STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHAMY RETREAT	**102 ANN STREET SPENCER, NC 28159**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 03/14/23 to 03/16/23.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the Commission of Public Health upon hire. The findings are: 1. Review of Staff A's personal care aide (PCA) personnel record revealed: -She was hired on 03/19/20. -There was documentation she completed one TB skin test on 08/08/22 with a negative result. -There was no documentation Staff A completed a second TB skin test.	C 140		

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Interview with Staff A on 03/14/23 at 4:30pm revealed:
-The Business Office Manager (BOM) kept up the staff personnel records.
-She thought she had completed two TB skin tests, but could not remember when she did the second TB skin test.
-The documentation of her second TB skin test should be in her personnel file in the business office.

Telephone interview with the BOM on 03/16/23 at 9:45am revealed:
-She and the full-time BOM worked together to maintain staff personnel records.
-She had been going through staff personnel records since November 2022 checking to see that all required components of the personnel records were in the files.
-She was not aware Staff A was missing her second TB skin test.

Telephone interview with the Administrator on 03/16/23 at 9:00am revealed:
-She thought Staff A had completed both TB skin testing.
-She was not aware Staff A was missing her second TB skin test.
-The BOM was responsible for ensuring personnel records had all the required components.
-There was no process in place for auditing personnel records, but she thought the BOM had recently gone through all of the personnel records to ensure they were complete with all of the required qualifications for hire.

2. Review of Staff B's personal care aide (PCA) personnel record revealed:
-She was hired 08/11/22.

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C 140	Continued From page 2 -There was documentation she completed a TB skin test on 08/05/22 with a negative result. -There was no documentation Staff B completed a second TB skin test. Interview with Staff B on 03/14/23 at 4:33pm revealed: -The Business Office Manager (BOM) kept up the staff personnel records. -She had not completed a second TB skin test. -In January 2023, the Administrator had told her she needed to complete a second TB skin test, but due to her work schedule she never found a day to go get the second TB skin test done and then she forgot. -The BOM had not reminded her about getting a second TB skin test completed. Telephone interview with the BOM on 03/16/23 at 9:45am revealed: -She and the full-time BOM worked together to maintain personnel records. -She had been going through personnel records since November 2022 checking to see that all required components of the personnel records were in the files. -She was not aware that Staff B was still missing her second TB skin test. Telephone interview with the Administrator on 03/16/23 at 9:00am revealed: -She thought Staff B had completed her two TB skin testing. -She was not aware Staff B was missing her second TB skin test. -The BOM was responsible for ensuring personnel records had all the required components. -There was no process in place for auditing personnel records, but she thought the BOM had	C 140		

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C 140	Continued From page 3 recently gone through all of the staff personnel records to ensure they were complete with all of the required qualifications for hire.	C 140		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) had completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #1's current FL2 dated 12/23/22 revealed diagnoses included schizophrenia. Review of Resident #1's Resident Register revealed an admission date of 02/09/18. Review of Resident #1's immunization and tuberculosis (TB) skin testing record dated	C 202		

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03/15/23 revealed:
-There was documentation of a TB skin test applied on 06/24/11 with no TB results documented.
-There was documentation of a TB skin test applied on 07/22/11 with a negative reading on 07/25/11.
-There was no other documented TB skin test or results available for review.

Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 11:00am revealed:
-She was responsible for ensuring all newly admitted residents had TB skin tests completed upon admission.
-She had not worked at the facility when Resident #1 was admitted, but it would have been the responsibility of either the Administrator or the RCC at the time of his admission to make sure he had the TB test.
-She did not audit resident records to see if residents had TB testing upon admission or not because the expectation was that it would already be completed.
-It was possible Resident #1 had completed a TB skin test upon admission but the documentation had gotten misplaced.

Interview with Resident #1 on 03/15/23 at 4:40pm revealed he could not remember if he had completed a TB skin test upon admission to the facility or not.

Telephone interview with the Administrator on 03/16/23 at 9:00am revealed:
-The RCC at the time of Resident #1's admission would have been responsible for ensuring Resident #1 had a TB skin test completed prior to admission.
-She was unsure if Resident #1 completed TB

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C 202	Continued From page 5 skin testing prior to admission. -She was not aware Resident #1 did not have documentation of completing a TB skin test when he was admitted to the facility.	C 202		
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide personal care for 1 of 3 sampled residents (#1) related to fingernails that needed to be trimmed. The findings are: Review of Resident #1's current FL2 dated 12/23/22 revealed: -Diagnoses included schizophrenia. -Resident #1 needed personal care assistance with bathing and dressing. Review of Resident #1's care plan dated 07/22/22 revealed he required limited assistance with bathing, dressing and grooming/personal hygiene. Observation of Resident #1 on 03/14/23 at 9:20am revealed: -Resident #1 was sitting down in a chair in the dining room.	C 242		

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-All of Resident #1's fingernails extended 3/8 of an inch beyond his finger tips.
-There was a dark brown color under all the fingernails.

Observation of Resident #1's personal care log on 03/15/23 at 8:55am revealed there was no documentation related to staff offered or the resident refused to have his fingernails trimmed.

