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
	HAL099018	A. BUILDING: ______ B. WING ______	R 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 03/22/23 to 03/23/23.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: Review of Staff C's, Resident Care Coordinator (RCC) personnel record revealed: -Staff C was hired on 06/14/22. -There was documentation a HCPR check was completed on 07/20/20. -There was no documentation a HCPR check was completed prior to Staff C's hire on 06/14/22. Interview with the Staff C on 03/23/23 at 5:48pm revealed: -She began working as the RCC in a sister facility in 06/14/22 and went between the two facilities helping as needed. -She began working at the current facility on a consistent basis in January 2023. -She had been working off and on at the facility	D 137		

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since 2015.
-She thought an old HCPR check had been pulled from her old personnel record and placed in her most recent personnel record.

Interview with the Administrator on 03/23/23 at 6:39pm revealed:
-The Business Office Manager (BOM) was responsible for maintaining personnel records and ensuring HCPR checks were completed upon hire.
-A HCPR check should have been completed for Staff C upon her hire date of 06/14/22.

Attempted telephone interview with the BOM on 03/23/23 at 6:45pm was unsuccessful.

D 273 | 10A NCAC 13F .0902(b) Health Care | D 273

10A NCAC 13F .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure health care follow up to meet the health care needs for 2 of 5 sampled residents (#2 and #4) who had episodes of choking on food and pills (#4) and a resident who had increased behaviors (#2).

The findings are:

1. Review of Resident #4's current FL2 dated 05/24/22 revealed:
-Diagnoses included bipolar disorder, mild cognitive impairment, depression, hypertension and diabetes.

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-She was ordered a regular textured diet and had double portions of meats ordered.

Review of Resident #4's diet order dated 01/10/23 revealed:
-She received a no concentrated sweets diet with special instructions for no salt at her table and to receive a double portion of meats.
-There was no order for pureed, chopped or ground consistency foods.

Review of Resident #4's progress notes revealed:
-On 01/15/23 at 6:27pm, a personal care aide (PCA) documented that Resident #4 "had gotten choked on the beef stew" at supper; staff assisted her quickly and the medication aide (MA) was also present.
-On 01/15/23 at 7:13pm, the MA documented that Resident #4 "got choked at dinner and had a hard time catching her breath" because she could not get her bite to go down, then refused to eat the remainder of her meal.
-On 02/09/23 at 6:50pm, the MA documented that Resident #4 choked on white rice and broccoli twice during dinner.
-On 02/24/23 at 10:43am, the MA documented that while taking her medications, Resident #4 choked and almost vomited because she could not get her pill to go down; the Resident Care Coordinator (RCC) was notified and said she would notify the primary care provider (PCP).

Review of Resident #4's PCP progress note dated 01/17/23 and 01/31/23 revealed there was no documentation about Resident #4's choking incidents or swallowing concerns or that the PCP had been notified.

Observation of Resident #4 during the lunch meal at 12:40pm on 03/23/23 revealed:

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-Resident #4 was served cornbread, chicken alfredo, a bean blend and fruit.
-Resident #4 ate all of her chicken alfredo without any episodes of coughing or choking.

Interview with a PCA on 03/23/23 at 12:50pm revealed:
-He had written the progress note about Resident #4 choking on 01/15/23.
-He had not observed Resident #4 having any further episodes of coughing or choking while eating.
-He thought Resident #4 had choked on her food on 01/15/23, because she was trying to eat too fast.
-Resident #4 had never needed the Heimlich maneuver, just some pats on her back.

Interview with a MA on 03/23/23 at 3:50pm revealed:
-She had documented the progress notes on 01/15/23, 02/09/23 and 02/24/23 about Resident #4 choking.
-The last time she had observed Resident #4 choking on something was a couple of days prior.
-Resident #4 had coughing and choking episodes because she ate too fast.
-The first time she had observed Resident #4 choking was in January 2023.
-Resident #4 seemed to struggle the most with chunks of red meats.
-Resident #4's PCP was aware of her episodes of choking because she had notified the RCC who then notified the PCP.
-She was not aware of any new orders for Resident #4 in regards to her swallowing.

Interview with Resident #4 on 03/23/23 at 4:16pm revealed:
-She never choked on her food or medications.

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-She did not have any trouble swallowing food or medications.
-She did not remember any choking incidents in January or February 2023.

Interview with the RCC on 03/23/23 at 5:00pm revealed:
-Resident #4 never actually choked, she just ate fast and started coughing.
-She notified Resident #4's PCP about her swallowing concerns and the PCP advised her to monitor Resident #4 and if the choking episodes continued to complete a change of condition care plan and she would refer her to home health for a speech therapy swallowing evaluation.
-She could not remember when she notified Resident #4's PCP, because it was a verbal conversation they had and there was no documentation from it.
-Resident #4 was on a regular texture diet and her PCP had not changed her diet order based on her choking episodes.

Interview with the Health and Wellness Coordinator (HWC) on 03/23/23 at 5:50pm revealed:
-She was not aware that Resident #4 had documented episodes of choking or coughing on food and pills while swallowing.
-She was not sure if the RCC had notified the PCP about Resident #4's swallowing concerns or not.
-She was in the dining room for breakfast and lunch Monday through Friday and had never observed Resident #4 choking or coughing during her meals.

Interview with the Administrator on 03/23/23 at 6:30pm revealed:
-She was not aware that Resident #4 had

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documented episodes of choking or coughing on food and pills while swallowing.
-She was in the dining room during various mealtimes usually Monday through Friday and sometimes on the weekend and had never observed Resident #4 coughing or choking while eating.
-Resident #4 had never reported trouble chewing or swallowing to her.
-She did not know if Resident #4's PCP was aware of her swallowing concerns.
-She would expect the staff who observed the coughing or choking to report the incident to the RCC, and for the RCC to notify the PCP.

Attempted telephone interviews with Resident #4's PCP on 03/23/23 at 11:30am and 4:50pm were unsuccessful.

2. Review of Resident #2's current FL2 dated 07/22/22 revealed diagnoses included severe manic bipolar 1 disorder with psychotic behaviors, agitation, ataxia, chronic renal insufficiency, and hyponatremia.

Review of Resident #2's care plan dated 06/27/22 revealed:
-Resident #3 had a history of mental illness and was currently receiving mental health services.
-Resident #3 suffered from schizoaffective disorder vs bipolar disorder and sever manic bipolar with disorder with psychotic behaviors.

Review of Resident #2's progress notes for February 2023 through March 2023 revealed:
-On 02/09/23, there was documentation Resident #2 did not appear to be acting herself and was changing several of her typical ways of thinking, acting, and doing.
-On 03/09/23, there was documentation Resident

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#2's behavior had been off baseline for her; she was arguing with staff over everything; Resident #2 had not appeared to be herself since the beginning of February 2023.
-On 03/16/23, there was documentation Resident #2 had been completely off baseline lately; she screamed at MAs and PCAs over the simplest things.
-On 03/22/23, there was documentation Resident #3 became irate yelling and screaming at staff.
-There was no documentation of communication with Resident #2's mental health provider (MHP).

Observation of Resident #2 on 03/22/23 between 10:26am and 10:30am revealed she was in the hallway in front of the Resident Care Coordinator's (RCC)/Health and Wellness Coordinator's (HWC) office yelling about a medication.

Telephone interview with Resident #2's MHP on 03/23/23 at 10:58am revealed:
-He saw Resident #2 for the first time on 12/23/22.
-He saw Resident #2 every four weeks and saw her on 01/26/23 and 02/21/23.
-He talked to staff during his visits and did not see anything in his notes out of the norm.
-He did not see any documentation staff notified him Resident #2 was not at her baseline.
-It was typical of any of his residents at the facility to have sporadic increases in behaviors.
-He would have expected staff to contact him to notify Resident #2 was continuing to have increased behaviors that were not at baseline for her.

