STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008042	A. BUILDING: _____ B. WING _____	R 04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted a follow-up survey April 4, 2023 to April 5, 2023.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 3 sampled residents (#1, #3) related to failing to ensure scheduling of a podiatry appointment (#1) and failing to inform a primary care provider (PCP) of a change in condition (#3) The findings are: 1. Review of Resident #1's current FL-2 dated 02/16/23 revealed: -Diagnoses included diabetes, lower left leg amputee, hypertension, and peripheral vascular disease. -The resident was constantly disoriented. Review of Resident #1's care plan dated 11/09/22 revealed he required extensive assistance with bathing, dressing, toileting, and grooming. Review of Resident #1's physician visit note dated 03/15/23 revealed there was an order for a podiatry referral for toenail dystrophy (toenail dystrophy mean deformed, thickened, or discolored nails).	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 1 Review of Resident #1's record revealed there was no documentation Resident #1 was seen by a podiatrist. Telephone interview with the facility's contracted podiatrist on 04/05/23 at 9:39am revealed: -Resident #1 was last seen by the podiatrist in October 2021. -The resident did not have any upcoming appointments scheduled. Observation of Resident #1 on 04/05/23 at 3:04pm revealed: -The resident was sitting in his wheelchair on the front porch. -A personal care aide (PCA) removed his sock, and the Administrator observed his right foot. -Some of his toenails were overgrown. -The right big toenail was 3/4 inch long extended from his toe, the toenail had jagged edges, was thick and yellow. -The second toenail on his right foot was ½ inch long extended from his toe with jagged edges. -The fourth toenail on his right foot was ¾ inch long extended from his toe, the toenail pressed against the right side of his third toe, and the toenail was yellow and thick. -The fifth toenail on his right foot was ¾ inch long extended from his toe and yellow. Interview with Resident #1 on 04/05/23 at 3:06pm revealed: -He had not had his toenails cut in several months. -He did not have pain in his right foot and had not asked anyone to cut his toenails. -The PCAs bathed him three times a week. Interview with a PCA on 04/05/23 at 3:10pm revealed:	{D 273}		

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{D 273}	Continued From page 2 -Resident #1 was bathed three times a week. -She had not informed the medication aide (MA) or Resident Care Coordinator (RCC) that the resident's toenails were long. -She should have reported that his toenails were too long to the MA or RCC. Telephone interview with a practice support specialist at the facility's contracted primary care provider (PCP) agency on 04/05/23 at 11:17am revealed: -When a PCP wrote a visit note on a resident it was reviewed by a practice support specialist at the agency. -If the PCP visit note had orders for a referral to a specialty provider, the orders would be sent to the outside referral department at the agency. -The outside referral department would contact a local specialty provider and initiate the referral for the resident. -The local specialty provider would then contact the facility to schedule an appointment for the resident. -She was not sure if there was a time-frame in which the facility should contact the contracted agency if they had not heard from a specialty provider for a resident. Telephone interview with the RCC on 04/05/23 at 4:08pm revealed: -She was no longer employed at the facility as of 04/04/23. -She had not noticed that the PCP had requested Resident #1 be seen by a podiatrist. -Resident #1 had diabetes and his toenails should have been trimmed by a podiatrist. -She was not aware that the resident's toenails were long, jagged, and yellow. -The company the facility's PCP worked with usually made referrals for residents.	{D 273}		

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{D 273}	Continued From page 3	{D 273}		

-She had not followed up with the facility's contracted PCP referral department to ensure they had scheduled a podiatrist appointment for the resident.

Interview with the Administrator on 04/05/23 at 4:40pm revealed:
-Her first day at the facility was 03/27/23.
-The RCC should have followed up with the facility's contracted PCP referral department to ensure Resident #1's podiatry referral had been scheduled.
-The facility was responsible for ensuring the resident's podiatry appointment was made; whether through the facility's contracted PCP referral department or the RCC following up to ensure the podiatry appointment had been scheduled.
-Resident #1 was diabetic and should be seen by a podiatrist for footcare to prevent further complications from his diabetes.

Telephone interview with Resident #1's primary care provider (PCP) on 04/05/23 at 12:05pm revealed:
-Resident #1 had diabetes and should be seen by a podiatrist to ensure proper care of his foot.
-The facility should have contacted her to let her know the facility's contracted PCP referral department had not made a referral for the resident.
-Resident #1 had an amputation above the left leg and it was important that the resident receive proper foot care because his right foot had decreased sensitivity which placed him at an increased risk of wounds.

2. Review of Resident #3's current FL-2 dated 2/10/23 revealed:
-Diagnosis included chronic kidney disease Stage

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{D 273}	Continued From page 4 3, chronic atrial fibrillation (irregular heartbeat), and hypertension. -The resident was constantly disoriented. Observation of Resident #3 on 03/21/23 at 09:00am revealed: -Resident #3 was sitting at the table by the front entrance door. -Resident #3 was staring out the window. -Resident #3 did not respond when spoken to. Interview with personal care aide (PCA) on 04/04/23 at 8:45am revealed: -On 03/21/23, Resident #3 did not go to his room to lie down after breakfast. -Resident #3 always went to his room to lie down after breakfast. -On 03/21/23 Resident #3 sat at the table after breakfast staring out the window. -Resident #3 did not respond when asked a question. -Resident #3 did not interact with his family member at breakfast. -The PCA reported Resident #3's current behaviors to the Resident Care Coordinator (RCC) on the morning of 03/21/23. Review of the Emergency Medical Services (EMS) incident report dated 03/21/23 revealed: -There was a call received on 03/21/23 at 9:21pm from a local assisted living facility. -EMS arrived at the facility at 9:50pm. -Resident #3, who was sitting in the wheel chair, stated, "I do not feel right." -A staff reported to EMS that Resident #3 started a new medication and was feeling weird. -EMS assisted Resident #3 to the stretcher. -Resident #3 was strapped and secured to the stretcher. -EMS checked Resident #3's vitals.	{D 273}		