Interview with a personal care aide (PCA) on 03/14/23 at 12:45pm revealed:
-Resident #1 was quiet and never asked her for help trimming his fingernails.
-She had never offered to trim his fingernails for him, because she did not have access to a nail clipper, and she did not know if that was something the medication aides (MA) had to do.
-Resident #1 did his own bathing and toileting so she thought he trimmed his nails on his own.

Interview with Resident #1 on 03/14/23 at 1:10pm revealed:
-Neither the PCAs nor the MAs had offered to trim his fingernails.
-He thought it had been about a month since his fingernails were last trimmed.
-He thought the PCA or MA would be willing to help him cut his fingernails if he asked them to.
-He wanted his fingernails to be trimmed.
-He had a nail clipper in his room and he tried to trim his nails himself, but it was hard for him to do.
-He had not asked staff to help him trim his fingernails, because he did not know who he was supposed to ask.
-His fingernails did not hurt or hinder him from doing anything, but they were longer than he preferred.

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Interview with a PCA on 03/15/23 at 8:50am revealed:
-She was the live-in PCA for the facility.
-It was probably her responsibility to trim Resident #1's fingernails but she had never been asked to.
-She had offered to trim Resident #1's fingernails in the past and he told her no.
-She had last offered to trim Resident #1's fingernails about a month ago.
-She did not have access to a nail clipper or manicure kit at the facility and had to use her own personal clipper.
-Resident #1 sometimes trim his own fingernails.
-She did not document her attempts or offers to trim Resident #1's fingernails because she had not thought to do so.
-She did not know if any other staff had offered to trim Resident #1's fingernails.

Interview with a MA on 03/15/23 at 9:30am revealed:
-Either the MAs or PCAs could trim Resident #1's fingernails.
-Resident #1 never asked her for help trimming his fingernails.
-She had noticed that Resident #1's fingernails were long, but thought the live-in PCA was keeping up with providing personal care to the residents.
-She was busy passing medications so she did not have as much time as the PCAs did for trimming fingernails.
-She did not know if Resident #1 ever refused personal care such as nail trimming.
-If the PCA trimmed Resident #1's fingernails she would document it in the personal care log.

Observation of the dining room on 03/15/23 at 9:50am revealed:
-The MA entered the facility and walked into the

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dining room with Resident #1.
-The MA arranged two chairs facing each other and Resident #1 sat down in one and she sat across from him.
-The MA trimmed all of Resident #1's fingernails, then asked him if they all felt "okay" to him.
-Resident #1 felt his fingernails and confirmed his nails felt better.

Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 11:00am revealed:
-She was not aware Resident #1's fingernails were long and needed to be trimmed.
-It would be the responsibility of any staff to help him trim his fingernails if he asked.
-The residents in the facility were independent with personal care so the PCAs and MAs were not expected to trim the residents' fingernails on a set schedule.
-She thought the facility had nail clippers available for the PCA to use if she needed to help a resident trim their fingernails.
-Resident #1 was able to advocate for himself and ask staff to help him trim his fingernails if he needed help.

Telephone interview with the Administrator on 03/16/23 at 9:00am revealed:
-The live-in PCA would be responsible for trimming Resident #1's fingernails because she was there all the time and would have the time to do it.
-Resident #1 never refused personal care.
-There were no personal care logs or required documentation for trimming fingernails.
-She was not aware Resident #1's fingernails were long and needed trimming.

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C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure physician notification for 1 of 3 sampled residents (#2) related to medication refusals. The findings are: Review of Resident #2's current FL2 dated 02/27/23 revealed diagnoses included acute debility, atrial fibrillation and reduced mobility. Review of Resident #2's signed physician order dated 11/16/22 revealed there was an order for Miralax (a laxative used to prevent or treat constipation) 17gm daily. Review of Resident #2's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax 17gm daily scheduled at 8:00am. -There was documentation Resident #2 refused Miralax 18 times from 01/01/23 through 01/31/23. Review of Resident #2's February 2023 eMAR revealed: -There was an entry for Miralax 17gm daily scheduled at 8:00am. -There was documentation Resident #2 refused Miralax 7 times from 02/01/23 through 02/28/23. Review of Resident #2 March 2023 eMAR from	C 246		

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03/01/23 through 03/14/23 revealed:
-There was an entry for Miralax 17gm daily scheduled at 8:00am.
-There was documentation Resident #2 refused Miralax 3 times from 03/01/23 through 03/14/23.

Observation of medication on hand for Resident #2 on 03/14/23 at 2:08pm revealed there was one bottle of Miralax powder that had a dispensed date of 01/25/23.

Telephone interview with a medication aide (MA) on 03/15/23 at 12:45pm revealed:
-She had documented Resident #2's Miralax as refused 10 times in January 2023, 1 time in February 2023, and 1 time in March 2023.
-She had not told the Resident Care Coordinator (RCC) or Resident #2's primary care provider (PCP) about the Miralax refusals because Resident #2 told her he still wanted to have the Miralax available if he needed it.