Interview with a MA on 03/23/23 at 4:01pm revealed:
-Resident #2 had previously accused another

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resident of touching her and the local department of social services and local law enforcement were involved.
-Resident #2 had not been behaving at baseline since she made the accusations.
-Prior to February 2023, Resident #2 had never screamed, yelled, or argued over medication.
-She had not talked to Resident #2's MHP about her increased behaviors.

Interview with the RCC on 03/23/23 at 5:26pm revealed:
-She documented Resident #2 did not appear to be acting herself on 02/09/23.
-Resident #2 began yelling, accused a male resident of touching her, requested only male staff to assist her, and yelling that she was wet, but found to be dry when incontinence care was provided.
-She notified Resident #2's MHP of Resident #2's changes in behaviors when he was at the facility about 3 weeks ago, but Resident #2 had refused to be treated by her MHP or have any medication changes.
-She had not documented speaking with Resident #2's MHP about her changes in behaviors.
-Resident #2 started yelling at staff about 2 weeks ago, but she did not notify Resident #2's MHP because Resident #2 stated she wanted to talk to her new primary care provider (PCP).
-She was responsible for notifying Resident #2's MHP regarding changes in behaviors.

Interview with HWC on 03/23/23 at 5:48pm revealed:
-She knew Resident #2 had increased behaviors.
-Resident #2 had become more impatient, demanding, started yelling, and had increased agitation since February 2023.
-Resident #2 also pushed a staff.

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D 273	Continued From page 8 -She told Resident #2's MHP that Resident #2 was off baseline when he visited at the facility, but there was no documentation of the conversation with the MHP. Interview with the Administrator on 03/23/23 at 6:39pm revealed: -Staff told her Resident #2 had been refusing to be seen and treated by her MHP. -She would have expected the RCC or the HWC to reach out to Resident #2's MHP provider to notify him of Resident #2's increased behaviors.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#4) who had an order for continuous oxygen therapy. The findings are: Review of Resident #4's current FL2 dated 05/24/22 revealed diagnoses included tobacco use, bipolar disorder, mild cognitive impairment, depression, hypertension and diabetes.	D 276		

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Review of Resident #4's sleep consultation dated 01/03/23 revealed:
-Resident #4 was referred by her primary care provider (PCP) for a sleep consultation.
-Resident #4 did not understand why she was at the consultation because she thought her sleep was fine.
-Resident #4 reported that she usually went to sleep quickly and woke up once at night to use the bathroom.
-She sometimes woke up with a dry mouth or startled but denied other symptoms.
-She reported taking naps often, and denied being short of breath even though her oxygen saturation upon arrival to her appointment was 94%.
-Resident #4 had smoked one pack of cigarettes per day for the last 40 years.
-Resident #4 did a 6-minute oxygen test which revealed that her oxygen saturation while at rest on room air was 88% or lower, and her oxygen saturation at rest while on 2 liters (L) oxygen was 96%.
-Resident #4 had significant hypoxic respiratory failure stemming from many factors such as smoking, chronic obstructive pulmonary disorder (COPD), and obesity.
-Oxygen therapy would be initiated, and a sleep study would be scheduled at some point in the future.

Review of Resident #4's equipment order dated 01/12/23 revealed:
-An order for continuous oxygen at 2L per minute via nasal cannula.
-Resident #4's diagnosis was COPD with a goal oxygen saturation to be greater than 89%.
-There was an equipment order for a portable concentrator with tubing and supplies.

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Review of Resident #4's signed physician's orders sheet dated 02/21/23 revealed there was no order listed for oxygen.

Review of Resident #4's January and February 2023 electronic medication administration records (eMAR) revealed there was no entry for continuous oxygen at 2L or for oxygen saturation checks.

Review of Resident #4's March 2023 eMAR from 03/01/23 through 03/22/23 revealed:
-On 03/22/23 an entry was added for oxygen 2L via nasal cannula at bedtime scheduled from 10:00pm to 6:00am.
-There was no documentation of oxygen administration or monitoring from 03/01/23 through 03/22/23.

Review of Resident #4's progress note dated 01/13/23 revealed:
-At 9:45am, the Resident Care Coordinator (RCC) documented Resident #4 had a sleep/walk study done on 01/03/23 to evaluate her possible need for oxygen use at night.
-The supervisor-in-charge (SIC) had contacted the office where the sleep consultation was to request the official diagnosis and orders that resulted from the appointment.

Review of Resident #4's progress note dated 01/13/23 revealed:
-At 5:52pm, a medication aide (MA) documented that she received Resident #4's oxygen order.
-Resident #4 required oxygen due to her diagnosis of COPD and needed to be on 2L.
-The MA helped Resident #4 work her oxygen concentrator and Resident #4 told her she would wear the oxygen at night.

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D 276	Continued From page 11 Review of Resident #4's progress note dated 01/15/23 revealed: -At 9:16am, a MA documented that Resident #4 was supposed to wear oxygen while sleeping but was refusing to put on the nasal cannula that was connected to her oxygen concentrator. -Resident #4 had been told numerous times that she needed to wear the oxygen due to her oxygen level decreasing. -Resident #4's oxygen saturation level was 86% when the MA woke Resident #4 up to take her medication. -The MA advised Resident #4 to put her oxygen on if she was going to be sleeping in bed and Resident #4 told her she was just going to lay in bed for another minute. Review of Resident #4's progress note dated 01/28/23 revealed: -At 2:02pm, a MA documented that Resident #4 was still refusing to wear her oxygen while sleeping and was also sleeping a majority of the day. -The MA checked Resident #4's oxygen saturation before lunch and it was 84% on room air. Review of Resident #4's progress note dated 01/29/23 revealed: -At 3:06pm, a MA documented that Resident #4 was refusing to wear oxygen and would only use it when the staff went into her room and asked her to put the oxygen on. -Whenever Resident #4 agreed to put her oxygen on, she seemed to take it back off when the staff left her room. Review of Resident #4's progress note dated 02/03/23 revealed: -At 3:55pm, a MA documented that Resident #4	D 276		

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had been found numerous times not using her oxygen while sleeping.
-Resident #4 stated she only needed to wear it at night, so she did not wear it during her naps during the day.

Review of Resident #4's progress note dated 02/23/23 revealed that at 9:41pm, a MA documented that Resident #4 was still refusing to use her oxygen while she was lying in bed sleeping.

Review of Resident #4's record on 03/23/23 at 9:00am revealed there was no documentation that Resident #4's PCP had been contacted regarding her refusal to wear oxygen continuously as ordered.

Review of Resident #4's physician progress note dated 01/17/23 and 01/31/23 revealed there was no documentation about Resident #4's new oxygen order or her refusals to wear oxygen continuously as ordered.

Observation of Resident #4 on 03/22/23 at 9:00am and 1:45pm and 3:00pm, and on 03/23/23 at 11:45am, 12:40pm, 2:26pm, 3:20pm, and 4:15pm revealed she was not wearing oxygen.

Observation of Resident #4's room on 03/22/23 at 1:45pm revealed:
-There was an oxygen concentrator next to her bed turned off.
-There was oxygen tubing on the floor that was connected to the concentrator.
-When the concentrator was turned on it was set for 2L.
-There were no portable oxygen tanks in Resident #4's room.

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Observation of Resident #4 walking in the hall on 03/23/23 at 3:40pm revealed:
-She was walking independently and did not have oxygen on.
-She did not appear or sound out of breath or short of breath while walking.

Observation of the oxygen supply room on 03/23/23 5:40pm revealed there were no portable oxygen tanks labeled for Resident #4.

Interview with Resident #4 on 03/22/23 at 3:00pm revealed:
-She thought her oxygen concentrator was new within the last day or two.
-She wore her oxygen at night but not during the day.
-She did not know what her oxygen order was.
-She did not get short of breath during the day or at night or during exertion such as walking.
-She did not think she needed the oxygen.
-She did not remember going to the sleep consultation in January 2023.
-She never received a portable oxygen tank.
-She could not remember who told her that she only needed to wear the oxygen at night.
-She would maybe wear the oxygen continuously if the staff had told her to.

