24/23 at 3:30pm revealed if a medication aide (MA) documented a medication was administered on Resident #3's eMAR on 02/18/23 she would have expected the bubble package to have been opened for one day. Interview with the Administrator on 02/24/23 at 4:15pm revealed she was not aware that Resident #3 did not receive his Eliquis as ordered from 01/09/23 to 01/24/23 as ordered.	D 358		

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Telephone interview with Resident #3's primary care provider (PCP) on 02/24/23 at 2:50pm revealed:
-She was not aware that Resident #3 did not receive his ordered Eliquis from 01/09/23 to 01/24/23.
-It was important for Resident #3 to receive his Eliquis because he had a newly diagnosed DVT.
-If Resident #3 was not receiving his Eliquis as ordered there was a risk that the DVT could travel and cause a heart attack or stroke.

Attempted interview with Resident #3 on on 02/22/23, 02/23/23, and 02/24/23 were unsuccessful.

2. Review of Resident #5's current FL-2 dated 01/26/23 revealed diagnoses included diabetes.

a. Review of Resident #5's physician order sheet dated 12/30/22 revealed there was an order for Novolog (a short-acting insulin used to treat high blood sugars) check fingerstick blood sugar (FSBS) before meals; sliding scale insulin FSBS of 200-250 3 units, FSBS of 251-300 5 units, FSBS greater than 300 7 units.

Review of Resident #5's current FL-2 dated 01/26/23 revealed:
-There was an order for fingerstick blood sugar (FSBS) before meals and at bedtime.
-There was an order for Novolog before meals, 3 units for a FSBS of 200 to 250, 5 units for a FSBS of 251 to 300, 7 units for a FSBS greater than 300.

Review of Resident #5's January 2023 eMAR revealed:
-There was an entry for Novolog check FSBS before meals sliding scale insulin FSBS 200-250

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= 3 units, FSBS 251-300 = 5 units, FSBS greater than 300 = 7 units scheduled for administration at 7:00am.
-Novolog 3 units was documented as administered for a FSBS of 296 at 7:00am on 01/02/23 when Novolog 5 units should have been administered.
-There was an entry for check FSBS before meals and at bedtime scheduled at 12:00pm.
-FSBS was documented as 338 on 01/02/23 at 12:00pm.
-Novolog 5 units was documented as administered for a FSBS of 317 at 7:00am on 01/23/23 when Novolog 7 units should have been administered.
-There was an entry for Novolog check FSBS before meals sliding scale insulin FSBS 200-250 = 3 units, FSBS 251-300 = 5 units, FSBS greater than 300 = 7 units scheduled for administration at 5:00pm.
-Novolog sliding scale was documented as administered as ordered at 5:00pm on 01/01/23 to 01/31/23.
-There was an entry for check FSBS at bedtime scheduled for 8:00pm.
-FSBS were documented as performed at 8:00pm on 01/01/23 to 01/31/23.
-FSBS ranged from 77 to 480 from 01/01/23 to 01/31/23.

Interview with Resident #5 on 02/23/23 at 9:22am revealed:
-As far as she knew she always received the correct dosage of insulin.
-Her blood sugars were always up and down and never the same thing.

Interview with a medication aide (MA) on 02/23/23 at 2:31pm revealed:
-When administering sliding scale insulin to a

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resident she would look at the resident's FSBS and then administer the correct dose of insulin based on the order.
-Based on Resident #5's FSBS of 296 on 01/02/23 the MA should have administered 5 units of Novolog to Resident #5.

Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 3:02pm revealed:
-She expected MAs to give the correct dosage of Novolog to Resident #5 every time it was administered, and it was unacceptable that it was not done for Resident #5.
-Not administering the correct dosage of Novolog to Resident #5 could cause her FSBSs to not be at a therapeutic level.

Interview with the Administrator on 02/24/23 at 4:11pm revealed it was important for MAs to give the correct dosage of Novolog to Resident #5 because it could cause her FSBS to become too high or too low if she received the wrong dosage.

Telephone interview with Resident #5's primary care provider's (PCP) nurse on 02/23/23 at 11:36am revealed she would speak to the PCP about issues with Resident #5's sliding scale Novolog and have the PCP call back.

Second telephone interview with Resident #5's PCP's nurse on 02/23/23 at 3:13pm revealed:
-She had spoken to Resident #5's PCP and he had provided answers to questions about Resident #5's sliding scale Novolog.
-The PCP was asked by the facility to discontinue Resident #5's sliding scaled insulin.
-The PCP expected Resident #5 to receive the correct dosage of Novolog and not receiving the correct dosage of Novolog could cause the risk of hyperglycemia (high blood sugars).

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D 358	Continued From page 71 -Hyperglycemia could lead to diabetic coma, renal and eye issues, kidney, liver, or nerve damage, as well as heart issues. b. Review of Resident #5's current FL-2 dated 01/26/23 revealed: -There was an order for Novolog (a short-acting insulin used to treat high blood sugar) 12 units twice daily 10 to 15 minutes prior to breakfast and dinner. -There was an order for Novolog before meals 3 units for a FSBS of 200 to 250, 5 units for a FSBS of 251 to 300, 7 units for a FSBS greater than 300. -There was an order for fingerstick blood sugar (FSBS) before meals and at bedtime. Review of Resident #5's physician order sheet dated 12/30/22 revealed: -There was an order for Novolog 12 units twice daily 10-15 minutes prior to breakfast and dinner. -There was an order for Novolog 8 units every day with lunch. Review of Resident #5's physician order sheet dated 01/26/23 revealed: -There was an order to discontinue sliding scale insulin. -There was an order for Novolog 15 units with each meal. Telephone interview Resident #5's PCP's nurse on 02/23/23 at 3:13pm revealed the PCP was asked by the facility to discontinue Resident #5's Novolog sliding scale insulin. Review of Resident #5's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 12 units twice a	D 358		

