STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031018	A. BUILDING: _____ B. WING _____	R 12/06/2022

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AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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 Duplin County Department of Social Services conducted an annual survey and complaint investigation on November 30, 2022, and December 1, 2, 5 and 6, 2022 . The complaint investigation was initiated by the Duplin County Department of Social Services on November 16, 2022.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 7 of 8 exit doors that were accessible to residents with known disorientation and wandering behaviors, were equipped with sounding devices that sounded when the exit doors were opened to alert staff. The findings are:	D 067		

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D 067	Continued From page 1 Observation of the facility entrance/exit doors on 11/23/22 revealed: -There was no audible sounding device heard when the front exterior and interior entrance/ exit doors were opened. -There was no attendant seated at the front entrance. Observations upon entrance to the facility on 11/30/22 at 8:45am and intermittently throughout the day until 6:00pm revealed: -There was no audible sounding device heard when the front exterior and interior entrance/ exit doors were opened. -There was no attendant seated at the front entrance. Observations of the facility on 11/30/22 at 10:48am revealed: -There were residents seated in the dayroom. -There was an unlocked door in the dayroom with no sounding device that led to the outside. -There were 7 of 8 entrance/ exit doors that were unlocked and unalarmed. Observation of the exit door in the day room on hall 2 on 12/01/22 from 8:27am until 9:16am revealed the door was unlocked and there was no staff in the day room or monitoring the door. Review of a list of residents' names provided by the facility revealed there were 18 of 60 residents in the facility who were either diagnosed with dementia, confusion, or had wandering behaviors. Review of Resident #6's current FL-2 dated 04/22/2022 revealed: -Diagnoses of high blood pressure and Alzheimer's Disease.	D 067		

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-She was constantly disoriented and semi-ambulatory.

Review of Resident #6's care plan dated 04/22/2022 revealed:
-The resident was forgetful with significant memory loss and required redirection.
-The resident was ambulatory with no assistive device.

Review of Resident #6's progress note dated 09/24/2022 at 6:00pm revealed she was "in the parking lot wandering and was redirected back to her room."

Review of Resident #6's 15 minute resident checks revealed there was no documentation of 15 minute checks after the resident wandered on 09/24/22.

Interview with a personal care aide (PCA) on 11/23/22 at 9:51am revealed:
-In October 2022 she witnessed Resident #6 walk outside at the end of a shift.
-She redirected Resident #6 back inside the facility and to her room.
-She notified the medication aide (MA) on duty and the Resident Care Coordinator (RCC), so they knew to "watch her more carefully."

A second interview with the PCA on 11/30/22 at 2:15pm revealed:
-Resident #6 was known to try to leave the facility and was very confused.
-The resident was known for standing at the front door to the facility asking where her children were.
-She was informed by a MA to watch the resident frequently to ensure she did not leave the facility.

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Interview with a medication aide (MA) on 11/30/22 at 1:55pm revealed:
-The facility had a list of residents who required every 15-minute checks.
-The entrance/ exit doors never had a sounding device and were unlocked from 6:00am to 6:00pm.

Interview with the Lead MA on 11/23/2022 at 11:15am revealed:
-The facility had residents with dementia who wandered.
-Resident #6 wandered inside and outside the building.
-Staff performed 15 min checks on Resident #6.
-She had observed Resident #6 follow another staff member outside, from the exit door located closest to the facility kitchen, when the staff walked outside to toss trash in the dumpster.

Interview with Resident Care Coordinator (RCC) on 11/30/2022 at 1:46pm revealed:
-Resident #6 often stood at her room door with her purse.
-Resident #6 had walked outside the building behind a staff member one time; staff were able to redirect Resident #6 back inside the building and to her room.

Interview with the Lead Supervisor on 11/30/22 at 2:01pm revealed the entrance/ exit doors in the facility were locked from 7:00pm to 7:00am.

Interview with the Resident Care Coordinator (RCC) on 11/30/22 at 1:55pm revealed:
-Resident #6 exited the facility, but she walked by the office window and staff saw her; she did not leave the parking lot (not sure of date).
-The only way for the facility to know if a resident had left the facility was to conduct every

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D 067	Continued From page 4 15-minute checks. -There had never been sounding devices on the entrance/ exit doors. Interview with the Executive Director on 11/30/22 at 2:15pm revealed: -The facility purchased door alarms (not sure of the date) because the corporate office suggested it. However, the door frames were not compatible; therefore, they were not put in place. -She was not aware the entrance/ exit doors needed a sounding device for residents that were confused or had wandering behaviors. -The entrance/ exit doors had never had a sounding device because they were always locked. -Residents who wandered out of the facility without facility staff's knowledge were at risk of getting hurt. _____ The facility failed to ensure 7 of 8 exit doors were equipped with a sounding device alerting staff when activated with known residents who were confused and had wandering behaviors. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/30/22. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2023.	D 067		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 269		

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Supervision
(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#3) related to toenails that were long, jagged, and curled; dry, and flakey skin on his feet.

The findings are:

Review of Resident #3's current FL-2 dated 02/23/22 revealed:
-Diagnoses included cognitive impairment, short term memory loss, history of stroke, and unable to care for self.
-The resident was intermittently disoriented, semi-ambulatory, and walked using a rollator.
-The resident required limited assistance with bathing and grooming.

Review of Resident #3's current care plan dated 04/20/22 revealed:
-The resident was sometimes disoriented.
-The resident was sometimes forgetful and needed reminders.
-The resident was independent with ambulation and transferring.
-The resident required limited assistance with bathing.

Observation of Resident #3 on 11/30/22 at

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D 269	Continued From page 6 9:20am revealed: -His toenail on his great toe on his right foot was approximately ½ an inch long. -His second and third toenails on his right foot were curved over and was approximately 3/4 inches in length. -His fourth toenail on his right foot was curved over and was approximately ½ an inch long. -The skin on his left foot was dry, scaly and flaking around his toes and the top and bottom of his foot. -His toenail on his left great toe on his left foot was approximately ½ an inch long and had jagged edges. -His third toenail was approximately ½ an inch long and curved over. -His fourth toenail was pressing into his third toe. Interview with Resident #3 on 11/30/22 at 9:30am revealed: -Staff usually provided him with a shower at 7:00pm three times a week. -He had asked staff to cut his toenails "all the time" but no one had cut his toenails. -He had not been seen by a podiatrist and thought that staff would trim his toenails at least once a month. -The toenails on his right foot hurt when he walked because several of those toenails were curved over and touching the skin on his toes. -It hurt to walk because some of his toenails dug into his shoes. Interview with a personal care aide (PCA) on 12/05/22 at 12:28pm revealed: -Resident #3 received showers three times a week. -PCAs provided him a complete bath, washed his feet and applied lotion following his shower. -She had not noticed that his toenails were long	D 269		

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and needed to be cut.
-He was not a diabetic resident so PCAs could cut his toenails.
-If a PCA was not comfortable cutting his toenails, they were expected to report the concern about toenails to a medication aide (MA).

Interview with a MA on 12/06/22 at 9:58am revealed:
-She felt confident that PCAs washed and observed Resident #3's feet.
-PCAs were expected to report any concerns about resident's feet to the MA.
-The MAs notify the RCC if a resident needed to see a podiatrist.
-The MAs could cut resident's toenails if they did not need to see a podiatrist.
-She was not aware that Resident #3's toenails were so long.

Interview with the Resident Care Coordinator (RCC) on 12/06/22 at 1:10pm revealed:
-PCAs were expected to provide nondiabetic residents with foot care when they received a shower; PCAs should clean and trim the residents' toenails.
-If a resident had long toenails, the PCA should report it to the MA.
-She was not aware that Resident #3 had toenails that curved over and were causing him pain when he walked.
-She expected the MA to notify her or the PCP that the resident needed to be seen by a podiatrist.

Interview with the Executive Director (ED) on 12/06/22 at 2:08pm revealed:
-She was not aware that Resident #3 had toenails that were curved over and causing him pain when he walked.