Interview with a MA on 03/15/23 at 3:25pm revealed:
-She had documented Resident #2's Miralax as refused 3 times in February 2023.
-She had not notified Resident #2's PCP about the Miralax refusals because the PCP was hard to get in touch with.
-She had not notified the RCC about Resident #2's Miralax refusals because the refusals for her were not in consecutive days.
-Resident #2 refused Miralax because he did not want to have loose stools and he did not have symptoms of constipation.
-Resident #2 never asked her to change his order to as needed instead of scheduled daily.

Interview with Resident #2 on 03/15/23 at 3:40pm revealed:

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-The MAs offered him Miralax every day.
-He did not want to take Miralax every day because he did not need it.
-He had not talked to his PCP about changing the Miralax order from scheduled daily to as needed.

Interview with the RCC on 03/15/23 at 3:45pm revealed:
-The facility's policy for medication refusals was to notify the PCP after three consecutive refusals of a medication.
-She was aware of Resident #2's Miralax refusals.
-She was unsure if she had gotten the Miralax order changed from once daily to as needed.
-She did not audit the resident's eMARs to look for frequent medication refusals; she relied on the MAs to let her know if a resident refused a medication three days or doses in a row.

Telephone interview with Resident #2's PCP on 03/15/23 at 5:40pm revealed:
-He was Resident #2's PCP in January 2023 and for the first half of February 2023.
-He was not aware that Resident #2 had been refusing to take Miralax every day as ordered.
-If he had known Resident #2 refused Miralax 18 times in January he would have either discontinued the order or changed it to take as needed.
-He expected the facility to administer medications as ordered or to notify him if they were not able to administer medications or if a resident was refusing to take medications as ordered.

Telephone interview with the Administrator on 03/16/23 at 9:00am revealed:
-She was not aware Resident #2 had been refusing Miralax.

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C 246	Continued From page 12 -The PCP was supposed to be notified if a resident refused a medication three times in a row per the facility policy. -There was no staff responsible for auditing the eMARs to look for missed medication doses or medication refusals. -The MA was expected to notify the PCP if a resident refused a medication for the third time and to also notify the RCC so that she could follow-up. -Resident #2 had complained of having loose stools in the pas,t but she could not remember when.	C 246		
C 291	10A NCAC 13G .0905 (c) Activities Program 10A NCAC 13G .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to	C 291		

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enhance the program;
(5) encourage residents to participate in activities; and
(6) assure there are supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to provide a monthly calendar of planned group activities, encourage resident participation in activities and have supplies available for planned group activities for the 5 residents residing at the facility.

The findings are:

Observation of the facility on 03/14/23 at 9:15am revealed:
-There was one activity calendar posted in the dining room of the facility.
-The activity calendar was dated January 2023.

Observation of the January 2023 activity calendar revealed:
-Activities scheduled included morning devotions, a trip to the store, hair day, coffee and cookies, movie, board games, card games, word puzzles, resident birthday party, painting, and spa day.
-There was at least one activity scheduled each day of the week from Sunday through Saturday.
-Each week had between 21 and 24 hours of planned activities scheduled.

Observation of the facility on 03/14/23 and

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C 291	Continued From page 14 03/15/23 revealed: -There had been no invitations to activities for the residents on 03/14/23 between 8:30am and 4:45pm. -There had been no invitations to activities for the residents on 03/15/23 between 8:30am and 5:15pm. -The common living area had three couches, a television, a desk and a piano. -In the television stand there were 21 books. -There was a stack of magazines on one of the end tables. Observation of the facility on 03/15/23 at 1:10pm revealed: -A dry erase activity calendar had been hung in the dining room/kitchen area. -There was notation on the calendar that all activities were done in the main building (sister facility across the street). -Between 12:10pm and 1:10pm the following activity supplied had been placed on the desk in the common living area: three games, a container of coloring crayons, and a box with papers. Interview with a personal care aide (PCA) on 03/14/23 at 9:17am revealed: -She thought there had been an activity calendar for February 2023, but she did not know what happened to it. -If the residents chose to participate in an activity they had to go across the street to join the residents at their sister facility where the activities were done. -The Activity Director (AD) either came to the facility to get the residents for an activity or called the facility to let the PCA know what activity she was about to do so the PCA could invite the residents. -If a resident wanted to go to an activity they	C 291		

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either walked to the sister facility with the AD if she came to get the residents, or walked to the sister facility on their own.
-Activities were usually offered three days per week.
-Most of the time, the residents at the facility chose not to participate in activities.

Interview with a resident on 03/14/23 at 11:00am revealed:
-All the residents used to get a copy of the activity calendar to keep in their room but the last calendar he had received was from October 2022.
-There had not been any activities that he was aware of for March 2023.
-He was interested in attending activities such as movies, crafts or bingo.
-The last time either the AD or staff from the sister facility had invited him to an activity was about two weeks prior when he was invited to go out to eat.
-There were never activities offered in the facility, they always had to go to the sister facility.
-If there was a current activity calendar posted he would go to more activities, because he would know what his options were.

Interview with a second resident on 03/14/23 at 11:10am revealed:
-The last activity calendar he was given to keep in his room was from January 2023.
-Other than a Valentine's Day activity they had at the facility, the residents always had to go across the street to the sister facility to attend activities.
-He did not go to the sister facility for activities because he did not know what was scheduled, and most of the time when he went over to the sister facility, they were not conducting any activities.