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day 10 to 15 minutes prior to breakfast and dinner scheduled for administration at 7:45am and 4:45pm.
-Novolog 12 units was documented as administered at 7:45am and 4:45pm on 01/01/23 to 01/31/23 except on 01/12/23, 01/15/23, and 01/31/23 at 7:45am where it was documented as refused and on 01/09/23 at 4:45pm where it was documented as refused.
-There was an entry for Novolog 8 units every day with lunch scheduled for administration at 12:15pm.
-Novolog 8 units was documented as administered at 12:15pm on 01/01/23 to 01/31/23 except on 01/03/23, 01/05/23, 01/06/23, 01/10/23, 01/13/23, 01/14/23, 01/17/23, 01/18/23, 01/20/23, 01/23/23, 01/26/23, and 01/29/23 where it was documented as refused.
-There was no entry for Novolog 15 units before meals.
-There was an entry for Novolog check FSBS before meals sliding scale insulin FSBS 200-250 = 3 units, FSBS 251-300 = 5 units, FSBS greater than 300 = 7 units scheduled for administration at 7:00am, 12:00pm, and 5:00pm.
-Novolog sliding scale insulin was discontinued on the eMAR on 01/26/23.
-There was an entry for check FSBS before meals and at bedtime scheduled at 7:00am, 11:30am, 4:30pm, and 8:00pm.
-On 01/01/23 to 01/26/23 Resident #4's FSBSs ranged from 93 to 480.
-On 01/27/23 to 01/31/23 Resident #4's FSBS ranged from 99 to "HI" ("HI" indicates a FSBS of greater than 500).

Review of Resident #5's February 2023 eMAR revealed:
-There was an entry for Novolog 12 units twice a day 10 to 15 minutes prior to breakfast and dinner

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scheduled for administration at 7:45am and 4:45pm.
-Novolog 12 units was documented as administered at 7:45am on 02/01/23 to 02/22/23 and at 4:45pm on 02/01/23 to 02/21/23 except at 7:45am on 02/07/23 and 02/22/23 where it was documented as refused.
-There was an entry for Novolog 8 units every day with lunch scheduled for administration at 12:15pm.
-Novolog 8 units was documented as administered at 12:15pm on 02/01/23 to 02/22/23 except on 02/02/23, 02/03/23, 02/07/23, 02/18/23, 02/21/23, and 02/22/23 where it was documented as refused.
-There was no entry for Novolog 15 units before meals.
-There was an entry for check FSBS before meals and at bedtime scheduled at 7:00am, 11:30am, 4:30pm, and 8:00pm.
-On 02/01/23 to 02/23/22 Resident #4's FSBSs ranged from 73 to "HI".

Interview with Resident #5 on 02/23/23 at 9:22am revealed:
-She refused her Novolog sometimes when she thought her FSBS was too low to take it.
-Her blood sugars were always up and down and never the same thing.

Interview with a medication aide (MA) on 02/23/23 at 2:31pm revealed:
-The Resident Care Coordinator (RCC) faxed new medications to the pharmacy and the pharmacy then changed the orders on the eMAR.
-MAs administered medications as they were listed on the eMAR.

Interview with the RCC on 02/24/23 at 3:02pm revealed:

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D 358	Continued From page 74 -It was either the MA, RCC, or Special Care Coordinator's (SCC) responsibility to fax new medication orders to the pharmacy. -She should have faxed Resident #5's new Novolog orders to the pharmacy when they were received. -There was no system in place to track medication orders. -There were no checks and balances in place to make sure a medication order did not get missed. -She did not know how the Novolog sliding scale insulin was discontinued on the eMAR but the Novolog dosage order did not get changed. Interview with the Administrator on 02/24/23 at 4:11pm revealed: -The RCC should have faxed Resident #5's new medication orders to the pharmacy the same day there were received. -She discontinued the Novolog sliding scale insulin on Resident #5's eMAR. -The pharmacy put new medication orders on the eMAR once they received the orders. Telephone interview with a pharmacist at Resident #5's pharmacy on 02/24/23 at 8:56am revealed: -The most current Novolog order that was on file for Resident #5 was from 06/10/22 for Novolog 12 units at breakfast and dinner and 8 units at lunch in conjunction with sliding scale insulin. -The pharmacy never received the new order to discontinue Resident #5's sliding scale insulin and increase her Novolog dosage. Telephone interview with Resident #5's primary care provider's (PCP) nurse on 02/23/23 at 11:36am revealed she would speak to the PCP about issues with Resident #5's Novolog and have the PCP call back.	D 358		

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D 358	Continued From page 75 Second telephone interview Resident #5's PCP's nurse on 02/23/23 at 3:13pm revealed: -She had spoken to Resident #5's PCP and he had provided answers to questions about Resident #5's Novolog. -The PCP was asked by the facility to discontinue Resident #5's Novolog sliding scale insulin. -The PCP discontinued Resident #5's Novolog sliding scale insulin but increased her breakfast, lunch, and dinner dose of Novolog to help cover the sliding scale insulin she was no longer receiving. -The PCP was fine with discontinuing the Novolog sliding scale insulin for Resident #5 but expected the facility to increase the Novolog as ordered. -Resident #5 not receiving the correct dosage of Novolog could cause hyperglycemia (high blood sugars). -Hyperglycemia could lead to diabetic coma, renal and eye issues, kidney, liver, or nerve damage, as well as heart issues. c. Review of Resident #5's physician order sheet dated 12/30/22 revealed there was an order for Lantus (used to treat high blood sugars) 13 units twice a day. Review of Resident #5's physician order sheet dated 01/19/23 revealed there was an order to increase Lantus to 30 units daily for one week, then 35 units daily for one week, then 40 units daily. Review of Resident #5's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus inject 13 units twice a day scheduled for administration at 8:00am and 8:00pm with an end date of 01/20/23.	D 358		