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D 269	Continued From page 8 -She expected the PCAs to report any concerns about a residents foot care needs to a MA or the RCC. -Resident #3's toenails should not have been unkept because it could cause him difficulty walking and he could be at a higher risk of falling. Interview with Resident #3's primary care physician (PCP) on 12/06/22 at 12:31pm revealed: -She was not aware that his toenails were causing him pain when he walked. -She would expect the MA or RCC to inform her that Resident #3 needed to see a podiatrist if they were unable to cut his toenails. -She was concerned that with the resident having pain with his toenails when he walked could make it more difficult for him to balance and increase his risk of falls.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 10 sampled residents (#1, #6) which resulted in a closed head injury, contusions to the	D 270		

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face and shoulder and a right shoulder fracture (#1) and a resident diagnosed with Alzheimer's disease who was confused and wandered out of the facility without staff's knowledge (#6).

The findings are:

1. Review of Resident #1's current FL-2 dated 03/29/22 revealed:
-Diagnoses included major depressive disorder, history of epilepsy, and Alzheimer's disease.
-The resident was constantly disoriented.
-She had neurological convulsions and seizures.
-She needed assistance with bathing, feeding, and dressing.

a. Review of Resident #1's progress notes dated 09/24/22 revealed she had a fall and was sent to the hospital via emergency medical services (EMS) transport and returned on 09/24/22.

Review of Resident #1's incident and accident report dated 09/24/22 revealed:
-She was found in her room lying on the floor between her nightstand and her bed.
-Her left leg was bruised and swollen.
-She was sent to the hospital via EMS transport.
-She returned to the facility on 9/24/22 with a diagnosis of accidental fall, with no new orders.
-The evaluation notes revealed signs were placed in her room to call for assistance before getting out of the bed.

Review of Resident #1's after visit summary dated 09/24/22 revealed the reason for the visit was due to an accidental fall.

Review of Resident #1's progress notes dated 09/25/22- 09/28/22 revealed she had no complaint of pain, and no additional injuries were

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observed.

Observation of Resident #1's room from 11/30/22- 12/02/22 and 12/05/22- 12/06/22 revealed there were no signs located in her room to call for assistance before getting out of the bed.

b. Review of Resident #1's progress notes dated 10/10/22 revealed:
-She was found on the floor from a fall and was sent to the hospital via EMS transport.
-She returned from the hospital on 10/10/22.

Review of Resident #1's incident and accident reports dated 10/10/22 revealed:
-She was found lying on the floor on her side in her room next to her bed.
-There were no injuries noted.
-She was sent to the hospital via EMS transport.
-She returned to the facility on 10/10/22 with a diagnosis of an accidental fall, with no new orders.
-The evaluation notes revealed a bed alarm was ordered.

Review of Resident #1's after visit summary dated 10/10/22 revealed the reason for the visit was due to an accidental fall.

Review of Resident #1's progress notes dated 10/11/22- 10/14/22 revealed she had no complaint of pain, and no additional injuries were observed.

Review of Resident #1's signed physician's telephone order dated 10/12/22 revealed an order for a bed alarm and to ensure the alarm was on and working while she was in the bed.

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Observation of Resident #1's room from 11/30/22- 12/02/22 and 12/05/22- 12/06/22 revealed there was a working bed alarm attached to her bed.

c. Review of Resident #1's progress notes dated 11/04/22 revealed she had a fall and was sent to the hospital via EMS transport and returned on 11/04/22.

Review of Resident #1's incident and accident report dated 11/04/22 revealed:
-She was laying in the floor with no signs of injury.
-She was found later with a bump on her head from the fall.
-She was sent to the hospital via EMS transport.
-She returned to the facility on 11/04/22 with diagnoses of accidental fall, closed head injury and contusion of right shoulder, with no new orders.
-The evaluation notes revealed staff were educated on the important times to lay her down when she showed signs of tiredness.

Review of Resident #1's after visit summary dated 11/04/22 revealed:
-The reason for the visit was due to an accidental fall.
-The diagnoses included an accidental fall, closed head injury and a contusion of the right shoulder.
-An x-ray to the right shoulder was completed.

Review of Resident #1's progress notes dated 11/05/22 revealed:
-A follow up from a fall, with bruising on the right side of her forehead.
-She did not complain of pain.

Review of Resident #1's progress notes dated 11/06/22 revealed a follow up from a fall, with

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bruising to her shoulder and the right side of her forehead.

Review of Resident #1's progress notes dated 11/07/22 revealed there were no additional injuries and no complaints of pain.

d. Review of Resident #1's progress notes dated 11/09/22 revealed:
-She had a fall and was sent to the hospital via EMS transport and returned on 11/09/22.
-She had an old bruise located on her forehead.

Review of Resident #1's incident and accident report dated 11/09/22 revealed:
-She was found in her room lying on the floor with her hands over her head.
-She had redness on her head and face.
-She was sent to the hospital via EMS transport.
-She returned to the facility on 11/09/22 with diagnoses of a fall and a contusion of her face, with no new orders.
-The evaluation notes revealed staff were educated to be aware of when family leaves from a visit with her to ensure the wheels were not locked on her wheelchair.

Review of Resident #1's progress notes dated 11/10/22- 11/14/22 revealed she had no complaint of pain, and no additional injuries were observed.

Review of Resident #1's after visit summary dated 11/09/22 revealed:
-The reason for the visit was due to an accidental fall.
-The diagnoses included a fall and a contusion of the face.
-A computed tomography (CT) spine and head contrast and an x-ray of the chest, hip and pelvis

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D 270	Continued From page 13 were done. Interview with a personal care aide (PCA) on 12/06/22 at 8:35am revealed: -On 11/09/22, there were 2 personal care aides (PCA)s and 2 medication aides (MA)s working on the floor in the facility. -She went on her 30-minute break and notified the MA before she left. -Resident #1's family was visiting her when she left for her break. -When she returned from break, she asked the MA if Resident #1's family was still visiting. The MA stated they were not. -She entered Resident #1's room and found her on the floor, with her wheelchair folded in half. -The Primary Care Provider (PCP) was in the facility when she found Resident #1 and sent her to the hospital. -The MA on the floor was responsible to check on her residents while she was on break. -The MA was aware the family was no longer visiting Resident #1. Interview with a second PCA on 12/06/22 at 9:19 am revealed: -The PCA was responsible to let the other PCA on duty or MA know when they were leaving for their break. -The other PCA and MA would check on all the residents while the PCA was on break. -If the MA was passing medications, then the other PCA would check on the residents. -On 11/09/22, Resident #1's family was visiting her. -The MA knew the family had left but did not make her aware. Interview with a MA on 12/06/22 at 2:00pm revealed:	D 270		

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-It was the responsibility of the MA to check on residents while the PCA was on break.
-On 11/09/22, she was passing medications when Resident #1 fell.
-The PCA returned from her break and found Resident #1 lying on the floor in her room.
-She did not know why she did not tell the other PCA to check on the residents while she passed the medications.

Interview with Executive Director on 12/06/22 at 2:30pm revealed:
-The MA was responsible to ensure the residents were checked while the PCA was on break.
-The MA was able to pass medications and still check on residents.

e. Review of Resident #1's progress notes dated 11/29/22 revealed:
-Her right shoulder was swollen, and she cried out when it was lifted.
-The PCP was notified.
-An x-ray for her right shoulder was ordered.

Review of Resident #1's incident and accident report dated 11/30/22 revealed:
-She had swelling in her right shoulder.
-She was sent to the hospital via EMS transport.
-An x-ray was done and showed a dislocated shoulder with impacted fracture.

Review of Resident #1's radiology report dated 11/30/22 revealed:
-The humerus was anteriorly and inferiorly dislocated.
-There was a mild impaction fracture of the lateral humeral head.
-The conclusion was the anterior right shoulder was dislocated with a humeral head impaction fracture.

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D 270	Continued From page 15 Review of Resident #1's emergency department (ED) notes dated 11/30/22- 12/01/22 revealed: -The facility staff reported she had a fall yesterday, 11/29/22 and an outpatient x-ray showed right humerus fracture. -She was sent to the emergency room (ER) for evaluation. -She was disoriented and confused. -She expressed tenderness when laid on her left side. Review of Resident #1's after visit summary dated 11/30/22 revealed: -The reason for the visit was due to a shoulder injury. -The diagnoses included an accidental fall and closed nondisplaced fracture of proximal end of right humerus. Interview with Resident #1's family member on 11/30/22 at 5:12pm revealed: -Resident #1 did not ambulate and leaned forward in her wheelchair. -Resident #1 needed total assistance. -She previously had 2 falls out of her bed and 2 falls out of her wheelchair. -The family spoke with the Resident Care Coordinator (RCC) and the PCP related to interventions to prevent her from falling. -The facility was supposed to check Resident #1 every 15 minutes. Second interview with Resident #1's family member on 12/02/22 at 9:59am revealed: -The hospital informed her Resident #1 had fallen 3 days prior to 11/30/22. -She asked the Executive Director (ED) if Resident #1 had fallen, and the ED stated Resident #1's right shoulder fracture came from	D 270		

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her fall on 11/09/22.