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-The live-in PCA offered to play cards or games with the residents, but most of the time the residents declined her offer.
-He had recently asked the live-in PCA for a March 2023 activity calendar for his room and she told him she had not been given the March 2023 activity calendars yet.

Interview with a third resident on 03/14/23 at 12:55pm revealed:
-There were no activities done at the facility.
-Since he moved to the facility, nobody had invited him to an activity at the sister facility across the street.
-He was not provided an activity calendar so that he would know what activities were being offered so he could choose to participate.
-He would be interested in going to activities, but it would depend on what the activity was.

Interview with the live-in PCA on 03/15/23 at 8:50am revealed:
-She had not been given an activity calendar for the residents since January 2023.
-The activity on the calendar was not always the activity that was actually provided because the activities got moved around a lot or cancelled.
-The residents at the facility were disappointed by activity cancellations or activities being rescheduled.
-There was a Valentine's Day party in the facility and since 02/14/23, the residents had not received a call at the facility inviting the residents to join them at the sister facility for an activity.
-Without an activity calendar, the residents did not know what activities were provided or at what time they should go to the sister facility to participate in activities.
-She had asked to be provided with little prizes to give the residents so she could play bingo with

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them at the facility, but she was never given any.
-There were no activity supplies available at the facility for the residents.

Interview with the AD on 03/15/23 at 10:45am revealed:
-She was not able to conduct activities in both facilities.
-She called the facility whenever she was conducting an activity to invite the residents to come.
-She tried to get all the residents to go to the sister facility to participate in activities, but they always declined and she could not force them to participate.
-She only worked on Mondays, Wednesdays and Fridays.
-On the days she was not working, the PCAs or other staff were supposed to conduct the scheduled activities with the residents if they had time.
-Her only job at the facility was to conduct activities in order to provide enough activity hours with the residents on the three days she worked, because she was conducting activities all day long three days per week.
-She always provided the activity that was scheduled on the activity calendar unless something came up and she was not able to conduct the activity.
-The activity that morning on 03/15/23, was coffee and cookies.
-She had asked one of the PCAs at the sister facility to bring cookies down to the facility for the residents.
-She had given the facility an activity calendar for February 2023, but she was behind on getting the March 2023 calendar to the residents.
-She offered at least 14 activity hours per week to the residents at the facility and the sister facility,

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but the residents never wanted to leave the facility to participate in activities since all the activities were done in the sister facility.
-Activity supplies were never kept at the facility, they were always stored at the sister facility.
-The residents had never asked to be provided with activity supplies.

Interview with a PCA on 03/15/23 at 11:45am revealed:
-She had not been told until after 11:00am that morning (03/15/23) that she was supposed to bring cookies to the facility from the sister facility for the residents as part of the cookies and coffee activity.
-The cookies had already been put away before she was told to bring some to the facility.
-She did not know the AD wanted her to help with an activity that morning.

Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 3:45pm revealed:
-The AD conducted activities for the facility at the sister facility across the street.
-The AD provided a variety of activities and conducted activities all day on the days that she worked.
-The residents were always invited to join the other residents at the sister facility for activities.
-None of the residents at the facility had complained to her about not having an activity calendar or not knowing what activities were being offered.
-The AD either called the facility or went to the facility to invite the residents to activities.
-The residents did not like to leave the facility so they rarely attended activities across the street at the sister facility.

Telephone interview with the Administrator on

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C 291	Continued From page 19 03/16/23 at 9:00am revealed: -The residents at the facility did not want to do activities, but the AD offered them. -The AD went to the facility to invite residents to activities. -When the AD was not working, the housekeeper invited residents to activities. -She was not aware the facility did not have a current activity calendar posted.	C 291		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed ensure medications were administered as ordered and per the manufacturer's instructions for 3 of 3 sampled residents (#1, #2, and #3) who had not been administered eye drops (#1), a resident administered insulin from an expired insulin vial (#2), and a resident administered insulin from an expired insulin pen (#3). The findings are: 1. Review of Resident #1's current FL2 dated 12/23/22 revealed:	C 330		

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-Diagnoses included schizophrenia.
-There was an order for Simbrinza 1%/0.2% eye drops (an ophthalmic solution used to lower pressure in the eyes caused by glaucoma) instill 1 drop in both eyes three times daily.

Review of Resident #1's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Simbrinza 1%/0.2% ophthalmic solution instill 1 drop in both eyes three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was documentation Simbrinza eye drops were administered three times daily from 01/01/23 through 01/31/23 except for 8:00am on 01/20/23, 01/23/23, 01/25/23 and 01/26/23 due to either the medication was not available or the resident was physically unable to take the medication.
-There was documentation the reason Simbrinza was not administered a total of 32 times between the dates of 01/16/23 and 01/31/23 was due to waiting on delivery of the medication from the pharmacy.

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for Simbrinza 1%/0.2% ophthalmic solution instill 1 drop in both eyes three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was documentation the reason Simbrinza eye drops were not administered at 2:00pm on 02/01/23, 02/02/23 and 02/03/23, and at 8:00pm on 02/28/23 was due to medication not being available.