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{D 273}	Continued From page 5 -Resident #3 was moved to the EMS unit and transported to a nearby hospital. Review of Resident #3's hospital record dated 03/23/23 revealed the resident was admitted to the hospital with diagnoses of atrial fibrillation (abnormal heart rhythm) with bradycardia (low heart rate) and heart failure. Review of Resident #3's record on 04/04/23 revealed the resident remained in the hospital. Interview with the Administrator on 04/05/23 at 4:46pm revealed she expected the facility's staff to contact the facility's primary care provider (PCP) immediately when a change was noticed in a resident's current behaviors or symptoms. Interview with Resident #3's PCP on 03/05/23 at 12:06pm revealed: -She expected the facility to contact her or the on-call provider immediately when staff noticed a change in a resident's routine or behavior. -She decided on the follow-up treatment that the facility would arrange for the residents. -If she had been contacted about Resident #3's change in behavior the morning of 03/21/23 she might have arranged to do a telehealth visit to assess the resident and send the resident to the hospital for further evaluation if needed. Based on observations, interviews, and record reviews it was determined that Resident #3 was not interviewable. 2. Review of Resident #3's current FL-2 dated 2/10/23 revealed: -Diagnosis included chronic kidney disease Stage	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 6 3, chronic atrial fibrillation (irregular heartbeat), and hypertension. -The resident was constantly disoriented. Observation of Resident #3 on 03/21/23 at 09:00am revealed: -Resident #3 was sitting at the table by the front entrance door. -Resident #3 was staring out the window. -Resident #3 was not responding when spoken to. Interview with personal care aide (PCA) on 04/04/23 at 8:45am revealed: -On 03/21/23, Resident #3 did not go to his room to lie down after breakfast. -Resident #3 always went to his room to lie down after breakfast. -On 03/21/23 Resident #3 sat at the table after breakfast staring out the window. -Resident #3 did not respond when asked a question. -Resident #3 did not interact with his wife at breakfast. -The PCA reported Resident #3's current behaviors to the Resident Care Coordinator (RCC) on the morning of 03/21/23. Review of the Emergency Medical Services (EMS) incident report dated 03/21/23 revealed: -There was a call received on 03/21/23 at 9:21pm from a local assisted living facility. -EMS arrived at the facility at 9:50pm. -Resident #3, who was sitting in the wheel chair, stated, "I do not feel right." -A staff reported to EMS that Resident #3 started a new medication and was feeling weird. -EMS assisted Resident #3 to the stretcher. -Resident #3 was strapped and secured to the stretcher.	{D 273}		

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{D 273}	Continued From page 7 -EMS checked Resident #3's vitals. -Resident #3 was moved to the EMS unit and transported to a nearby hospital. Review of Resident #3's hospital record dated 03/23/23 revealed the resident was admitted to the hospital with diagnoses of atrial fib with bradycardia (low heart rate) and heart failure. Review of Resident #3's record on 04/04/23 revealed the resident remained in the hospital. Interview with the Administrator on 04/05/23 at 4:46pm revealed she expected the facility's staff to contact the facility's primary care provider (PCP) immediately when a change was noticed in a resident's current behaviors or symptoms. Interview with Resident #3's PCP on 03/05/23 at 12:06pm revealed: -She expected the facility to contact her or the on-call provider immediately when staff noticed a change in a resident's routine or behavior. -She decided on the follow-up treatment that the facility would arrange for the residents. -If she had been contacted about Resident #3's change in behavior the morning of 03/21/23 she might have arranged to do a telehealth visit to assess the resident and send the resident to the hospital for further evaluation if needed. Based on observations, interviews, and record reviews it was determined that Resident #3 was not interviewable.	{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	D 276		

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following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure implementation of orders for 3 of 3 sampled residents (#1, #2, #3) related to dressing changes (#2), and blood pressure checks (#1, #2, #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 02/16/23 revealed:
-Diagnoses included diabetes, lower left leg amputee, hypertension, and peripheral vascular disease.
-The resident was constantly disoriented.

Review of Resident #1's current FL-2 dated 02/16/23 revealed there was an order for monthly blood pressure (BP) checks.

Review of Resident #1's February 2023 electronic medication administration record (eMAR) revealed there was no entry for BP checks.

Review of Resident #1's March 2023 eMAR revealed there was no entry for BP checks.

Review of Resident #1's April 2023 eMAR revealed there was no entry for BP checks.

Interview with Resident #1 on 04/05/23 at 3:04pm revealed a medication aide (MA) checked his BP

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but he did not know how often.

Refer to interview with medication aide (MA) on 04/05/23 at 2:10pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:08pm.

Refer to interview with the Administrator on 04/05/23 at 4:40pm.

Refer to telephone interview with the facility's contract primary care provider (PCP) on 04/05/23 at 12:05pm.

2. Review of Resident #2's current FL-2 dated 02/16/23 revealed:
-Diagnoses included diabetes, psychosis, and depression.
-The resident was constantly disoriented.

a. Review of Resident #2's history and physical note dated 02/10/23 revealed the resident was being seen at a wound clinic for a stage II wound to his right foot and an unstageable wound to his left 4th toe (Wounds are staged from I to IV. A stage II pressure wound is a shallow open ulcer with a pink wound bed. A wound is unstageable when the wound bed cannot be visualized due to a layer of tissue over the wound).