Second interview with the MA on 12/02/22 at 11:54am revealed:
-The MA from the night shift noticed the right shoulder was swollen and obtained an order from the PCP to have a mobile x-ray done.
-A mobile x-ray to Resident #1's right shoulder was done on 11/30/22.
-The facility called the PCP to inform her of the x-ray results for Resident #1's right shoulder.
-The PCP had Resident #1 sent out to the hospital because the x-ray results showed the right shoulder was fractured.
-She did not know how Resident #1 acquired the right shoulder fracture.
-She did not remember the last time Resident #1 fell.

Attempted telephone interview on 12/02/22 at 12:07pm, 12:08pm, 12/05/22 at 8:25am, 10:42am, 2:08pm, 12/06/22 at 8:22am with the MA who reported on 11/29/22 Resident #1's right shoulder was swollen and requested an order for an x-ray was unsuccessful.

f. Review of Resident #1's incident and accident report dated 12/02/22 revealed:
-She had a fall in the hallway with injury to the right side of her head.
-She was sent to the hospital via EMS transport.

Review of Resident #1's after visit summary dated 12/02/22 revealed:
-The reason for the visit was due to an accidental fall.
-The diagnoses included an accidental fall, traumatic hematoma of her forehead, closed fracture of the end of the right humerus (bone in the arm that is closest to the shoulder) and

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dislocation of her right shoulder joint.

Review of Resident #1's encounter notes from ED dated 12/02/22 revealed:
-She arrived at the ED after a fall face first from her wheelchair.
-She was laying on her right side when the EMS transport arrived at the facility.
-She had a previous dislocated shoulder and a large hematoma on the right side of her forehead.

Review of Resident #1's signed physician's telephone orders dated 12/02/22 revealed:
-Chair alarm to be used when she was up and in her wheelchair daily every shift.
-Ensure the chair alarm was on and working.
-Ensure a fall mat was in place every shift while she was in her bed.

Interview with the Executive Director (ED) on 12/02/22 at 9:30am revealed:
-Resident #1 fell this morning, 12/02/22 at the nurses' station.
-There were 2 facility staff at the nurses' station when Resident #1 fell out of her wheelchair.

Second interview with Resident #1's family member on 12/02/22 at 9:59am revealed:
-The facility notified the family Resident #1 had fallen.
-The facility staff told her they had Resident #1 lined up in the hallway for breakfast and she fell face forward.

Third interview with the MA on 12/01/22 at 10:26am revealed:
-She was walking toward the dining room when Resident #1 fell on 12/02/22.
-The facility staff were in the hallway counting medications at the medication cart when Resident

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D 270	Continued From page 18 #1 fell. -One of the facility staff screamed and attempted to catch her before she fell but was not successful. Interview with a third PCA on 12/02/22 at 11:22am revealed Resident #1 was on the floor when she came out of the dining room during breakfast on 12/02/22. Observations of Resident #1's room on 12/05/22 at 10:47am to 11:27am revealed: -At 10:47am, 2 PCAs entered her room. -At 11:02am, the first PCA was pushing another resident in their wheelchair down the opposite hall of Resident #1. -There were 6 other residents sitting and standing around the nurses' station but there was no facility staff present. -At 11:07am, the first PCA came from another hall around the corner pushing the same resident in their wheelchair and went down the opposite hallway from Resident #1's room. -At 11:11am, the second PCA was walking down the hallway opposite of Resident #1's room. -At 11:15am, 2 PCAs were pushing residents into the dining room by the nurses' station. -At 11:23am, a third PCA was on the hall and peeped into Resident #1's room. -No facility staff checked on Resident #1 from 10:47am to 11:23am (36 minutes). Interview with the RCC on 12/02/22 at 11:00am revealed she thought the interventions that were put in place for Resident #1, after her falls were appropriate. Interview with the PCP on 12/02/22 at 12:29pm revealed: -Resident #1's dementia had progressed.	D 270		

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-She was aware of Resident #1's history of falls.
-On 11/30/22, when the results from the x-ray came back, she sent Resident #1 out to the hospital.
-The x-ray showed dislocation and fracture of the right shoulder.
-She thought Resident #1 fell around 11/30/22 and the right shoulder fracture was related.
-Resident #1 needed her arm to be placed immediately in a sling to demobilize the joint.
-Resident #1's falls could lead to a decrease in range of motion, pain, head injury and or a hip or back fracture which would require surgery and rehab.
-Resident #1's quality of life could change with all the risk involved with frequent falls due to her advanced dementia and age.

Interview with the ED on 12/06/22 at 2:30pm revealed:
-She was not sure why Resident #1 was falling.
-Residents "can fall in a split second."
-Falls were what happened in healthcare.
-The facility put the interventions in place that they felt were appropriate for Resident #1.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

2. Review of Resident #6's current FL-2 dated 04/22/2022 revealed:
-Diagnoses of high blood pressure and Alzheimer's Disease.
-The Resident required personal care assistance with bathing, feeding and dressing.
-She was constantly disoriented and semi-ambulatory.
-Her recommended level of care was Domiciliary (Rest Home).

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D 270	Continued From page 20 Review of Resident #6's care plan dated 04/22/2022 revealed: -The resident was forgetful with significant memory loss and required redirection. -The resident was ambulatory with no assistive device. -The resident required limited assistance with eating, toileting, dressing and grooming. -The resident required extensive assistance with bathing. -The resident required supervision with ambulation and transfers. Review of Resident #6's Resident Progress Notes dated 09/24/2022 at 6:00pm revealed the Lead Medication Aide (MA) documented that the resident was "in the parking lot wandering and was redirected back to her room." Review of Resident #6's 15 minute resident checks revealed there was no documentation of 15 minute checks after the resident wandered on 09/24/22. Review of Resident #6's initial psychiatry visit on 08/24/2022 revealed: -The resident had a diagnosis of dementia with moderate symptoms occurring intermittently throughout the week and month. -Staff reported that the resident was only oriented to person, and she wandered at times. Review of Resident #6's follow-up psychiatry visit dated 09/30/2022 revealed: -The resident was confused and unable to recall if she had eaten that day. -The resident expressed that she was "feeling a bit lost because she hasn't been here before" and "was a bit worried about the new place."	D 270		

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-Staff reported that resident experienced increased confusion and was more difficult to redirect.
-She ordered staff to continue to monitor and document resident's signs, symptoms and behaviors.
-There was no documentation in the record of how staff monitored resident's signs, symptoms and behaviors.

Review of Resident #6's follow-up psychiatry visit dated 10/27/2022 revealed:
-The resident was confused, had a history of Alzheimer's Disease with moderate symptoms occurring intermittently throughout the week and month.
-Staff reported to the psychiatrist that the resident wandered at times.
-She ordered staff to continue to monitor and document resident's signs, symptoms and behaviors.
-There was no documentation in the record of how staff monitored resident's signs, symptoms and behaviors.

Interview with personal care aide (PCA) on 11/23/22 at 9:51am revealed:
-She worked 1st shift 7:00am-3:00pm and other times as needed.
-The facility had residents with a diagnosis dementia who wandered.
-In October 2022 the PCA witnessed Resident #6 walk outside at the end of a shift.
-The PCA redirected Resident #6 back inside the facility and to her room.
-The PCA notified medication aide (MA) and Resident Care Coordinator (RCC), so they knew to "watch her more carefully."