Review of Resident #1's March 2023 eMAR for 03/01/23 through 03/14/23 revealed:

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-There was an entry for Simbrinza 1%/0.2% ophthalmic solution instill 1 drop in both eyes three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was documentation Simbrinza eye drops were administered three times daily from 03/01/23 through 03/14/23 except at 8:00pm on 03/13/23 where there was no documentation for the reason the medication was not administered.

Observation of medication on hand for Resident #1 on 03/14/23 at 2:08pm revealed there was no Simbrinza 1%/0.2% eye drops available on the medication cart for Resident #1.

Interview with a medication aide (MA) on 03/14/23 at 1:50pm revealed:
-A refill for Resident #1's Simbrinza eye drops had been ordered and would be delivered that day (03/14/23).
-Resident #1 received his medications through the Veteran's Administration (VA) and it took a long time for them to respond to communication and to mail the medications to the facility.
-She did not know when the refill had been requested prior to the Simbrinza eye drops running out in January 2023, and she remembered Resident #1 had been out of Simbrinza eye drops for a while.
-She had documented Resident #1's Simbrinza eye drops as administered that morning, 03/14/23, but thought she had added a note that the eye drops were not available and awaiting delivery from the pharmacy.
-She did not remember which day the Simbrinza eye drops for Resident #1 had ran out, but she remembered telling the Resident Care Coordinator (RCC) they needed to be reordered recently.
-Resident #1 had not complained of having eye

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pressure or pain in the previous three months and he was able to communicate his symptoms with staff if he was having symptoms.

Interview with the RCC on 03/15/23 at 11:00am revealed:
-It was the responsibility of either herself or the MAs to contact Resident #1's primary care provider (PCP) for refills of his eye drops.
-Resident #1's PCP office was aware that he ran out of Simbrinza eye drops in January 2023, because she had called and requested a new prescription.
-She had recently requested another refill of his eye drops and they would be delivered that day (03/14/23).
-In order to get refills of Resident #1's Simbrinza eye drops, she had to contact the VA call center and they forwarded messages to the prescribing provider; she was not able to speak directly with the VA pharmacy.
-Once the VA pharmacy received the new prescription for the eye drops, they had to mail it out which took a week to be delivered so the process for refilling medications was slow.
-She did not document her refill requests or phone calls to the PCP office or pharmacy.
-Resident #1 had not complained of eye pressure, pain or other eye symptoms in the previous three months.
-She did not complete audits of the eMARs to look for frequent missed doses of medication.
-The MAs were responsible for completing medication cart audits and looking for medications that were running low and needed to be refilled.

Interview with Resident #1 on 03/15/23 at 4:40pm revealed:
-He remembered being out of eye drops between

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January and February 2023.
-He had not experienced any eye pain, pressure or other symptoms during that time.
-He had discussed the missed doses at his recent appointment with his eye doctor who told him it was okay to miss doses of Simbrinza for a short time, but he refilled the medication so it would not happen again.

Telephone interview with a representative from Resident #1's ophthalmologist's office on 03/16/23 at 10:00am revealed:
-There was documentation that Resident #1 was historically non-compliant with his eye drops to treat his diagnosis of glaucoma.
-There was no documentation that the ophthalmologist had been aware of Resident #1's missed doses of Simbrinza eye drops between January and March 2023.
-Resident #1's Simbrinza eye drop prescription automatically refilled unless the prescription ran out of refills.
-There was documentation that a refill request had been made for Resident #1's Simbrinza eye drops on 01/20/23, so the pharmacy renewed the prescription and the ophthalmologist signed off on the order.
-Resident #1's Simbrinza eye drops had been dispensed 01/25/23 for a 60-day supply but they take up to a week to be delivered to the facility so would have arrived at the facility around 02/01/23.
-Resident #1's Simbrinza eye drops had also been dispensed 03/14/23 for a 60-day supply.
-It was important for Resident #1 to take the Simbrinza eye drops as ordered because they helped to reduce the pressure in his eyes and Resident #1's glaucoma was documented as being severe.
-Resident #1 last saw his eye doctor on 02/28/23 and his prescription for Simbrinza eye drops was

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renewed.
-The facility needed to request refills or prescription renewals at least 30 days in advance so they had time to process the order and have the prescription mailed to the facility.
-If the facility ran out of Simbrinza eye drops and did not have any available to administer to the resident, it was likely because the prescription had not been requested early enough.

Telephone interview with the Administrator on 03/16/23 at 9:00am revealed:
-The RCC was responsible for reordering medications prior to them running out.
-The MAs were responsible for letting the RCC know if medications were running low or needed a new prescription renewal.
-The MAs completed medication cart audits monthly and the RCC was responsible for following up behind the MAs to ensure they were completed.
-The VA should automatically refill Resident #1's eye drops because they were a scheduled medication and not as needed.
-She was not aware Resident #1's Simbrinza eye drops had ran out in January 2023 and were not available on the medication cart on 03/14/23.
-Resident #1 had not complained to her about symptoms of eye pressure or pain.

