Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086014	A. BUILDING: ______ B. WING ______	R **02/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWOOD ALF	**711 W ATKINS DR** **DOBSON, NC 27017**

(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 conducted an annual and follow-up survey from 02/22/23 to 02/24/23 and exit via telephone on 02/27/23.	D 000		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a licensed health professional support (LHPS) competency validation checklist had been completed with a return demonstration for tasks including checking fingerstick blood sugar (FSBS), administration of	D 161	Correction date 2/28/23 per conversation with Administrator 3/31/23. SG Staff A was checked off on fingerstick bloodsugars (FSBS) with return demonstration by a licensed pharmacist on 1/18/2023 Staff A was checked off on LHPS skills with return demonstrations including the admnistration of oxygen by a registered nurse on 1/16/23 See attached skills validation forms attached.	

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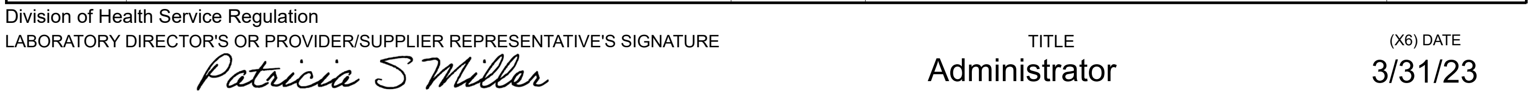

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia S Miller	Administrator	3/31/23

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D 161		D 161		

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oxygen, and administration of medication via injection for 1 of 3 sampled staff (Staff A).

The findings are:

Review of Staff A's medication aide (MA) personnel record revealed:
-Staff A was hired on 01/16/23.
-There was documentation she completed a licensed health professional support (LHPS) skills validation checklist on 01/16/23.

Review of a resident's January 2023 electronic medication administration record (eMAR) revealed:
-Staff A had documented checking fingerstick blood sugar (FSBS) values on 9 days in January 2023.
-Staff A had documented administration of oxygen on 01/27/23.
-Staff A had documented insulin administration on 9 days in January 2023.

Review of a resident's February 2023 from 02/01/23 to 02/27/23 eMAR revealed:
-Staff A had documented checking FSBS values on 9 days in February 2023.
-Staff A had documented administration of oxygen on 02/04/23 and 02/15/23.
-Staff A had documented insulin administration on 9 days in February 2023.

Interview with Staff A on 02/24/23 at 4:00pm revealed:
-She thought when she was hired she completed the LHPS competency validation checklist with the pharmacy staff who completed her medication administration competency validation clinical skills checklist.
-She had completed a LHPS competency

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D 161	Continued From page 2 validation checklist at the facility she worked at previously. -She could not remember if the Executive Director (ED) had told her that she needed to complete a LHPS competency validation checklist upon hire. Telephone interview with the ED on 02/27/23 at 1:45pm revealed: -She was responsible for hiring staff and ensure their personnel records were current and complete. -The LHPS nurse who had previously been coming to the facility to do on-site LHPS competency validation checklists with staff still did the check offs, but via FaceTime with no in-person return demonstration. -Staff A completed her LHPS competency validation skills checklist with the LHPS nurse via FaceTime with no in-person return demonstration. -The pharmacist had checked Staff A off on her hands-on skills such as FSBS and administering medication via injection when Staff A completed her medication administration competency validation clinical skills checklist. -The pharmacy staff had Staff A do a return demonstration during her medication administration competency validation clinical skills checklist so she thought that covered the need for return demonstration for the LHPS tasks too. -She was not at the facility when Staff A completed her skills checklist with the pharmacy staff.	D 161		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation	D 167		

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D 167	Continued From page 3 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed an accredited course on cardiopulmonary resuscitation (CPR) within the last 24 months for 22 of 28 sampled shifts. The findings are: Review of the facility's work schedule from 02/10/23 through 02/23/23 revealed: -The medication aides (MA) worked 12-hour shifts. -There were no staff working in the facility who had current cardiopulmonary resuscitation (CPR) training on the dates and times as follows: -On 02/10/23 from 7:00am to 9:00am, and from 5:00pm to 11:59pm; -On 02/11/23, 02/12/23, 02/15/23, 02/18/23, 02/19/23 and 02/20/23 from 12:00am to 11:59pm; -On 02/13/23, 02/14/23 and 02/16/23 from	D 167	Administrator will ensure that ALL current staff are CPR certified by 4/30/23 and will ensure that there will at all times be at least one person on the premises who is certified in CPR. Administration will also ensure that staff recertify their CPR training every 2 years.	4/30/23

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12:00am to 7:00am;
-On 02/13/23, 02/14/23 and 02/16/23 from 7:00pm to 11:59pm;
-On 12/17/23, from 12:00am to 9:00am and from 3:00pm to 11:59pm;
-On 02/21/23, from 12:00am to 10:00am and from 12:00pm to 11:59pm;
-On 02/22/23, from 12:00am to 9:00am and from 11:00am to 11:59pm;
-On 02/23/23, from 12:00am to 9:30am and from 5:00pm to 11:59pm.

Interview with a MA on 02/24/23 at 4:00pm revealed:
-She last took a CPR training course in 2017.
-She thought she had taken another CPR course since 2019 when her training expired, but she could not remember.
-She did not think that her CPR training was current.
-Nobody at the facility had advised her on what to do if a resident needed CPR.
-If she had an incident where a resident needed CPR, she would perform CPR for that resident because she knew how to do it.
-When she was hired, the Executive Director (ED) had not told her she needed to take another CPR training course.
-She did not know if anyone else at the facility had a current CPR certification.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed:
-The ED was responsible for hiring staff and managing personnel records.
-The ED created the staff schedules.
-He was aware that he was the only staff at the facility with current CPR certification.
-The ED had tried several times to get someone

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to come to the facility and do CPR training, but it never worked out.
-He had done his CPR training at the college he was attending.
-All the staff knew that he lived across the street and they could call him at any time if CPR was needed because he could be in the facility within 2 minutes.
-If he was not available or at home and a resident at the facility needed CPR the staff would call 911 and follow their instruction.

Telephone interview with the ED on 02/27/23 at 1:45pm revealed:
-She was responsible for hiring staff and ensuring all components of the personnel records were current and complete.
-In the previous few years she had everyone at the facility take a CPR training course including the MAs and personal care aides (PCAs), but all of those certifications had now expired.
-The previous two times she had a CPR certification course scheduled for all her staff it had to be canceled because there was nobody available to go to the facility to do the training.
-She had tried and was not successful at finding someone to go to the facility to do CPR training with her staff.
-The RCC was the only staff who had a current CPR certification.
-The staff were all told that if someone needed CPR, they were to call 911 and follow their guidance.
-The MAs would do CPR if they were told to because they had all previously taken a CPR course and knew how even if they were not currently certified.

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D 234	Continued From page 6	D 234		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#1 and #5) had completed two-step tuberculosis (TB) skin testing upon admission. The findings are: 1. Review of Resident #1's current FL2 dated 11/14/22 revealed diagnoses included osteoarthritis, morbid obesity, muscle weakness, hypothyroidism, hyperlipidemia, and heart disease. Review of Resident #1's Resident Register revealed an admission date of 11/30/21. Review of Resident #1's record revealed: -There was documentation Resident #1 had a TB skin test on 01/29/22 and the result was negative. -There was no documentation a two-step TB skin test was given for Resident #1. Interview with Resident #1 on 02/23/23 at	D 234	Beginning immediately, administrator or RCC will ensure that all new admissions have documentation of either a two-step tuberculin skin test or a single interferon gamma release assay as allowed by Permanent Rule Change 10A NCAC 41A .0205	3/27/2023

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11:39am revealed:
-She had a TB skin test when she was admitted to the facility.
-She thought she had a two-step TB skin test.

Interview with the Executive Director (ED) on 02/23/23 at 12:16pm revealed:
-Resident #1 did not have her two-step TB skin test completed.
-Resident #1's two-step TB skin test could have fallen through the cracks.
-The former Resident Care Coordinator (RCC) was responsible for ensuring TB tests were completed when Resident #1's second TB skin test was due.
-She and the current RCC were now responsible for ensuring two-step TB tests were completed.

Refer to interview with the RCC on 02/27/23 at 12:42pm.

Refer to interview with the ED on 02/27/2 at 3:05pm.

2. Review of Resident #5's current FL2 dated 02/13/23 revealed diagnoses included hypoglycemia, enlarged pituitary gland, hypothyroidism, elevated enzymes, tachycardia, Vitamin D deficiency, acute kidney injury, chronic obstructive pulmonary disease, history of seizures, schizophrenia, hypertension, hyperlipidemia, and macrocytic anemia.

Review of Resident #5's record revealed there was no documetation of a 2-step TB skin test.

Interview with the Executive Director (ED) on 02/23/23 at 12:16pm revealed:
-Resident #5 had resided at the facility since 1995 which was prior to the current administration.

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D 234	Continued From page 8 -The current ownership took over in 2014 and she assumed Resident #5 had his two-step TB test because he was already a resident. -She was responsible for ensuring TB skin tests were completed for residents. Interview with Resident #5 on 02/23/23 at 12:42pm revealed he did not know if he had a TB skin test completed. Refer to interview with the RCC on 02/27/23 at 12:42pm. Refer to interview with the ED on 02/27/2 at 3:05pm. ______________ Telephone interview with the RCC on 02/27/23 at 12:42pm revealed: -The ED was responsible for ensuring two-step TB skin tests were completed for residents. -Residents usually had verification of a two-step TB test prior to admission. Telephone interview with the ED on 02/27/23 at 3:05pm revealed: -The first TB skin test was completed for residents upon admission. -The second step TB skin test was completed within 30 days of the first TB skin test or when she could get a nurse to complete it. -There had been no audits of resident records to ensure a 2-step TB skin tests had been completed for all residents.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 270		

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D 270	Continued From page 9 (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: Based on observations, record reviews and interviews, the facility failed to provide supervision according to the needs of 1 of 5 sampled residents (#2) who had a history of wandering into other residents' rooms. The findings are: Review of Resident #2's current FL2 dated 01/31/23 revealed: -Diagnoses included fetal alcohol syndrome, epilepsy, anxiety disorder, and mental development delay. -He was constantly disoriented. -He had a functional limitation regarding his speech and sight. Review of Resident #2's psychiatry progress note dated 12/09/22 revealed there was documentation Resident #2 continued to go into other resident's rooms and grab things but was redirectable. Review of Resident #2's progress note dated 12/21/22 revealed there was documentation that Resident #2 was agitated and trying to get into other resident's rooms, so an as-needed anxiety medication was administered. Review of Resident #2's progress note dated 02/21/23 revealed: -At 3:00pm, staff reported seeing another	D 270	Administrator and/or RCC will ensure that staff increase supervision of residents who are disoriented by implementing facility's 15- minute monitoring system and that RCC will notify the physician of any changes in behavior of residents that result in disorientation.	3/31/23

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resident physically assault Resident #2.
-The personal care aide (PCA) who witnessed the altercation reported that the other resident had Resident #2 by the throat up against the wall and was punching him in the face.
-The Executive Director (ED) initiated an involuntary commitment (IVC) for the other resident.
-There was no documentation that increased supervision of Resident #2 was implemented.

Interview with a PCA on 02/23/23 at 9:32am revealed:
-She was the only staff who had witnessed the altercation between Resident #2 and the other resident.
-She thought the altercation happened on 02/21/23 at 12:40pm, because the other residents and staff were in the dining room for lunch.
-The other resident walked up behind the Resident #2 after leaving the dining room and punched him twice on the left side of the face and twice on the shoulder.
-Resident #2 did not yell out or act hurt during the physical assault.
-She immediately stepped between the two residents to stop the assault.
-She thought the fight happened because Resident #2 sometimes went into the other resident's room and took his baseball items.
-Up to the time of the physical altercation on 02/21/23, the staff had just been keeping an eye on Resident #2 and trying to redirect him if they saw him in a room that was not his.
-The altercation on 02/21/23 was the first time the other resident had shown aggression towards Resident #2.
-She checked Resident #2 over for injury, but did not see any visible injuries and he was not acting hurt in any way.

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-Once the other resident returned to the facility, she had not been advised to do anything differently for him or Resident #2.