A second interview with the PCA on 11/30/22 at

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D 270	Continued From page 22 2:15pm revealed: -Resident #6 was known to try to leave the facility and was very confused. -The resident was known for standing at the front door to the facility asking where her children were. -She was informed by a MA to watch the resident frequently to ensure she did not leave the facility. Observation of facility entrance/exit doors on 11/23/22 revealed there was no staff stationed at the doors to monitor when a resident entered or exited the building. Interview with a second PCA on 11/23/2022 at 10:44am revealed: -She worked 1st shift from 7:00am-3:00pm and other times as needed. -The facility had residents with dementia who wandered. -Resident #6 was constantly confused and wandered inside the building. -Resident #6 was known to sit outside the building on the facility's front porch and told staff she was waiting for her family to come pick her up. -Staff was performed 15 min checks on Resident #6. -There was documentation of 15 min checks on Resident #6 for November 2022. Interview with a third PCA on 11/23/2022 at 3:43pm revealed: -She worked 2nd shift from 3pm-11pm. -The facility had residents with a diagnosis of dementia that wandered. -Resident #6 wandered inside the building. -Staff were expected to perform 15 minute checks for Resident #6 to "keep a close eye on her."	D 270		

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D 270	Continued From page 23 Interview with an MA on 11/23/2022 at 12:14pm revealed: -She worked 1st shift from 7:00am-3:00pm and 2nd shift from 3:00pm-11:00pm. -The facility had residents with a diagnosis of dementia that wandered. -The MA stated a PCA saw Resident #6 in the facility parking lot and brought her back inside. -Resident #6 told the PCA that she was "trying to go home." -The incident occurred in early October 2022, but she was unaware if any other staff were notified of the incident. Interview with the Lead MA on 11/23/2022 at 11:15am revealed: -She worked 1st shift from 7:00am-3:00pm or 2nd shift from 3:00pm-11:00pm. -The facility had residents with dementia who wandered. -These residents were difficult for staff to manage because it was not possible for on-duty staff to provide the level of supervision they needed. -The facility needed to admit fewer dementia residents or to increase the number of on-duty staff on each shift. -Resident #6 wandered inside and outside the building. -Staff performed 15 min checks on Resident #6. -She had observed Resident #6 follow another staff member outside, from the exit door located closest to the facility kitchen, when the staff walked outside to toss trash in the dumpster. Review of Resident #6's Resident Record on 12/1/22 revealed documentation of 15 min checks for Resident #6 from November 2022. Interview with Lead MA on 11/23/2022 at 11:50am	D 270		

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revealed:
-She worked 1st shift from 7am-3pm and other times as needed.
-The facility had residents with a diagnosis of dementia.
-There were no residents that had elopement or wandering behaviors.
-Staff were expected to always have knowledge of the whereabouts of all residents.
-Resident #6 walked around the inside of the building but she was not lost or wandering.
-Staff performed 15 minute checks for Resident #6 because she stood at the front door of the facility or walked out the front door to sit on porch.
-The Lead MA had no knowledge of Resident #6's incidents of elopement.

Interview with Resident Care Coordinator (RCC) on 11/30/2022 at 1:46pm revealed:
-The facility had residents with diagnosis of dementia.
-There were no residents with elopement behaviors.
-No residents wandered outside the facility, in the parking lot or near the highway in front of facility.
-Staff did "keep a closer eye on" Resident #6 because of her dementia diagnosis and behaviors.
-Resident #6 often stood at her room door with her purse.
-Resident #6 had walked outside the building behind a staff member one time; staff were able to redirect Resident #6 back inside the building and to her room.
-She did not recall specific dates, times or staff involved in the incident; and it was an isolated incident.
-The facility has an Elopement Protocol which included staff searching the premises including the building's interior/exterior as well as alerting

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911/Law Enforcement and the facility's Executive Director, Lead MA and resident's family.

Interview with the Executive Director (ED) on 12/02/22 at 2:19pm revealed:
-She had been the ED at the facility since the middle of July 2022.
-She as still learning the process for falls; the corporate leadership was still teaching her about policies and procedures when a resident has a fall or is injured in an accident.
-Management holds fall meetings at least one time a month to discuss interventions; she had let the Resident Care Coordinator (RCC) and corporate leadership guide her on the process of implementing interventions when a resident had a fall.
-Falls were discussed every morning during staff meetings to ensure staff were aware of residents that required increased supervision.
-She focused on re-educating staff on supervision of the residents and continuously tell them the importance of supervising residents to prevent falls.
-She and the RCC made rounds daily to ensure that 15 minutes checks were being completed by staff for residents that needed increased supervision.
-All staff were responsible for supervision of residents because the facility does not have the option of one on one supervision of the residents.
-When a resident was on 15 minute checks, PCAs or MAs would document each 15 minute check on a form.
-The RCC and/or Lead SIC were checked the 15 minute check forms to ensure they were being completed.
-When a resident had a fall, staff would respond quickly.
-Residents looked out for each other and at times

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D 270	Continued From page 26 were the first to notify staff that a resident fell. The failure of the facility to ensure supervision for a resident who was in severe pain by crying out due to a right shoulder fracture, had a history of multiple falls which resulted in a closed head injury and contusions to the face and shoulder (Resident #1) and a resident who was confused and had wandering behaviors leaving out of the facility without staff's knowledge (Resident #6). This failure of the facility resulted in serious neglect and constitutes a Type A1 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/24/22 and 12/02/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 5, 2023.	D 270		
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, interviews and record reviews, the facility failed to ensure physician orders for a chair alarm were implemented for 1 of 5 sampled residents (#1), who had a history of falls with injuries.	D 276		

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D 276	Continued From page 27 The findings are: Review of Resident #1's current FL-2 dated 03/029/22 revealed: -Diagnoses included major depressive disorder, history of epilepsy and Alzheimer's disease. -The resident was constantly disoriented. -The resident had neurological convulsions and seizures. -The resident needed assistance with bathing, feeding, and dressing. Review of Resident #1's signed physician's telephone orders dated 12/02/22 revealed: -Chair alarm to be used when she was up and in her wheelchair daily every shift. -Ensure the chair alarm was on and working. Observation of Resident #1's room 12/02/22 at 10:26am revealed a medication aide (MA) brought a chair alarm into the room and placed it in the wheelchair. Interview with the MA on 12/02/22 at 10:26am revealed the Resident Care Coordinator (RCC) told her to put the chair alarm in Resident #1's wheelchair. Observation of Resident #1's room on 12/05/22 at 11:07am revealed: -Her chair alarm was sitting on top of her refrigerator. -She was lying in her bed. Observation of Resident #1's room on 12/05/22 from 11:37am to 12:07pm revealed: -2 PCAs entered her room and took her to the dining room in her wheelchair. -There was no chair alarm attached to the	D 276		

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wheelchair.
-The chair alarm was sitting on top of the resident's refrigerator.
-At 12:07pm, a personal care aide (PCA) returned with Resident #1; there was no chair alarm attached to the wheelchair.

Interview with a PCA on 12/05/22 at 12:09pm revealed:
-The RCC or Lead Supervisor were responsible to ensure communication regarding orders for chair alarms were provided to the facility staff.
-She was not aware Resident #1 had a chair alarm.

Second interview with the MA on 12/05/22 at 12:32pm revealed:
-The MAs and the RCC were responsible to ensure the order for the chair alarm was communicated to the facility staff and the MAs.
-She informed the PCAs to ensure the alarm was on Resident #1, but she did not specify which alarm.
-The PCAs were responsible to ensure the chair alarm was in the chair.

Interview with the Lead Superevisor on 12/05/22 at 12:22pm revealed:
-The RCC and the Lead Supervisor informed staff of new orders in the daily morning meetings but neither of them was in attendance this morning, 12/05/22.
-In the absence of the RCC and Lead Supervisor in the morning meetings, the Executive Director (ED) was responsible to communicate new orders for residents to the facility staff.
-The MAs participated in the morning meetings where new orders were discussed.
-The RCC and Lead Supervisor had not had time this morning to communicate new orders for

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D 276	Continued From page 29 Resident #1's chair alarm. -The MAs were responsible to communicate to the PCAs new orders for Resident #1's chair alarm. Observation of Resident #1's room on 12/05/22 at 12:36pm revealed the MA went into the room, removed the chair alarm from sitting on top of the refrigerator, verified it was working and attached it to the wheelchair. Interview with the ED on 12/05/22 at 12:26pm revealed: -She did not know why the facility staff were not told about Resident #1's chair alarm. -The RCC was responsible to inform the facility staff Resident #1 had an order for a chair alarm. -The MAs were responsible to ensure the chair alarm was in the wheelchair and working properly. -She was not aware Resident #1's chair alarm was in her room, sitting on top of the refrigerator; she thought it had to be ordered. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.	D 282		

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D 282	Continued From page 30 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents' food was free from contamination as evidence by multiple flies flying around during meals and landing on their food. The findings are: Observations of the main dining room on 11/30/22 at 5:45pm revealed: -There were residents in the dining room eating dinner. -There were at least 2 facility staff, and 2 family members present in the dining room. -There were flies flying around the residents while they were eating. -A fly landed on 2 residents' sandwiches while the residents were eating. -No staff were present at the tables with the residents. -The surveyor prompted the facility staff, and the staff replaced the food. Observations of the back dining room on 12/01/22 at 7:42am revealed: -Scrambled eggs, hash brown potatoes, sausage link, toast and diced pineapples were served for breakfast. -There were residents in the dining room eating breakfast. -There were 2 facility staff and one staff from the kitchen present. -There were flies flying around the residents and the tables. -The facility staff placed 2 plates of food on the table where no residents were sitting. -A fly landed on the plate of eggs and a bowl of pineapples and crawled around the bowl and crawled inside the bowl.	D 282		

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-A fly landed on the mouthpiece of a resident's opened carton of milk.
-The surveyor prompted the facility staff, and the staff replaced the food and the milk.