Telephone interview with a representative from the facility's contracted pharmacy on 03/23/23 at 10:25am revealed:
-They did not enter orders for oxygen on the facility's eMAR.
-They had not received an order for oxygen for Resident #4.

Telephone interview with a representative from Resident #4's sleep study center on 03/23/23 at

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D 276	Continued From page 14 2:30pm revealed: -Resident #4's oxygen order was for 2L via nasal cannula continuously. -Resident #4's last appointment at their office was 01/03/23 and she had not yet completed a sleep study. -There was documentation that Resident #4 had significant hypoxia (an absence of enough oxygen in the body to sustain bodily functions). -Resident #4 was ordered a portable oxygen concentrator so that she could wear oxygen continuously as ordered. -They had not received any notification from the facility that Resident #4 was not wearing oxygen continuously. -They would want to know if Resident #4 was not wearing oxygen as ordered so they could re-educate her on the importance of adhering to use of oxygen as the doctor had ordered it. -Possible risks of not wearing her oxygen at 2L continuously included her blood oxygen saturation levels dropping which could cause damage to all her vital organs. -The doctor expected staff to ensure Resident #4 was wearing oxygen continuously at 2L or to notify them if she had refused. Telephone interview with the oxygen equipment supplier on 03/23/23 at 3:35pm revealed: -Resident #4's order was for 2L continuous oxygen. -They had dropped off oxygen equipment at the facility for Resident #4 to include an oxygen concentrator, tubing, and portable tanks (number not specified). -The facility would be responsible for calling them if Resident #4 ran out of oxygen in her portable tanks and needed them refilled. -They had not received any requests from the facility to refill Resident #4's oxygen tanks.	D 276		

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D 276	Continued From page 15 Interview with a MA on 03/23/23 at 3:50pm revealed: -She had documented the progress notes about Resident #4 refusing to wear her oxygen at night. -Resident #4 did not have a portable oxygen tank and never did. -She was not aware that Resident #4's oxygen order was for continuous oxygen, not just at night. -The Health and Wellness Coordinator (HWC) and RCC were responsible for reviewing new orders and adding the orders to the eMAR. -Neither the HWC or RCC had advised staff that Resident #4's oxygen order was for 2L continuous oxygen. -She had never seen an order for continuous oxygen on the eMAR for Resident #4. -She did not think Resident #4 would wear oxygen continuously because of how frequently she went outside to smoke. -Resident #4 was always short of breath but she was a heavy smoker. -She had notified Resident #4's PCP about her non-compliance with wearing oxygen and was just told to keep an eye on her. Interview with the RCC on 03/23/23 at 5:00pm revealed: -She had processed Resident #4's oxygen order. -She was working the day the oxygen equipment was delivered for Resident #4 but had not seen what specific items had been delivered. -She had seen an oxygen concentrator and tubing for Resident #4 but never saw portable tanks for her. -There were no portable tanks in the facility specifically for Resident #4, but they did have a storage closet full of portable oxygen tanks from a different oxygen equipment company. -She did not think Resident #4 needed portable	D 276		

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oxygen tanks because her order was to wear 2L oxygen at nighttime only.
-She was told verbally over the phone that Resident #4's order would be at night only since that was when she had the most difficulty with her breathing, so she had tried to get the order clarified since the order form said 2L oxygen continuously.
-The order clarification had not been documented since it was discussed verbally over the phone.
-She had given the oxygen equipment company the phone number for the doctor who had ordered the oxygen for Resident #4 so they could clarify what the order should be since she felt like the middleman.
-She had not received an order to change the oxygen order from 2L continuous to 2L at night.
-The oxygen order should have been added to Resident #4's eMAR by either the HWC or herself but they both forgot, so the HWC added the order to eMAR the day prior, on 03/22/23.
-Resident #4's PCP was aware of Resident #4's oxygen order and that she was refusing to keep her oxygen on at night or while in bed.
-The PCP had advised the RCC to encourage Resident #4 to wear her oxygen as ordered, but did not request any change to her orders.

Interview with the HWC on 03/23/23 at 5:50pm revealed:
-Resident #4 had oxygen ordered in January 2023.
-She just added Resident #4's oxygen to the eMAR on 03/22/23 because she realized it was not entered on the eMAR.
-The RCC was responsible for processing new orders for the residents.
-The RCC had wanted to get Resident #4's oxygen order clarified because it was for 2L continuous but she had been told over the phone

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by the doctor that she only needed to wear it at night.
-She did not know if a new oxygen order had been written in response to the request for clarification.
-She did not think Resident #4's oxygen order had been changed since the initial order was received in January 2023.
-Resident #4 did not appear to be short of breath during meals when she was able to observe her.
-If Resident #4 was not in the dining room for a meal or outside smoking, she was usually in her bed in her room where her oxygen concentrator was.
-Staff had not been routinely checking Resident #4's oxygen saturation levels because they did not have an order for it.
-She did not know if Resident #4's PCP was aware of Resident #4 refusing to wear oxygen as it was ordered, but she thought the RCC had sent her a notification about it.
-Since the oxygen had not been added to the eMAR the MAs were not documenting on it, but they were all told that Resident #4 should be wearing oxygen at 2L at night or while sleeping.

Interview with the Administrator on 03/23/23 at 6:30pm revealed:
-She was aware that there had been a lot of back-and-forth communication between the doctor who ordered Resident #4's oxygen and the company who was dispensing the oxygen equipment regarding if the oxygen order was continuous or not.
-She was not aware of an order change from Resident #4's initial order for oxygen at 2L continuously.
-If Resident #4 needed to wear oxygen continuously or needed oxygen while out of her room they had a lot of portable tanks available.

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-She did not know if the PCP was aware of how often Resident #4 was wearing her oxygen.
-Resident #4 never appeared short of breath during the day.
-She expected the RCC to encourage Resident #4 to wear her oxygen continuously as ordered, and to document order clarification requests or notifications of non-compliance with the doctor.
-She was not aware that Resident #4's oxygen had not been on the eMAR until yesterday, 03/22/23.
-She was aware that Resident #4 was not wearing oxygen continuously as ordered, so she advised her staff to encourage Resident #4 to put on her oxygen whenever they saw her without it.

Attempted telephone interview with Resident #4's guardian on 03/23/23 at 11:40am was unsuccessful.

Attempted telephone interviews with Resident #4's PCP on 03/23/23 at 11:30am and 4:50pm were unsuccessful.

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10A NCAC 13F .0909 Resident Rights

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on record reviews, observations, and interviews, the facility failed to ensure 1 of 5 sampled residents' (#2) was treated with respect, consideration, and dignity and residents' rights were maintained by receiving mail and packages unopened.

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The findings are:

1. Review of Resident #2's current FL2 dated 07/22/22 revealed diagnoses included severe manic bipolar 1 disorder with psychotic behaviors, agitation, ataxia, chronic renal insufficiency, and hyponatremia.

Observation of the hallway on 03/22/23 between 10:26am and 10:30am revealed:
-Surveyors were in a room with the door closed close on the right hallway close to the nurse's desk which was located near the main entrance front hallway.
-A resident and staff were overheard yelling about medication.
-There were 2 residents present in the hallway (not Resident #2).
-Resident #2 backed into the main hallway, in her wheelchair, from the short hall leading to the Resident Care Coordinator's (RCC)/Health and Wellness Coordinator's (HWC) office at the end of the right hallway as she and staff continued to yell at one another.
-The staff who were yelling were not visible from the hallway.
-The housekeeper and another resident were standing near Resident #2.

Interview with the housekeeper on 03/22/23 at 10:41pm revealed:
-Resident #2 had an appointment on 02/21/23 and had new medication orders, but the new orders had not been received at the facility yet.
-She became aware of the information about Resident #2's medication orders because of the yelling between Resident #2 and staff.
-"It was hard not to hear it."
-She thought staff were just trying to make

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Resident #2 understand when they spoke loudly to her.
-Resident #2 was having a hard time understanding.