2. Review of Resident #2's current FL2 dated 02/27/23 revealed:
-Diagnoses included acute debility, atrial fibrillation, and reduced mobility.
-There was an order for insulin aspart (Novolog insulin, a rapid-acting insulin used to lower blood sugar) 100unit(u)/mL, inject subcutaneously per sliding scale: 150-200 = 2u, 201-250 = 4u, 251-300 = 6u, 301-350 = 8u, discard 28 days after opening.

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C 330	Continued From page 25 Review of Novolog's manufacturer's instructions dated March 2023 revealed: -Insulin should be stored at room temperature or refrigerated for up to 28 days. -Insulin should be disposed of after 28 days, even if there was insulin left in the pen or vial. Observation of medication on hand for Resident #2 on 03/14/23 at 2:10pm revealed: -There was one vial of insulin aspart with a dispensed date of 01/25/23. -There was an opened on date of 01/26/23 written on the plastic tube the insulin was stored in which would create an expiration date of 02/24/23. Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for insulin aspart (Novolog insulin) 100unit(u)/mL, inject subcutaneously per sliding scale: 150-200 = 2u, 201-250 = 4u, 251-300 = 6u, 301-350 = 8u, discard 28 days after opening, scheduled at 8:00am and 5:30pm. -There was documentation insulin was administered on 02/24/23, 02/25/23, 02/26/23 02/27/23 and 02/28/23. Review of Resident #2's March 2023 eMAR from 03/01/23 through 03/14/23 revealed: -There was an entry for insulin aspart (Novolog insulin) 100unit(u)/mL, inject subcutaneously per sliding scale: 150-200 = 2u, 201-250 = 4u, 251-300 = 6u, 301-350 = 8u, discard 28 days after opening, scheduled at 8:00am and 5:30pm. -There was documentation insulin was administered 21 times from 03/01/23 through 03/14/23.	C 330		

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Observation of the facility's medication cart audit book on 03/15/23 at 12:10pm revealed:
-There was one MA assigned to complete the medication cart audit in the facility.
-The last time Resident #2's medication was audited was in December 2022 and the audit sheet had not been signed by the staff who completed the audit.

Interview with a medication aide (MA) on 03/14/23 at 1:50pm revealed:
-She usually checked insulin for the date of expiration prior to administering the insulin.
-She had administered insulin to Resident #2 after it had expired on 02/24/23, 02/25/23, 03/06/23, 03/10/23, and 03/14/23 but overlooked the expiration date.
-Resident #2's insulin was sliding scale, and since Resident #2 did not receive insulin each time they checked his blood sugar, she thought the expiration date got overlooked.
-Sometimes the MAs got busy doing their medication pass and either forgot to check when the expiration date for the insulin would be after 28 days from the opened-on date, or they forgot how many days insulin was good for prior to expiring.

Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 11:00am revealed:
-All the MAs had been trained to discard insulin 28 days after it was opened and the instruction for when to discard the insulin was even listed on the eMAR under the entry for the insulin order.
-The MAs were expected to complete a medication cart audit once every month, then she was supposed to follow up behind the MAs if they had a concern about a medication during the audit.
-Checking expiration dates of medication and

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insulin was part of the medication cart audit.
-Resident #2 did not need to use insulin every day, so his insulin did not run out within 28 days of the vial being opened.
-The MAs should all be checking the opened-on date prior to administering insulin to prevent administration of expired insulin.
-She was not aware Resident #2's insulin on the medication card had expired.

Telephone interview with a MA on 03/15/23 at 12:45pm revealed:
-She was responsible for completing medication cart audits at the facility.
-She completed medication cart audits every month prior to the 15th day of the month.
-She had not yet completed a medication cart audit for March 2023.
-She completed a medication cart audit for February 2023, but had not turned in her documentation of it yet.
-She had audited Resident #2's medications in January 2023, but did not know where the audit sheet was if it was not in the medication cart audit book.
-She checked insulin for expiration dates during her audits, but Resident #2's insulin might have been overlooked.
-She knew Resident #2's insulin needed to be discarded 28 days after it was opened.
-When she administered insulin to Resident #2, she normally checked when it was opened to make sure it was not expired ,but she must have overlooked it when she administered his insulin 03/02/23, 03/04/23, 03/05/23, 03/09/23, and 03/13/23.

Telephone interview with the Administrator on 03/16/23 at 9:00am revealed:
-The MAs should be checking all medication for

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C 330	Continued From page 28 expiration during their monthly medication cart audits and prior to administering insulin. -All the MAs had been trained on when to discard insulin after it had been opened. -She was not aware that Resident #2's insulin had been administered after it had expired. Attempted telephone interviews with a representative from Resident #2's pharmacy on 03/15/23 at 11:45am and on 03/16/23 at 8:30am were unsuccessful. 3. Review of Resident #3's current FL2 dated 12/27/22 revealed: -Diagnoses included diabetes mellitus, chronic kidney disease stage 5, hypertension and chronic pain. -There was an order for insulin lispro (Humalog, a rapid-acting insulin used to lower blood sugar levels), check fingerstick blood sugar (FSBS) before each meal and inject subcutaneously per sliding scale: 180-200 = 1 unit (u), 201-250 = 3u, 251-300 = 5u, 301-350 = 6u, 351-400 = 8u, greater than 400 call provider. Discard 28 days after opening. Review of Humalog insulin's manufacturer's instructions dated October 2022 revealed insulin lispro should be discarded 28 days after being opened even if insulin remains in the insulin pen. Observation of medication on hand on for Resident #3 on 03/14/23 at 2:15pm revealed: -There was one lispro insulin pen in a bag labeled for Resident #3 with a dispensed date of 11/28/22. -There was a handwritten opened on date on the label of 12/22/22 which would create an expiration date of 01/20/23.	C 330		