Interview with a personal care aide (PCA) on 12/01/22 at 7:57am revealed:
-There was a bag to catch flies in the dining room, but someone removed it.
-The facility was aware how bad the flies were in the dining room.
-She fanned the flies away from the residents' food but could not fan them all.
-She tried to ensure the residents were all in the dining room before serving their plates to prevent the flies from landing on their food.

Interview with a resident on 12/01/22 at 8:00am revealed:
-The flies were bad, and the facility needed to do something.
-There were fly strips hanging in the dining room, but the facility took them down.

Interview with a second PCA on 12/01/22 at 8:04am revealed:
-She tried to ensure the residents were all in the dining room before serving their plates to prevent the flies from landing on their food.
-She fanned the flies away from the residents to prevent them from landing on their food.
-There were fly strips hanging in the dining room, but someone (not sure who) told us we had to remove them.

Interview with the Dietary Manager (DM) on 12/01/22 revealed:
-He made the Executive Director (ED) and the owner aware of how bad the flies were in the kitchen.

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-The local health department stated to him he could use the disposable fly trap bags but not the fly strips.
-The owner recommended he used the disposable fly trap bags.

Interview with the Maintenance Director (MD) on 12/01/22 at 8:20am revealed:
-She took down all the fly strips and old disposable fly trap bags about 2 weeks ago (not sure of specific date).
-She planned to put disposable fly trap bags in both the dining rooms.
-She had not had time to hang the disposable fly trap bags.

Telephone interview with a representative of the local environmental health office on 12/05/22 at 8:05am revealed:
-She suggested to the facility to work with a local pest control company related to the flies in the facility.
-The facility was not allowed to use any household products to control or prevent the flies.
-The facility had to use products labeled for facility use to control or prevent the flies.
-There was a concern with the flies when they landed on residents' food because that made the food unfit to consume; therefore, causing contamination.

Interview with the ED on 12/01/22 at 8:26am revealed:
-She was aware there was a problem with the flies.
-She did not know how to keep the flies from landing on residents' food while they were in the dining room.

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure that the rights of all residents were maintained related to residents being treated with respect and dignity and residents being free of mental and physical abuse. The findings are: 1. Review of Resident #14's current FL-2 dated 10/04/22 revealed: -Diagnoses included cerebral infarction, epilepsy, seizures, anxiety, and major depressive disorder. -She was intermittently disoriented. -She was semi-ambulatory. Interview with Resident #14 on 12/01/22 at 10:35am revealed: -A personal care aide (PCA) was rough with her while giving her a shower (not sure of exact date). -The PCA grabbed her arm and caused it to bruise. -The PCA was verbally rude and had a bad attitude toward her. -The PCA treated her like "a dog." -She told the Resident Care Coordinator (RCC) and the medication aide (MA) working on duty (not sure which MA) that the PCA was rude and rough with her.	D 338		

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-The RCC stated that was a big accusation against someone.
-She showed the bruises to the RCC.
-The RCC informed the Administrator of her complaint against the PCA.
-Afterwards, the RCC and the Administrator never said anything to her about the incident.
-She felt like the RCC, and the Administrator did not care about what happened to her.

Interview with the RCC on 12/02/22 at 10:18am revealed:
-Resident #14 accused a PCA of being rough and not attending to her needs.
-She informed Resident #14 the allegation was serious, and the facility would investigate.
-She informed the Administrator of the incident.
-The PCA was suspended while an investigation was completed.

Interview with the Administrator on 12/02/22 at 11:24am revealed:
-Resident #14 stated a PCA was rough with her during her personal care.
-Resident #14 did not show her any bruises.
-She completed an investigation and found the allegations were unsubstantiated.

Review of Resident #14's shower skin assessment dated 09/05/22 revealed:
-There was an old bruise on the left side of her stomach.
-There was swelling in her left foot.

Review of the investigation report dated 09/07/22 revealed Resident #14 reported to the RCC on the evening of 08/31/22 the PCA had taken her gown off roughly and it caused a bruise on her stomach, and she took her sock off roughly causing a bruise on her foot.

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D 338	Continued From page 35 Attempted telephone interviews with the PCA on 12/05/22 at 2:18pm and 12/06/22 at 8:58am were unsuccessful. 2. Interview with a resident on 12/05/22 at 1:04pm revealed: -Staff did not want to help residents. -Some staff were not nice. -She had pain in her stomach and burning with urination which made it hard to sleep. -Some MAs did not care to give her medication for her stomach and an antibiotic that worked. -She did not have an order for the medications, but no one contacted the primary care provider to get an order for "a long time". Interview with a second resident on 12/01/22 at 10:08am revealed: -The exit door in the day room on hall 2 was locked that morning (12/01/22) while he was outside on the porch area. -No one told him the door would be locked when he went out of the unlocked door. -No one told him how to re-enter the facility. -No one came out to check on him or offer assistance getting back in. -He had to walk to the front the door which was "quite a ways" with a cane and he feared falling. -"It's terrible to live like this, I feel like I'm not considered at all." Telephone interview with a former staff on 12/03/22 at 10:36am revealed: -During the first week of November 2022, she heard Staff B tell a resident that came to her for a cup of ice, "Jesus Christ, you couldn't have went to someone on the back hall? You had to bother me?" -She reported the incident to the Administrator,	D 338		

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but Staff B continued to ignore and speak disrespectfully to residents.
-Staff B was reported to the Resident Care Coordinator (RCC) and Administrator several times.
-The RCC and Administrator did not see how staff treated residents because they never came out of their offices.

Interview with the Administrator on 12/06/22 at 1:10pm revealed:
-The former staff who posted the allegations on 11/14/22 did not report concerns to her related to how staff treated residents.
-No one had reported concerns about how staff treated residents.
-If the former staff or anyone had reported the concerns, she would have initiated an immediate investigation.
-Nothing was done at the time of the social media post because it was a social media rant of a disgruntled employee.

3. Interview with a resident on 11/30/22 at 10:49am revealed:
-Some of the dietary staff had an "attitude".
-One of the dietary staff told the resident that she would not warm up the resident's breakfast because "it was not her job" in a disrespectful tone.
-The resident tried to speak to the dietary staff person, but the staff person would turn around and not speak to the resident.
-There was a second dietary staff person who was in the hall yesterday (11/29/22) and asked the resident in a disrespectful tone if the resident wanted something because the resident was standing in the hall.
-There was a personal care aide (PCA) who spoke "hateful' to the resident and "disrespects

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me" by ignoring the resident.
-The Administrator was aware and had spoken to one of the staff a couple of weeks ago, but it did not do any good; the staff person was still disrespectful.

Interview with the Administrator on 12/06/22 at 1:10pm revealed no one had reported staff being disrespectful or talking in a disrespectful manner to residents.

4. Observation of a resident's bathroom on 11/30/22 at 10:20am revealed:
-There was a washcloth approximately 13 inches by 13 inches hanging on a towel rack to the right of the sink.
-The washcloth had strings approximately 2 inches in length around each edge of the washcloth where the washcloth had been overused.