Telephone interview with Resident #2's guardian on 02/23/23 at 9:50am revealed:
-The facility contacted her if there were incidents with Resident #2.
-She had not been contacted in the previous week regarding any incidents.
-She relied on the facility to keep her updated on what was happening with Resident #2, because he was not able to communicate for himself.
-She was aware that Resident #2 sometimes went into other the residents' rooms, but he did not know any better.
-She would want to be contacted any time there was any incident involving Resident #2.

Interview with the other resident on 02/23/23 at 11:10am revealed:
-Resident #2 went in his room to try to steal his stuff and he did not like that.
-He felt as if Resident #2 went through his stuff every time he left his room to go to the dining room for meals.
-He did not have many belongings and did not want someone stealing the few possessions that he did have.
-He knew Resident #2 was not "smart", but he did hit him one time anyway on 02/21/23 because he was frustrated that he had gone through his stuff.

Telephone interview with the county Adult Home Specialist (AHS) on 02/23/23 at 12:15pm revealed:
-She had not received an incident report regarding the altercation between Resident #2 and the other resident because the ED had told her what happened over the phone.

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Continued From page 12

-She had not requested a written incident report.

Interview with a medication aide (MA) on 02/23/23 at 2:45pm revealed:
-After the physical altercation on 02/21/23 between Resident #2 and another resident, all the staff were told by the ED to monitor Resident #2 and make sure he stayed out of the other residents' rooms.
-There was nowhere to document that they were watching Resident #2.
-The other resident sometimes told Resident #2 to stay out of his room, but never showed aggression towards him in the past.

Telephone interview with Resident #2's PCP on 02/24/23 at 9:15am revealed:
-He was not aware of the physical altercation between Resident #2 and the other resident.
-He would expect the facility staff to notify either him or the on-call provider about a physical altercation if it happened after office hours.
-He was not aware of any increased supervision for Resident #2 due to his behavior of wandering into other residents' rooms.

Telephone interview with Resident #2's mental health provider (MHP) on 02/24/23 at 11:25am revealed:
-He was not aware of the physical altercation on 02/21/23 between Resident #2 and another resident.
-It would be hard to control Resident #2's impulses to go into other resident's room due to his mental capacity.
-He did not think that increased supervision checks would resolve Resident #2 from going into rooms that were not his, because as soon as staff left him, he could get up and go.
-He would have expected staff to make him

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aware of what had happened so that he could address it with both residents his next time at the facility.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed:
-He was aware that Resident #2 wandered into other residents' rooms and that some of the other residents did not like it.
-The resident who physically assaulted Resident #2 for going into his room had not shown aggression towards Resident #2 prior to the incident on 02/21/23.
-Since the altercation on 02/21/23, staff were advised by the ED to monitor the two residents when they were near each other, but he was not aware of any new protocols put into place or documentation for the staff to complete.

Telephone interview with the ED on 02/27/23 at 1:45pm revealed:
-Prior to the physical altercation on 02/21/22, the other resident had not shown any aggression towards Resident #2 other than cursing at him to stay out of his room.
-There had been no formal monitoring or supervision of Resident #2 in place prior to the physical altercation on 02/21/23, the staff just knew to redirect Resident #2 out of other residents' rooms if needed.
-She was told that the physical assault had happened because Resident #2 had been in the other resident's room.
-She was told the incident had happened in the hallway and was witnessed only by the one PCA.
-She had requested the PCA look Resident #2 over for injury, but had not asked her to check vital signs.
-She had not been at the facility at the time of the

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D 270	Continued From page 14 altercation, but went to the facility after the incident had happened, and Resident #2 seemed to be at his baseline and no apparent injury. -She had not increased supervision or implemented anything new for the staff to do for Resident #2 since the altercation happened, but all the staff knew to keep an eye on Resident #2. -She had not completed an incident report for the altercation between Resident #3 and the other resident because she told the AHS via telephone what had happened and that she was sending Resident #3 out for an IVC. Based on record review and attempted interview, it was determined Resident #2 was not interviewable.	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: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure follow-up with the primary care provider (PCP) to meet the health care needs for 4 of 5 sampled residents (#3, #2, #1, and #4), including a resident who had physically assaulted another resident and missed laboratory work ordered weekly (#3), a resident who had been physically assaulted by another resident (#2), a resident who did not have valproic acid levels checked as ordered (#1), and a resident who had multiple medication refusals and not administered medications as ordered	D 273	Administrator and/or RCC will ensure that PCP is notified of any and all altercations between residents. RCC will ensure that any outside laboratories who come to the facility to draw blood for labs will provide documentation of which residents lab draws were successful or refused and that results of labs will be sent to PCP when facility receives reports from the lab.	3/31/23

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(#4).

The findings are:

1. Review of Resident #3's current FL2 dated 10/03/22 revealed:
-Diagnoses included coronary artery disease, cerebral artery occlusion, history of stroke, secondary parkinsonism, hypertension, and cognitive disorder.
-He was intermittently disoriented.
-He had a functional limitation regarding his speech.

a. Review of Resident #3's Psychiatry progress notes dated 02/06/23 revealed:
-He was prescribed sertraline (an antidepressant medication) for mood.
-Staff reported to the mental health provider that Resident #3 appeared irritated when things were not done for him immediately.
-He was prescribed quetiapine (an antipsychotic medication used to treat diagnoses such as schizophrenia, bipolar disorder and depression) for behaviors.
-Staff had not documented any behavioral concerns for Resident #3.

Review of Resident #3's progress notes dated 02/21/23 revealed:
-Resident #3 continued to refuse his all of his medications since 02/16/23.
-At 3:00pm, staff reported seeing Resident #3 physically assault another resident.
-The personal care aide (PCA) who witnessed the altercation reported that Resident #3 had the other resident by the throat up against the wall and was punching the resident in the face.
-The Executive Director (ED) initiated an involuntary commitment (IVC) for Resident #3.

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-At 3:30pm, law enforcement arrived and transported Resident #3 to the hospital.
-The ED left a voicemail for Resident #3's guardian and updated the guardian's supervisor via telephone about Resident #3's behavior and the IVC.
-There was no documentation the primary care provider (PCP) was notified.

Review of Resident #3's IVC hospital discharge summary dated 02/22/23 revealed:
-Resident #3 was documented as having been evaluated due to an IVC.
-His diagnoses were combined receptive and expressive aphasia (difficulty speaking caused by brain damage) as a late effect of cerebrovascular accident (CVA/stoke).
-There was an order to continue taking quetiapine 50mg every morning, quetiapine 100mg every evening and sertraline 100mg daily.

Interview with a PCA on 02/23/23 at 9:32am revealed:
-She was the only staff who had witnessed the altercation between Resident #3 and the other resident.
-She thought the altercation on 02/21/23 happened around 12:40pm, because the other residents and staff were in the dining room for lunch.
-Resident #3 walked up behind the other resident after leaving the dining room and punched him twice on the left side of the face and twice on the left shoulder.
-The other resident did not yell out or act hurt during the physical assault.
-She immediately stepped between the two residents to stop the assault.
-The other resident was not cognitively aware enough to know how to stop the assault.

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-She thought the fight happened because Resident #3 liked baseball, and the other resident sometimes went into Resident #3's room and took his baseball items.
-The altercation on 02/21/23, was the first time Resident #3 had shown aggression towards the other resident.
-Once the residents' altercation was broken up, she reported the incident to the Executive Director (ED) who then called the police to come take Resident #3 away.
-The ED had not asked her to complete any documentation or reports regarding the incident because she would write the report herself.
-The ED had just asked her to verbally describe what she had witnessed.
-She checked the other resident over for injury, but did not see any visible injuries and the other resident was not acting hurt in any way.
-Resident #3 returned from the hospital on 02/22/23.
-Once Resident #3 returned to the facility, she had not been advised to do anything differently for him.
-Resident #3 had not had any concerning behaviors since returning from the hospital.
-She did not think Resident #3 had been having any behavioral issues prior to the physical assault on the other resident.

Interview with Resident #3 on 02/23/23 at 11:10am revealed:
-He had lived at the facility for almost a year and was not happy there because he felt like he could not get along with the ED.
-The ED would not talk to him, and he was frustrated that he had trouble communicating with her.
-He had a stroke and ever since the stroke he was not able to think or speak well.

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-He tried to be nice to everyone.
-There was one resident at the facility who came in his room to try to steal his stuff and he did not like that.
-He felt as if the other resident went through his stuff every time he left his room to go to the dining room for meals.
-He did not have many belongings and did not want someone stealing the few possessions that he did have.
-He knew the other resident was not "smart", but he did hit him the other day anyway, because he was frustrated that he had gone through his stuff.

Telephone interview with Resident #3's guardian on 02/23/23 at 12:20pm revealed:
-He was aware that Resident #3 was sent to the hospital for an IVC on 02/21/23.
-He had been off work that day so had received the notification on 02/22/23, and he also spoke with the hospital regarding the IVC on 02/22/23.
-Resident #3 had never had an altercation with another resident prior to the incident on 02/21/23.
-Aside from Resident #3 being upset over not having permission to walk to town to go to the store by himself, he did not have a history of behaviors.

Interview with a medication aide (MA) on 02/23/23 at 2:45pm revealed:
-After the physical altercation on 02/21/23, all the staff were told by the ED to monitor the other resident and make sure he stayed out of Resident #3's room.
-There was nowhere to document that they were watching Resident #3's room.
-Resident #3 sometimes told the other resident to stay out of his room, but never showed aggression towards him in the past.

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Telephone interview with Resident #3's PCP on 02/24/23 at 9:15am revealed:
-He was not aware of the altercation between Resident #3 and the other resident.
-He would expect the facility staff to either notify him about a physical altercation or to notify the on-call provider if it happened after office hours.
-He did not think that the medications Resident #3 had missed due to refusing them would have caused his behavior on 02/21/23.
-He agreed with the ED's decision to send Resident #3 out for an IVC and would not have advised her to do anything different.

Telephone interview with Resident #3's mental health provider (MHP) on 02/24/23 at 11:25am revealed:
-He was not aware of the altercation between Resident #3 and the other resident from 02/21/23.
-Both Resident #3 and the other resident were patients of his, and he would have wanted to be notified of the altercation between the two of them.
-He would not have advised the facility to do anything differently, but would have expected them to make him aware of what had happened so that he could address it with both residents his next time at the facility.
-Resident #3 had a hard time communicating due to his stroke which caused him to be frustrated a lot.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed:
-He was not working on 02/21/23 when Resident #3 hit the other resident.
-The ED would have been responsible for following up with both residents' doctors but he did not know if the ED had notified the PCP

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regarding the altercation.
-Resident #3 had not shown aggression towards the other resident prior to the incident on 02/21/23.
-Since the physical altercation on 02/21/23, staff were advised by the ED to monitor the two residents when they were near each other, but he was not aware of any new protocols put into place or documentation for the staff to complete.

Telephone interview with the ED on 02/27/23 at 1:45pm revealed:
-Prior to the altercation on 02/21/22, Resident #3 had not shown any aggression towards the other resident other than cursing at him to stay out of his room.
-She was told that the physical assault by Resident #3 had happened because the other resident had been in Resident #3's room.
-She was told the incident had happened in the hallway and was witnessed only by the one PCA.
-She would have been the staff responsible for notifying the PCP, but had not sent a notification to Resident #3's PCP or MHP regarding the incident, because she had Resident #3 sent out to the hospital for an IVC instead.
-She had not been at the facility at the time of the altercation, but she went to the facility after it had happened.

b. Review of Resident #3's physician order dated 08/01/22 revealed an order for weekly international normalized ratio (INR) (a blood lab used to check coagulation time or effectiveness of a blood thinning medication) laboratory work due to taking warfarin (a blood thinning medication).

Review of Resident #3's laboratory results revealed:

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-There was documentation Resident #3 had an INR blood draw once weekly except on 11/29/22, 12/06/22, and 02/07/23.
-On 02/14/23, Resident #3's INR was 1.71 (therapeutic range was 2.0-3.0).
-On 02/21/23, Resident #3's INR was 1.25 (therapeutic range was 2.0-3.0).

Telephone interview with a representative from the facility's contracted laboratory on 02/22/23 at 3:25pm revealed:
-On 11/29/22, there was an order placed to obtain Resident #3's INR, but no specimen had been received which indicated it had not been drawn.
-There was no order to obtain an INR from Resident #3 on 12/06/22 or 02/07/23.
-When they collected a laboratory specimen from Resident #3 the result was sent to the resident's electronic medical record (EMR) and an online portal for both the facility staff and the doctor to access the result.