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Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for lispro insulin check FSBS before each meal and inject subcutaneously per sliding scale: 180-200 = 1u, 201-250 = 3u, 251-300 = 5u, 301-350 = 6u, 351-400 = 8u, if greater than 400 call provider. Discard 28 days after opening, scheduled at 7:30am, 11:30am, and 5:00pm.
-There was documentation lispro was administered four times from 01/20/23 through 01/31/23.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for insulin lispro, check FSBS before each meal and inject subcutaneously per sliding scale: 180-200 = 1u, 201-250 = 3u, 251-300 = 5u, 301-350 = 6u, 351-400 = 8u, if greater than 400 call provider. Discard 28 days after opening, scheduled at 7:30am, 11:30am, and 5:00pm.
-There was documentation lispro was administered 10 times from 02/01/23 through 02/28/23.

Review of Resident #3's March 2023 eMAR from 03/01/23 through 03/14/23 revealed:
-There was an entry for insulin lispro, check FSBS before each meal and inject subcutaneously per sliding scale: 180-200 = 1u, 201-250 = 3u, 251-300 = 5u, 301-350 = 6u, 351-400 = 8u, if greater than 400 call provider. Discard 28 days after opening, scheduled at 7:30am, 11:30am, and 5:00pm.
-There was documentation insulin lispro was administered 6 times from 03/01/23 through 03/14/23.

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Observation of the facility's medication cart audit book on 03/15/23 at 12:10pm revealed:
-There was one MA assigned to complete the medication cart audit in the facility.
-The last time Resident #3's medication was audited was in January 2023 by a medication aide (MA) who was not assigned the role of auditing the medication cart.
-There was no medication cart audit sheet for Resident #3 for February or March 2023.

Interview with a MA on 03/14/23 at 1:50pm revealed:
-She usually checked insulin for the date of expiration prior to administering the insulin.
-She had administered insulin to Resident #3 after it had expired on 02/23/23, 02/06/23, 02/18/23, 02/21/23, and 03/10/23, but overlooked the expiration date.
-Resident #3's insulin was sliding scale, so since he did not receive insulin each time they checked his blood sugar, she thought the expiration date got overlooked.
-She thought sometimes the MAs got busy doing their medication pass and either forgot to check when the expiration date for the insulin would be after 28 days from the opened-on date, or they forgot how many days insulin was good for prior to expiring.
-She had completed the medication cart audit in January 2023 to help out the other MA who was assigned to audit the facility's medication cart.
-She did not know if the other MA had audited Resident #3's medications in February or March 2023.

Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 11:00am revealed:
-All the MAs had been trained to discard insulin 28 days after it was opened and the instruction

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for when to discard the insulin was even listed on the eMAR under the entry for the insulin order.
-The MAs were expected to complete a medication cart audit once every month, then she was supposed to follow up behind the MAs if they had a concern about a medication during the audit.
-Checking expiration dates of medication and insulin was part of the medication cart audit.
-Resident #3 did not need to use insulin every day, so his insulin had not ran out within 28 days of the vial being opened.
-The MAs should all be checking the opened-on date prior to administering insulin to prevent administration of expired insulin.
-She was not aware Resident #3's lispro insulin on the medication card had expired.

Telephone interview with a MA on 03/15/23 at 12:45pm revealed:
-She was responsible for completing medication cart audits at the facility.
-She did medication cart audits every month prior to the 15th day of the month.
-She had not yet completed a medication cart audit for March 2023.
-She did complete a medication cart audit for February 2023, but had not turned in her documentation of it yet.
-She did check insulin for expiration dates during her audits but Resident #3's insulin might have been overlooked.
-She knew Resident #3's insulin needed to be discarded 28 days after it was opened.
-When she administered insulin to Resident #3, she normally checked when it was opened to make sure it was not expired but she must have overlooked it when she administered his insulin 01/22/23, 02/01/23, 02/08/23, 02/23/23, 03/08/23, and twice on 03/13/23.

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C 330	Continued From page 32 Telephone interview with the Administrator on 03/16/23 at 9:00am revealed: -The MAs should be checking all medication for expiration during their monthly medication cart audits and prior to administering insulin. -All the MAs had been trained on when to discard insulin after it had been opened. -She was not aware that Resident #3's insulin had been administered after it had expired. Attempted telephone interviews with a representative from Resident #3's pharmacy on 03/15/23 at 11:45am and on 03/16/23 at 8:30am were unsuccessful.	C 330		
C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures.	C 350		

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A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.