Observation of the community spa on 12/01/22 at 8:37am revealed:
-There was a 3 drawer plastic container beside the sink.
-The top drawer had one bath towel approximately 27 inches by 52 inches that was not folded.
-Observation of the towel after removing it from the top drawer revealed there was a hole in the middle of the towel approximately 7 inches and an area near the right edge of the towel that had thin strings covering an area of approximately 4 inches wide.
-This was the only towel observed in the community spa on 12/01/22.

Observation of the laundry room on 12/01/22 at 8:52am revealed:
-There were 13 towels folded on a table.

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-One folded towel had a brown stain on the white towel.
-Six of the folded white towels had frayed edges.
-There were 10 folded washcloths on the table.

Interview with a resident's family member on 12/05/22 at 1:05pm revealed:
-She was related to two residents that shared a room and visited them daily.
-She had purchased 20 washcloths and 20 towels for both family members a year ago and written their names on them.
-She had reported her concern to the Administrator a few times in the past 2 months that she was unable to find their washcloths and towels and the resident's deserved to have the towels and washcloths she had purchased for their personal use.
-She was frustrated because her two family members did not have enough washcloths and towels.
-She visited her family every day to be sure they did not need anything.

Interview with a resident whose family member was present during the interview on 12/05/22 at 1:20pm revealed:
-He went to the community bathroom earlier today to get a washcloth and towel to bathe himself.
-A personal care aide (PCA) came to his room a few minutes later and "snatched" the items out of his hand and told him he could not have the washcloth and towel.

Interview with a personal care aide (PCA) on 12/06/22 at 9:18am revealed:
-She had reported her concerns of limited towels and washcloths to the Administrator several times; most recently the beginning of November

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D 338	Continued From page 39 2022. -The Administrator had informed her that she would address the issue of limited washcloths and towels each time she reported her concern; however, there was never any improvement. Telephone interview with a former staff on 12/03/22 revealed: -There were not enough towels in the facility for 2 to 3 months and the washer was broken in October 2022, so towels were not cleaned fast enough for residents to shower and bathe. -The towels would normally run out on first shift and residents who were scheduled for second shift showers would not have clean towels. -In the first week of November 2022, a resident was sobbing in the hallway because the personal care aides (PCAs) told her she could not shower due to no clean towels. _____ The facility failed to ensure all residents were treated with respect and dignity and residents being free of mental and physical abuse. The facility's failure resulted residents being handled roughly during care, spoken to in a disrespectful manner and not being granted access in and out of the building and to every day items such as a cup of ice and clean towels. This failure was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/22/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2023.	D 338		

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AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

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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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 8 residents (#2, #3, #8, #9) sampled for record review including errors with medications for moderate to severe pain (#2, #3, #8), a medication used to aid in the digestion of food (#2), medications for anxiety (#2, #8), and a lubricant eye drop for dry eyes (#9). The findings are: 1. Review of Resident #2's current FL-2 dated 07/04/22 revealed diagnoses included type 2 diabetes, difficulty in walking, and muscle weakness. a. Review of Resident #2's current FL-2 dated 07/04/22 revealed an order for Oxycodone/Acetaminophen (APAP) 10-325mg take 1 tablet every 6 hours. (Oxycodone/APAP is a controlled substance used to treat moderate to severe pain.)	D 358		

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D 358	Continued From page 41 Review of Resident #2's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 12:00am, 6:00am, 12:00pm, and 6:00pm. -Oxycodone/APAP 10-325mg was not documented as administered on 10/31/22 at 12:00am, 6:00am, 12:00pm, or 6:00pm due to being "on hold" for those 4 doses. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 12:00am, 6:00am, 12:00pm, and 6:00pm. -Oxycodone/APAP 10-325mg was not documented as administered on 11/01/22 at 12:00am, 6:00am, 12:00pm, or 6:00pm due to being "on hold" for those 4 doses. Review of Resident #2's October 2022 and November 2022 controlled substance records (CSRs) revealed: -There was a dose of Oxycodone/APAP 10-325mg documented as administered on 10/30/22 at 5:00pm, leaving a balance of 0 tablets. -There were 4 doses of Oxycodone/APAP 10-325mg not documented as administered on 10/31/22 at 12:00am, 6:00am, 12:00pm, and 6:00pm for a total of 4 missed doses. -There were 4 doses of Oxycodone/APAP 10-325mg not documented as administered on 11/01/22 at 12:00am, 6:00am, 12:00pm, and 6:00pm for a total of 4 missed doses. -There was a 0 balance with no Oxycodone/APAP 10-325mg tablets available to administer for the 8 consecutive missed doses on 10/31/22 and	D 358		

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11/01/22.
-There was documentation of 120 Oxycodone/APAP 10-325mg tablets being received on 11/01/22 at 9:04pm, increasing the balance from 0 to 120 tablets on hand.

Review of Resident #2's physician's orders revealed no orders were signed on 10/31/22 or 11/01/22 to hold the Oxycodone/APAP 10-325mg and there were no verbal orders to hold the medication on 10/31/22 and 11/01/22.

Review of Resident #2's pharmacy dispensing, delivery and shipping records for August 2022 - November 2022 revealed:
-There were 120 Oxycodone/APAP 10-325mg tablets dispensed on 08/31/22 and delivered to the facility on 08/31/22.
-There were 120 Oxycodone/APAP 10-325mg tablets dispensed on 09/25/22 and delivered to the facility on 09/26/22.
-There were 120 Oxycodone/APAP 10-325mg tablets dispensed on 10/31/22 and shipped on 10/31/22.

Review of Resident #2's provider notification forms revealed:
-On 10/30/22, 10/31/22, and 11/01/22, medication aides (MAs) wrote notes to request to hold Oxycodone/APAP.
-The notes were requests not verbal orders.
-The provider notification forms were signed by the primary care provider (PCP) on 11/09/22, after the medication was resumed on 11/02/22 and no longer being held due to unavailability.

Interview with Resident #2 on 11/30/22 at 10:49am revealed:
-She took Oxycodone for pain and the facility had run out of the Oxycodone "about every month".

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-She last ran out of Oxycodone last month and she was out of it for the "whole weekend".
-She had surgery on her back 3 times in the past, so she took Oxycodone for lower back pain.
-She also took Oxycodone for her left knee which she had surgery on in the past as well.
-The pain "was bad", when she was out of the Oxycodone.
-When she was out of the Oxycodone last month, her pain level was "probably a 20" on a scale of 0 to 10 with 0 being no pain and 10 being severe pain.

Telephone interview with a MA on 12/05/22 at 11:04am revealed:
-When Resident #2 was out of her pain medication, the resident was upset and complained of being in pain.
-Resident #2 did not want to do a lot or talk a lot when she was out of her pain medication.

Interview with a second MA on 12/05/22 at 11:46am revealed:
-Resident #2 kept asking for her pain medication when it ran out.
-She was unsure why Resident #2 ran out of her pain medication.

Telephone interview with a pharmacist at the facility's new contracted pharmacy on 12/05/22 at 4:21pm revealed:
-The facility sent a fax refill request for Resident #2's Oxycodone/APAP 10-325mg tablets on 10/30/22.
-They did not receive a refill request for Resident #2's Oxycodone/APAP 10-325mg prior to 10/30/22.
-They received a prescription for Resident #2's Oxycodone/APAP 10-325mg dated and dispensed on 10/31/22 that was delivered to the

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facility on 11/01/22.

Interview with Resident #2's PCP on 12/06/22 at 11:45am revealed:
-Resident #2 took Oxycodone/APAP 10-325mg every 6 hours because she had severe degenerative disc disease, chronic stenosis of the lumbar spine, and a cervical spine fusion last year.
-The resident also had a left knee replacement and degenerative joint disease, causing chronic pain syndrome.
-The facility staff sometimes called or texted her when they needed a hard prescription.
-There was usually a list of residents in her folder who needed hard prescriptions when she made weekly visits to the facility.
-She was concerned that Resident #2 would be in pain when the medication was unavailable.
-She was concerned that Resident #2 could have withdrawal symptoms such as body aches and overall not feeling good within 4 hours of missing a dose of Oxycodone/APAP.

b. Review of Resident #2's current FL-2 dated 07/04/22 revealed an order for Lorazepam 1mg take 1 tablet twice daily. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #2's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 1mg take 1 tablet twice a day scheduled for 8:00am and 8:00pm.
-Lorazepam was not documented as administered on 10/25/22 at 8:00am to being "on hold" for that dose.