Telephone interview with a representative from the facility's contracted laboratory on 02/27/23 at 10:00am revealed:
-Resident #3 had an order on file to have an INR obtained every week.
-There was no documentation his INR had been obtained on 11/29/22, 12/06/22 or 02/07/23 or that the facility had contacted them to come obtain Resident #3's blood specimen on those days.
-There was no documentation Resident #3 had refused to have his blood drawn on those days.
-The order had not been entered properly by the laboratory, so the technician had not gotten the report to obtain an INR for Resident #3.
-There was no documentation the facility had contacted the laboratory regarding the missed laboratory visits for Resident #3.

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Interview with Resident #3 on 02/23/23 at 11:10am revealed:
-He had his blood drawn every week because he was taking warfarin.
-He did not remember missing any weeks with his blood draws.
-He did not think he had ever refused to have his blood drawn.

Interview with a medication aide (MA) on 02/23/23 at 2:45pm revealed:
-The Resident Care Coordinator (RCC) was responsible for communication with the laboratory and the primary care provider (PCP).
-The MAs did not keep track of laboratory orders or follow up with the laboratory if a blood draw was needed.
-She did not know if Resident #3 had ever missed an INR laboratory draw.

Telephone interview with Resident #3's physician on 02/23/23 at 3:30pm revealed:
-He was the physician who supervised Resident #3's PCP.
-He saw Resident #3 in person every 6 months, but also received notifications regarding resident concerns while he was in the office.
-Resident #3 was taking warfarin for a diagnosis of left ventricular thrombus.
-Resident #3's goal range for his INR was 2.0-3.0.
-He was more concerned about Resident #3's INR value being high rather than low.
-Any INR value below the goal range of 2.0-3.0 placed Resident #3 at risk for blood clots or stroke.

Telephone interview with Resident #3's PCP on 02/24/23 at 9:15am revealed:

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-He reviewed Resident #3's INR results every Monday when he was at the facility.
-He was not aware of Resident #3 not having an INR obtained on 11/29/22, 12/06/22, or 02/07/23.
-He would expect the facility to follow up with the laboratory if they did not obtain Resident #3's weekly INR.

Telephone interview with the RCC on 02/27/23 at 12:45pm revealed:
-It was his responsibility to fax laboratory orders to the laboratory and follow up with them regarding laboratory draws or results.
-The laboratory came to the facility every week to obtain a blood specimen from Resident #3 to check his INR level.
-Once the laboratory result was sent to the facility he would print the result and place it in Resident #3's folder for the PCP to review.
-He had not noticed that there was no INR obtained for Resident #3 on 11/29/22, 12/06/22 or 02/07/23.
-There was no process in place for him to keep track of which laboratory work was due and which laboratory work was obtained and to follow up with the laboratory if a blood draw was missed.

Telephone interview with the Executive Director (ED) on 02/27/23 at 1:45pm revealed:
-She was not aware of Resident #3's missed laboratory draws on 11/29/22, 12/06/22, and 02/07/23.
-The laboratory technician gave the RCC a list of all the residents they came to obtain blood from and if they were successful in obtaining the specimen or not, so the RCC would know if Resident #3 refused his laboratory work.
-There were no documented laboratory refusals for Resident #3 that she was aware of.
-The RCC was responsible for ensuring all the

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ordered laboratory work was completed and following up with the laboratory and the PCP if laboratory work was not completed as ordered.

2. Review of Resident #2's current FL2 dated 12/12/22 revealed:
-Diagnoses included fetal alcohol syndrome, epilepsy, anxiety disorder, and mental development delay.
-He was constantly disoriented.
-He had a functional limitation regarding his speech and sight.

Review of Resident #2's psychiatry progress note dated 12/09/22 revealed there was documentation Resident #2 continued to go into other resident's rooms and grab things but was redirectable.

Review of Resident #2's progress note dated 12/21/22 revealed there was documentation that Resident #2 was agitated and trying to get into other resident's rooms, so his as-needed anxiety medication was administered.

Review of Resident #2's progress note dated 02/21/23 revealed:
-At 3:00pm, staff reported seeing another resident physically assault Resident #2.
-The personal care aide (PCA) who witnessed the altercation reported that the other resident had Resident #2 by the throat up against the wall and was punching him in the face.
-The Executive Director (ED) initiated an involuntary commitment (IVC) for the other resident.
-There was no documentation that Resident #2's guardian or primary care provider (PCP) had been notified about the incident.

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Interview with a PCA on 02/23/23 at 9:32am revealed:
-She was the only staff who had witnessed the altercation between Resident #2 and the other resident.
-She thought the altercation happened on 02/21/23 at 12:40pm, because the other residents and staff were in the dining room for lunch.
-The other resident walked up behind the Resident #2 after leaving the dining room and punched him twice on the left side of the face and twice on the shoulder.
-Resident #2 did not yell out or act hurt during the physical assault.

Telephone interview with Resident #2's guardian on 02/23/23 at 9:50am revealed:
-The facility contacted her if there were incidents with Resident #2.
-She had not been contacted in the previous week regarding any incidents.
-The last phone call she received from staff at the facility was on 02/01/23 regarding a podiatry appointment.
-She relied on the facility to keep her updated on what was happening with Resident #2 because he was not able to communicate for himself.
-She was aware that Resident #2 sometimes went into other the residents' rooms, but he did not know better.
-She would want to be contacted any time there was any incident involving Resident #2.

Telephone interview with Resident #2's PCP on 02/24/23 at 9:15am revealed:
-He was not aware of the altercation between Resident #2 and the other resident.
-He would expect the facility staff to notify either him or the on-call provider about a physical altercation if it happened after office hours.

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-He expected the staff at the facility to use their clinical judgment regarding after-care for Resident #2.
-If he had known about Resident #2 being punched in the head he probably would have suggested monitoring him for 24 hours after the incident or completing neurological assessments on him such as checking for facial drooping, change in pupil size or other neurological deficits.

Telephone interview with Resident #2's mental health provider (MHP) on 02/24/23 at 11:25am revealed:
-He was not aware of the altercation from 02/21/23 between Resident #2 and the other resident.
-Both Resident #2 and the other resident were patients of his, and he would have wanted to be notified of the altercation between the two of them.
-It would be hard to control Resident #2's impulses to go into other resident's room due to his mental capacity.
-He did not think that increased supervision checks would resolve Resident #2 from going into rooms that were not his, because as soon as staff left him, he could get up and go.
-He would not have advised the facility to do anything differently, but would have expected them to make him aware of what had happened so that he could address it with both residents his next time at the facility.

Telephone interview with Resident #2's physician on 02/23/23 at 3:30pm revealed:
-He was Resident #2's physician who oversaw the work of the PCP and also received notifications about resident concerns while he was in the office.
-He was not aware of the physical altercation

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between Resident #2 and the other resident that happened on 02/21/23.
-He would expect the facility to notify their office about a physical altercation between residents.
-If the ED was not able to get into contact with the PCP, he would have advised her to have Emergency Medical Services (EMS) come to the facility to evaluate Resident #2 to determine if neurological assessments were needed.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed:
-He was not working on 02/21/23 when Resident #2 was hit by the other resident.
-He did not know if the ED had notified the PCP regarding the altercation.

Telephone interview with the ED on 02/27/23 at 1:45pm revealed:
-She had not sent a notification to Resident #2's PCP or MHP regarding the incident because Resident #2 did not appear injured in any way.
-She had left a voicemail for Resident #2's guardian on 02/21/23, but she did not know if the guardian had called back or been notified of the incident.

Based on record review and attempted interview, it was determined Resident #2 was not interviewable.

3. Review of Resident #1's current FL2 dated 11/14/22 revealed:
-Diagnoses included bipolar disorder, anxiety, and major depressive disorder.
-There was documentation on the medication section "see MAR."

Review of Resident #1's previous FL2 dated

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10/31/22 revealed:
-Diagnoses included hypoglycemia episode, diabetes mellitus type II, melena, Chron's disease, hypothyroidism, and osteoarthritis.
-There was an order for divalproex sodium (Depakote) (used to treat symptoms of bipolar disorder) 125mg daily at 12:00pm and 500mg daily at bedtime.

Review of Resident #1's physician's orders dated 06/20/22 revealed an order for Depakote 125mg 3 times daily.

Review of Resident #1's physician's orders dated 10/21/22 revealed an order to check Resident #1's valproic acid (VPA) level. (VPA tests measure the amount of valproic acid in the blood to ensure Depakote is administered and within the therapeutic range.)

Review of Resident #1's record revealed there was no documentation of a VPA level check completed after 10/21/22.

Interview with the facility's contracted laboratory on 02/23/23 at 3:23pm revealed:
-There was no documentation the laboratory had received the order dated 10/21/22 to check Resident #1's VPA level.
-Resident #1's last VPA level check was completed on 07/05/22, but he could not confirm the results.

Interview with Resident #1 on 02/23/23 at 11:39am revealed she last had her blood drawn some time before December 2022, but she did not know when or if her VPA level was checked.

Telephone interview with Resident #1's Mental Health Provider (MHP) on 02/24/23 at 11:45am

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revealed:
-She did not know Resident #1 did not have a VPA level check as ordered on 10/21/22.
-VPA levels were routinely checked for residents administered Depakote to ensure the VPA level was not above the therapeutic level of 120; she tried to have VPA levels checked twice a year.
-If the VPA level was above 120, she would start reducing the dosing for Depakote.
-VPA levels above 120 could cause toxicity, low sodium levels, and low platelet levels.
-She would have expected the facility to follow through with the order dated 10/21/22 to have Resident #1's VPA level checked.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:42pm revealed:
-He was responsible for faxing orders to the laboratory within a day or so of the order date.
-He did not remember the order dated 10/21/22 for Resident #1 to have her VPA level checked or if he followed up with the order.

Telephone interview with the Executive Director (ED) on 02/27/23 at 3:05pm revealed:
-The RCC was responsible for sending orders to the contracted laboratory.
-She did not know Resident #1 had an order dated 10/21/23 to have her VPA levels checked.
-She expected the RCC to make sure physician's orders for laboratory tests were sent to the facility's contracted laboratory.

4. Review of Resident #4's current FL2 dated 07/18/22 revealed:
-Diagnoses included chronic schizophrenia, migraines, chronic pain syndrome, chronic obstructive pulmonary disease Polydipsia, history of mouth cancer, and gastroesophageal reflux

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disease.
-There was an order for benztropine (used to treat physical restlessness, agitation, fidgeting, and spasms of the eyes, tongue, jaw, neck and back muscles) 1mg, 1 and 1/2 tablets at bedtime.
-There was an order for docqlace (used to treat constipation) 100mg, 1 capsule twice a day.
-There was an order for hydroxyzine (used to treat anxiety) 25mg, 1 tablet at bedtime.
-There was an order for mirtazapine (used to treat depression and anxiety) 15mg, 1 and 1/2 tablets at bedtime.
-There was an order for valproic acid (used to treat bipolar disorder) syrup 250/5ml, 4ml at bedtime.

Review of Resident #4's physician's orders dated 10/07/23 revealed an order for melatonin (used to aid with sleep) 3mg 1 tablet at bedtime.

Review of Resident #4's February 2023 electronic Medication Administration Record (eMAR) from 02/01/23 through 02/22/23 revealed:
-There was an entry for benztropine 1 mg, 1 and 1/2 tablets at bedtime scheduled for administration at 8:00pm.
-There was an entry for hydroxyzine 2mg, 1 tablet at bedtime scheduled for administration at 8:00pm.
-There was an entry for melatonin 3mg, 1 tablet at bedtime scheduled for administration at 8:00pm.
-There was an entry for mirtazapine 15mg, 1 and 1/2 tablets at bedtime scheduled for administration at 8:00pm.
-There was an entry for valproic acid syrup 250/5ml, 4ml at bedtime scheduled for administration at 8:00pm.
-There was documentation Resident #4 refused

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benztropine, hydroxyzine, melatonin, mirtazapine, and valproic acid for 5 of 22 opportunities on 02/03/23, 02/11/23, 02/12/23, 02/13/23, and 02/16/23.
-There was no documentation Resident #4 was administered benztropine, hydroxyzine, melatonin, mirtazapine, and valproic acid 7 times with blank spaces on 02/04/23, 02/09/23, 02/14/23, 02/15/23, 02/17/23, 02/18/23, and 02/19/23.