Interview with two residents between 11:03am and 11:06am revealed:
-A resident heard staff and Resident #2 yelling at each other; she was in the front hallway near the nurse's desk.
-Another resident had been in their room and heard a resident and staff yelling at each other, but she did not know who the resident was; the resident and staff were yelling about a medication.

Interview with the HWC on 03/22/23 at 10:46pm revealed:
-She had been talking to Resident #2 when she was in the hallway yelling.
-Resident #2 went to see a new provider on 03/21/23 and the new provider had not sent over any new medication orders to the facility.
-Resident #2 had been requesting administration of insulin which were not a part of her current orders.
-She was trying to tell Resident #2 that MAs could not administer medication differently until they received new orders from her new provider.
-She had to be "stern" with Resident #2.
-Resident #2 was hard of hearing and kept yelling, "What?"
-She had to keep getting louder when she spoke to Resident #2 so she could hear her.

Interview with the Administrator on 03/22/23 at 10:15am revealed:
-She walked up when Resident #2 was still in the hallway, but she was not yelling at the time.
-She had not heard Resident #2 or staff yelling.

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-She came to where Resident #2 was because staff had called her and told her there was a situation with Resident #2.

Interview with Resident #2 on 03/22/23 at 11:08am revealed:
-It made her feel angry when staff were yelling at her earlier on 03/22/23.
-She did not know why she could not get her fast-acting insulin when she did not get her short acting insulin.
-Staff told her she could not get fast-acting insulin because the order had not been processed yet.
-Staff had yelled at her before, but she did not remember when.
-"It makes me want to get back at them."

Interview with the RCC on 03/22/23 at 2:49pm revealed:
-She told Resident #2 repetitively that staff could not give her anything that they did not have orders for.
-She talked loudly to Resident #2 because she had a hard time hearing.
-She and other staff did not deescalate because the louder they talked, the louder Resident #2 got because she thought they were yelling at her.
-Staff had recent training on deescalating which included talking to residents calmly, refraining from screaming, and making residents feel like staff were talking to them and not at them.

Interview with Resident #2's Mental Health Provider (MHP) on 03/23/23 at 11:58am revealed:
-He did not know about staff's interactions with Resident #2 on 03/22/23.
-He had not witnessed staff yelling or arguing with residents at the facility when he visited.
-He expected staff to talk residents down from agitation, let them have a moment to themselves,

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and then try to reengage with the resident in a calm way.
-He expected staff to deescalate a situation if a resident was becoming agitated.

Interview with a medication aide (MA) on 03/23/23 at 4:01pm revealed:
-She spoke loudly to Resident #2 on 03/23/23 because Resident #2 did not understand what she was trying to say to her.
-Resident #2 was asking her for a fast-acting insulin and it was not time for the insulin yet.
-Resident #2 called her a name and she told her she was not going to continue to argue with her and walked away.
-There was nothing she could do to deescalate.
-Staff had training about a month ago on what to say to residents if they become agitated.

Interview with the HWC on 03/23/23 at 5:48pm revealed:
-She reviewed Residents Rights upon hire and recently had a training on dealing with residents with behaviors.
-The training instructed staff to get on the resident's level and have eye contact, try to redirect the resident, and to talk in a normal, calm voice.
-"That did not happen on yesterday (03/22/22)."
-She did not know what else to do on 03/22/22, but to raise her voice.

Interview with the Administrator on 03/23/23 at 6:39pm revealed:
-There was training on Residents' Rights at the facility a few months ago.
-There was staff training a few weeks ago focusing on aggressive residents and deescalation.
-She expected staff to respond to Resident #2 on

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03/22/22 by walking away instead of matching her tone and voice level.
-Staff's interaction with Resident #2 on 03/22/22 was not appropriate.

2. Review of Resident #2's current FL2 dated 07/22/22 revealed diagnoses included severe manic bipolar 1 disorder with psychotic behaviors, agitation, ataxia, chronic renal insufficiency, and hyponatremia.

Review of Resident #2's progress note dated 03/09/23 at 2:38pm revealed:
-Facility policy was that residents' packages be opened by staff and items in the packed be reviewed to be sure they did not contain any medications, weapons, or etc.
-Resident #2 yelled at staff for almost an hour over "that."
-Resident #2 was arguing with staff about her medications, not doing things right as she demanded, and believed staff was purposely trying to make her mad.

Interview with the Resident Care Coordinator (RCC) on 03/23/23 at 10:59am revealed:
-She documented the progress note for Resident #2 on 03/09/23.
-She opened Resident #2's package at the door of the medication room and Resident #2 was present at the door.
-There was no medication in the package, but there were bacon bits in the package which sounded like medication.
-Resident #2 was upset because she wanted to open the package herself.

Second interview with the RCC on 03/23/23 at 5:26pm revealed:
-There was no facility policy regarding residents'

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mail.
-The Administrator told staff to open residents' packages in front of the resident and to look through the package to make sure there were no medication or items the residents could not have.

Interview with Resident #2 on 03/23/23 at 3:33pm revealed:
-Staff opened her packages before they brought them to her.
-The package that contained bacon bits was opened before she received it; the package was brought to her room by staff.
-The package that contained the bacon bits also contained two boxes of greeting cards.
-A day or two after she received the package a staff came to her room and handed her another box of greeting cards that were not packaged.
-Her mail was personal, and "it made her mad" that staff opened her personal mail before they gave it to her.
-She was told by a medication aide (MA) that staff had a right to open the residents' packages.
-She asked the Administrator about staff opening packages and the Administrator told her staff could not open her mail and that it was a federal violation.

Interview with the Activity Director (AD) on 03/23/23 at 3:51pm revealed:
-She picked up mail, including packages, from the main office and delivered to the facility on Mondays, Wednesdays, and Fridays.
-She gave mail and packages to residents and watched them open the mail or package.
-She did not open mail or packages prior to giving them to residents.
-There was one resident who received cigarettes via mail and another resident who received medication via mail.

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-The Resident Care Coordinator (RCC) opened the packages with cigarettes and she opened the package of medication with the resident, allowed him to look at the medications, then took the medications to the medication room for him.

Interview with a MA on 03/23/23 at 3:51pm revealed:
-Residents' mail and packages were brought to the RCC's office and staff usually opened mail and packages at the medication office with the resident.
-Resident #2 complained about her opening her package, but she opened it in the RCC's room with Resident #2 present.
-Resident #2 told her she was going to send her to federal prison.

Interview with two residents on 03/23/23 at 4:39pm revealed:
-A MA brought one of the residents a package sent by her family member.
-The package had been opened when the resident received it and the staff told her what was in the package.
-Staff had not opened any mail or packages in front of her.
-Another resident stated staff opened all his letters and gave him mail already opened.
-Staff had never opened his mail in front of him.
-He did not feel it was right for staff to open his mail.

Interview with the HWC on 03/23/23 at 5:48pm revealed:
-Mail and packages were picked up from the main office by the AD.
-Staff usually opened residents' packages because a lot of the residents ordered medications through the mail, but they opened

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the packages in front of the residents.
-There had been times when staff opened packages without the resident being present, but only if they thought it was medication.
-Staff did not open residents' personal mail.

Interview with the Administrator on 03/23/23 at 10:50am revealed:
-There was no facility policy regarding residents' mail.
-Mail was picked up by the AD and delivered to the facility on Mondays, Wednesdays, and Fridays.
-Mail and packages were given to residents when brought to the facility.
-Staff were not to inspect or open residents' packages.
-Staff asked residents to open packages in front of them if they thought the package contained something that may not be appropriate such as medications.
-The information documented Resident #2's progress note dated 03/09/23 regarding a facility policy that staff opened packages was incorrect.