This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to notify the physician when the resident was non-compliant with physician's orders for 1 of 3 sampled residents (#3) related to a resident on dialysis who was ordered a phosphate lowering medication.

The findings are:

Review of Resident #3's current FL2 dated 12/27/22 revealed:
-Diagnoses included chronic kidney disease stage 5 with dialysis three times per week, renal disorder, hypertension, diabetes and chronic pain.
-There was an order for sevelamer (a medication used to lower high phosphorus levels in people who are on dialysis due to severe kidney disease) 800mg twice a day between meals with snacks (may self-administer).
-There was an order for sevelamer 800mg take 2 tablets three times daily with meals (may self-administer).

Review of Resident #3's January, February, and March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for sevelamer 800mg take 2 tablets three times daily with meals scheduled at 7:30am, 11:30am and 5:00pm (may self-administer).
-There was an entry for sevelamer 800mg take 1 tablet twice daily with snacks scheduled at

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10:00am and 3:00pm (may self-administer).
-There was documentation by each time slot that medication was not given by facility.

Review of Resident #3's record on 03/14/23 at 10:00am revealed there was no documented assessment for competency for self-administering medication.

Observation of Resident #3's room on 03/14/23 at 4:20pm revealed:
-There was one pill bottle labeled for Resident #3 containing sevelamer 800mg tablets with instruction to take two tablets three times a day with meals and one tablet with snacks in between meals.
-The pill bottle was filled 11/04/22 and was documented to contain 125 tablets.
-The pill bottle was full.
-There was a paper taped to his wall with instruction to take two tablets with each meal at 7:30am, 11:30am and 5:00pm and to take one tablet with his snack at 9:30am and 1:00pm.

Interview with Resident #3 on 03/14/23 at 4:15pm revealed:
-He took sevelamer one tablet three times per day before each meal instead of two tablets before each meal.
-He did not take sevelamer twice daily between meals with snacks because he did not remember to.
-He knew sevelamer was used to lower phosphorus levels in his blood since he was on dialysis.
-The MAs did not ask him if he took his doses of sevelamer.
-He did not document or write down when he took sevelamer.

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Telephone interview with a medication aide (MA) on 03/15/23 at 12:45pm revealed:
-Resident #3 kept his sevelamer in his room because he self-administered that medication.
-She did not ask Resident #3 if he took sevelamer or how he took sevelamer because Resident #3 was independent supposed to be responsible for taking the medication on his own.
-She only checked Resident #3's sevelamer pill bottle from time to time to see if he needed it to be refilled or reordered from the pharmacy.

Telephone interview with a representative from Resident #3's primary care provider (PCP) office on 03/15/23 at 2:40pm revealed:
-Resident #3 was taking sevelamer to treat increased blood phosphorus levels due to being on dialysis.
-Resident #3's last documented phosphate level was on 01/07/23 and was 6.2 milligrams per deciliter (mg/dL), and normal range was 2.4 - 4.7 mg/dL.
-Resident #3's phosphate level on 11/22/22 was 6.7 mg/dL, normal range was 2.4 - 4.7 mg/dL.
-Elevated phosphate levels indicated kidney damage, but Resident #3 was already receiving dialysis for that.
-There was no documentation that Resident #3's PCP was aware he was only taking one tablet three times daily instead of two tablets three times daily with meals and one tablet twice daily with snacks.
-Resident #3's PCP was aware that Resident #3 was self-administering sevelamer so it was possible the PCP talked about dosing with Resident #3 during his appointments.

Interview with a MA on 03/15/23 at 3:25pm revealed:
-She did not ask Resident #3 about how or when

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he took sevelamer.
-She told Resident #3 to let her know if he needed sevelamer refilled but she did not check on the quantity in his pill bottle.
-There was no documentation to check to see if Resident #3 was taking sevelamer as ordered or not.

Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 3:45pm revealed:
-Resident #3 was his own decision maker so was responsible for administering sevelamer as ordered by the doctor.
-There was no process in place at the facility to screen residents for their ability to safely self-administer medication.
-There was no documentation expected of the resident to document when and how many sevelamer he took during the day.
-She was not aware that Resident #3 was not taking sevelamer as it was ordered.
-If Resident #3 was not taking his medication as directed on the medication bottle or on the paper hanging on his wall, he would not be able to continue self-administering.

Telephone interview with the Administrator on 03/16/23 at 9:00am revealed:
-Resident #3 was independent but she did not think he recognized how serious his condition was or how important it was for him to take his sevelamer as ordered.
-She was not aware Resident #3 was not taking sevelamer as it was ordered.
-Resident #3 had requested to take sevelamer on his own and his PCP signed the order allowing him to self-administer that medication.
-Other than asking Resident #3 if he was taking sevelamer correctly, the MAs were not expected to follow up with Resident #3 about

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C 350	Continued From page 37 self-administering his medication. -Neither the MAs nor Resident #3 were expected to document sevelamer administration. -Resident #3 was expected to take his sevelamer as ordered. -Resident #3 should not be self-administering his medication if he was not going to follow the doctor's orders for taking the medication.	C 350		