Resident #4's February 2023 eMAR from 02/01/23 through 02/22/23 revealed benztropine, hydroxyzine, melatonin, mirtazapine, and valproic acid were not documented as administered for a total of 12 of 22 opportunities at 8:00pm.

Continued review of Resident #4's February 2023 electronic Medication Administration Record (eMAR) for 02/01/23 through 02/23/23 revealed:
-There was an entry for docqlace 100mg, 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Resident #4 refused docqlace for 6 of 46 opportunities on 02/03/23 at 8:00pm, 02/11/23 at 8:00pm, 02/12/23 at 8:00pm, 02/13/23 at 8:00pm, and 02/16/23 at 8:00am and 8:00pm.
-There was no documentation Resident #4 was administered docqlace 7 times with blank spaces on 02/04/23 at 8:00pm, 02/09/23 at 8:00pm, 02/14/23 at 8:00pm, 02/15/23 at 8:00pm, 02/17/23 at 8:00pm, 02/18/23 at 8:00pm, and 02/19/23 at 8:00pm.

Resident #4's February 2023 eMAR from 02/01/23 through 02/22/23, docqlace was not documented as administered for a total of 1 of 23 opportunities at 8:00am and 12 of 22 opportunities at 8:00pm.

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Interview with Resident #4 on 02/23/23 at 11:59am revealed:
-He did not refuse medications.
-The residents had to go to the window at the medication room to receive their medications.
-The MAs told the residents if they did not go to the medication room window to get their medications, they would mark them down as refused.
-Staff must have marked him as refused when he did not show up at the medication room window to get his medication; sometimes he was in bed asleep during medication administration times and staff did not bring his medication to him or wake him up.

Interview with a medication aide (MA) on 02/23/23 at 2:46pm revealed:
-MAs were to notify the Resident Care Coordinator (RCC) if a resident refused a medication for 3 consecutive days.
-She went to Resident #4's room to administer him medications if he did not come to the medication room window.
-Resident #4 had not refused medications for her so she had not needed to report any refusals to the RCC.

Telephone interview with Resident #4's primary care provider (PCP) on 02/24/22 at 10:15am revealed:
-He expected staff to notify him between 48 and 72 hours if a resident refused their medications consistently.
-Staff had not made him aware Resident #4 refused his medications or had not been administered medications.
-He needed to know if medications were not administered so that he could see if there was an

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D 273	Continued From page 33 issue with the facility or with the pharmacy. Telephone interview with the RCC on 02/27/23 at 12:42pm revealed: -If a resident consistently refused medications for 3 days, he would notify the PCP. -Resident #4 refused medications occasionally, but not consistently for more than 3 days. -Refusals should have been documented on the eMAR so he did not know why there were blank spaces. -If there was a blank space on the eMAR, the medication was not administered. -He had not reviewed the eMARs for refusals, because he had not been told he needed to. -He did not know who reviewed the eMARs. -He did not know Resident #4 refused his medications or that there were blank spaces on Resident #4's eMAR. -He relied on the MA Supervisor to let him know which residents refused medications or that medications were not administered, and he would contact the resident's PCP. Telephone interview with the Executive Director (ED) on 02/27/23 at 3:05pm revealed: -The PCP was to be notified when a resident refused medication for 3 consecutive days. -The RCC was responsible for contacting the residents' PCP regarding refusals. -She did not know about Resident #4's refusals or about blank spaces on the eMAR. -If there was a blank space on Resident #4's eMAR, it meant that Resident #4 did not get up to take his medication and the MA waited to see if he would take the medication later. -She and the RCC were responsible for notifying Resident #4's PCP when medications were not administered as ordered.	D 273	Med Aides will be counseled on properly administering medications and documentation of medication administration or refusals. RCC will conduct weekly audits of medication cart and EMAR to insure that medications are being administered and documented as such. All med aides will be instructed to take medications to rooms of residents who do not come to the med room for meds and to make every effort to administer medications as directed.	4/30/2023

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D 273	Continued From page 34 Attempted telephone interview with the evening shift MA on 02/24/23 at 10:30am and 4:30pm, and on 02/27/23 at 8:50am was unsuccessful. Attempted telephone interview with a second evening shift MA on 02/24/23 at 10:32am and 4:32pm, and on 02/27/23 at 8:52am was unsuccessful. ______________________ The facility failed to notify the physician about a physical altercation between two residents which resulted in one resident (#2) being physically harmed who was not able to verbally report symptoms of pain; a resident who missed INR laboratory work resulting in the PCP unaware of a decrease in his INR results below therapeutic range which placed the resident at risk for blood clots or stroke (#3); and a resident who was administered Depakote three times daily and did not have a VPA level check completed as ordered which placed the resident at risk of decreased sodium levels, decreased platelet levels, and toxicity (Resident #1). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ______________________ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on February 24, 2023. THE CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED APRIL 13, 2023.	D 273	Correction date 2/28/23 per conversation with Administrator 3/31/23. SG Administrator and/or RCC will ensure that staff assess any residents involved in physical altercations and that residents' physicians are notified of any injuries as well as notifying physicians of altercations involving residents who are unable to verbalize symptoms of pain. RCC will create a system of checks and balances for physicians' orders of laboratory work, consisting of forms for staff and phlebotomists to document lab draws and/or refusals of lab draws by residents to ensure that all orders for lab work are carried out or documented as to why they were not which will allow RCC to notify physicians of unsuccessful lab draws and to reschedule if so directed by the ordering physician. (See attached sample form)	2/24/23 3/31/23
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:	D 276		

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D 276	Continued From page 35 (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 record reviews and interviews, the facility failed to ensure implementation of orders for 5 of 5 sampled residents (#1, #2, #3, #4, and #5) who had orders for monthly weights and vital signs. The findings are: 1. Review of Resident #2's current FL2 dated 12/12/22 revealed diagnoses included fetal alcohol syndrome, epilepsy, anxiety disorder, and mental development delay. Review of Resident #2's physician order dated 03/22/22 revealed an order to obtain a monthly weight and set of vital signs to include blood pressure, heart rate, oxygen saturation, and temperature. Review of Resident #2's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for weight and vitals monthly, no specified date. -There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight. -There were no weights or vital signs documented from 12/01/22 through 12/31/22. Review of the facility's monthly weight and vital signs sheet revealed there was a form with	D 276	Beginning immediately, RCC will ensure that med aides check vitals and weigh residents who have orders for weights and vitals and that results will be entered into the EMAR. Administrator will monitor the EMAR system to ensure completion of these tasks.	3/1/23

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weights and vital signs documented for January 2023 and February 2023 but not for December 2022.

Interview with the Executive Director (ED) on 02/22/23 at 12:45pm revealed:
-It was part of the facility's standing orders for all residents to have monthly weights and vital signs checked.
-If Resident #2 did not have a weight or set of vital signs documented for December 2022 he might have refused or been unable to hold still long enough for staff to obtain the weight and vital signs.

Telephone interview with Resident #2's primary care provider (PCP) on 02/24/23 at 9:15am revealed:
-Since Resident #2 did not have diagnoses of heart failure or adult failure to thrive it was not critical for his weight and vital signs to be monitored every month.
-He expected the facility to obtain the monthly weight and set of vital signs for Resident #2 because it was ordered.

Telephone interview with the ED on 02/27/23 at 1:45pm revealed the weights and vital signs for Resident #2 for December 2022 might have been obtained but never entered into the eMAR.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm.

Refer to telephone interview with the ED on 02/27/23 at 1:45pm.

2. Review of Resident #3's current FL2 dated 10/03/22 revealed diagnoses included coronary artery disease, cerebral artery occlusion, history

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of stroke, secondary parkinsonism, hypertension, and cognitive disorder.

Review of Resident #3's physician order dated 07/18/22 revealed an order to obtain a monthly weight and set of vital signs to include blood pressure, heart rate, oxygen saturation, and temperature.

Review of Resident #3's December 2022, January 2023, and February 2023 electronic medication administration record (eMAR) revealed there was no entry for monthly weight and vital signs.

Review of the facility's monthly weight and vital signs sheets revealed:
-There was no form to document weight and vital signs on for December 2022.
-There was a form for January 2023 with resident's weights and vitals documented on it but there was not a weight or vital signs documented for Resident #3.

Interview with the Executive Director (ED) on 02/22/23 at 12:45pm revealed:
-It was part of the facility's standing orders for all residents to have monthly weights and vital signs checked.
-Since there was no entry on Resident #3's eMAR to document weights and vital signs on, the eMAR would not trigger the medication aides (MA) to check his weight or vital signs.
-Nobody had mentioned to her that Resident #3 did not have a place on his eMAR to document weights and vital signs.
-She often worked on the medication cart in the role of MA and had not noticed that Resident #3 did not have a place to document weights or vital signs either.

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-Resident #3's primary care provider (PCP) had never asked to see his weight or vital sign values.

Telephone interview with Resident #3's PCP on 02/24/23 at 9:15am revealed:
-Since Resident #3 did not have diagnoses of heart failure or adult failure to thrive it was not critical for his weight and vital signs to be monitored every month.
-He expected the facility to obtain the monthly weight and set of vital signs for Resident #3 because it was ordered.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed he was not aware there was no entry on Resident #3's eMAR for MAs to document weights and vital signs.

Telephone interview with the ED on 02/27/23 at 1:45pm revealed:
-The weights and vital signs for Resident #3 for December 2022 and January 2023 might have been missed since there was no entry on his eMAR for it.
-The MAs created the list of residents who needed their weights and vital signs checked by printing the list in the eMAR, but it would not include a resident who did not show as being due for a weight and vital sign check such as Resident #3.
-She had not told the MAs to do anything differently about how they created their list for weights and vitals because she was not aware that Resident #3 did not have an entry on his eMAR for that information.

Refer to telephone interview with the RCC on 02/27/23 at 12:45pm.

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Refer to telephone interview with the ED on 02/27/23 at 1:45pm.

3. Review of Resident #1's current FL2 dated 11/14/22 revealed:
-Diagnoses included osteoarthritis, morbid obesity, muscle weakness, hypothyroidism, hyperlipidemia, and heart disease.
-Resident #1 was non-ambulatory.

Review of Resident #1's standing orders for medication and treatment dated 12/17/21 revealed an order to obtain weight and vital signs including blood pressure, heart rate, oxygen saturation, and temperature monthly.

Review of Resident #1's care plan dated 12/05/22 revealed Resident #1 was non-ambulatory, needed a wheelchair, and required extensive assistance with transferring.

Review of Resident #1's electronic Medication Administration Record (eMAR) for December 2022 revealed:
-There was an entry for weight and vitals monthly, no specified date.
-There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight.
-There were no weights or vital signs documented from 12/01/22 through 12/31/22.

Review of the facility's monthly weight and vital signs sheet revealed there was a form with weights and vital signs documented for January 2023 and February 2023 but there was not a form for December 2022.

Review of Resident #1's eMAR for January 2023 revealed:

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-There was an entry for weight and vitals monthly, no specified date.
-There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight.
-There was documentation of Resident #1's vital signs on 01/02/23, but there was no documentation of Resident #1's weight from 01/01/23 through 01/31/23.

Review of the facility's monthly weight and vital signs sheet for January 2023 revealed documentation of Resident #1's vital signs for January 2023, but there was no documentation of Resident #1's weight.

Review of Resident #4's eMAR for February 2023 revealed:
-There was an entry for weight and vitals monthly, no specified date.
-There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight.
-There was no documentation of Resident #1's vital signs or weights from 02/01/23 through 02/28/23.

Review of the facility's monthly weight and vital signs sheet for February 2023 revealed documentation of Resident #1's vital signs, but there was no documentation of Resident #1's weight.

Interview with Resident #1 on 02/23/23 at 11:39am revealed:
-She could not stand up to be weighed.
-The facility did have a seated scale, but they had not used it to weigh her since around the time she was admitted in 2021.

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Interview with a MA on 02/23/23 at 2:46pm revealed:
-Resident #1 refused to be weighed on the standing scale in February 2023, but she did obtain her vital signs.
-She did not document Resident #1 refused to be weighed.