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D 358	Continued From page 76 -Lantus 13 units was documented as administered at 8:00am 01/01/23 to 01/20/23 except on 01/12/23 where it was documented as refused. -Lantus 13 units was documented as administered at 8:00pm on 01/01/23 to 01/19/23 except on 01/06/23 and 01/11/23 where it was documented as refused. -There was an entry for Lantus inject 30 units every day for 7 days scheduled for administration at 8:00am with an effective date of 01/21/23 and an end date of 01/27/23. -Lantus 30 units was not documented as administered at 8:00am on 01/21/23 to 01/23/23. -There was a "X" on the eMAR for Lantus 30 units on 01/21/23 to 01/23/23 with no indication of why. -Lantus 30 units was documented as administered at 8:00am on 01/24/23 to 01/27/23. -There was an entry for Lantus inject 35 units every day for 7 days scheduled for administration at 8:00am with an effective date of 01/28/23 and an end date of 02/03/23. -Lantus 35 units was documented as administered 01/28/23 to 01/31/23. -There was an entry for check fingerstick blood sugar (FSBS) before meals and at bedtime scheduled for 7:00am, 11:30am, 4:30pm, and 8:00pm. - FSBS ranged from 77 to 381 on 01/01/23 to 01/20/23. -FSBS ranged from 147 to 480 on 01/21/23 to 01/24/23. Interview with Resident #5 on 02/23/23 at 9:22am revealed: -She refused her Lantus sometimes when she thought her FSBS was too low to take it. -Her blood sugars were always up and down and never the same thing.	D 358		

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D 358	Continued From page 77 Interview with a medication aide (MA) on 02/24/23 at 10:49am revealed: -Once a new medication order was entered into the eMAR by the pharmacy the Resident Care Coordinator (RCC) had to approve the order so it would show up on the eMAR. -The "X"s on Resident #5's eMAR for 01/21/23 to 01/23/23 could be because the new orders were not approved by the RCC yet. Interview with the RCC on 02/24/23 at 3:02pm revealed: -She was still in training in January 2022 and had to ask someone how to approve new medication orders. -The computers had been "acting up" and maybe that was why Resident #5's Lantus did not get approved in the computer on time. Interview with the Administrator on 02/24/23 at 4:11pm revealed: -After a new medication was entered into the computer by the pharmacy it had to be approved by the RCC in order for the medication to show up on the eMAR. -The "X"s on Resident #5's eMAR for her Lantus on 01/21/23 to 01/23/23 looked like the new Lantus orders had not been approved yet. -If the new Lantus orders had not been approved by the RCC then Lantus would not pop up on the eMAR for the MAs to administer it. Telephone interview with Resident #5's primary care provider's (PCP) nurse on 02/23/23 at 11:36am revealed she would speak to the PCP about issues with Resident #5's Lantus and have the PCP call back. Second telephone interview with Resident #5's	D 358		

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PCP's nurse on 02/23/23 at 3:13pm revealed:
-She had spoken to Resident #5's PCP and he had provided answers to questions about Resident #5's Lantus.
-The PCP changed Resident #5's Lantus dosage because she was having high blood sugars.
-The PCP expected Resident #5 to receive her new dosage of Lantus as ordered.
-Missing 3 days of Lantus in a row could cause Resident #5 to have hyperglycemia (high blood sugars).
-Hyperglycemia could lead to diabetic coma, renal and eye issues, kidney, liver, or nerve damage, as well as heart issues.

d. Review of Resident #5's physician order sheet dated 12/30/22 revealed there was an order for Trulicity (used to treat high blood sugars) 1.5mg weekly.

Review of Resident #5's physician order sheet dated 01/19/23 revealed there was an order to increase Trulicity to 3mg weekly.

Review of Resident #5's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Trulicity 1.5mg weekly scheduled for administration at 8:00am.
-Trulicity 1.5mg was documented as administered at 8:00am on Monday, 01/02/23 and Monday, 01/09/23.
-Trulicity was not documented as administered at 8:00am on Monday 01/16/23 with no explanation for the omission.
-Resident #4 did not receive Trulicity the week of 01/15/23 to 01/21/23.

Telephone interview with a pharmacist at Resident #5's pharmacy on 02/24/23 at 8:56am

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revealed:
-Four pens of Trulicity, which was a 28-day supply, was last dispensed for Resident #5 on 01/09/23 (According to manufacturer's instructions each pen of Trulicity contains 1 dose of Trulicity).
-Prior to that, 4 pens of Trulicity was dispensed to Resident #5 on 12/12/22.

Observation of Resident #5's medications on hand on 02/24/23 at 10:46am revealed there was one unopened Trulicity pen on the cart for Resident #4.

Interview with Resident #5 on 02/23/23 at 9:22am revealed:
-She did know if she missed a dose of Trulicity or not.
-Her blood sugars were always up and down and never the same thing.

Interview with a medication aide (MA) on 02/23/23 at 2:31pm revealed:
-Resident #5's Trulicity would only pop up on the eMAR on the days it should be administered.
-She was not sure why Resident #5's Trulicity was not administered on 01/16/23 because it should have come up on the eMAR to be administered.

Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 3:02pm revealed if Trulicity was not documented as administered to Resident #5 on 01/16/23 that meant it was not administered.

Interview with the Administrator on 02/24/23 at 4:11pm revealed if Trulicity was not documented on the eMAR as administered to Resident #5 on 01/16/23 that meant it was not administered and she missed a dose.