Review of Resident #2's physician visit note dated 03/09/23 revealed there was an order for dry dressing to right 3rd toe after cleaning with soap and water daily, no tub soaks.

Review of Resident #2's March 2023 electronic medication administration record (eMAR) revealed there was no entry for dry dressings to right 3rd toe daily.

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D 276	Continued From page 10 Review of Resident #2's physician visit note dated 03/30/23 revealed the resident was released from the wound clinic. Telephone interview with Resident #2's specialty provider on 04/05/23 at 9:30am revealed the wound to the resident's toe was healed at his visit on 03/30/23. Interview with a medication aide (MA) on 04/05/23 at 2:10pm revealed: -MAs knew to perform dressing changes on residents because it would be on the eMAR. -Dressing changes for residents were documented on the eMAR. -She did not recall ever performing a dry dressing change on Resident #2's toe. Telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:08pm revealed: -She was no longer employed at the facility as of 04/04/23. -Medication aides knew to change dressings for residents because it was on the eMAR. -Dressing change orders were faxed to the facility's contracted pharmacy and the pharmacy would put the orders on the eMAR. -A MA, the RCC, or the Administrator could send new orders to the pharmacy. -Resident #2 was being seen at a wound clinic for dressing changes on his feet. -She did not recall seeing an order for Resident #2 to receive dry dressing changes daily to his toe. Interview with the Administrator on 04/05/23 at 4:40pm revealed: -Her first day at the facility was 03/27/23.	D 276		

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-She found Resident #2's physician order sheet from 03/09/23 in a transportation folder on 04/04/23.
-All physician visit sheets were placed in the transportation folder after residents had been to outside provider appointments.
-She thought Resident #2's physician order sheet from 03/09/23 got missed since it was still in the transportation folder and not in the resident's chart.
-Resident #2's physician order sheet should have been faxed to the pharmacy by the RCC so the pharmacy could put the order for the dressing changes on the eMAR.

Telephone interview with Resident #2's primary care provider (PCP) on 04/05/23 at 12:05pm revealed Resident #2 had diabetes and it was important that dressing changes be performed to his feet as ordered because the wounds could worsen and cause complications such as infection.

Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable.

b. Review of Resident #2's history and physical dated 02/10/23 revealed there was an order for monitor blood pressure (BP) once monthly.

Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed there was no entry for monthly BP checks.

Review of Resident #2's March 2023 eMAR revealed there was no entry for monthly BP checks.

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Review of Resident #2's April 2023 eMAR revealed there was no entry for monthly BP checks.

Review of Resident #2's record revealed there was no documentation of monthly BP checks.

Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable.

Refer to interview with medication aide (MA) on 04/05/23 at 2:10pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:08pm.

Refer to interview with the Administrator on 04/05/23 at 4:40pm.

Refer to telephone interview with the facility's contract primary care provider (PCP) on 04/05/23 at 12:05pm.

3. Review of Resident #3's current FL-2 dated 2/10/23 revealed:
-Diagnosis included chronic kidney disease Stage 3, chronic atrial fibrillation (irregular heartbeat), and hypertension.
-The resident was constantly disoriented.
-There was an order for monthly blood pressure (BP) checks.

Review of Resident #3's February 2023 electronic medication administration record (eMAR) revealed there was no entry for BP checks.

Review of Resident #3's March 2023 eMAR revealed there was no entry for BP checks.

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Review of Resident #3's record on 04/04/23 revealed the resident was sent to the Emergency Department (ED) on 03/21/23 and the resident remained in the hospital.

Telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:09pm revealed:
-The medication aides (MA) were responsible for checking the resident's eMAR to ensure accuracy.
-The MAs were responsible for informing the RCC of any inaccurate eMARs.
-The RCC could have contacted the pharmacy to notify them that Resident #3's monthly BP checks were not on the eMAR.

Based on observations, interviews, and record reviews it was determined that Resident #3 was not interviewable.

Refer to interview with medication aide (MA) on 04/05/23 at 2:10pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:08pm.

Refer to interview with the Administrator on 04/05/23 at 4:40pm.

Refer to telephone interview with the facility's contract primary care provider (PCP) on 04/05/23 at 12:05pm.

_____

Interview with a medication aide (MA) on 04/05/23 at 2:10pm revealed:
-BP checks were performed by MAs.
-MAs knew to perform BP checks on a resident because it came up on the eMAR to check their BP.

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D 276	Continued From page 14 -Resident's BPs were recorded on the eMAR. Telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:08pm revealed: -She no longer worked for the facility as of 04/04/23. -Resident's BP orders should be on their eMAR. -Orders were faxed to the facility's contracted pharmacy by a MA, the RCC, or the Administrator and the pharmacy placed the orders on the eMAR. -A MA would know to check the resident's BP when they saw it come up on the eMAR. -BP results were documented on the resident's eMAR. Interview with the Administrator on 04/05/23 at 4:40pm revealed: -BP check should come up on the eMAR. -BP checks were performed by MAs and recorded on the resident's eMAR. Telephone interview with the facility's contracted primary care provider (PCP) on 04/05/23 at 12:05pm revealed it was important to check resident's BPs monthly as ordered to monitor the resident's health status.	D 276		
{D 283}	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.	{D 283}		

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{D 283}	Continued From page 15 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to expired food that was molded, improper storage of food items in the freezer, and the freezer not working properly. The findings are: Observation of a local health department food establishment inspection report of the kitchen, pantry and freezer on 04/05/23 at 9:45am revealed: -The facility received a score of 93.5. -There were no hand towels at the hand sink in the kitchen at the time of inspection. -The hand sink in the kitchen was blocked by a chair and a fan. -Raw beef was stored above a container of juice and ready to eat items inside of a refrigerator door. -Pasta noodles, green beans, and collards in the refrigerator were stored at 44 degrees Fahrenheit (F) to 45 degrees F; all cold food should be kept at 41 degrees F. Observation of the freezer in the kitchen pantry on 04/04/23 at 8:55am revealed: -There were two areas of water on the floor in front of the freezer door. -There was not a thermometer in the freezer. -The freezer was not cold and there was a thin layer of water on the bottom shelf of the freezer. -The top shelf of the freezer had a 32 ounce	{D 283}		