Observation of the facility on 02/23/23 at 3:29pm revealed:
-The MA asked the co-owner where the seated scale was.
-The co-owner told the MA to check in the employee lounge.
-The MA opened the door to the storage room and pointed to a board leaning against a back wall and stated she thought that was the wheelchair scale.
-There was a seated scale at the back of the storage room.

A second interview with the MA on 02/23/23 at 3:33pm revealed:
-She did not know if she was able to stand up for the standing scale or not.
-She did not know the seated scale was in the storage area.
-No one told her the facility had a seated scale for residents who were not able to stand.

Interview with Resident #1's Primary Care Provider (PCP) on 02/24/23 at 9:13am revealed:
-He expected the facility to obtain Resident #1's weights and vital signs monthly and have them available for review when he visited the facility.
-He did not know the seated scale at the facility was not in working condition.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm

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revealed:
-The facility used a stand on scale to weigh residents monthly.
-He did not know why Resident #1's vital signs were not obtained in December 2022 and weights were not obtained in December 2022, January 2023 or February 2023.
-He did not know if Resident #1's vital signs and weights were not obtained or not documented.
-He did not know how residents who were not able to stand were weighed.
-Resident #1 would have difficulty standing to be weighed.
-He thought the seated scale was not working.
-It was the Executive Director's (ED) responsibility to ensure there was a working scale in the facility for residents who could not stand and had physician's orders to be weighed.

Telephone interview with the ED on 02/27/23 at 3:05pm revealed:
-She did not know Resident #1's vital signs were not obtained in December 2022 and weights were not obtained in December 2022, January 2023 or February 2023.
-She did not know if monthly weights and vital signs were included in the facility's standing orders for all residents.
-There was not a seated scale right now; she thought that the seated scale would not calibrate correctly.
-The RCC was responsible for ensuring the facility had a working scale in place to weigh residents who were not able to stand.
-The RCC was responsible for notifying the PCP for residents who were not able to weigh because they could not stand.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm.

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Refer to telephone interview with the ED on 02/27/23 at 1:45pm.

4. Review of Resident #4's current FL2 dated 07/18/22 revealed diagnoses included chronic schizophrenia, migraines, chronic pain syndrome, chronic obstructive pulmonary disease polydipsia, history of mouth cancer, and gastroesophageal reflux disease.

Review of Resident #4's physician's orders dated 06/20/22 revealed an order to obtain and record weight and vital signs monthly (no documentation of which vital signs).

Review of Resident #4's standing orders for medication and treatment dated 03/22/22 revealed an order to obtain weight and vital signs including blood pressure, heart rate, oxygen saturation, and temperature monthly.

Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2022 revealed:
-There was an entry for weight and vitals monthly, no specified date.
-There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight.
-There were no weights or vital signs documented from 12/01/22 through 12/31/22.

Review of the facility's monthly weight and vital signs sheets revealed there was not a monthly weight and vital signs form for December 2022.

Review of Resident #4's eMAR for January 2023 revealed:
-There was an entry for weight and vitals monthly,

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no specified date.
-There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight.
-There were no weights or vital signs documented from 01/01/23 through 01/31/23.

Review of the facility's monthly weight and vital signs sheet for January 2023 revealed no documentation of Resident #4's weights or vital signs.

Interview with Resident #4 on 02/23/23 at 11:59am revealed:
-The facility did not weigh him and take his vital signs monthly.
-Staff recently took his vital signs, but he did not remember when.
-The last time he remembered the facility weighing him was round December 2022.

Interview with Resident #4's Primary Care Provider (PCP) on 02/24/23 at 9:13am revealed:
-Resident #4 had a diagnosis of weight loss.
-He expected the facility to obtain Resident #4's weights and vital signs monthly and have them available for review when he visited the facility.
-When he reviewed Resident #4's weights and vital signs, he looked for gains and losses in his weights.
-He was not sure why Resident #4's weights and vital signs were not completed.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed he was not aware Resident #4 did not have documentation of his vital signs and weights for December 2022 and January 2023.

Telephone interview with the ED on 02/27/23 at

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3:05pm revealed she did not know Resident #4's vital signs and weights were not obtained in December 2022 or January 2023.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm.

Refer to telephone interview with the ED on 02/27/23 at 1:45pm.

5. Review of Resident #5's current FL2 dated 02/13/23 revealed diagnoses included hypoglycemia, enlarged pituitary gland, hypothyroidism, elevated enzymes, tachycardia, Vitamin D deficiency, acute kidney injury, chronic obstructive pulmonary disease, history of seizures, schizophrenia, hypertension, hyperlipidemia, and macrocytic anemia.

Review of Resident #5's physician's orders dated 06/20/22 revealed an order to obtain and record weight and vital signs monthly (no documentation of which vital signs).

Review of Resident #5's electronic Medication Administration Record (eMAR) for December 2022 revealed:
-There was an entry for weight and vital signs monthly, no specified date.
-There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight.
-There were no weights or vital signs documented from 12/01/22 through 12/31/22.

Review of the facility's monthly weight and vital signs sheet revealed there was a form with weights and vital signs for January 2023 and February 2023 but there was not a form for December 2022.

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Interview with Resident #5 on 02/23/23 at 12:42pm revealed he did not remember when he was last weighed or had his vital signs checked.

Interview with Resident #5's Primary Care Provider (PCP) on 02/24/23 at 9:13am revealed:
-He expected the facility to obtain Resident #5's weights and vital signs monthly and have them available for review when he visited the facility.
-He did not know the seated scale at the facility was not in working condition.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed he did not know Resident #5's weights and vital signs were not obtained in December 2022.

Telephone interview with the ED on 02/27/23 at 3:05pm revealed she did not know Resident #5's vital signs and weights were not obtained in December 2022.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm.

Refer to telephone interview with the ED on 02/27/23 at 1:45pm.

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Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed:
-The MA was responsible for obtain a weight and set of vital signs on every resident towards the first of each month.
-The MAs wrote the weight and vital signs down on a piece of paper as they went from resident to resident then manually entered the values into the eMAR system afterward.

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-If a resident refused to have their weight or vital signs checked the MA would be expected to document the refusal.
-The only reason for there to be no documentation of a resident's weight and vital signs would be if the MA had planned to go back to that resident at a later time because they were sleeping or initially refused, then forgot to do it.
-There was no staff responsible for reviewing the weights and vital signs in the eMAR once they were entered.

Telephone interview with the ED on 02/27/23 at 1:45pm revealed:
-It was the MAs responsibility to ensure the weights and vital signs were entered in the eMAR but sometimes they had the personal care aides (PCA) help obtain the weight and vital signs.
-The MAs created the list of residents who needed their weights and vital signs checked by printing the list in the eMAR, but it would not include residents who did not have an entry for weights on their eMAR.
-When she worked in the role of MA at the beginning of the month she would create her list based on the resident census rather than who was showing as due for weights and vitals in the eMAR to ensure nobody was missed.
-She was not aware there were no vitals or weights documented for residents for the month of December 2022.

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10A NCAC 13F .0903(a) Licensed Health Professional Support

10A NCAC 13F .0903 Licensed Health Professional Support
(a) An adult care home shall assure that an appropriate licensed health professional

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participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks:
(1) applying and removing ace bandages, ted hose, binders, and braces and splints;
(2) feeding techniques for residents with swallowing problems;
(3) bowel or bladder training programs to regain continence;
(4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches;
(5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter;
(6) chest physiotherapy or postural drainage;
(7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents;
(8) collecting and testing of fingerstick blood samples;
(9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage);
(10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater;
(11) inhalation medication by machine;
(12) forcing and restricting fluids;
(13) maintaining accurate intake and output data;
(14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established);
(15) medication administration through injection;
Note: Unlicensed staff may only administer

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D 278	Continued From page 49 subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an updated licensed health professional support (LHPS) evaluation had been completed by an appropriate licensed health professional for 3 of 5 sampled residents	D 278	Administrator will ensure that a licensed health professional will be provided by contracting pharmacy as part of the contract between pharmacy and facility and will ensure that LHPS evaluations are completed on all resident's with LHPS tasks each quarter. RCC will monitor residents charts every quarter to ensure that LHPS evaluations are completed.	6/30/2023

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(Resident #1, #4, and #5) with LHPS tasks of transferring a non-ambulatory resident, fingerstick blood sugar (FSBS) checks, and insulin injections (#1), FSBS checks and insulin injections (#5), and an as needed medication injection used to treat allergic reactions (#4).

The findings are:

1. Review of Resident #1's current FL2 dated 11/14/22 revealed:
-Diagnoses included bipolar disorder, anxiety, and major depressive disorder.
-Resident #1 non-ambulatory.
-There was documentation "See MAR," but there was no documentation of medication attached to the FL2.

Review of Resident #1's FL2 dated 10/31/22 revealed:
-There was an order for FSBS before meals and at bedtime.
-There was an order for humalog kwikpen 100u/ml, 15 units at breakfast and lunch.
-There was an order for lantus 100u/ml, 30 units daily.

Review of Resident #1's care plan dated 12/05/22 revealed:
-Resident #1 was non-ambulatory and needed a wheelchair.
-Resident #1 required extensive assistance with ambulating and transferring.
-There were no LHPS tasks listed.

Review of Resident #1's electronic Medication Administration Record (eMAR) for December 2022, January, and February 2023 from 02/01/23 to 02/27/23 revealed:
-There was an entry for check fingerstick blood

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sugar (FSBS 3 times daily before meals scheduled for 7:00am, 11:00am, and 5:00pm.
-There was entry for Humalog kwikpen insulin inject 15 units at breakfast and lunch and hold if FSBS was less than 120 scheduled for administration at 7:00am and 11:00am.
-There was an entry for Levemir insulin inject 30 units twice daily scheduled for administration at 8:00am and 5:00pm.

Review of Resident #1's electronic Treatment Administration Record (eTAR) for December 2022, January, and February 2023 from 02/02/23 to 02/27/23 revealed there was an entry for oxygen at 2L/minute via nasal cannula continuous at bedtime scheduled for administration between 12:00am and 7:00am and between 8:00pm and 11:00pm.

Review of Resident #1's LHPS evaluation dated 04/14/22 revealed:
-LHPS tasks included oxygen administration and monitoring and medication administration through injection.
-Collecting and testing fingerstick blood samples and transferring semi-ambulatory or non-ambulatory residents was not listed as a marked task.

Review of Resident #1's record revealed there were no LHPS evaluations completed after 04/14/22.

Interview with Resident #1 on 03/23/23 at 11:39am revealed:
-She used oxygen at night when she was in the bed.
-Staff assisted her with transfers in the shower room when she transferred from her wheelchair to the shower chair.

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-Medication aides (MA) collected her FSBS 3 times daily and administered her two different insulins.
-She did not know the last time she was assessed by a nurse.

Interview with a MA on 02/23/23 at 4:01pm revealed:
-Resident #1 had physician's orders for fingerstick blood sugars (FSBS) and insulin injections.
-Staff assisted Resident #1 with transfers from her wheelchair to the shower chair in the shower room.
-Resident #1 had oxygen and used it at bedtime.
-She did not know who was responsible for ensuring LHPS evaluations were completed.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:42pm.

Refer to telephone interview with the Executive Director (ED) on 02/27/23 at 3:05pm.

2. Review of Resident #5's current FL2 dated 02/13/23 revealed:
-Diagnoses included hypoglycemia, enlarged pituitary gland, hypothyroidism, elevated enzymes, tachycardia, Vitamin D deficiency, acute kidney injury, chronic obstructive pulmonary disease, history of seizures, schizophrenia, hypertension, hyperlipidemia, and macrocytic anemia.
-Resident #5 was non-ambulatory.

Review of Resident #5's physician's orders dated 06/20/22 revealed an order for blood glucose check fingerstick blood sugars (FSBS) twice a week.

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Review Resident #5's physician's orders dated 02/06/23 revealed an order to discontinue FSBSs.

Review of Resident #5's electronic Treatment Administration Records (eTAR) for December 2022, January, and February 2023 from 02/01/23 through 02/23/23 revealed there was an entry for blood glucose check FSBS 2 times a week.

Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 05/31/22 revealed LHPS tasks included FSBS.

Review of Resident #5's record revealed there were no LHPS evaluations completed between 05/31/22 and the discharge date of 02/07/23.