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D 358	Continued From page 80 Telephone interview with Resident #5's primary care provider's (PCP) nurse on 02/23/23 at 11:36am revealed she would speak to the PCP about issues with Resident #5's Trulicity and have the PCP call back. Second telephone interview with Resident #5's PCP's nurse on 02/23/23 at 3:13pm revealed: -She had spoken to Resident #5's PCP and he had provided answers to questions about Resident #5's Trulicity. -Trulicity was administered weekly to treat high blood sugars. -Resident #5 missing a dose of Trulicity put her at risk for hyperglycemia (high blood sugars). -Hyperglycemia could lead to diabetic coma, renal and eye issues, kidney, liver, or nerve damage, as well as heart issues. 3. Review of Resident #4's current FL-2 dated 11/15/22 revealed diagnoses included Vitamin D deficiency, hyperlipidemia (high cholesterol), and unspecified hearing loss. a. Review of Resident #4's current FL-2 dated 11/15/22 revealed there was an order for metoprolol succinate ER 25mg every morning for hypertension (Metoprolol succinate ER is used to treat high blood pressure). Review of Resident #4's physician order sheet dated 01/17/23 revealed there was an order to check blood pressure (BP) once daily before giving metoprolol, hold metoprolol if systolic blood pressure (SBP) is less than 100, inform MD if SBP is over 160. Review of Resident #4's January 2023 electronic medication administration record (eMAR)	D 358		

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revealed:
-There was an entry for metoprolol succinate ER 25mg for hypertension, hold if SBP is less than 100, inform MD if SBP is over 160 scheduled for administration at 9:00am.
-Metoprolol succinate ER was documented as administered 01/01/23 to 01/31/23.
-There were no BP readings on the eMAR for Resident #4.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for metoprolol succinate ER 25mg for hypertension, hold if SBP is less than 100, inform MD if SBP is over 160 scheduled for administration at 9:00am.
-Metoprolol succinate ER was documented as administered 02/01/23 to 02/22/23.
-There were no BP readings on the eMAR for Resident #4.

Review of Resident #4's record revealed there were no BP readings.

Interview with the Administrator on 02/24/23 at 9:26am revealed she had reviewed Resident #4's record and no one had been checking his BP daily before administering his metoprolol succinate ER.

Interview with a medication aide (MA) on 02/24/23 at 11:50am revealed:
-MAs were responsible for checking a resident's BP if it was ordered.
-MAs knew to check BPs on residents because it would pop up on the eMAR that it needed to be checked.
-The BP could pop up on the eMAR as a separate order or sometimes when a MA clicked on a medication it would pop up on the eMAR to

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check a BP before administering the medication.
-She was not aware that Resident #4 needed his BP checked prior to administering metoprolol succinate ER.
-She did not notice the written instructions on Resident #4's eMAR to hold his metoprolol succinate ER for a SBP of 100.
-It did not pop up on the eMAR to check Resident #4's BP.
-BP checks were put on the eMAR by either the Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC).

Interview with the RCC on 02/24/23 at 3:02pm revealed:
-MAs where responsible for checking BPs on residents and they knew to do so because it would pop up on the eMAR that it needed to be done.
-The former SCC was putting BP entries on the eMAR for residents.
-She did not know how to put BP entries on the eMAR for residents.
-It was important to check Resident #4's BP as ordered before administering his metoprolol succinate ER because if his BP was too low when he took the medication it could drop his BP even lower.

Second interview with the Administrator on 02/24/23 at 4:11pm revealed:
-The prior SCC used to put BPs on the eMARs for residents.
-The RCC had been trained how to put BPs on the eMAR for residents.
-She expected Resident #4 to get his BP checked daily prior to the administration of metoprolol succinate as ordered.

Telephone interview with Resident #4's primary

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care provider (PCP) on 02/24/23 at 2:37pm revealed:
-She was not aware that the facility was not checking Resident #4's BP prior to administering his metoprolol succinate ER.
-She expected facility staff to check Resident #4's BP prior to administering his metoprolol succinate ER as ordered.
-She ordered for Resident #4's BPs to be checked because Resident #4 was already weak and if he received his metoprolol succinate ER and his SBP was less than 100 it could make him weaker.
-Resident #4 becoming weaker could lead to decreased responsiveness or the resident could fall.
-If Resident #4's BP went too low it could also cause him to have to go to the hospital.

Attempted interview with Resident #4 on 02/24/23 at 1:02pm was unsuccessful.

b. Review of Resident #4's current FL-2 dated 11/15/22 revealed there was an order for Vitamin D3 (a supplement) 25mcg every morning for vitamin deficiency.

Review of Resident #4's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D3 25mcg every morning for vitamin deficiency scheduled for administration at 9:00am.
-Vitamin D 25mcg was documented as administered on 12/01/22 to 12/09/22 and 12/15/22 to 12/31/22.
-Vitamin D 25mcg was documented as awaiting pharmacy delivery on 12/10/22 to 12/14/22.

Interview with a pharmacist at the facility's

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contracted pharmacy on 02/24/23 at 10:05am revealed:
-Eighteen tablets of Vitamin D3 25mcg was dispensed to Resident #4 on 11/17/22.
-Twenty-eight tablets of Vitamin D3 25mcg was dispensed to Resident #4 on 11/28/22.
-Nineteen tablets of Vitamin D3 25mcg was dispensed to Resident #4 on 12/14/22.
-Resident #4 was dispensed more Vitamin D3 than he needed so she was not sure why the facility would have run out of the medication unless it was misplaced.

Interview with a medication aide (MA) on 02/24/23 at 10:49am revealed:
-She did not remember if Resident #4 was out of Vitamin D3 in December 2022 or not but since she documented on the eMAR that he was out of it he must have been.
-MAs requested refills on medications for residents when the medications got down to the blue part on the medication card.
-Refills were faxed to the pharmacy by the MA or the Resident Care Coordinator (RCC).

Interview with the RCC on 02/24/23 at 3:02pm revealed:
-MAs were responsible for reordering resident's medication when the medication got down to the blue part on the medication card.
-She did not know why Resident #4's Vitamin D was documented as awaiting pharmacy delivery if he had enough Vitamin D3 dispensed.
-If it was documented on the eMAR that the facility was awaiting pharmacy delivery for Resident #4's Vitamin D3 that meant he did not receive it on those days.

Interview with Resident #4's primary care provider (PCP) on 02/24/23 at 2:37pm revealed:

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-She expected the facility to obtain refills on resident's medications before they ran out of the medication.
-She did not know that Resident #4 went 5 days without his Vitamin D3 but she expected him to receive it daily for his Vitamin D deficiency.

Attempted interview with Resident #4 on 02/24/23 at 1:02pm was unsuccessful.

c. Review of Resident #4's physician order sheet dated 02/07/23 revealed there was an order for Debrox ear drops, instill 5 drops in each ear twice daily for 4 days (Debrox is used to treat ear wax buildup).