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{D 283}	Continued From page 16	{D 283}		

styrofoam cup without a lid with ¼ inch of liquid in the cup.
-There was a large cardboard box of bacon in a plastic bag that was opened and the bacon was not frozen.
-There was a sealed package of hamburger patties that were soft and not frozen on the shelf to the right of the box of bacon.
-There was a package of french fries in a clear plastic bag with a knot tied at the top sitting on top of the sealed package of hamburger patties.
-The second shelf of the freezer had a 10 pound tube of ground beef that was soft and not frozen.
-The 10 pound tube of ground beef was stamped with a use/freeze by date of 04/05/23; keep refrigerated between 28 degrees Fahrenheit (F) to 34 degrees F and may be frozen.
-There was a clear plastic bag that was not sealed that contained 8 fried chicken patties beside the tube of ground beef.
-There was a cardboard box of waffles in a plastic bag that was opened on the shelf beside the tube of ground beef.
-The third shelf of the freezer had 3 sealed packages of hashbrowns and 6 unopened packages of vegetables.

Observation of the kitchen pantry on 04/04/23 at 9:10am revealed:
-There were two 40 pound cases of oranges.
-There was a strong, sour smell coming from the two cases of oranges.
-The two cases of oranges were stacked on top of each other with one case on the floor and a second case on top; against the wall under a window.
-Each case contained approximately eight 48 ounce plastic bags of oranges.
-Approximately 75% of the oranges in the 48 ounce plastic bags had a thick dark green mold.

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{D 283}	Continued From page 17 -There were six 24.5 ounce packages of 6 inch flour tortillas on the pantry shelf that were stamped with an expiration date of 02/27/23. -There was one 12 ounce can of beans with bacon soup that had a handwritten date of 01/04/22 on the top of the can but there was a stamp on the can with a best by date of 01/19/20. Observation of a sign hanging on the pantry shelf across from the freezer revealed: -There was a form hanging on the pantry shelf for dietary staff to document freezer temperatures daily. -The form had dates listed that the freezer temperature was checked from 12/01/22 to 12/25/22; but there were no temperatures listed. Observation of a dry erase board on the refrigerator in the kitchen on 04/04/23 at 9:21am revealed there was a handwritten note that all food must be dated and after food was two days old it should be thrown away. Interview with the DM on 04/04/23 at 9:16am revealed: -He had worked at the facility as the DM for 3 weeks. -The freezer had been working correctly but there were approximately three times in the past two weeks that he noticed it was not working correctly; the temperature was not always cold. -The freezer had been working "on and off" during the past two weeks. -He had not reported that the freezer was not working to the Resident Care Coordinator (RCC) or the Administrator. -He had not noticed that there was not a thermometer mounted in the freezer to accurately record the freezer temperatures. -He had not reported to the RCC or the	{D 283}		

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{D 283}	Continued From page 18	{D 283}		

Administrator that there was not a thermometer in the freezer.
-He had not documented freezer temperatures since he became employed as the DM.

Interview with a medication aide (MA) on 04/04/23 at 11:55am revealed:
-He worked as a cook for approximately one month before the new DM was hired 3 weeks ago.
-He had noticed the freezer not cooling as well two times but did not report it to anyone because it started working properly again.
-He had not recorded any temperature checks of the freezer recently.
-He forgot to report the freezer not cooling properly to the Administrator.

Observation of the dietary manager (DM) preparing lunch on 04/04/23 at 12:00pm revealed:
-There were 3 packages of the 24.5 ounce packages of 6 inch flour tortillas on the kitchen counter.
-The 3 packages of 6 inch flour tortillas were stamped with an expiration date of 02/27/23.

Second interview with the DM on 04/04/23 at 12:01pm revealed:
-He planned to serve the 6 inch flour tortillas to residents for lunch.
-He had not noticed the expiration date on the packages of flour tortillas.
-He had not checked the expiration date on the package of flour tortillas because the tortillas did not have mold on them.
-He disposed of all expired packages of expired flour tortillas.

Interview with the Administrator on 04/04/23 at

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{D 283}	Continued From page 19 9:30am revealed: -Her first day at the facility was 03/27/23. -She completed a tour of the kitchen on 03/27/23 but was not aware where the pantry and freezer were located at the facility until today. -The DM had not notified her that the freezer at the facility was not working properly. -The DM was responsible for identifying and disposing of expired foods. -She was not aware that the freezer was not working properly and did not have a thermometer to log the temperatures. -She expected the DM to report any problems with food storage to her or the Resident Care Coordinator (RCC). -She was going to the grocery store today to pick up ground beef for the residents lunch since the ground beef in the freezer was discarded from the freezer today. Interview with the primary care provider (PCP) 04/05/23 at 12:05pm revealed: -She expected staff to ensure there were no expired or molded food items served to residents and expected the freezer to work properly. -Foods should have been stored properly at the facility to prevent gastrointestinal distress for residents. _____ The facility failed to ensure expired and molded food items were disposed of, the freezer worked properly and food was safe from contamination of improper food storage to prevent residents from gastrointestinal illness. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/04/23 for this violation.	{D 283}		