Interview with Resident #5 on 02/23/23 at 12:42pm revealed she received FSBS checks by staff up until a few weeks ago.

Interview with a medication aide (MA) on 02/23/23 at 4:01pm revealed:
-Resident #5 had orders for fingerstick blood sugars (FSBS) until February 2023.
-She did not know who was responsible for ensuring LHPS evaluations were completed.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:42pm.

Refer to telephone interview with the Executive Director (ED) on 02/27/23 at 3:05pm.

3. Review of Resident #4's current FL2 dated 07/18/22 revealed:
-Diagnoses included chronic schizophrenia, migraines, chronic pain syndrome, chronic obstructive pulmonary disease polydipsia, history

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of mouth cancer, and gastroesophageal reflux disease.
-There was an order for Epinephrine injection 0.3mg as needed for anaphylaxis reaction.

Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2022, January, and February 2023 from 02/01/23 to 02/27/23 revealed there was an entry for epinephrine injection 0.3mg use as needed for anaphylaxis reaction.

Review of Resident #4's record revealed there were no LHPS evaluations for Resident #4.

Interview with a medication aide (MA) on 02/23/23 at 4:01pm revealed:
-Resident #4 had an order for epinephrine injections as needed.
-She had not needed to administer epinephrine, but she would be responsible for administering the medication through injection if Resident #4 needed it.
-She did not know who was responsible for ensuring LHPS evaluations were completed.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:42pm.

Refer to telephone interview with the Executive Director (ED) on 02/27/23 at 3:05pm.

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Telephone interview with the RCC on 02/27/23 at 12:42pm revealed:
-The ED was responsible for ensuring LHPS evaluations were completed.
-He thought a nurse from the pharmacy was supposed to complete LHPS evaluations for residents with LHPS tasks.

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D 278	Continued From page 55 Telephone interview with the ED on 02/27/23 at 3:05pm revealed: -She was responsible for ensuring LHPS evaluations were completed for residents with LHPS tasks. -The facility had not had a contracted LHPS nurse in 6 months, because she had not been able to find one. -The previous LHPS nurse divided the residents up and completed LHPS evaluations for a few residents each month. -She thought the last LHPS evaluations were completed for some residents in June 2022. -She was trying her best to find a registered nurse to complete LHPS evaluations for the residents.	D 278		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of a variety of group activities were provided each week for the residents. The findings are: Review of the February 2023 activity calendar posted in the activity room on 02/23/23 at 9:00am	D 317	Administrator will ensure that 14 hours of activities are provided every week for residents and that in the event that the Activities Director is absent, that activities will be rescheduled or carried out by other facility staff and documented for the AD. Administrator will monitor time sheets for AD tand activities calendar monthly.	3/31/2023

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revealed:
-There were activities scheduled Monday through Saturday.
-Every Monday through Friday "Free Time" was scheduled from 11:00am to 12:00pm.
-Every Monday through Friday there was an activity scheduled from 12:00pm to 2:00pm, except for 02/01/23 and 02/15/23 when Bingo was scheduled from 1:00pm to 3:00pm.
-Every Monday through Friday there was an activity scheduled from 4:00pm to 5:00pm.
-On Saturday 02/04/23 and 02/18/23 the only activity scheduled was ring toss from 12:00pm to 2:00pm.
-On Saturday 02/11/23 and 02/25/23 the only activity scheduled was movie night from 7:00pm to 9:00pm.
-There were no activities scheduled on Sundays.
-The activities included book club, card games, paper crafts, exercise, acrylic painting, jewelry making, watercolor painting, wood crafts, religious study, birthday party, music time, and outing to be determined.

Review of the Activity Participation Logs in the activity room on 02/23/23 at 9:02am revealed:
-There was a log dated 12/01/22 with the activity documented as cards and coloring with 5 resident names listed as participants.
-There was a log dated 12/05/22 with the activity documented as cards with 5 resident names listed as participants.
-There was a log dated 12/09/22 with the activity documented as cards and coloring with 5 resident names listed as participants.
-There was a log dated 12/19/22 with the activity documented as Christmas crafts with 7 resident names listed as participants.
-There was a log dated 12/28/22 with the activity documented as coloring with 3 resident names

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listed as participants.
-There was a log dated 12/30/22 with the activity documented as cards and coloring with 5 resident names listed as participants.
-There was a log dated 01/17/23 with the activity documented as cards, coloring and music with 4 resident names listed as participants.
-There was a log dated 02/07/23 with the activity documented as cards and coloring with 5 resident names listed as participants.

Review of the staff schedule from 02/10/23 through 02/23/23 revealed the AD was scheduled to be working every Monday through Friday during those two weeks, the hours were not specified.

Observation of the facility during the initial tour on 02/22/23 at 9:00am revealed:
-The door the activity room was closed and locked.
-There were no activity calendars posted in the resident rooms or hallways.

Observation of the activity room on 02/23/23 at 9:05am revealed:
-There was a certificate on the wall for the Activity Director (AD) documenting completion of the North Carolina Assisted Living Activity Professional Training Course dated 09/08/22.
-Activity supplies observed included markers, papers, and a board game.

Observation of the common lounge room on 02/22/23 at 12:35pm revealed:
-There were chairs and couches for residents to sit on.
-There was one tv.
-There was a piano and a stationary bike.
-There was one bookshelf which held books,

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hymnals, and puzzles.
-There was no activity calendar posted.

Observation of the facility during various hours on 02/22/23 from 8:45am to 4:45pm, on 02/23/23 from 7:40am to 5:00pm, and 02/24/23 from 8:30am to 5:15pm revealed there were no activities provided for residents during those times.

Interview with a resident on 02/22/23 at 9:10am revealed:
-There were no activities offered at the facility at all that he was aware of.
-He would be interested in participating in activities if they were offered to him.
-There were puzzles available for the residents to use, but no group activities.
-He would like to go to the store because the store the facility had on-site never had anything in it.

Interview with a second resident on 02/22/23 at 9:18am revealed:
-The AD did an exercise class for the residents once a week.
-There was an activity room with some activity supplies in it.
-Occasionally there would be bingo offered as a group activity.
-Activities were usually offered twice a week by the AD because she was not at the facility every day.

Interview with a third resident on 02/22/23 at 9:20am revealed he had lived at the facility for a couple of weeks and had not seen any activities offered.

Interview with a fourth resident on 02/22/23 at

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9:27am revealed:
-The facility went through period where they offered activities and periods where there were no activities depending on which staff were available.
-The last activity that he knew about was one month prior.
-He would participate in activities if they were offered.
-He would be interested in activities such as puzzles, coloring, or a coffee social.

Interview with a fifth resident on 02/24/23 at 2:30pm revealed:
-The AD took residents to the store once a month if they requested to go.
-Some activities he had participated in included playing monopoly and cards.
-The AD was at the facility two to three days per week.
-There were no activities offered to him on the days the AD was not at the facility.

Interview with a personal care aide (PCA) on 02/23/23 at 9:32am revealed:
-Usually the door to the activity room was opened every afternoon around 2:30.
-There had not been any activities the previous day, 02/22/23 because the AD was out sick and there was nobody to replace her.
-The AD was the only staff in the facility who did activities with the residents.
-Activities usually lasted about 40 minutes.
-Some of the activities she had seen included cards, music, or going outside.
-The AD offered activities to whoever was around at the time she was going to start an activity.

Interview with a resident on 02/23/23 at 2:25pm revealed:

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-The AD was at the facility a couple of days per week.
-She was a volunteer to do activities with the other residents and had a key to the activity room.
-The Activity Participation Log sheets in the activity room were all from activities that she had done with the residents.
-She did activities with the residents every day including coloring, cards, exercise, and music.
-The previous day, on 02/22/23, she had played a game of Uno with some residents while a couple of other residents colored.
-She volunteered to do activities at the facility because she felt like she needed something to complete her days.
-The AD was out sick that week.
-She did not know how long the AD stayed at the facility on the days she was there.
-The residents seemed content to do their own thing.

Interview with a medication aide (MA) on 02/23/23/ at 2:45pm revealed:
-The AD was the only staff who did activities with the residents and she was not at the facility every day.
-She had heard the residents comment on being bored before, but had never specifically mentioned wanting more activities.
-There was not much available at the facility for the residents to do for entertainment.
-She last saw the AD the previous week.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed:
-He did not have a set schedule at the facility and the AD was in-and-out too so he did not know which days she was scheduled to be at the facility.

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D 317	Continued From page 61 -He had observed her doing various activities including coloring, games, bingo, popcorn and a movie in the lounge, and a Valentine's day party. -He did not hear the residents complain of being bored. Telephone interview with the Executive Director (ED) on 02/27/23 at 1:45pm revealed: -The AD was the only staff who did activities, and she was out sick that week. -They did not have enough staff to cover for the AD when she was out sick. -The facility had a resident volunteer who opened the activity room for residents so they could do coloring or games. -The AD recently did a Valentine's Day party with the residents and she brought residents to the store every two weeks. -She thought the AD followed the posted activity calendar. -The AD was usually in the facility every Monday through Friday in the afternoons after 2:30pm. -She did the activity that was scheduled from 12:00pm to 2:00pm whenever she arrived at the facility for the day. -The AD never worked on Saturday or Sunday and she did not know who did the activity scheduled every Saturday. -She was not aware there was an activity scheduled on Saturdays. Attempted telephone interview with the AD on 02/23/23 at 3:50pm and 02/27/23 at 9:55am were unsuccessful.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 62 (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: Based on record reviews, observations, and interviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (Residents #4, #5, and #3) regarding 2 antipsychotic medications, an anti-inflammatory medication, and an anti-hypertensive medication (#5), a laxative, an anti-anxiety medication, an anti-depressant medication, an anti-convulsant medication and insomnia medication (#4), and an antipsychotic medication, pain/fever medication, and cholesterol medication (#3). The findings are: 1. Review of Resident #5's current FL2 dated 02/13/23 revealed diagnoses included hypoglycemia, enlarged pituitary gland, hypothyroidism, elevated enzymes, tachycardia, Vitamin D deficiency, acute kidney injury, chronic obstructive pulmonary disease, history of seizures, schizophrenia, hypertension, hyperlipidemia, and macrocytic anemia. a. Review of Resident #5's current FL2 dated 02/13/23 revealed: -There was documentation to "see MAR." -The electronic Medication Administration Record (eMAR) was signed by Resident #5's Primary Care Provider (PCP) and included an order for	D 358	After further investigation, it was learned that medications were not administered because they were unavailable due to pharmacy shortages and back-orders. In the future, RCC will ensure that pharmacists send documentation of medications that are unavailable or on back-order and that every effort will be made to obtain needed medications from alternate pharmacies and that if medications are unable to be obtained, RCC will notify the physician and request direction.	3/1/23

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Haldol (used to treat schizophrenia) 2mg/ml, 1 ml twice daily.

Review of Resident #5's eMAR for 02/01/23 through 02/23/23 revealed:
-There was an entry for Haldol 2mg/ml, 1 ml twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Haldol was not administered for 3 of 23 opportunities at 8:00am on 02/19/23, 02/20/23, and 02/21/23 due to medication not available.
-There was documentation Haldol was not administered for 2 of 22 opportunities at 8:00pm on 02/19/23, and 02/20/23 at 8:00pm due to medication not available and 1 blank space on 02/17/23 at 8:00pm.

Interview with Resident #5 on 02/23/23 at 12:42pm revealed he did not remember being out of any of his medications.

Observation of Resident #5's medications available for administration on 02/23/23 at 4:09pm revealed:
-Haldol was available for administration with a dispense date of 02/02/23.
-There was about one-half inch of Haldol liquid remaining in the bottle that had been dispensed.

Telephone interview with a representative from the facility's contracted pharmacy on 02/27/23 at 9:15am revealed:
-Resident #5 had an order for Haldol 2mg/ml, 1 ml twice daily.
-Haldol was dispensed to the facility on 11/09/22, 12/26/22, 02/22/23, and on 02/27/23 with a month's supply each time.
-If the facility staff had contacted him to let him know more Haldol was needed prior to the refill

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date, he would have tried to assist them.

Interview with a medication aide (MA) on 02/23/23 at 2:46pm revealed:
-She knew Resident #5 had been out of his Haldol.
-Resident #5 was out of Haldol during her shift on 02/19/23 and she was going to reorder it, but there was documentation someone had attempted to reorder Haldol on 02/14/23 and it was too early to reorder.
-She did not contact the pharmacy on 02/19/23 to see if she could reorder the Haldol.
-She did not tell anyone that Haldol was not available in the facility for administration.