Review of Resident #2's October 2022 controlled

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substance record (CSR) revealed:
-There was a dose of Lorazepam 1mg documented as administered on 10/24/22 at 8:30pm, leaving a balance of 0 tablets.
-Lorazepam was not documented as administered on 10/25/22 at 8:00am
-There were 60 Lorazepam 1mg tablets documented as received on 10/25/22 at 4:57pm, increasing the balance from 0 to 60 tablets.

Review of Resident #2's pharmacy dispensing and shipping records for October 2022 revealed there were 60 Lorazepam 1mg tablets dispensed and shipped on 10/24/22.

Review of Resident #2's physician's orders revealed no order to hold Lorazepam on 10/25/22.

Interview with Resident #2 on 12/06/22 at 11:37am revealed:
-She took Lorazepam because she was anxious at times
-She did not recall running out of Lorazepam.

Interview with Resident #2's primary care provider (PCP) on 12/06/22 at 11:45am revealed:
-Resident #2 took Lorazepam for anxiety
-Not receiving Lorazepam could cause the resident to have withdrawal symptoms such as abdominal pain and dizziness.

c. Review of Resident #2's current FL-2 dated 07/04/22 revealed:
-There was an order for Creon 36000 units take 2 capsules 3 times a day with meals. (Creon is used to aid in digestion when the pancreas does not produce enough enzymes for proper digestion.)
-There was an order for Creon 36000 units take 1

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capsule with each snack at 10:00am, 3:30pm, and 7:00pm.

Review of Resident #2's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Creon 36000 units take 2 capsules 3 times daily with meals scheduled for 8:00am, 12:00pm, and 5:00pm.
-Creon was not documented as administered on 10/20/22 and 10/21/22 at 5:00pm due to being "on hold" for those 2 doses.
-There was an entry for Creon 36000 units take 1 capsule with each snack at 10:00am, 3:30pm, and 7:00pm.
-Creon was not documented as administered on 10/21/22 at 3:30pm and 7:00pm due to being "on hold" for those 2 doses.

Review of Resident #2's physician's orders revealed no orders were signed on 10/20/22 or 10/21/22 to hold the Creon and there were no verbal orders to hold the medication on 10/20/22 and 10/21/22.

Review of Resident #2's pharmacy dispensing and shipping records for September 2022 and October 2022 revealed:
-There were 81 (9-day supply) Creon 36000 unit capsules dispensed on 09/29/22.
-There were 42 (7-day supply) Creon 36000 unit capsules dispensed and shipped on 10/03/22.
-There were 90 (10-day supply) Creon 36000 unit capsules dispensed and shipped on 10/04/22.
-There were 90 (10-day supply) Creon 36000 unit capsules dispensed and shipped on 10/20/22.

Review of Resident #2's provider notification forms revealed:
-On 10/20/22 and 10/21/22, a medication aide

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(MA) wrote a note that Creon was on hold on the form.
-The notes were requests not verbal orders.
-The provider notification forms were signed by the primary care provider (PCP) on 10/31/22, after the medication was resumed on 10/22/22 a no longer being held due to unavailability.

Interview with Resident #2 on 12/06/22 at 11:37am revealed:
-She took Creon because of issues with her intestines that caused her to have diarrhea.
-When she was out of the Creon (in October 2022), she had diarrhea.

Interview with Resident #2's PCP on 12/06/22 at 11:45am revealed:
-She did not originally prescribe Creon for Resident #2.
-She was not sure why the resident was taking Creon but thought it may be related to gastrointestinal issues.
-She was unsure how missing doses of Creon would affect the resident since she was unsure why the resident was taking it.

Interview with a MA on 12/05/22 at 12:08pm revealed:
-She usually tried to order medications when there was a 7 to 10 days supply on hand because the medications had to come from the new contracted pharmacy in another state.
-The new contracted pharmacy usually made 1 delivery on weekdays between 1:00pm - 4:00pm.
-There was a local back-up pharmacy but they had to contact the contracted pharmacy who would send orders to the back-up pharmacy.
-Scheduled medications were on weekly cycle fills except for controlled substances.
-They sometimes needed a hard prescription for

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the controlled substances and the MAs, the Resident Care Coordinator (RCC), the Lead Supervisor, and Supervisors were all responsible for getting hard prescriptions.
-The hard prescriptions were sent to the new contracted pharmacy via mail and a copy was faxed to the pharmacy.
-They usually received the medications within 1 to 2 days of sending the order to the pharmacy.
-If they ran out of a resident's medication, the MAs usually "wrote an order" on a provider notification form to put the medication on hold and they would put it in the PCP's folder to sign when she came to the facility.
-The MAs were trained to put a medication on hold in the eMAR system when a medication was unavailable rather than document the medication was unavailable.
-There was no physician's order to hold the medication and the PCP may not be aware a medication was unavailable until she saw the provider notification form during her weekly visit to the facility.
-The MAs, RCC, Lead Supervisor, or Supervisors had access to and could put a medication on hold in the eMAR system.

Telephone interview with a second MA on 12/05/22 at 11:04am revealed:
-The MAs were responsible for notifying the provider when a hard prescription was needed.
-With the new contracted pharmacy, they wanted a hard copy of the prescription and there was a 3-day shipping process.
-The MAs were supposed to reorder when there was a one-week supply on hand.
-The MAs were trained to document "on hold" instead of unavailable when a medication was not on hand to administer.
-The MAs had to write a "hold order" and put it in

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the PCP's folder for her to sign.
-The MAs did not take a verbal order to hold the medications, they just wrote a request to hold when a medication was unavailable.
-The MAs would put the order "on hold" in the eMAR system until the medication came in from the pharmacy.
-The MAs were holding medications without an order to hold the medications because they were not allowed to document a medication was unavailable.
-This was done for any medication, including controlled substances.
-She was trained to do this by other MAs.
-The former Lead Supervisor called her once after she had documented a medication unavailable and told her to never document that medications were unavailable but to document the medication as "on hold".

Interview with a third MA on 12/05/22 at 11:46am revealed:
-If a medication was not available, the MAs had to "write a hold order to cover themselves" and the PCP would sign it when she came to the facility.
-She was always told by supervisors to put "on hold" on the eMAR and not to document a medication was unavailable.
-She could also call or text the PCP for a new order but she did not document the calls or texts.
-She usually reordered a medication when the supply got down to 20 pills but she thought some MAs reordered when there were 10 pills remaining.
-The MAs were supposed to let the PCP know and the PCP would write a new hard prescription and the prescriptions were mailed to the new contracted pharmacy in another state.
-The facility had a local back up pharmacy but it still took a long time to get medication from the

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back up pharmacy.
-She thought with the new contracted pharmacy, the facility only got medication deliveries about twice a week.
-The former contracted pharmacy usually delivered medications the same day they were ordered.

Telephone interview with the Front End Manager at the facility's former contracted pharmacy provider on 12/02/22 at 1:08pm revealed:
-The facility was responsible for getting hard prescriptions or notifying the provider of the need for an e-script for controlled substances.
-If the pharmacy received a prescription before the cut off time, the medication would be sent that same night.
-If the pharmacy received a prescription after the cut off time, the medication would be sent the next day.
-She could not recall the facility's cut off time when they serviced the facility.
-The pharmacy would not have requested a refill or prescription from a provider unless the facility requested a refill from the pharmacy.

Telephone interview with a pharmacist at the facility's new contracted pharmacy on 12/05/22 at 4:21pm revealed:
-They started providing services to the facility on 10/03/22.
-The facility should allow 3 business days for refill requests for controlled substances.
-The refill request could be made by phone or fax and all medications were delivered by courier.
-The pharmacy delivered on weekdays and Saturdays but not on Sunday.
-The facility could utilize the local back up pharmacy if needed, especially for antibiotics or controlled substances.