D 358 10A NCAC 13F .1004(a) Medication Administration D 358

10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:

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D 358	Continued From page 27 Based on observations, record reviews and interviews, the facility failed to administer medications ordered for 2 of 5 sampled residents (#2 and #5) who had an order for an as needed diuretic to be administered for weight gain and fluid retention (#2) and a resident who had orders to discontinue an acid reflux medication (#5). The findings are: 1. Review of Resident #2's current FL2 dated 07/22/22 revealed: -Diagnoses included ataxia, chronic renal insufficiency, thoracic aortic aneurysm, obesity and hyponatremia. -There was an order for daily weights. -There was an order for furosemide 40mg, 1 tablet as needed for weight gain of 2 pounds or more in 24 hours or if the patient was exhibiting worsening peripheral swelling. Review of Resident #2's progress note dated 01/27/23 at 6:45am revealed Resident #2's feet were really swollen so her thrombo-embolic deterrent (TED)hose were not applied. Review of Resident #2's progress note dated 02/03/23 at 12:48pm revealed: -Staff felt as though Resident #2 was attempting to use as needed furosemide as a form of weight loss. -She was constantly complaining of being overweight. Review of Resident #2's progress note dated 02/14/23 at 6:26am revealed: -Resident #2's feet were swollen from sleeping in her chair all night. -Resident #2 was asked 5 times throughout the night to lay down in the bed and to get out of her	D 358		

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chair.

Review of Resident #2's progress note dated 02/16/23 at 12:35pm revealed:
-Resident #2 yelled at staff if she was not administered as needed furosemide.
-She did not have weight gain within 24 hours, so her as needed furosemide was not administered.
-Resident #2 stated her legs were swollen and she needed her as needed furosemide.
-The MA tried several times to get Resident #2 to put on her TED hose, but she insisted that she did not need the TED hose for swelling, but she needed her as needed furosemide instead.

Review of Resident #2's progress note dated 02/25/23 at 10:49am revealed:
-Staff were concerned Resident #2 was attempting to use her as needed furosemide for weight loss.
-Resident #2 was currently between providers.
-The Resident Care Coordinator (RCC) was going to try to get Resident #2 in with another provider on next week and get clarification on Resident #2's direct use of her as needed medication.
-Resident #2 refused to wear TED hose and then complained of swelling in her legs and feet and requested an as needed furosemide.
-One of the medication aides (MA), the RCC and the Health and Wellness Coordinator (HWC) tried to explain to Resident #2 that she had to wear her TED hose since they were scheduled and then if the swelling did not go away after TED hose were applied, an as needed furosemide may be administered to her.
-Resident #2 also fell asleep on her personal toilet early in the morning before her TED hose were applied and her legs dangled downwards causing more swelling.

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Review of Resident #2's electronic Medication Administration Records (eMARs) for January 2023 revealed:
-There was an entry for furosemide 40mg 1 tablet as needed for weight gain of 2 pounds or more in a 24-hour period or patient is exhibiting worsening peripheral swelling.
-Resident #2's weight ranged from 215.8 pounds to 226 pounds.
-There was an entry for weights, check weight daily scheduled for 9:00am from 01/01/23 through 01/03/23.
-There was an entry for weights, check weight daily scheduled for 9:00am to 11:00am from 01/04/23 through 01/31/23.
-Resident #2's weight was documented as 218.7 pounds on 01/03/23 and 221.8 pounds on 01/04/23 equaling a weight gain of 3.1 pounds in 24 hours; there was no documentation furosemide was administered on 01/04/23.
-Resident #2's weight was documented as 221.8 pounds on 01/04/23 and 224 pounds on 01/05/23 equaling a weight gain of 2.2 pounds in 24 hours; there was no documentation furosemide was administered on 01/05/23.
-Resident #2's weight was documented as 216.4 pounds on 01/11/23 and 220.8 pounds on 01/12/23 equaling a weight gain of 4.2 pounds in 24 hours; there was no documentation furosemide was administered on 01/12/23.
-Resident #2's weight was documented as 220.4 pounds on 01/15/23 and 222.4 pounds on 01/16/23 equaling a weight gain of 2 pounds in 24 hours; there was no documentation furosemide was administered on 01/06/23.
-Resident #2's weight was documented as 215.8 pounds on 01/20/23 and 219.6 pounds on 01/21/23 equaling a weight gain of 3.7 pounds in 24 hours; there was no documentation

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furosemide was administered on 01/21/23.
-There was no documentation Resident #2 was administered furosemide on 01/27/23 in response to the increased swelling in her feet documented in the progress note dated 01/27/23.
-There was no documentation furosemide was administered in January 2023 due to worsening peripheral swelling.

Review of Resident #2's eMARs for February 2023 revealed:
-There was an entry for furosemide 40mg 1 tablet as needed for weight gain of 2 pounds or more in a 24-hour period or patient is exhibiting worsening peripheral swelling.
-Resident #2's weight ranged from 215.8 pounds to 224 pounds.
-There was an entry for weights, check weight daily scheduled for as needed.
-Resident #2's weight was documented as 219.6 pounds on 02/10/23 and 222 pounds on 02/ 11/23 equaling a weight gain of 2.4 pounds in 24 hours; there was no documentation furosemide was administered on 02/11/23.
-There was no documentation Resident #2 was administered furosemide on 02/14/23 in response to the swelling in her feet documented in the progress note dated 02/14/23.
-There was no documentation furosemide was administered in February 2023 due to worsening peripheral swelling.

Review of Resident #2's eMARs for 03/01/23 through 03/22/23 revealed:
-There was an entry for furosemide 40mg 1 tablet as needed for weight gain of 2 pounds or more in a 24-hour period or patient is exhibiting worsening peripheral swelling.
-Resident #2's weight ranged from 214.3 pounds to 221.8 pounds.

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-There was an entry for weights, check weight daily scheduled for as needed.
-Resident #2's weight was documented as 217.6 pounds on 03/04/23 and 219.7 pounds on 03/05/23 equaling a weight gain of 2.1 pounds in 24 hours; there was no documentation furosemide was administered on 03/05/23.
-There was no documentation furosemide was administered from 03/01/23 through 03/22/23 due to worsening peripheral swelling.

Interview with Resident #2 on 03/22/23 at 11:08am revealed:
-She was to be administered furosemide when she had a weight gain of 2 pounds or if she had swelling in her feet and legs.
-Staff have told her about her weight gains of 2 pounds or more and given her as needed furosemide to get the fluid off her body.
-She had not had any as needed furosemide recently, but she had been administered as needed furosemide less than a month ago.

Interview with Resident #2 on 03/23/23 at 3:33pm revealed:
-Sometimes sitting in her wheelchair for long periods of time with her feet not elevated caused her feet to swell.
-She asked for her furosemide as needed when her legs and feet were swollen.
-She had not refused to wear her TED hose.
-MAs have told her they were not applying her TED hose because her legs were too swollen, but sometimes did not administer her as needed furosemide.
-Sometimes MAs administered furosemide to her when she requested it for increased swelling and sometimes, they did not.

Interview with a MA on 03/22/23 at 2:49pm

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revealed:
-As needed furosemide was administered to Resident #2 when she had a weight gain of 2 pounds or more and when she had extreme swelling.
-MAs documented the administration of the as needed furosemide on Resident #2's eMAR.

Interview with a MA on 03/23/23 at 4:01pm revealed:
-Resident #2 was to be administered furosemide as needed if she had a 2-pound weight gain or if she had swelling in her legs and feet.
-Resident #2 requested furosemide as needed if she gained any amount of weight.
-If MAs did not administer the as needed furosemide to Resident #2, she screamed at them.
-Resident #2 refused to put on her TED hose and she had swelling in her feet and legs when she refused to put them on.
-If she refused to have TED hose applied or if she sat in her wheelchair for a long time, she had increased swelling in her legs and feet.
-If Resident #2 refused to have her TED hose applied and had swelling in her legs and feet, MAs did not administer her an as needed furosemide tablet.
-Resident #2's previous Primary Care Provider (PCP) stated she needed to wear her TED hose.
-Resident #2's previous PCP told staff to not administer the as needed furosemide if Resident #2 was purposefully swelling (sitting in her chair for long periods and not wearing her TED hose) to get medication.
-Resident #2 was not gaining weight, she was swelling.
-If Resident #2's previous PCP said to not administered the as needed furosemide, then she did what the previous PCP said to do.