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{D 283}	Continued From page 20 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 20, 2023.	{D 283}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#4, #5) observed during the medication pass including errors with medications used to treat diabetes (#4) and a medication used to treat seasonal allergies (#5) and for 3 of 3 residents sampled for record review (#1, #2, #3) including medications used to treat high blood sugar (#1, #2) and a medication used to treat irregular heartbeat (#3). The findings are:	{D 358}		

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{D 358}	Continued From page 21 1. The medication error rate was 7% as evidenced by the observation of 3 errors out of 38 opportunities, during the 8:00 a.m. medication pass on 04/04/23. a. Review of Resident #4's current FL-2 dated 11/09/22 revealed: -Diagnoses included type 2 diabetes. -There was an order for Metformin HCL ER (used to treat high blood sugars) 500mg take 2 tablets two times a day with food. Observation of the 8:00am medication pass on 04/04/23 revealed: -The medication aide (MA) administered 12 pills to Resident #4 at 8:36am. -The MA administered 1 tablet of Metformin HCL ER 500mg to Resident #4 instead of 2 tablets. Observation of Resident #4's medications on hand on 04/04/23 at 3:20pm revealed: -There was a medication card labeled Metformin HCL ER 500mg take 2 tablets by mouth 2 times daily with food. -One hundred twenty four tablets of Metformin HCL ER 500mg were dispensed on 03/17/23. -Each bubble on the medication card contained 1 tablet of Metformin HCL ER. -There were 9 tablets of Metformin HCL ER 500mg remaining in the medication card. Review of Resident #4's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Metformin HCL ER 500mg take 2 tablets 2 times a day with food scheduled for administration at 8:00am and 5:00pm. -Metformin HCL ER 500mg 2 tablets was documented as administered to Resident #4 at	{D 358}		

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{D 358}	Continued From page 22 8:00am on 04/01/23 to 04/05/23 and at 5:00pm on 04/01/23 to 04/04/23. Interview with the MA on 04/04/23 at 3:21pm revealed he knew Resident #4 was supposed to receive 2 tablets of Metformin HCL ER 500mg but he was trying to go too fast and accidentally administered 1 tablet of Metformin HCL ER 500mg instead. Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26pm revealed the MA should have administered 2 tablets of Metformin HCL ER to Resident #4 because she had diabetes, and it was important that she receive her medications as ordered. Interview with the Administrator on 04/04/23 at 3:42pm revealed the MA should have read the instructions on the eMAR and administered 2 tablets of Metformin HCL ER to Resident #4 as ordered. Telephone interview with Resident #4's primary care provider (PCP) on 04/05/23 at 12:05pm revealed: -Resident #4 not receiving the correct dosage of Metformin HCL ER could affect her blood sugars over time. -If Resident #4 was not receiving the correct dosage of Metformin HCL ER and it affected her blood sugar the PCP might adjust her medications when the resident may not need adjustments if she were receiving the correct dosage. b. Review of Resident #4's current FL-2 dated 11/09/22 revealed: -Diagnoses included Type 2 diabetes. -There was an order for Lantus (used to treat	{D 358}		

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high blood sugars) inject 26 units every day for diabetes (Lantus manufacturer's instructions read to perform a safety check before each injection by turning the dosage selector on the Lantus pen to 2 units, placing the pen needle on the Lantus pen and removing the cap, then pressing the injection button all the way in until insulin comes out of the tip of the needle, a process known as priming. When injecting Lantus, the injection button should be pressed all the way in and slowly count to 10 before withdrawing the needle).

Observation of the 8:00am medication pass on 04/04/23 revealed:
-The medication aide (MA) dialed the Lantus pen to 26 units and placed the needle on the insulin pen.
-The MA administered Lantus 26 units to Resident #4 at 8:38am.
-The MA immediately withdrew the insulin pen without holding it in place for 10 seconds.
-The MA did not perform a safety check by dialing the pen to 2 units and pressing the injection button until insulin came out of the needle prior to administering Lantus to Resident #4.

Review of Resident #4's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus inject 26 units every day for diabetes scheduled for administration at 8:00am.
-Lantus 26 units was documented as administered at 8:00am on 04/01/23 to 04/04/23.

Interview with the MA on 04/04/23 at 3:21pm revealed:
-He knew he should have primed Resident #4's Lantus pen with 2 units of insulin before

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administering it to the resident but he forgot to do so.
-He should have held Resident #4's Lantus pen in place at least 4 to 5 seconds after injecting the Lantus.

Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26pm revealed:
-Prior to administering Lantus to Resident #4 the MA should have dialed the Lantus pen to 26 units to make sure there was enough insulin in the pen.
-The MA should have then dialed the Lantus pen back to zero.
-After dialing the Lantus pen back to zero the MA should have then dialed it to 26 units and administered the 26 units to Resident #4.
-The MA should have held the Lantus pen in place for 4 to 5 seconds after administering the medication to make sure Resident #4 received the whole dose.
-She was not aware that the Lantus pen should be primed with 2 units of insulin prior to dialing up the correct dosage.

Interview with the Administrator on 04/04/23 at 3:42pm revealed:
-A Lantus insulin pen should be primed with 2 units of insulin prior to administering insulin to get the air out of the needle.
-The Lantus pen should have been held in place for several seconds after administering the medication to Resident #4.

Telephone interview with Resident #4's primary care provider (PCP) on 04/05/23 at 12:05pm revealed:
-The Lantus pen should have been primed with 2 units prior to administering the medication to Resident #4 in order to get the air out and make sure she received the correct dosage of insulin.

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-The Lantus pen should have been held in place for at least 10 seconds after administering it to Resident #4 to ensure the resident received all the medication.
-Not receiving all of the dosage of Lantus could cause Resident #4 to have higher blood sugars.

c. Review of Resident #5's current FL-2 dated 02/16/23 revealed:
-Diagnoses included schizophrenia, paranoia, and vitamin deficiency.
-The resident was constantly disoriented.
-There was an order for fluticasone propionate 50mcg (used to treat seasonal allergies) 1 spray into each nostril daily.