Review of Resident #4's physician order sheet dated 02/14/23 revealed there was an order for refill Debrox, instill 5 drops in each ear twice daily for 4 days.

Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Debrox place 5 drops in each ear twice a day for 4 days scheduled for administration at 8:00am and 8:00pm with an effective date of 02/08/23 and an end date of 02/13/23.
-Debrox was documented as administered at 8:00am on 02/09/23 to 02/13/23 and at 8:00pm on 02/08/23 to 02/12/23.
-Debrox was administered at 8:00am and 8:00pm for 5 days instead of the 4 days it was ordered.
-There was an entry for Debrox place 5 drops in each ear twice a day for 4 days scheduled for administration at 8:00am and 8:00pm with an effective date of 02/10/23 and an end date of 02/22/23.
-Debrox was documented as administered at

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8:00am on 02/17/23 to 02/21/23 and at 8:00pm on 02/15/23 to 02/21/23.
-Debrox was administered at 8:00am for 5 days and at 8:00pm for 7 days instead of the 4 days it was ordered.

Interview with a medication aide (MA) on 02/24/23 at 11:50am revealed she administered Resident #4's Debrox on the days that it popped up on the eMAR to be administered.

Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 3:02pm revealed:
-The administration dates for medications were put on the eMAR by the pharmacy.
-It was the facility's responsibility to make sure residents received the correct medications on the correct days and times.
-She expected Resident #4 to receive his Debrox for the correct number of days.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/24/23 at 10:05am revealed:
-A 15 milliliter (mL) bottle of Debrox was dispensed to Resident #4 on 02/07/23 and was received by the facility on 02/08/23.
-A 15 mL bottle of Debrox should have lasted around 15 days if it was administered as ordered.
-A 15 mL bottle of Debrox was dispensed to Resident #4 on 02/14/23 and received by the facility on 02/15/23.

Telephone interview with Resident #4's primary care provider (PCP) on 02/24/23 at 2:37pm revealed:
-Resident #4 was hard of hearing and also had ear wax buildup in his ears which could contribute to his decreased hearing.
-She ordered Debrox for Resident #4 to help with

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the removal of the ear wax.
-There were no adverse effects of giving the Debrox to Resident #4 more days than was ordered but she expected the facility to only administer it for 4 days as ordered.

Attempted interview with Resident #4 on 02/24/23 at 1:02pm was unsuccessful due to the resident being out of the facility.

_____

The facility failed to administer medications as ordered to 3 of 5 residents sampled. Resident #3 was sent to the emergency room with low potassium levels and discharged on potassium and magnesium replacement therapy on 02/11/23. The potassium and magnesium replacement medications were never started for Resident #3 and the resident was sent to the hospital for a fall with complaints of chest pain, hospitalized, and required inpatient admission on 02/18/23. Resident #3 not receiving his ordered medications to replace low potassium and magnesium levels placed him at risk for falls, chest pain, and cardiac arrhythmia's. Resident #3 was ordered a blood thinner to treat a deep vein thrombosis and missed 15 days of medication (30 doses) because the medication was not in the facility to administer placing the resident at risk of stroke and heart attack. Resident #5 was not administered the correct dosage of insulin as well as two different types of insulin being omitted which resulted in high blood sugars which could lead to diabetic coma, renal and eye issues, kidney, liver, or nerve damage, as well as heart issues. The failure of the facility resulted in serious physical harm and neglect and constitutes a Type A1 Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/23/23 for

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D 358	Continued From page 88 this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED March 26, 2023.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation has not been abated. Based on observations, interviews, and record reviews, the facility failed to ensure residents were observed taking their medications for three observations including a medication used for aide in sleeping found in another resident's room (#4 ,#6), a multivitamin (#7), and a medicated ointment (#8). The findings are: Review of the facility's Medication Administration Policy, dated 08/23/22, revealed the staff member	D 366		

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administering a medication must stay with the resident and observe that the resident has safely consumed the medication.

1. Observation of Resident #4's room on 02/22/23 at 9:40am revealed a medication aide (MA) exited the resident's room.

Observation of Resident #4's room on 02/22/23 at 9:43am revealed:
-Resident #4 was sitting in his recliner.
-The resident was the only resident that resided in the room.
-There was no staff in the room or in view of the resident in the room from the doorway.
-There was a medication cup on the dresser with one unidentified whole tablet.
-The tablet was round, white, and did not have an imprint.

Review of Resident #4's current FL-2 dated 11/15/22 revealed:
-Diagnoses included unspecified visual loss, vascular dementia, and unspecified hearing loss.
-Resident #4's recommended level of care was assisted living.
-There was an order for Melatonin 10mg to be given at bedtime for insomnia (Melatonin is a sleep aide used to treat insomnia).

Interview with a MA on 02/22/23 at 9:47am revealed:
-She did not notice the medication cup with one tablet on the resident's dresser.
-The MA on third shift must have left it on his dresser.
-Resident #4 was visually impaired.
-She stayed with the resident when she administered his medications to ensure he took his medications.