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Interview with the RCC on 03/23/23 at 5:26pm revealed:
-Resident #2 had an order for furosemide as needed for a weight gain of 2 pounds or more or if she had increased swelling in her legs and feet.
-MAs should have documented when a tablet of furosemide was administered as needed.
-She had not noticed there was no documentation furosemide was administered as needed when Resident #2 had a weight gain of 2 pounds or more.
-Staff did not feel like Resident #2 should be administered furosemide as needed unless her scheduled treatment, TED hose, were being used.
-The previous PCP told staff to hold the as needed furosemide if Resident #2 was not wearing her TED hose.
-She, the HWC and a MA spoke to Resident #2's PCP about holding the furosemide, but the previous PCP's office did not provide an order to hold the as needed furosemide if Resident #2 did not have her TED hose applied.
-She did not know if any of the conversations with Resident #2's previous PCP were documented.

Interview with the Administrator on 03/23/23 at 6:39pm revealed:
-She expected MAs to administer as needed furosemide as ordered.
-She expected the RCC and the HWC to review residents' eMARs weekly to ensure medication was being administered as ordered.
-She did not know furosemide was not given when Resident #2 had a weight gain of 2 pounds or more or when she had increased swelling in her legs and feet.

Attempted interview with Resident #2's previous

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PCP's office on 03/23/23 at 3:56pm was unsuccessful.

2. Review of Resident #5's current FL2 dated 05/24/22 revealed:
-Diagnoses included inguinal hernia, hypertension, diabetes, stroke, and schizoaffective disorder bipolar type.
-There was an order for omeprazole (a medication used to treat acid reflux) 40mg take 1 capsule twice daily.

Review of Resident #5's physician order dated 12/27/22 revealed an order for pantoprazole (a medication used to treat acid reflux) 40mg daily.

Review of Resident #5's physician order dated 02/07/23 revealed an order to discontinue omeprazole because Resident #5 was also on pantoprazole.

Review of Resident #5's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for omeprazole 40mg, take 1 capsule twice daily scheduled at 8:00am and 8:00pm.
-There was documentation omeprazole 40mg was administered twice daily from 02/01/23 through 02/28/23; there was no documentation of the discontinue order dated 02/07/23 on the eMAR.
-There was an entry for pantoprazole 40mg daily scheduled at 8:00am.
-There was documentation pantoprazole was administered daily from 02/01/23 through 02/28/23.

Review of Resident #5's March 2023 eMAR from 03/01/23 through 03/22/23 revealed:

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-There was an entry for omeprazole 40mg, take 1 capsule twice daily scheduled at 6:00am and 6:00pm.
-There was documentation omeprazole 40mg was administered twice daily from 03/01/23 through 03/22/23.
-There was an entry for pantoprazole 40mg daily scheduled at 6:00am.
-There was documentation pantoprazole was administered daily from 03/01/23 through 03/22/23.

Observation of medication on hand for Resident #5 on 03/23/23 at 9:20am revealed:
-There was one medication card for omeprazole 40mg with a dispensed date of 03/17/23.
-There were 18 out of 29 total dispensed omeprazole capsules in that medication card remaining.
-There was one medication card for pantoprazole 40mg with a dispensed date of 03/17/23.
-There were 23 out of 29 total dispensed pantoprazole capsules in the medication card remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 03/23/23 at 10:25am revealed:
-Resident #4 had current orders on file at the pharmacy for omeprazole 40mg, take 1 capsule twice daily, and pantoprazole 40mg take 1 capsule daily.
-They had not received an order at the pharmacy from 02/07/23 to discontinue omeprazole.
-Omeprazole was part of Resident #5's cycle-fill medications and had been dispensed 03/17/23 for a one-month supply.

Interview with Resident #5 on 03/23/23 at 11:47am revealed:

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-He had symptoms of acid reflux.
-He was not familiar with which medications he was taking for acid reflux or if any of his orders had recently changed.

Interview with a medication aide (MA) on 03/23/23 at 3:50pm revealed:
-Resident #5 was receiving omeprazole 40mg twice daily as ordered.
-She was not aware of an order to discontinue omeprazole for Resident #5.
-When medication orders changed, it was usually the Resident Care Coordinator (RCC) who was responsible for ensuring the pharmacy received the order change and it was reflected on the resident's eMAR.

Interview with the RCC on 03/23/23 at 5:00pm revealed:
-When the primary care provider (PCP) wrote an order to discontinue a resident's medication, the order was sent into their fax system where she, the Health and Wellness Coordinator (HWC) and the operations manager had access to it.
-The PCP also faxed new medication orders directly to the pharmacy.
-The pharmacy changed medication orders in their eMAR system, and she and the HWC were responsible for monitoring the eMAR to approve the medication order change on their end.
-She was not aware that Resident #5's order for omeprazole was discontinued or that Resident #5 was still receiving omeprazole.
-The order to discontinue Resident #5's omeprazole must have been overlooked.
-The medication cart audits only compared the medications on the cart to the medications listed on the eMAR.
-She was not aware of any staff being responsible for completing audits of the resident records to

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D 358	Continued From page 37 ensure all medication orders were processed and residents were receiving their medications as ordered. Interview with the HWC on 03/23/23 at 5:50pm revealed: -New medication orders were faxed from the PCP to both the facility and the pharmacy. -Once the pharmacy changed the medication order on their end, they added it to the dashboard on the eMAR so the facility could review the order change for accuracy and approve it. -The pharmacy might not have received the order for Resident #5's omeprazole to be discontinued on 02/07/23 since they continued to dispense the medication. -The facility did have an order tracking log where the RCC wrote down any medication order changes so she could follow up with them and ensure the order changes were reflected on the eMAR for the MAs. -The RCC reviewed the order tracking log weekly. -The order to discontinue Resident #5's omeprazole was overlooked. Interview with the Administrator on 03/23/23 at 6:30pm revealed: -She was not aware of Resident #5's omeprazole order not being discontinued as ordered. -It was the responsibility of the RCC to review all medication order changes and follow up with the pharmacy if the order was not discontinued. Attempted telephone interviews with Resident #5's PCP on 03/23/23 at 11:30am and 4:50pm were unsuccessful.	D 358		
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10A NCAC 13F .1010 Pharmaceutical Services
(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include the following provisions:
(1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;
(2) written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include:
(A) the name and strength of the medication;
(B) the directions for administration as prescribed by the resident's physician; and
(C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;
(3) the resident's medication shall be provided in a capped or closed container that will protect the

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medications from contamination and spillage; and
(4) labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.
The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews, the facility failed to ensure the provision of medication for 1 of 5 sampled residents (#3) who went on temporary leave from the facility for three weeks without his medications.

The findings are:

Review of the facility's Medication Administration policy for Medications Leaving the Facility revealed:
-When more than one dosage of medication was required for temporary leave of a resident, the medications would be released in the original containers and the directions for use would be

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provided to the resident or responsible party.
-Documentation by qualified staff would be provided for all medications leaving and returning to the facility.
-Documentation would be kept in the facility, readily available, and would include the medication name, quantity released, and quantity returned.

Review of Resident #3's current FL2 dated 01/03/23 revealed:
-Diagnoses included major neurocognitive disorder, possible front temporal degeneration, schizoaffective disorder depressive type, and anxiety disorder.
-He was intermittently disoriented.
-He had medication orders as follows:
-Amlopidine (used to treat high blood pressure) 5mg daily.
-Benztropine (used to treat tremors) 1mg every night at bedtime.
-Fluoxetine (used to treat depression) 20mg every night at bedtime.
-Haloperidol (used to treat mental/mood disorders) 10mg every night at bedtime.
-Montelukast (used to treat asthma) 10mg every night at bedtime.
-Pantoprazole (used to treat acid reflux) 40mg twice daily.
-Simvastatin (used to treat high cholesterol levels) 20mg every night at bedtime.
-Tamsulosin (used to treat urinary retention) 0.4mg every night at bedtime.
-Valsartain (used to treat high blood pressure) 160mg daily.