Interview with Resident #5's mental health provider (MHP) on 02/23/23 at 11:45am revealed:
-Resident #5 was ordered Haldol for schizophrenia.
-She did not know Resident #5 missed 5 consecutive doses of Haldol and would have expected the facility to notify her.
-She expected the facility to reach out to her for assistance if they were not able to get Haldol from the pharmacy.
-Missing consecutive doses of Haldol could have caused Resident #5 to have psychosis, paranoia, and hallucinations.

Telephone interview with Executive Director (ED) on 02/27/23 at 3:05pm revealed:
-She knew Resident #5 had been out of Haldol.
-She requested Haldol from the pharmacy twice, but the pharmacy did not send it.
-A representative from the pharmacy told her it was too soon to get the medication filled.
-She thought Resident #5 ran out of Haldol because the pharmacy sent the wrong amount once and Resident #5 dropped a dose of Haldol

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twice when she administered.
-Haldol should have been reordered when there appeared to be a few days of the liquid Haldol remaining in the bottle.
-She did not know why the label on the Haldol available on the medication cart was dated 02/02/23.

Attempted telephone interview with the evening shift MA on 02/24/23 at 10:30am and 4:30pm, and 02/27/23 at 8:50am was unsuccessful.

Attempted telephone interview with a second evening shift MA on 02/24/23 at 10:32am and 4:32pm, and 02/27/23 at 8:52am was unsuccessful.

b. Review of Resident #5's current FL2 dated 02/13/23 revealed:
-There was documentation to "see MAR."
-The electronic Medication Administration Record (eMAR) was signed by Resident #5's Primary Care Provider (PCP) and included the following orders:
-There was an order for Haldol (used to treat schizophrenia) 2mg/ml, 1 ml twice daily.
-There was an order for hydrocortisone (used to treat inflammation) 10mg, 1.5 tablets twice daily.
-There was an order for metoprolol (used to treat high blood pressure) 50mg, 1 tablet twice daily.
-There was an order for quetiapine (used to treat schizophrenia) 100mg, 1 tablet at bedtime.
-There was an order for quetiapine (used to treat schizophrenia) 50mg, 1.5 tablets every morning and 1 tablet at bedtime.

Review of Resident #5's electronic Medication Administration Record (eMAR) for December 2022 revealed:
-There was an entry for Haldol 2mg/ml 1 ml twice

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D 358	Continued From page 66 daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for hydrocortisone 10mg 1.5 tablets twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for metoprolol 50mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for quetiapine 100mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was an entry for quetiapine 50mg 1.5 tablet every morning and 1 tablet at bedtime scheduled for administration at 8:00am and 8:00pm. -There were blank spaces with no documentation of administration of Haldol, hydrocortisone, metoprolol, quetiapine 50mg, or quetiapine 100mg for 8 times at 8:00pm on 12/01/22, 12/05/22, 12/07/22, 12/19/22, 12/20/22, 12/21/22, 12/24/22, and 12/25/22. Review of Resident #5's eMAR for January 2023 revealed: -There was an entry for Haldol 2mg/ml 1 ml twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for hydrocortisone 10mg 1.5 tablets twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for metoprolol 50mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for quetiapine 100mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was an entry for quetiapine 50mg 1.5 tablet every morning and 1 tablet at bedtime scheduled for administration at 8:00am and 8:00pm.	D 358		

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-There were blank spaces with no documentation of administration of Haldol, hydrocortisone, metoprolol, quetiapine 50mg, or quetiapine 100mg for 2 times at 8:00pm on 01/08/23 and 01/18/23.

Observation of Resident #5's medications available for administration on 02/23/23 at 4:09pm revealed:
-Haldol was available for administration with a dispense date of 02/02/23.
-There was about one-half inch of Haldol liquid remaining in the bottle that had been dispensed.
-All the other medications were in refillable plastic cassettes that held two weeks' worth of medication in them.
-The cassettes had the date of the initial order printed on the sticker rather than the most recent dispensed date.
-Hydrocortisone, metoprolol, quetiapine 50mg and quetiapine 100mg were available, but it was not observed how many tablets remained of each medication.

Interview with Resident #5 on 02/23/23 at 12:42pm revealed he did not remember being out of any of his medications or not being administered medication.

Interview with Resident #5's mental health provider (MHP) on 02/23/23 at 11:45am revealed:
-She did not know Resident #5 missed doses of his psychotropic medications and would have expected the facility to notify her.
-She expected the facility to reach out to her for assistance if they were not able to get psychotropic medications from the pharmacy.

Telephone interview with Resident #5's primary care provider (PCP) on 02/24/22 at 10:15am

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revealed:
-He was not aware Resident #5's medications had not been administered.
-If his medications were unavailable, the facility needed to let him know within 48 to 72 hours so he could get a prescription to the pharmacy.
-He needed to know if medications were not administered so that he could see if there was an issue with the facility or with the pharmacy.

Interview with a medication aide (MA) on 02/23/23 at 2:46pm revealed:
-When she administered medication, entered her initials on the eMAR to document she administered the medication.
-If there was a blank space on the eMAR, it meant that the medication had not been administered.
-She did not know why a medication would not have been administered.

Telephone interview with a representative from the facility's contracted pharmacy on 02/27/23 at 9:15am revealed:
-Resident #5 had an order for Haldol 2mg/ml 1 ml twice daily.
-Haldol was dispensed to the facility on 11/09/22, 12/26/22, 02/22/23, and on 02/27/23 with a month's supply each time.
-Cycle filled medications were dispensed on the first day of each month.
-The medications were delivered to the facility in medication cassettes, filled with a two week supply, and refilled every two weeks.
-Resident #5 had orders for hydrocortisone 10mg 1.5 tablet twice daily; metoprolol 50mg 1 tablet twice daily; quetiapine 50mg 1.5 tablets every morning and 1 tablet at bedtime; and quetiapine 100mg 1 tablet at bedtime.
-Cassettes of hydrocortisone, metoprolol,

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quetiapine 50mg and quetiapine 100mg were dispensed to the facility on 12/01/22, 01/01/23, and 02/01/23 with a 30 day supply.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:42pm revealed:
-He did not know there were blank spaces on the eMARs where medication administration should have been documented for Resident #5 or why there were blank spaces.
-If there was a blank space on the eMAR, the medication was not administered.
-He had not reviewed the eMARs, because he had not been told he needed to.
-He did not know who reviewed the eMARs.
-He relied on the MA Supervisor to let him know that medications were not administered, and he would contact the resident's PCP.

Telephone interview with the Executive Director (ED) on 02/27/23 at 3:05pm revealed:
-She did not know about the blank spaces on Resident #5's eMAR.
-If there was a blank space on Resident #5's eMAR, it meant that Resident #5 did not get up to take his medication and the MA waited to see if he would take the medication later; the MA just forgot to document the medication was given.
-If the medication was given, it should have been documented by the MA as administered.

Attempted telephone interview with the evening shift MA on 02/24/23 at 10:30am and 4:30pm, and 02/27/23 at 8:50am was unsuccessful.

Attempted telephone interview with a second evening shift MA on 02/24/23 at 10:32am and 4:32pm, and 02/27/23 at 8:52am was unsuccessful.

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2. Review of Resident #4's current FL2 dated 07/18/22 revealed:
-Diagnoses included chronic schizophrenia, migraines, chronic pain syndrome, chronic obstructive pulmonary disease polydipsia, history of mouth cancer, and gastroesophageal reflux disease.
-There was an order for benztropine (used to treat physical restlessness, agitation, fidgeting, and spasms of the eyes, tongue, jaw, neck and back muscles) 1 mg, 1.5 tablets at bedtime.
-There was an order for docqlace (used to treat constipation) 100mg, 1 capsule twice daily.
-There was an order for hydroxyzine (used to treat and anxiety) 25mg, 1 tablet every evening.
-There was an order for mirtazapine (used to treat depression and anxiety) 15mg, 1.5 tablets every evening.
-There was an order for valproic acid (used to treat bipolar disorder) syrup 250/5ml, 4ml at bedtime.

Review of Resident #4's physician's orders dated 10/07/23 revealed an order for melatonin (used to aid with sleep) 3mg 1 tab at bedtime.

Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2022 revealed:
-There was an entry for 1 mg 1.5 tablets at bedtime scheduled for administration at 8:00pm.
-There was an entry for docqlace 100mg 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm.
-There was an entry for hydroxyzine 25mg 1 tablet at bedtime scheduled for administration at 8:00pm.
-There was an entry for melatonin 3mg 1 tablet at bedtime scheduled for administration at 8:00pm.

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-There was an entry for mirtazapine 15mg 1.5 tablet at bedtime scheduled for administration at 8:00pm.
-There was an entry for valproic acid 1 tablet every evening scheduled for administration at 8:00pm.
-There were blank spaces with no documentation of administration of benztropine, docqlace, hydroxyzine, melatonin, mirtazapine or valproic acid for 6 times at 8:00pm on 12/6/22, 12/15/22, 12/19/22, 12/20/22, 12/21/22, and 12/29/22.

Review of Resident #4's eMAR for January 2023 revealed:
-There was an entry for benztropine 1 mg 1.5 tablets at bedtime scheduled for administration at 8:00pm.
-There was an entry for docqlace 100mg 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm.
-There was an entry for hydroxyzine 25mg 1 tablet at bedtime scheduled for administration at 8:00pm.
-There was an entry for melatonin 3mg 1 tablet at bedtime scheduled for administration at 8:00pm.
-There was an entry for mirtazapine 15mg 1.5 tablet at bedtime scheduled for administration at 8:00pm.
pm.
-There was an entry for valproic acid 1 tablet every evening scheduled for administration at 8:00pm.
-There were blank spaces with no documentation of administration of benztropine, docqlace, hydroxyzine, melatonin, mirtazapine, or valproic acid for 11 times at 8:00pm on 01/02/23, 01/04/23, 01/08/23, 01/12/23, 01/16/23, 01/17/23, 01/18/23, 01/20/23, 01/22/23, 01/30/23, 01/31/23.

Review of Resident #4's eMAR for 02/01/23

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through 02/22/23 revealed:
-There was an entry for benztropine 1 mg 1.5 tablets at bedtime scheduled for administration at 8:00pm.
-There was an entry for docqlace 100mg 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm.
-There was an entry for hydroxyzine 25mg 1 tablet at bedtime scheduled for administration at 8:00pm.
-There was an entry for melatonin 3mg 1 tablet at bedtime scheduled for administration at 8:00pm.
-There was an entry for mirtazapine 15mg 1.5 tablet at bedtime scheduled for administration at 8:00pm,
-There was an entry for valproic acid 1 tablet every evening scheduled for administration at 8:00pm.
-There were blank spaces with no documentation of administration of benztropine, docqlace, hydroxyzine, melatonin, mirtazapine or valproic acid for 7 times at 8:00pm on 02/04/23, 02/09/23, 02/14/23, 02/15/23, 02/17/23, 02/18/23, and 02/19/23.

Observation of medications available for Resident #4 on 02/23/23 at 3:55pm revealed:
-The medications were in refillable plastic cassettes that held two weeks' worth of medication in them.
-The cassettes had the date of the initial order printed on the sticker rather than the most recent dispensed date.
-Benztropine, hydroxyzine, melatonin, mirtazapine, and valproic acid were available, but it was not observed how many tablets remained of each medication.

Interview with Resident #4 on 02/23/23 at 11:59am revealed:

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-The residents had to go to the window at the medication room to receive their medications.
-The MAs told the residents if they did not go to the medication room window to get their medications, they would mark them down as refused, but he never refused medications.
-Sometimes he did not go to the medication window because he was asleep, and staff did not bring his medication to him.
-He did not remember being out of any medications when he went to the window for medication administration.

Telephone interview with Resident #4's primary care provider (PCP) on 02/24/22 at 10:15am revealed:
-He was not aware Resident #4's medications had not been administered.
-If his medications were unavailable, the facility needed to let him know within 48 to 72 hours so he could get a prescription to the pharmacy.
-He needed to know if medications were not administered so that he could see if there was an issue with the facility or with the pharmacy.