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D 366	Continued From page 90 -She was unable to identify the pill that was in the medication cup on the resident's dresser. Observation of Resident #4's medications on hand on 02/22/23 at 10:00am revealed: -Medications were dispensed in a bubble pack. -There was not a bubble pack with the unidentified pill that was found in Resident #4's room in a medication cup. Review of Resident #6's current FL-2 dated 06/28/22 revealed: -Diagnoses included unspecified dementia. -Resident #6's recommended level of care was assisted living. -Resident #6 was intermittently confused. -There was an order for Melatonin 3mg at bedtime (Melatonin is a sleep aide used to treat insomnia). Interview with a second MA on 02/23/23 at 3:45pm revealed: -He was a second shift (3:00pm to 11:00pm) MA that was responsible for administering Resident #4 and Resident #6's medications. -He administered Resident #6's medications separately because she liked to take her Melatonin after the rest of her medications. -Two shifts prior (02/21/23) he remembered taking Resident #6's medication cup that contained her Melatonin into Resident #4's room when he administered Resident #4's eye drops. -He should not have taken another resident's medication into a different resident's room. -There were times when the facility was short staffed which could be overwhelming so there were sometimes shortcuts that happened. Observation of Resident #6's medications on hand on 02/23/23 at 3:31pm revealed:	D 366		

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D 366	Continued From page 91 -There was a bottle of Melatonin 3mg. -The tablet was round, white, and did not have an imprint. Interview with Resident #6 on 02/23/23 at 3:20pm revealed: -The MAs brought in her medication at night. -She did not know what medications she received at night. Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 2:40pm revealed: -MAs should not take another resident's medication into another resident's room because that medication was not prescribed for them. -It was a safety issue to leave resident's medications at the bedside especially ones that were not their own because a resident might have an allergy. -Staff should observe Resident #6 swallowing her medication prior to going to the next resident room to administer medication. -Once a resident took their medications, the MA should take the empty medication cup out of the resident's room after their medications were administered. Telephone interview with the facility's mental health provider (MHP) on 02/24/23 at 8:48am revealed: -Resident #4 had dementia as well as problems with vision so he might accidentally take another resident's medication if it was left in his room. -She prescribed Melatonin for Resident #4 to help with sleep issues. -Resident #4 was prescribed Melatonin 10mg every night and taking extra Melatonin put the resident at risk for increased sedation which also put him at risk for falls.	D 366		

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D 366	Continued From page 92 Refer to the interview with the Administrator on 02/24/23 at 4:15pm. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/24/23 at 2:50pm. Based on observations, interviews, and record reviews it was determined that Resident #4 was not interviewable. 2. Observation of Resident #7's room on 02/23/23 at 9:34am: -Resident #7 was sitting in his wheelchair beside a round table in his room. -The resident was the only resident that resided in the room. -There was no staff in the room or in view of the resident in the room from the doorway. -There was a medication cup on the round table with two unidentified gummies. -One gummy was a light brown and the second gummy was orange. Review of Resident #7's current FL-2 dated 11/11/22 revealed diagnoses included hypertension, anxiety, cerebral vascular accident with left hemiparesis, and carotid arterial stenosis. Observation of Resident #7's medications on hand on 02/24/23 at 1:28pm revealed: -There was a bubble package of multivitamin gummies with a pharmacy label and instructions to chew and shallow 2 gummies (one serving) every day. -There were two gummies to each bubble. -There were 16 doses remaining in the bubble packet that was dispensed on 01/19/23.	D 366		

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D 366	Continued From page 93 Review of Resident #7's facility record revealed the resident did not have a self-administration order for the multivitamin. Interview with Resident #7 on 02/23/23 at 9:35am revealed: -The two gummies in the medication cup were his vitamins. -The medication aide (MA) brought them to him earlier this morning in the medication cup and left them on his round table. Interview with a MA on 02/23/23 at 9:47am revealed: -She stayed with Resident #7 and observed him take his medications before leaving his room. -The resident preferred to take his gummies last. -She observed him chew his 2 gummies and drink water after he chewed the gummies. -She was not aware that Resident #7 had 2 whole gummies in his medication cup on the round table in his room. -She did not stay with the resident to observe him take his gummies on 02/23/23. -She left the 2 gummies in a medication cup on the round table for Resident #7 to take when he was ready. -She was supposed to stay with residents to ensure they received all medications as ordered. Refer to the interview with the Administrator on 02/24/23 at 4:15pm. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/24/23 at 2:50pm. _____ Interview with the Administrator on 02/24/23 at 4:15pm revealed she expected medication aides to administer medications according to the	D 366		

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D 366	Continued From page 94 facility's policy which meant that they should observe the residents swallow their medications and not leave any medications unattended at the bedside. Telephone interview with the facility's primary care provider (PCP) on 02/24/23 at 2:50pm revealed: -Residents should be observed swallowing their ordered medications at the time of administration. -It was important for residents to get the medication they were prescribed because they were prescribed a certain medication for a reason. The facility failed to ensure medication aides observed residents take their prescribed medications. Resident #6's medication used to treat insomnia was left at the bedside of Resident #4 who has a diagnosis of dementia, and was already ordered a sleeping aide. Leaving Resident #6's medication in Resident #4 room and failing to observe Resident #6 actually take his medication at the time of adminstration was detrimental to the health and safety of Resident #4 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 02/22/23.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367		

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D 367	Continued From page 95 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 medication administration records were accurate for 2 of 5 sampled residents (#3, #5) including inaccurate documentation of supplements and a blood thinner (#3) and inaccurate documentation of insulin dosage (#5). The findings are: Review of the facility's Medication Administration Policy, dated 08/23/22 revealed: -In the event that a medication is withheld, refused, or given at a time other than the scheduled time, staff administering the medication will circle the medication administration record (MAR) space provided for the drug and dose and enter a note into the record as to the reason. The physician will be notified if indicated. -The staff person administering medication must initial the MAR on the appropriate line after	D 367		

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administering the medication.
-As required or indicated the resident MAR will reflect the date/time the medication was given, dosage, route of administration, injection site if applicable, any complaints or symptoms for which an as needed medication was administered as well as the effectiveness, and signature and title of the individual administering the medication.

1. Review of Resident #3's current FL-2 dated 04/07/22 revealed diagnoses included late onset Alzheimer's disease, chronic atrial fibrillation (irregular heart rate), diabetes, and hyperlipidemia

a. Review of Resident #3's hospital discharge summary dated 01/01/23 revealed there was an order to start Eliquis 5mg, take two tablets (10mg) twice a day for 6 more days then 5mg twice a day [Eliquis is an anti-coagulant, blood thinner used to treat deep vein thrombosis (blood clots)].