Review of Resident #3's physician's order dated 01/06/23 revealed an order for olanzapine (used to treat mental/mood conditions) 5mg daily.

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Review of Resident #3's physician's order dated 01/31/23 revealed an order for a Vitamin D supplement (used to treat low Vitamin D levels) 2000 units daily.

Review of Resident #3's Resident Register dated 11/30/22 revealed:
-Resident #3 was admitted to the facility on 11/30/22.
-He was his own responsible party and did not have a Power of Attorney (POA), a Guardian, or any family contact information listed.

Review of Resident #3's Care Plan dated 11/30/22 revealed:
-Resident #3 was receiving medications for mental illness and was receiving mental health treatment services.
-He was sometimes disoriented, his memory was forgetful, and he needed reminders.

Review of Resident #3's February 2023 electronic medication administration record (eMAR) revealed:
-There were no medication refusals documented.
-There was documentation that Resident #3 was out of the facility from 02/09/23 through 02/28/23.

Review of Resident #3's progress note dated 02/09/23 revealed:
-At 9:09am, the Health and Wellness Coordinator (HWC) documented that Resident #3 left the facility that day to go to another state due to an illness in the family and would be gone for three weeks.
-She asked Resident #2 if he already had his medications and he stated yes.

Review of Resident #3's progress note dated 02/21/23 revealed:

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-At 2:15pm, the HWC documented that Resident #3's step-parent called the facility upset because Resident #3 had told her he was going to another state to visit and planned to leave on 02/20/23, but he arrived with no clothes or medications.
-Resident #3 had told the facility on 02/03/23 that his family member was dying in another state and his family friend was arranging transportation for him to go to the other state.
-Resident #3 was picked up from the facility by a taxi on 02/09/23.
-The HWC had asked Resident #3 if he had everything he needed and if he got his medications from the medication aide (MA) and he had told her yes.
-The HWC later learned that Resident #3 had not taken his medications with him.
-Resident #3's step-parent told her that Resident #3 was acting out and refusing to leave her house and she did not know how Resident #3 was going to get back to the facility unless he willingly got on a plane.
-Resident #3's step-parent had contacted law enforcement to help with her situation with Resident #3.
-The HWC advised Resident #3's step-parent to ask law enforcement to do an involuntary commitment (IVC) for Resident #3 since he had been without his medications since leaving the facility on 02/09/23.
-Resident #3's step-parent said she would do what the HWC suggested, and would have law enforcement or the hospital contact the facility if they had any questions.

Review of Resident #3's progress note dated 02/23/23 revealed at 3:17pm, the Resident Care Coordinator (RCC) documented that Resident #3's step-parent contacted her to let her know Resident #3 would be getting on a flight from the

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other state on 02/28/23 and would take a taxi from the airport to the facility.

Review of Resident #3's progress notes from 02/23/23 through 03/02/23 revealed:
-On 02/23/23 at 9:27pm, a MA documented that Resident #3 was at a hospital in another state and she faxed his eMAR to them upon their request.
-On 02/28/23 at 3:20pm, the RCC documented that the facility had not received any updates on Resident #3 yet that day.
-On 02/28/23 at 10:03pm, a MA documented that Resident #3 returned to the facility around 8:30pm, gave his medications to the MA and went to this room; he told her he was fine, just tired.
-On 03/02/23 at 9:43pm, a MA documented that since returning to the facility Resident #3 did not seem "mentally the same as before" leaving for the other state; he was more quiet and seemed more confused.

Review of Resident #3's psychiatry progress note dated 02/28/23 revealed:
-Resident #3 was taking fluoxetine to treat schizophrenia.
-Resident #3 was taking haloperidol to treat anxiety.
-Resident #3 was taking benztropine to treat neurocognitive disorder.
-There was no documentation that the provider assessed Resident #3.
-There was no documentation that the provider was aware of Resident #3 missing doses of his medication while out of the facility.
-There were no medication changes or new orders.

Interview with Resident #3 on 02/23/23 at 10:00am revealed:

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D 411	Continued From page 44 -He went to another state to visit his family member and try to help his step-parent with his family member's care. -The facility knew he was leaving to go to another state a couple of weeks in advance, but nobody knew when he would be returning to the facility because he had not known when he would return either. -He had a general idea about what medications he was prescribed and how to take them. -Prior to his leave of absence from the facility, nobody at the facility had provided education on his medications or when to take them. -Prior to leaving the facility, the RCC had him sign some papers but he did not know what he was signing or if they were related to his medications. -As he was leaving the facility to get in the taxi that was picking him up, one of the MAs asked him if he had his medications for his trip and he told her yes because he thought that he had them in his bag already. -He realized once he had left the facility that he did not have his medications for his trip. -He thought he went without taking any of his medications for about a week. -He did not experience any symptoms, side effects, or feel differently without taking his medication. -His step-parent had called the police on him because they got in a fight over him wanting to stay at her house and not having his medications. -He had not stayed overnight at a hospital or any other facility during his leave of absence. -The police had suggested his step-parent call the facility to have his prescriptions sent to a local pharmacy so she did. -His step-parent drove him to the local pharmacy and they gave him all of the same medications he had been taking at the facility. -The local pharmacy dispensed a week's supply	D 411		

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of his medications to him and he did not remember having any of the medications left with him upon his return to the facility.
-Once he picked up his prescriptions from the local pharmacy, he took them as ordered without help from his step-parent.
-He did not think that his PCP knew he had gone without his medications because she had not mentioned it to him when she saw him for his routine visit after his return to the facility.
-He did not know if his mental health provider (MHP) knew that he had missed doses of his medication while he was out on leave from the facility.

Telephone interview with a representative from the facility's contracted pharmacy on 03/23/23 at 10:10am revealed:
-Resident #3's medications were all on a cycle fill system.
-All of his medications had been dispensed on 02/10/23 for a 28-day supply, and on 03/10/23 for a 29-day supply.
-They had not forwarded his prescriptions to another pharmacy.

Interview with the RCC on 03/23/23 at 11:03am revealed:
-The facility knew two to three weeks in advance that Resident #3 would be leaving the facility for two weeks to go out of state to visit family.
-The process for a resident going on a leave of absence from the facility was to pull all their medication cards from the medication cart and put them in a bag along with a release of medications form and a current eMAR.
-Resident #3 had told the HWC that he had everything he needed for his trip including his medications.
-Resident #3 did not take his medications with

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him when he left the facility for his trip, so they put his medication cards back in the medication cart and threw away his release of medication form and eMAR.
-She thought the resident had been taken to the hospital for an IVC while he was out of state, but she did not have any paperwork from the hospital.
-The MA who prepared the resident's medications for his leave of absence was the person responsible for providing the resident or their responsible party with education regarding how and when to take each medication.
-The night shift MA had prepared Resident #3's medications for his leave of absence because he left the facility around 8:00am.
-Since Resident #3 left without taking his medications from the MA, he had not received education on how to take his medications.
-They had noticed before the taxi left the facility's parking lot that Resident #3 had forgotten his medications, but they did not have a way to contact Resident #3 and did not have contact information for his family in the other state so there was nothing they could do.
-Resident #3's step-parent called the facility after he had been there for two weeks to report that Resident #3 did not have any medication with him and that she did not know what to do with him.
-The HWC told Resident #3's step-parent to call law enforcement or have him involuntarily committed at the hospital.
-She was told that Resident #3 went to the hospital voluntarily and might have stayed there overnight.
-She had faxed Resident #3's eMAR and face sheet to the hospital so they knew which medications he had been taking at the facility.
-Resident #3's step-parent reported that he was getting agitated with her because of some

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complex family history they had, but did not feel the argument was because he missed his medications because they had the same argument in the past.
-Resident #3 returned to the facility with a bottle of pantoprazole so they disposed of the medication in the pill destructor bottle in the medication room; there was no documentation about the medication disposal or quantity of medication disposed.