Observation of the 8:00am medication pass on 04/04/23 revealed:
-The medication aide (MA) administered 9 pills to Resident #5 at 8:12am.
-Fluticasone propionate was not administered to Resident #5.

Observation of Resident #5's medications on hand on 04/04/23 at 3:18pm revealed there was a bottle of fluticasone propionate 50mcg.

Review of Resident #5's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone propionate 50mcg use 1 spray into each nostril daily scheduled for administration at 8:00am.
-Fluticasone propionate 50mcg was documented as administered at 8:00am on 04/01/23 to 04/04/23.

Interview with the MA on 04/04/23 at 3:21pm revealed:
-He did not administer fluticasone propionate to

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{D 358}	Continued From page 26 Resident #5 with his other morning medications because he missed seeing it on the eMAR. -After he administered medications to some other residents, he went back to Resident #5 and asked if he wanted his fluticasone propionate and the resident stated he did not want to take it. Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26am revealed: -Resident #5 did not usually refuse medications. -The MA should have offered to administer Resident #5's fluticasone propionate when he administered his other morning medications. -If Resident #5 refused the fluticasone propionate at that time the MA should have gone back 30 minutes later and offered it to the resident again. Interview with the Administrator on 04/04/23 at 3:42pm revealed: -Fluticasone propionate should have been administered to Resident #5 with the rest of his morning medications. -The MA should not have missed administering fluticasone propionate to Resident #5 because it was on the eMAR to be administered at 8:00am with his other medications. Telephone interview with Resident #5's primary care provider (PCP) on 04/05/23 at 12:05pm revealed: -Fluticasone propionate was used for allergy symptom relief. -Resident #5 not receiving fluticasone propionate as ordered could cause him to have congestion or a runny nose. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable.	{D 358}		

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{D 358}	Continued From page 27 2. Review of Resident #2's current FL-2 dated 02/16/23 revealed: -Diagnoses included diabetes, psychosis, and depression. -The resident was constantly disoriented. -There was an order for Humulin 70/30 insulin (used to treat high blood sugars) check fingerstick blood sugar (FSBS) prior to giving, inject 12 units everyday at breakfast and evening, hold if FSBS below 100. a. Review of Resident #2's FL-2 dated 11/09/22 revealed there was an order for Humulin 70/30 insulin inject 12 units before breakfast and evening meals, hold dose if FSBS below 100. Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Humulin 70/30 insulin check FSBS prior to giving insulin and inject 12 units before breakfast and evening meals, hold dose if FSBS is below 100 scheduled for administration at 8:00am and 5:00pm. -Humulin 70/30 12 units was documented as administered at 8:00am on 02/01/23 to 02/28/23. -Humulin 70/30 12 units was documented as administered at 5:00pm on 02/01/23, 02/03/23 to 02/10/23, and 02/12/23 to 02/28/23. -On 02/02/23 at 5:00pm FSBS was documented as 120. -On 02/02/23 at 5:00pm Humulin 70/30 was documented as administered with a note stating, "blood sugar was 120, gave 6 units of Humulin, didn't want him to drop real low due to giving 12 units with a blood sugar of 120". -FSBS was documented as 118 on 02/03/23 at 8:00am. -On 02/11/23 at 5:00pm FSBS was documented as 116.	{D 358}		

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{D 358}	Continued From page 28 -On 02/11/23 at 5:00pm Humulin 70/30 was not documented as administered with a note stating, "blood sugar was 116, 12 units too much for blood sugar of 116". -FSBS was documented as 316 on 02/12/23 at 8:00am. Interview with the medication aide (MA) on 04/05/23 at 2:10pm revealed: -On 02/02/23 at 5:00pm Resident #2 did not want to take 12 units of Humulin 70/30 because he said it was too much insulin. -Resident #2 stated he wanted to take 6 units of Humulin 70/30 instead of 12 units and that is why she administered 6 units of Humulin 70/30 instead of the 12 units that was ordered. -She did not write the note correctly on the eMAR on 02/02/23. -She should not have administered 6 units of Humulin 70/30 to Resident #2 on 02/02/23 but should have documented it as refused on the eMAR or she should have contacted Resident #2's primary care provider (PCP) to see how much insulin to administer. -On 02/11/23 at 5:00pm Resident #2 refused Humulin 70/30. -She did not write the note correctly on Resident #2's eMAR on 02/11/23. -She should have documented Resident #2's Humulin 70/30 as refused on the eMAR on 02/11/23 instead of writing a note stating 12 units of Humulin 70/30 was too much for a FSBS of 116. Telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:08pm revealed: -The MA should not have administered a different dose of Humulin 70/30 to Resident #2 without checking with his PCP first.	{D 358}		

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-If Resident #2 refused Humulin 70/30 on 02/11/23 it should have been documented as refused.
-She had never known Resident #2 to refuse any of his medications.

Interview with the Administrator on 04/05/23 at 4:40pm revealed:
-If Resident #2 stated he wanted to take 6 units of Humulin 70/30 instead of 12 units the MA should have documented Humulin 70/30 as refused.
-The MA should not have administered 6 units of Humulin 70/30 to Resident #2 without receiving an order from his PCP.
-If Resident #2 refused Humulin 70/30 on 02/11/23 the MA should not have written a note stating 12 units of Humulin 70/30 was too much but should have documented it as refused.