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Eliquis 5 mg tablets, with instructions to take 2 tablets (=10mg) twice a day for 6 days, scheduled for administration at 8:00am and 8:00pm.
-Eliquis 10mg was documented as administered on 01/03/23 to 01/08/23 at 8:00am and 8:00pm.
-There was an entry for Eliquis 5mg twice a day, scheduled for administration at 8:00am and 8:00pm.
-Eliquis 5mg was documented as administered on 01/09/23 to 01/24/23 at 8:00am and 8:00pm, except on 01/11/23 at 8:00pm, 01/12/23 at 8:00am, 01/14/23 at 8:00am, 01/14/23 at 8:00pm, 01/15/23 at 8:00am, 01/16/23 at 8:00pm,

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01/18/23 at 8:00pm, 01/19/23 at 8:00pm, and 01/24/23 at 8:00am when it was documented as not administered because of "awaiting medication delivery from pharmacy".

Telephone interview with pharmacist at the facility's contracted pharmacy on 02/23/23 at 3:35pm revealed:
-The pharmacy received the initial order for Resident #3's Eliquis on 01/01/23 and dispensed 24- 5mg tablets (which equaled 12 doses or 6 days medication).
-The pharmacy did not dispense any additional Eliquis until 01/24/23 when they dispensed 12-5mg tablets (which equaled 12 doses or 6 days of medication).

Interview with a medication aide (MA) on 02/23/23 at 3:45pm revealed:
-If a medication was not available for administration, there was a spot on in the electronic documentation system to document the reason why it was not administered.
-Some examples of why a medication would not be administered would be that the resident refused, the resident was out of the facility, or that they were waiting on a medication.

Refer to interview with the Administrator on 02/24/23 at 4:15pm.

b. Review of Resident #3's hospital discharge summary dated 02/11/23 revealed:
-There was an order for the resident to start taking magnesium oxide 400mg tablets with instructions to take one tablet every day for 10 days (Magnesium oxide is a medication used to treat low levels of magnesium).
-There was an order for the resident to start taking magnesium gluconate 500mg tablets with

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instructions to take ½ tablet every day (Magnesium gluconate is a medication used to treat low levels of magnesium).
-There was an order for the resident to start taking potassium chloride 20mEq tablets with instructions to take one tablet every day (Potassium chloride is a medication used to treat low levels of potassium).

Review of Resident #3's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for magnesium oxide 400mg with instructions to take one tablet every date for 10 days, scheduled for administration at 8:00am and documented as administered on 02/18/23 at 8:00am.
-There was an entry for magnesium gluconate 500mg tablets with instructions to take ½ tablet every day, scheduled for administration at 8:00am and documented as administered on 02/18/23 at 8:00am.
-There was an entry for potassium chloride 20mEq tablets with instructions to take one tablet every day, scheduled for administration at 8:00am and documented as administered on 02/18/23 at 8:00am.

Observation of Resident #3's medications on hand on 02/24/23 revealed:
-Resident #3 had a bubble package of magnesium oxide 400mg tablets with instructions to take one tablet every day for 10 days.
-There were 10 magnesium oxide 400mg tablets in the package.
-Ten 400mg tablets were dispensed on 02/16/23 and none were administered.
-Resident #3 had a bubble package of magnesium gluconate 500mg tablets with instructions to take ½ tablet every day.

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-There were 11 magnesium gluconate ½ tablets in the package.
-Eleven magnesium gluconate 500mg ½ tablets were dispensed on 02/16/23 and none were administered.
-Resident #3 had a bubble package of potassium chloride 20mEq tablets with instructions to take one tablet every day.
-There were 11 potassium chloride 20mEq tablets in the package.
-Eleven potassium chloride 20mEq tablets were dispensed on 02/16/23 and none were administered.

Interview with the Special Care Coordinator (SCC) on 02/24/23 at 3:30pm revealed if a MA documented administered on Resident #3's medications on 02/18/23 she would have expected the bubble package to have been opened for one day.

Interview with a medication aide (MA) on 02/23/23 at 3:45pm revealed:
-If a medication was not available for administration, there was a spot on in the electronic documentation system to document the reason why it was not administered.
-Some examples of why a medication would not be administered would be that the resident refused, the resident was out of the facility, or that they were waiting on a medication.

Refer to interview with the Administrator on 02/24/23 at 4:15pm.
2. Review of Resident #5's current FL-2 dated 01/26/23 revealed:
-Diagnoses included diabetes.
-There was an order for Novolog (a short-acting insulin used to treat high blood sugars) before meals 3 units for a fingerstick blood sugar (FSBS)

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D 367	Continued From page 100 of 200 to 250, 5 units for a FSBS of 251 to 300, 7 units for a FSBS greater than 300. Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog check FSBS before meals sliding scale insulin FSBS 200-250 = 3 units, FSBS 251-300 = 5 units, FSBS greater than 300 = 7 units scheduled for administration at 12:00pm. -Novolog 23 units was documented as administered for a FSBS of 133 at 12:00pm on 12/17/22. -There was an entry for Novolog check FSBS before meals sliding scale insulin FSBS 200-250 = 3 units, FSBS 251-300 = 5 units, FSBS greater than 300 = 7 units scheduled for administration at 5:00pm. -FSBS was documented as 275 on 12/17/22 at 5:00pm. Review of Resident #5's January 2023 eMAR revealed: -There was an entry for Novolog check FSBS before meals sliding scale insulin FSBS 200-250 = 3 units, FSBS 251-300 = 5 units, FSBS greater than 300 = 7 units scheduled for administration at 7:00am. -Novolog 6 units was documented as administered for a FSBS of 266 at 7:00am on 01/24/23. -There was an entry for Novolog check FSBS before meals sliding scale insulin FSBS 200-250 = 3 units, FSBS 251-300 = 5 units, FSBS greater than 300 = 7 units scheduled for administration at 12:00pm. -FSBS was documented as 480 at 12:00pm on 01/24/23.	D 367		

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Interview with the medication aide (MA) on 02/23/23 at 2:31pm revealed:
-The code to use on the eMAR to indicate that a medication was not administered was 23.
-She must have accidentally entered 23 in the wrong place on Resident #5's eMAR on 12/17/23.
-She would not have administered 23 units of insulin to Resident #5 because it would have been way too much.
-When she documented that she administered 6 units of Novolog to Resident #5 on 01/24/23 she must have mistakenly mixed up the documentation of the site that she administered the medication.
-Six was one of the codes used to document the site which the insulin was administered.
-She would not have administered 6 units of insulin to Resident #5 on 01/24/23 but she would have administered 5 units as ordered.
-She should have documented the right numbers in the right places on the eMAR.