Telephone interview with Resident #3's MHP on 03/23/23 at 11:50am revealed:
-When a resident left the facility for any length of time, the facility was expected to ensure the resident had enough medication for their time of leave.
-He was aware that Resident #3 had left the facility for three weeks, but did not know that he had went without taking his medications for about two of those weeks.
-He did not think Resident #3 was competent enough to be responsible for taking all of his medications as ordered.
-He thought that he had seen Resident #3 in person on 02/28/23 but it was his first time meeting him so he was unfamiliar with how Resident #3 was at baseline or his mannerisms.
-Resident #3 was taking olanzapine to treat schizophrenia and olanzapine was not a medication that a resident should stop taking abruptly.
-Possible side effects from stopping fluoxetine and olanzapine abruptly included withdrawal symptoms such as increased depression or thoughts of suicidal ideation.
-Resident #3 was taking haloperidol for anxiety, and possible side effects from stopping haloperidol abruptly included withdrawals, agitation, defiance, and verbal or physical

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aggression.
-Resident #3 was taking benztropine for neurocognitive disorder to help with tremors and dyskinesia, and possible side effects for stopping benztropine abruptly included an increase in tremors or involuntary muscle movements.

Telephone interview with Resident #3's step-parent on 03/23/23 at 12:00pm revealed:
-After Resident #3 had been staying at her house for two weeks, she noticed she had not seen him take any of his medications.
-When she asked Resident #3 about where his medications were, he told her that he did not need them.
-She and Resident #3 had gotten into a fight because Resident #3 wanted to move in with her and his family member, but she could not take care of both Resident #3 and her spouse so she told him no.
-She contacted law enforcement to help because she did not know how she would get Resident #3 out of her house and back to the facility.
-Resident #3 had not been taking any of his medications so she was concerned about him.
-The police came to her house and she asked for them to initiate an IVC for Resident #3 at the hospital, but the police told her that he did not meet the criteria because he did not have concerning behavior and was not experiencing any symptoms.
-She took Resident #3 to the hospital anyway and after they assessed him, told her that since Resident #3 did not have signs or symptoms of withdrawals they could not IVC him.
-She had asked the hospital staff to call the facility and request Resident #3's medication list so that he could restart his medications and they agreed to doing that.
-The doctor at the hospital sent a short supply of

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all of Resident #3's medications to the local pharmacy.
-She drove Resident #3 to pick up his medications from the pharmacy.
-The facility did not have any of her contact information prior to Resident #3's trip to visit.
-She had not noticed Resident #3 experiencing any side effects or symptoms from missing doses of his medications.

Interview with the HWC on 03/23/23 at 1:00pm revealed:
-She was aware of Resident #3's planned leave of absence from the facility for about a week before he left.
-The third shift MA prepared the medication release form and all of Resident #3's medications the morning he left the facility.
-Resident #3 was leaving the facility to get in the taxi as she arrived for work that morning on 02/09/23 around 7:45am.
-She asked Resident #3 if he had his medications and everything he needed for his trip and he told her he did.
-She thought the third shift MA had given Resident #3 his medications.
-After Resident #3 left, she noticed his medications were still in the medication room.
-There was nothing she could do to get Resident #3 his medications once he had left because they had no way to contact him or his family.
-She threw away his medication release form and eMAR and put his mediation cards back in the medication cart.
-She knew Resident #3 was going to another state to visit family, but had not requested any contact information because Resident #3 was his own responsible person and had the right to leave if he wanted to.
-Resident #3's step-parent called the facility to let

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them know that he arrived in the other state without his medications.
-She had advised Resident #3's step-parent to contact the police and have Resident #3 placed under an IVC since he had been without his medications for a couple weeks.
-Resident #3 ended up at the hospital and they faxed his eMAR to the hospital so they could restart his medications.
-She thought Resident #3 had stayed a couple of nights at the hospital because he was aggressive towards his step-parent.
-The hospital sent prescriptions for all Resident #3's medications to the local pharmacy.
-Resident #3's step-parent called the facility back a couple of days later to let them know he would be back at the facility on 02/28/23.
-She was not aware of Resident #3 returning to the facility with any medications or any documentation of which prescriptions he arrived back at the facility with and what quantities.
-She had contacted Resident #3's MHP to let him know that Resident #3 had been out of the facility on leave without taking his medications and had not received any new orders from him.
-There was no documentation of her conversation with Resident #3's MHP because it was a verbal conversation so she could not remember which day the conversation took place.
-She had not noticed Resident #3 acting any differently upon his return to the facility and felt his demeanor was at his baseline.

Interview with a MA on 03/23/23 at 3:50pm revealed:
-She had worked day shift on 02/09/23 when Resident #3 left the facility for his leave of absence.
-She was doing a medication pass when Resident #3 left the facility somewhere between

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8:00am and 9:00am.
-Resident #3 had told the HWC that the third shift MA had given him his medications for his time of leave, and he told the third shift MA that the day shift MA was going to prepare his medications.
-Resident #3's medications were on the medication cart when she started her medication pass on 02/09/23.
-Resident #3 was competent enough to know to take his medications so she did not know why he said that he had them when he did not.
-Whenever a resident left the facility on a leave of absence, the MA was responsible for preparing a medication release form and having the resident sign it right before they walk out of the facility so that the medication counts were accurate.
-The staff were aware of which day Resident #3 was leaving, but she did not think he ever told them what time his taxi was picking him up.
-She was not the MA who prepared Resident #3's medications and medication release form because he told her he already had them.
-She was not working on the day that Resident #3 returned to the facility.
-She had documented the progress note about Resident #3 being more confused since his return to the facility.
-Since his return to the facility, Resident #3 had been talking to himself and entering into the delusions that his roommate had.
-She had reported her concerns about Resident #3 to his MHP on 02/28/23 when he was at the facility, but it was a verbal conversation so there was no documentation.
-The MHP had told her that he would go and assess Resident #3, but she had not received any new orders or instructions from him.

Interview with the Administrator on 03/23/23 at 6:30pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: ______ B. WING ______	R 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(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 411	Continued From page 52	D 411		

-She was aware of Resident #3's leave of absence from the facility without his medications.
-The MAs were expected to prepare Resident #3's medications prior to his leaving the facility on furlough.
-The medications needed to be counted upon the resident leaving the facility and upon return to ensure the medications were taken correctly.
-She was not sure if Resident #3 returned with any medications.
-Resident #3 had his normal demeanor since returning to the facility, she had not noticed any behavioral changes from him.
-She knew that Resident #3's MHP was aware of his leave of absence without having his medications, but was unsure if his PCP was aware.
-She was not aware of any new order received for Resident #3 based on his missed doses of medications.

Attempted telephone interview with the MA who was working night shift 02/09/23 when Resident #3 was leaving the facility and on 02/28/23 when resident returned to the facility on 03/23/23 at 4:35pm was unsuccessful.

Attempted telephone interviews with Resident #3's PCP on 03/23/23 at 11:30am and 4:50pm were unsuccessful.

____

The facility failed to ensure the provision of medications for Resident #3 who left the facility on a leave of absence for three weeks and did not receive any of his medications from 02/09/23 to 02/23/23 resulting in the resident being taken to a hospital on 02/23/23 for behaviors, which could have resulted in withdrawals, suicidal ideation, muscle tremors, agitation or physical aggression. This failure was detrimental to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: ______ B. WING ______	R 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(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 411	Continued From page 53 health, safety, and welfare of the resident which constitutes a Type B Violation. ________________ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on March 23, 2023 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 07, 2023.	D 411		