Telephone interview with a representative from the facility's contracted pharmacy on 02/27/23 at 9:15am revealed:
-Cycle filled medications were dispensed on the first day of each month.
-The medications were delivered to the facility in medication cassettes, filled with a two week supply, and refilled every two weeks.
-Resident #4 had orders for benztropine 1 mg 1.5 tablets at bedtime; docqlace 100mg 1 capsule twice daily; hydroxyzine 25mg 1 tablet at bedtime; melatonin 3mg 1 tablet at bedtime; mirtazapine 15mg 1.5 tablet at bedtime; valproic acid 1 tablet every evening.
-Cassettes of benztropine, docqlace, hydroxyzine,

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melatonin, mirtazapine, and valproic acid were dispensed to the facility on 12/01/22, 01/01/23, and 02/01/23 with a 30 day supply.

Telephone interview with the RCC on 02/27/23 at 12:42pm revealed:
-He did not know there were blank spaces on where medication administration should have been documented on Resident #4's eMAR or why there were blank spaces.
-If there was a blank space on the eMAR, the medication was not administered.
-He had not reviewed the eMARs, because he had not been told he needed to.
-He did not know who reviewed the eMARs.
-He relied on the MA Supervisor to let him know that medications were not administered, and he would contact the resident's PCP.

Telephone interview with the Executive Director (ED) on 02/27/23 at 3:05pm revealed:
-She did not know about the blank spaces on Resident #4's eMAR.
-If there was a blank space on Resident #4's eMAR, it meant that Resident #4 did not get up to take his medication and the MA waited to see if he would take the medication later; the MA just forgot to document the medication was given.
-If the medication was given, it should have been documented by the MA as administered.

Attempted telephone interview with the evening shift MA on 02/24/23 at 10:30am and 4:30pm, and 02/27/23 at 8:50am was unsuccessful.

Attempted telephone interview with a second evening shift MA on 02/24/23 at 10:32am and 4:32pm, and 02/27/23 at 8:52am was unsuccessful.

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4. Review of Resident #3's current FL2 dated 10/03/22 revealed:
-Diagnoses included coronary artery disease, cerebral artery occlusion, history of stroke, secondary parkinsonism, hypertension, and cognitive disorder.
-There was an order for acetaminophen (an over-the-counter medication used to treat pain and fever) 325mg, take two tablets three times daily.
-There was an order for pravastatin (a medication used to treat high cholesterol levels) 40mg every evening.
-There was an order for quetiapine (an antipsychotic medication used to treat schizophrenia, bipolar disorder or depression) 100mg every evening.

Review of Resident #3's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for acetaminophen 325mg, take two tablets three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was an entry for pravastatin 40mg every evening scheduled at 8:00pm.
-There was an entry for quetiapine 100mg every evening scheduled at 8:00pm.
-There was no documentation of administration of acetaminophen, pravastatin or quetiapine at 8:00pm on 12/09/22 or 12/25/22.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for acetaminophen 325mg, take two tablets three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was an entry for pravastatin 40mg every evening scheduled at 8:00pm.
-There was an entry for quetiapine 100mg every

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evening scheduled at 8:00pm.
-There was no documentation of administration of acetaminophen, pravastatin or quetiapine at 8:00pm on 01/17/23 or 01/18/23.

Observation of medication on hand for Resident #3 on 02/22/23 at 3:45pm revealed:
-The medications were in refillable plastic cassettes that held two weeks' worth of medication in them.
-The cassettes had the date of the initial order printed on the sticker rather than the most recent dispensed date.
-There were three cassettes for acetaminophen 325mg tablets, two had 10 doses remaining in them and one had 11 doses remaining.
-There was one cassette for pravastatin 40mg with 10 doses remaining.
-There was one cassette for quetiapine 100mg with 10 doses remaining.

Interview with Resident #3 on 02/23/23 at 11:10am revealed:
-He had not refused medication in December 2022 or January 2023.
-He did not remember missing doses of his 8:00pm medications on 12/09/22, 12/25/22, 01/17/23 or 01/18/23.

Interview with the Executive Director (ED) on 02/23/23 at 11:55am revealed:
-If a medication was not documented on the eMAR as either administered or refused, it would show up as a blank space on the eMAR.
-She had not been aware that Resident #3 had blank spaces on his eMAR where medication was not documented as administered.
-If there was no documentation that a medication was administered, it meant the medication had not been administered.

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	HAL086014	A. BUILDING: ______ B. WING ______	R 02/27/2023

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Telephone interview with Resident #3's primary care provider (PCP) on 02/24/23 at 9:15am revealed:
-He was not aware that Resident #3 had not been administered acetaminophen, pravastatin or quetiapine twice in December 2022 and twice in January 2023.
-There would be risk of adverse effects for missing two doses per month of those medications
-He expected the medication aides (MA) to administer medications as ordered.

Telephone interview with a representative from the facility's contracted pharmacy on 02/27/23 at 9:15am revealed:
-Medications were dispensed to the facility on the first day of each month, and the cassettes were refilled every two weeks.
-Resident #3's acetaminophen 325mg tablets had been dispensed on 12/01/22, 01/01/23, and 02/01/23 with a quantity of 180 tablets each time.
-Resident #3's pravastatin 40mg had been dispensed on 12/01/22, 01/01/23, and 02/01/23 with a quantity of 30 tablets each time.
-Resident #3's quetiapine 100mg had been dispensed on 12/01/22, 01/01/23, and 02/01/23 with a quantity of 30 tablets each time.

Telephone interview with the Resident Care Coordinator (RCC) on 02/27/23 at 12:45pm revealed:
-If there were blank spaces on the eMAR where a medication was not documented as administered, then the medication had not been administered.
-He was not aware of the blank spaces on Resident #3's eMAR for acetaminophen, pravastatin and quetiapine at 8:00pm on 12/09/22, 12/25/22, 01/17/23 or 01/18/23.

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D 358	Continued From page 78 -There were no staff at the facility who were responsible for completing audits of the eMARs to ensure medications had been administered as ordered. -The MAs were expected to document all medications as either administered, or not administered along with the reason why; there should be no blank spaces on the eMAR. Attempted telephone interview with the evening shift MA on 02/24/23 at 10:30am and 4:30pm, and 02/27/23 at 8:50am was unsuccessful. Attempted telephone interview with a second evening shift MA on 02/24/23 at 10:32am and 4:32pm, and 02/27/23 at 8:52am was unsuccessful.	D 358		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 1 of 5 sampled residents (#3) was treated with respect and dignity related to being told he would lose privileges if he did not do what staff asked him to do. The findings are: Review of Resident #3's current FL2 dated 10/03/22 revealed:	D911	Facility administration will ensure that all residents are treated with respect and dignity and that privileges are not withheld from any residents.	3/1/2023

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-Diagnoses included coronary artery disease, cerebral artery occlusion, history of stroke, secondary parkinsonism, hypertension, and cognitive disorder.
-He was intermittently disoriented.
-He had a functional limitation regarding his speech.

Review of Resident #3's progress note dated 12/21/22 revealed:
-The note was written by the Executive Director (ED).
-There was documentation at 3:30pm, the ED told Resident #3 he could not have any more shopping trips and could not visit the resident store until he took a shower and washed his hair; Resident #3 became very angry and cursed at the ED and took a shower.
-There was documentation at 5:00pm, the ED took Resident #3 his medication and he told her he was mad at her; the ED told Resident #3 she did not care, and Resident #3 appeared as if he was going to hit the ED but he did not.

Review of Resident #3's progress note dated 01/03/23 revealed:
-The note was written by the ED.
-There was documentation at 4:40pm, Resident #3 was upset because the ED did not have time to talk to him for a moment, so he refused to take his medication.

Review of Resident #3's progress note dated 02/20/23 revealed:
-Resident #3 refused to take his medication all weekend and again that morning.
-The ED told Resident #3 that he would not get any privileges such as shopping or going to town if he continued with those negative behaviors and continued to refuse his medications.

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-Resident #3 became visibly upset and shook his fists at the ED.
-The ED called to notify Resident #3's guardian but was unable to reach him.

Observation of Resident #3's room on 02/24/23 at 2:41pm revealed:
-There was a handwritten note on Resident #3's bed.
-The note read: when you don't take your medicine you are putting your health at risk. If you take your 4:00pm medicine, I will go to the store and get what you need.
-The note was not signed.

Observation of the on-site resident store on 02/23/23 at 3:20pm revealed:
-The store was next to the main entrance of the facility.
-The store had shelves with food items for sale including: a bucket of individually wrapped bubble gum for 50 cents a piece, packs of crackers for $1.00 a piece, packs of candy coated chocolate with no price posted, packs of microwave popcorn with no price listed, chocolate bars with no price listed, a variety of snack cakes with no prices listed, snack size bags of chips with no price listed, and packs of noodles for $2.00 each.
-There was a refrigerator with freeze pops in the freezer and cans of soda in the refrigerator for $2.00 each and a limit of two per day.

Interview with Resident #3 on 02/23/23 at 11:10pm revealed:
-He had resided at the facility for almost a year.
-The ED would not talk to him, she just walked past him whenever he tried.
-He was "a good guy and tried to be nice to everyone".
-He was getting really frustrated because it was

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hard for him to talk and communicate with people since his stroke.
-He wanted to be able to talk better.
-He felt like nobody at the facility would let him do anything because he wanted to go to the store to buy snacks and was told he could not go.
-He just wanted to go to the store and the Activity Director (AD) told him she would take him to the store, but had not yet.
-He wanted to be able to go shopping at the store once a week so he could get grapes, cheese, popcorn and candy.

Telephone interview with Resident #3's guardian on 02/23/23 at 12:20pm revealed:
-Resident #3 contacted him within the previous week and told him that he felt like he was not being talked to by anyone at the facility.
-Resident #3 had a history of getting upset over money and the fact that he needed supervision to go to the store.
-He thought the AD brought him to the store every couple of weeks.

Telephone interview with Resident #3's mental health provider (MHP) on 02/24/23 at 11:25am revealed:
-Resident #3 had a difficult time communicating, but seemed to do better with some staff than others.
-Resident #3 had never reported that staff had taken any privileges from him, but he did say that he could not please the ED or get along with her.

Interview with the ED on 02/24/23 at 12:19pm revealed:
-The AD opened the on-site resident store a couple of days per week and offered Resident #3 to shop in the on-site resident store, but could not bring him to town to shop at that time.

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-The AD had been bringing Resident #3 to shop at the store in town once per month.
-Resident #3 declined to shop in the on-site resident store, because he wanted grapes and cheese and those were things they did not have in their on-site resident store.
-She had not offered to get those items for Resident #3 in the past week because he had not specifically asked her for them.

Interview with Resident #3 on 02/24/23 at 2:40pm revealed:
-The ED had given him a note that day that said if he did what she wanted him to do like take his medications she would be willing to go buy the items he had been wanting from the grocery store.
-He was working on writing a shopping list but he was a slow writer so it had taken him a couple of hours to get his list written.
-It had been about three weeks since he was last able to go to the store to buy what he wanted.
-He did not like to shop in the on-site resident store because it was a rip off and they charged $3.00 for a pack of M&Ms and did not have the other things he wanted to buy.

Telephone interview with the ED on 02/27/23 a 1:45pm revealed:
-Resident #3 had not had consistent refusals for personal care or taking medication.
-She did have to have a talk with Resident #3 once or twice about showering because he had been avoiding it.
-She only had two conversations with Resident #3 where she felt she had to say no more shopping trips unless he showered or took his medications.
-She had sat down with Resident #3 numerous times in her office passing notes back and forth because that was an easier method of

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communication for him.
-She did not think that she ignored or avoided talking to Resident #3.
-The facility did not have the staff available to drive Resident #3 to the store every week like he wanted.
-Due to Resident #3's recent behaviors she had not felt comfortable with Resident #3 going to the store but he did give her a shopping list on 02/24/23 so she did a store run for him.
-The shopping trip she did for Resident #3 on 02/24/23 was contingent on him taking his medications, following the facility rules and not acting out.
-If Resident #3 had not taken his medication on Friday 02/24/23 he would have needed to just shop at the on-site resident store.
-Resident #3's shopping list included grapes, cheese, a 2-Liter bottle of soda, frozen meals and other things that they did not keep in the on-site resident store.
-She had only withheld privileges from Resident #3 that were above and beyond what all the other residents got, such as frequent trips to the grocery store.