Interview with Resident #5 on 02/23/23 at 9:22am revealed as far as she knew she always received the correct dosage of insulin.

Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 3:02pm revealed she expected MAs to record the accurate dosage of insulin on Resident #5's eMAR because it looked like she received too much insulin on 12/17/23 and 01/24/23 when she did not.

Refer to interview with the Administrator on 02/24/23 at 4:15pm.

Interview with the Administrator on 02/24/23 at 4:15pm revealed she expected staff to follow the medication administration policy which instructed

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D 367	Continued From page 102 them to document accurately and completely on the medication administration record.	D 367		
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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services of a fall that required an inpatient hospital stay for 1 of 5 residents sampled (#3). The findings are: Review of the facility's Incident Report policy, dated 06/01/16, revealed the written incident report must be sent to the licensing division within 48 hours of any of the following incidents including accidents or illnesses that requires hospitalization and hospitalization. Review of Resident #3's current FL-2 dated 04/07/22 revealed: -Diagnoses included late onset Alzheimer's disease, hypertension, chronic atrial fibrillation (irregular heartbeat), depression, diabetes, and hyperlipidemia. -The resident's recommended level of care was a	D 451		

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Special Care Unit (SCU).
-The resident was ambulatory and constantly disoriented.

Review of Resident #3's Incident/Accident Report dated 12/30/22 revealed:
-Resident #3 had an unwitnessed fall in his bedroom around 6:30pm.
-Staff entered Resident #3's room and found him laying on the floor with apparent injuries including a skin tear to left hand and hematoma on his head (A hematoma is a bruise that happens when an injury causes blood to collect and pool under the skin).
-Notifications of the incident were made to Resident #3's primary care provider (PCP), the resident's responsible party, and the facility's Administrator.
-The resident was transported to the hospital for medical evaluation.

Interview with a medication aide (MA) on 02/23/23 at 2:40pm revealed:
-She completed the Incident/Accident Report on Resident #3 for his fall and hospitalization on 12/30/22 in the electronic documentation system.
-She was not sure who was responsible for sending the report to the local county Department of Social Services (DSS) but she completed the notifications she was responsible for including the PCP, the resident's family and the facility's management.

Review of Resident #3's hospital discharge summary dated 01/01/23 revealed:
-Resident #3 was admitted on 12/30/22 and discharged 01/01/23.
-Resident #3 was admitted with concerns from a fall.
-Resident #3's discharge diagnoses included a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025037	A. BUILDING: _____ B. WING _____	R 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROATAN VILLAGE	4522 OLD CHERRY POINT ROAD NEW BERN, NC 28560

(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 451	Continued From page 104 deep vein thrombus [(DVT) blood clot] and chronic hypotension. Interview with the local county DSS Adult Home Specialist (AHS) on 02/23/23 at 1:15pm revealed she did not receive Resident #3's Incident/Accident Report for the incident on 12/30/22. Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 2:40pm revealed: -She was in the process of learning how to email the AHS Incident/Accident reports. -She started at the facility in December of 2022. -She was being trained by the previous Special Care Coordinator (SCC) during that time and could not recall if she was trained about sending Incident/Accident reports that required hospitalization to the AHS. Interview with the Administrator on 02/24/23 at 4:15pm revealed it was the responsibility of the RCC and SCC to email the AHS Incident/Accident reports that required reporting.	D 451		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon	D 454		

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D 454	Continued From page 105	D 454		

as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the Healthcare Power of Attorney (HCPOA) for 1 of 5 residents sampled (#1) when the resident had a fall that resulted in injury and evaluation at the emergency room.

The findings are:

Review of Resident #1's current FL2 dated 10/28/23 revealed:
-The recommended level of care was Special Care Unit (SCU).
-Diagnoses included Alzheimer's disease, essential hypertension, fall/nasal fracture, elevated troponin, and alcohol dependency.
-The resident was intermittently disoriented.
-The resident was ambulatory.

Review of Resident #1's Incident Report dated 12/17/22 revealed:
-Resident #1 had an unwitnessed fall on 12/17/22 at 5:00pm in their bedroom.
-Resident #1 had apparent injuries including

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D 454	Continued From page 106	D 454		

bleeding.
-Resident fell while trying to use the bathroom.
-Staff was going into Resident#1's bedroom to get them for dinner and saw her on the floor.
-Resident #1 was transported to the local emergency department (ED).
-Family was called at 5:09pm with no answer.

Telephone interview with Resident #1's HCPOA on 02/23/23 at 3:10pm revealed:
-She visited the resident and noticed bruises on her face, forehead, and around her eye.
-She asked the facility what happened, and they stated Resident #1 fell and went to the emergency room (ER) on 12/17/22.
-She was not notified of any incidents and had not received a call from the facility regarding the incident on 12/17/22.
-She asked the staff what number was called, and it was an old number.
-She updated the facility with new phone number over a year ago.
-She was concerned that she gave the facility their updated phone number, but they did not call it when she had an injury from a fall that sent her to the hospital.
-She was concerned about not knowing that Resident #1 was injured and was in the ER when she was HPOA.

Interview with the Resident Care Coordinator (RCC) on 02/24/23 at 2:32pm revealed the expectation of contacting family was to call all numbers on the computer, and to continue to call until you reach someone or leave a message.

Interview with the Special Care Coordinator (SCC) on 02/24/23 at 3:32pm revealed if staff could not get in contact with the resident's family when an incident occurred, they would leave a

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D 454	Continued From page 107 voicemail, and try to call back again.	D 454		