Telephone interview with Resident #2's PCP on 04/05/23 at 12:05pm revealed:
-She expected MAs to follow orders for administration of Resident #2's Humulin 70/30.
-The MA should not have decided to administer a different amount of Humulin 70/30 to Resident #2 than what was ordered.
-Resident #2 not receiving Humulin 70/30 when he should or receiving a lower dosage than he should could cause him to have high blood sugars.
-High blood sugars could cause damage to Resident #2's heart, pancreas, or liver.
-Resident #2 was being seen by a wound clinic for a wound on his foot in February 2023 and not receiving the correct dosage of insulin could have caused delayed wound healing.

Review of Resident #2's history and physical note dated 02/10/23 revealed the resident was being seen at a wound clinic for a stage II wound to his

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right foot and an unstageable wound to his left 4th toe (Wounds are staged from I to IV. A stage II pressure wound is a shallow open ulcer with a pink wound bed. A wound is unstageable when the wound bed cannot be visualized due to a layer of other tissue over the wound).

Review of Resident #2's physician visit note dated 03/30/23 revealed the resident was released from the wound clinic.

Telephone interview with Resident #2's specialty provider on 04/05/23 at 9:30am revealed the wounds to both of his feet were healed at his visit on 03/30/23.

Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable.

b. Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Humulin 70/30 insulin check FSBS prior to giving insulin and inject 12 units before breakfast and evening meals, hold dose if FSBS is below 100 scheduled for administration at 8:00am and 5:00pm.
-FSBS was documented as 89 on 02/28/23 at 8:00am.
-Humulin 70/30 12 units was documented as administered on 02/28/22 at 8:00am when it should have been held.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Humulin 70/30 insulin check FSBS prior to giving insulin and inject 12 units before breakfast and evening meals, hold dose if FSBS is below 100 and was scheduled for

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administration at 8:00am and 5:00pm.
-FSBS was documented as 99 on 03/20/23 at 8:00am.
-Humulin 70/30 12 units was documented as administered on 03/20/23 at 8:00am when it should have been held.
-FSBS was documented as 88 on 03/25/23 at 8:00am.
-Humulin 70/30 12 units was documented as administered on 03/25/23 at 8:00am when it should have been held.
-FSBS was documented as 84 on 03/26/23 at 8:00am.
-Humulin 70/30 12 units was documented as administered on 03/26/23 at 8:00am when it should have been held.
-FSBS was documented as 99 on 03/30/23 at 8:00am.
-Humulin 70/30 12 units was documented as administered on 03/30/23 at 8:00am when it should have been held.
-FSBS was documented as 99 on 03/31/23 at 8:00am.
-Humulin 70/30 12 units was documented as administered on 03/31/23 at 8:00am when it should have been held.
-FSBS ranged from 100 to 448 at 5:00pm on 03/25/23 to 03/31/23.

Telephone interview with Resident Care Coordinator (RCC) on 04/05/23 at 4:08pm revealed:
-She usually performed FSBS checks on Resident #2 around 7:00am or 8:00am.
-Resident #2 usually did not eat breakfast until around 8:30am to 9:00am and that was when she administered his Humulin 70/30.
-She usually rechecked Resident #2's FSBS before administering Humulin 70/30 between 8:30am to 9:00am.

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{D 358}	Continued From page 32 -When she documented that she administered Humulin 70/30 to Resident #2 on 02/28/23, 03/20/23, 03/25/23, 03/26/23, and 03/31/23 Resident #2's FSBS must have been above 100 when she rechecked it. -Resident #2's FSBS and Humulin 70/30 were in the same place on the eMAR so they were documented at the same time. -She did not know why she would document Resident #2's FSBS from earlier in the day instead of the current FSBS on the eMAR. Interview with the Administrator on 04/05/23 at 4:40pm revealed: -The RCC or MA should have held Resident #2's Humulin 70/30 as ordered if his FSBS was less than 100. -Resident #2's entry on the eMAR for his FSBS check and his Humulin 70/30 administration were in the same place so the FSBS and Humulin 70/30 would be documented at the same time. -The FSBS that was documented for Resident #2's eMAR at 8:00am should be what his FSBS was at that time and his Humulin 70/30 administration should match with the FSBS that was documented on the eMAR. Telephone interview with Resident #2's primary care provider (PCP) on 04/05/23 at 12:05pm revealed administering Humulin 70/30 to Resident #2 when his FSBS was below 100 could cause a low FSBS which could result in Resident #2 going into a coma. Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable. 3. Review of Resident #1's current FL-2 dated 02/16/23 revealed:	{D 358}		

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-Diagnoses included diabetes, lower left leg amputee, hypertension, and peripheral vascular disease.
-The resident was constantly disoriented.
-There was an order for Humalog insulin (a short-acting insulin used to treat high blood sugars) check fingerstick blood sugar (FSBS) 4 times a day before meals and at bedtime; sliding scale insulin (SSI) FSBS 201-250 administer 2 units of insulin, FSBS 251-300 administer 4 units of insulin, FSBS 301-350 administer 6 units of insulin, FSBS 351-400 administer 8 units of insulin, and FSBS over 400 administer 10 unit of insulin.

Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog check FSBS 4 times a day before meals and at bedtime; sliding scale insulin FSBS 201-250 administer 2 units of insulin, FSBS 251-300 administer 4 units of insulin, FSBS 301-350 administer 6 units of insulin, FSBS 351-400 administer 8 units of insulin, and FSBS over 400 administer 10 unit of insulin.
-A FSBS of 222 was documented at 12:00pm on 03/02/23; Humalog was not documented as administered, when Humalog 2 units should have been administered.
-A FSBS of 262 was documented at 8:00am on 03/05/23; Humalog was not documented as administered, when Humalog 4 units should have been administered.
-A FSBS of 227 was documented at 8:00am on 03/19/23; Humalog was not documented as administered when, Humalog 2 units should have been administered.
-Humalog 6 units was documented as administered for a FSBS of 500 at 12:00pm on

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03/14/23 when Humalog 10 units should have been administered.
-Humalog 4 units was documented as administered for a FSBS of 420 at 8:00pm on 03/16/23 when Humalog 10 units should have been administered.
-FSBS ranged from 177 to 578 from 03/01/23 to 03/31/23.

Telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:08pm revealed:
-The resident had not refused to have his FSBS's taken, she and MAs were expected to check his FSBS as ordered by the primary care provider (PCP).
-She and the MAs had parameters to follow for Resident #1's FSBS to help control his diabetes.
-She did not realize that she had not administered the incorrect dose of Humalog per the PCP orders to the resident.
-She and MAs were expected to follow the PCP's parameters for SSI for Resident #1 and to notify the PCP of any changes.

Interview with the Administrator on 04/05/23 at 4:40pm revealed:
-She expected the MAs and RCC to follow PCP orders.
-MAs and the RCC should have followed the PCP SSI parameters as ordered.
-The RCC was responsible for ensuring that residents received their medication as ordered to prevent complications from diabetes.

Telephone interview with Resident #2's primary care provider (PCP) on 04/05/23 at 12:05pm revealed:
-She expected MAs to follow SSI orders for administration of Resident #1's Humalog per the

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parameters ordered.
-The MAs and RCC were expected to administer the correct dosage of Humalog to prevent high blood sugars for Resident #1.
-High blood sugars could cause damage to Resident #1's heart and pancreas.

4. Review of Resident #3's current FL-2 dated 2/10/23 revealed:
-Diagnosis included chronic kidney disease Stage 3, chronic atrial fibrillation (irregular heartbeat), and hypertension.
-The resident was constantly disoriented.

Review of Resident #3's electronic transmittal prescription dated 03/01/23 revealed an electronic order for Digoxin 125 mcg (0.125mg), take one tablet by mouth every other day for arrhythmia, hold if apical pulse (a pulse take with a stethoscope by listening to the bottom tip of the heart) is less than 60. (Digoxin is used to treat irregular heartbeat.)

Review of Resident #3's March 2023 electronic medication administration record(eMAR) on revealed:
-There was an entry for Digoxin 125mcg, take one tablet by mouth every other day for arrhythmia, hold if apical pulse is less than 60.
-On 03/21/23 Resident #3's apical pulse was 57 and Digoxin was documented as administered.
-On 03/22/23 Resident #3 was of the facility and in a nearby hospital.
-On 0326/23 Resident #3 was out of the facility and in a nearby hospital.
-On 3/28/23 Resident #3 was out of the facility and in a nearby hospital.
-On 03/30/23 Resident #3 was out of the facility and in a nearby hospital.

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{D 358}	Continued From page 36 Telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:09pm revealed: -Digoxin was to be held if Resident #3's apical pulse was less than 60. -She checked Resident #3's apical pulse twice on 03/21/23 and did not enter the apical pulse over 60 on the eMAR. Interview with the Administrator on 04/05/23 at 4:46pm revealed medication aides (MAs) were expected to withhold medication as prescribed by a physician. Telephone interview with Resident #3's primary care provider (PCP) on 04/05/23 at 12:30pm revealed: -She expected MAs to withhold Digoxin as ordered by the provider. -Digoxin could lower heart rate and if Resident #3's apical pulse was lower than 60 and Digoxin was administered it could cause an increase in low heart rate, dizziness, and an increase in falls. Based on observations, interviews, and record reviews it was determined that Resident #3 was not interviewable. _____ The facility failed to follow medication orders and administered an arbitrary dose of insulin to a resident and held insulin without an order from the primary care provider which caused a high blood sugar which could cause damage to the resident's heart, pancreas, and liver as well as delayed wound healing to a wound on his foot (#1) and administered the incorrect dose of sliding scale insulin on at least 5 occasions which resulted in high blood sugars ranging from 177 to 578 (#2). The facility's failure was detrimental to the health, safety, and welfare of the residents	{D 358}		

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{D 358}	Continued From page 37 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/05/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 20, 2023.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by:	{D 367}		

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Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#5) including inaccurate documentation of a medication used to treat seasonal allergies.

The findings are:

Review of Resident #5's current FL-2 dated 02/16/23 revealed:
-Diagnoses included schizophrenia, paranoia, and vitamin deficiency.
-The resident was constantly disoriented.
-There was an order for fluticasone propionate 50mcg (used to treat seasonal allergies) 1 spray into each nostril daily.

Observation of the 8:00am medication pass on 04/04/23 revealed:
-The medication aide (MA) administered 9 pills to Resident #5 at 8:12am.
-Fluticasone propionate was not administered to Resident #5.

Review of Resident #5's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone propionate 50mcg use 1 spray into each nostril daily scheduled for administration at 8:00am.
-Fluticasone propionate 50mcg was documented as administered at 8:00am on 04/04/23.

Interview with the MA on 04/04/23 at 3:21pm revealed:
-He did not administer fluticasone propionate to Resident #5 with his other morning medications because he missed seeing it on the eMAR.
-After he administered medications to some other

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 39 residents, he went back to Resident #5 and asked if he wanted his fluticasone propionate and the resident stated he did not want to take it. -He should have documented Resident #5's fluticasone propionate as refused instead of documenting it was administered. Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26pm revealed if Resident #5 refused fluticasone propionate the MA should have documented it as refused on the eMAR. Interview with the Administrator on 04/04/23 at 3:42pm revealed: -Resident #5's fluticasone propionate should not have been documented as administered. -Resident #5's fluticasone propionate should have been documented as refused.	{D 367}		