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D 358	Continued From page 51 -For controlled substances, a hard prescription was needed or the provider could send an e-script. Interview with the Lead Supervisor on 12/05/22 at 12:42pm revealed: -The facility switched contracted pharmacies around the beginning of October 2022. -She usually reordered medications or got a new hard prescription when there was a 7-day supply of medication on hand. -With the new pharmacy, a hard prescription was usually faxed and mailed to the pharmacy. -Medications were usually delivered to the facility between 2:00pm and 3:00pm Monday through Friday. -Until about 2 weeks ago, the new pharmacy would not send a controlled substance without a hard prescription but now the providers could send e-scripts. -The facility had run out of some residents' medications while waiting for hard prescriptions to get sent to the new pharmacy. -The MAs were responsible for contacting the provider to see if there was anything they could do to get the medication through the back-up pharmacy. -If a medication was unavailable, it was documented as on hold in the eMAR system. -She thought the medications were on hold because the MAs were told by the provider to put them on hold. -If there were verbal orders to hold the medications, verbal orders should be specified and documented in the resident's record. -The MAs were supposed to call the provider for a verbal order to hold a medication each time the medication was unavailable. -She first stated she was not aware of MAs being instructed to document unavailable medications	D 358		

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as on hold in the eMAR system, then she changed her statement and said she was trained to put those medications on hold as well.
-She printed an eMAR compliance report every Friday and could see any medications documented as on hold.
-She gave the reports to the MAs and the MAs were responsible for notifying the providers and the RCC.
-She did not follow-up with the MAs to see if the MAs were notifying the provider or the RCC.

Interview with the RCC on 12/06/22 at 12:36pm revealed:
-Controlled substance should be ordered 5 days prior to the resident running out of medication because she did not think insurance would pay for it sooner.
-A hard prescription should be requested 5 days before a medication ran out or an e-script could be sent to the new pharmacy.
-If a hard prescription was obtained, it was mailed via express overnight mail to the new pharmacy.
-If it was mailed today and requested to be sent out, the facility would receive the medication tomorrow.
-The facility's back up pharmacy could also be used if needed.
-The facility's contracted PCP was at the facility once a week so they could get prescriptions from her.
-The MAs should let her know if they were having trouble getting a medication in for a resident.
-If a medication was unavailable, it was placed on hold in the eMAR system.
-The MAs were supposed to call and get a verbal order to hold the medication as soon as it was placed on hold in the eMAR system.
-She thought the MAs were documenting the verbal orders on the provider notification forms

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and putting them in the facility's contracted PCP's folder for her to countersign each week.
-She had not noticed the MAs were not doing verbal orders but requesting hold orders instead.
-The MAs should not hold a medication without an order from the provider.

Interview with the Administrator on 12/05/22 at 1:55pm revealed:
-She became the full-time Administrator at the facility in the end of July 2022.
-She was not aware of or familiar with the facility's policy for ordering medications.
-She relied on the RCC to oversee the medication ordering process.
-She was not aware residents' medications were unavailable.
-She would expect to be notified by staff if a medication was needed and not in the facility.
-If a medication was unavailable, she expected them to find out why it was unavailable and get it in the facility one way or another.
-She did not review any reports related to the eMARs yet because she was still being taught how to read those reports.

Interview with Resident #2's PCP on 12/06/22 at 11:45am revealed:
-She thought there may have been some issues with the new facility pharmacy needing hard prescriptions.
-She thought the facility was requesting hold orders when the medication was not in the facility because of problems with the pharmacy.
-She signed the requests for hold orders that were left in her folder because she thought the medication was not in the facility at that time.
-She was not aware the facility was not requesting refills or hard prescriptions until the medication had already run out.

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-Staff had not called her for a verbal order for each dose of a missed medication.
-They usually called her or texted her if they needed a hard prescription.
-She was not aware the facility was actually holding medications in the eMAR system without notifying her at the time they held the medication.

2. Review of Resident #3's current FL-2 dated 02/23/22 revealed diagnoses included cognitive impairment, short term memory loss, major depression, hypertension, history of falls, and clavicle fracture.

Review of Resident #3's physician's order dated 06/03/22 revealed an order for Hydrocodone/Acetaminophen (APAP) 5-325mg take 1 tablet 4 times a day. (Hydrocodone/APAP is a controlled substance used to treat moderate to severe pain.)

Review of Resident #3's Event Report dated 11/14/22 revealed:
-A medication error was discovered on 11/14/22 at 12:57pm during controlled substance count.
-The medication aide (MA) pulled the incorrect resident's medication and administered Oxycodone/APAP 10-325mg instead of Hydrocodone/APAP 5-325mg to Resident #3. (Oxycodone/APAP is a controlled substance used to treat moderate to severe pain. Oxycodone and Hydrocodone are not the same.)
-The primary care provider (PCP) was notified and instructions were given to check the resident hourly for 24 hours and notify the PCP of any change.
-The MA was counseled on the rights of medication administration.

Review of Resident #3's November 2022

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electronic medication administration record (eMAR) revealed:
-There was an entry for Hydrocodone/APAP 5-325mg take 1 tablet 4 times a day scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Hydrocodone/APAP 5-325mg was documented as administered 4 times a day including the 12:00pm dose on 11/14/22.

Review of Resident #3's November 2022 electronic controlled substance record (CSR) revealed:
-On 11/14/22 at 12:07pm, 1 Hydrocodone/APAP 5-325mg tablet was documented as administered leaving a balance of 15 tablets.
-On 11/14/22 at 12:52pm, 1 Hydrocodone/APAP 5-325mg tablet was documented as "received", increasing the balance to 16 tablets.
-The next tablet was documented as administered on 11/14/22 at 4:54pm.

Review of the other resident's November 2022 electronic CSR revealed on 11/14/22 at 12:53pm, 1 tablet was documented as "gave wrong medication" and the balance was declined by 1 tablet.

Interview with Resident #3 on 12/05/22 at 5:07pm revealed:
-He had received the wrong medication "once or twice", but he could not recall the details or when.
-He did not recall having any side effects from receiving the wrong medication.

Telephone interview with the MA on 12/02/22 at 3:51pm revealed:
-On 11/14/22, she was being observed and tested during the medication pass by the Area Clinical Director/Registered Nurse (ACD/RN).
-She administered another resident's

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D 358	Continued From page 56 Oxycodone/APAP 10-325mg tablet to Resident #3 instead of his Hydrocodone/APAP 5-325mg in error. -She called the PCP and the PCP said the resident would be fine. -She was no longer administering medications because of the medication error and she was told she was not filling out progress notes correctly. Interview with the ACD/RN on 12/06/22 at 11:28am revealed: -On 11/14/22, she was doing revalidation with a MA during a medication pass. -She did annual revalidation for all MAs but she also revalidated this particular MA because the MA had concerns with her comfort on administering medications. -She was with the MA at the medication cart during the medication pass on 11/14/22. -During the medication pass, Resident #3 came to the medication cart and the MA asked the resident if he wanted his Hydrocodone and the resident said yes. -The MA pulled out a medication card from the controlled substance drawer of the medication cart and "popped" a medication into a cup and administered it to Resident #3. -She did not see which medication the MA put into the medication cup and administered to the resident. -She thought it was Resident #3's Hydrocodone/APAP tablet. -She had no explanation for not checking the medication during the revalidation process. -Once she completed the revalidation with the MA, the MA did a controlled substance count with another MA prior to handing off the keys to the medication cart. -The MAs found a discrepancy when they did the controlled substance count and realized Resident	D 358		

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#3 was administered another resident's Oxycodone/APAP in error.
-The MAs notified their supervisor, the Administrator, and the Resident Care Coordinator (RCC).
-A medication error report was completed and the PCP was notified.
-She discussed the medication error with the MA and the MA reported she did not want to administer medications anymore because she was uncomfortable doing it.
-The resident was monitored but had no symptoms or side effects from receiving the wrong medication.

Interview with Resident #3's PCP on 12/06/22 at 11:45am revealed:
-She was notified Resident #3 was administered Oxycodone/APAP instead of Hydrocodone/APAP.
-She gave instructions for the resident to be monitored because Oxycodone/APAP was a stronger medication than Hydrocodone/APAP.
-Oxycodone/APAP could cause the resident to have increased grogginess and an increased feeling of being "high" because it was a stronger medication.
-No side effects were reported for the resident due to the medication error.

3. Review of Resident #8's current FL-2 dated 10/24/22 revealed diagnoses included chronic obstructive pulmonary disease, obesity, functional paraparesis, sinus bradycardia, type II diabetes mellitus, major depressive disorder, anxiety and dementia.

a. Review of Resident #8's FL-2 dated 10/24/22 revealed an order for oxycodone/acetaminophen (APAP) 10/325mg every 4 hours.
(Oxycodone/APAP is a controlled substance used

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D 358	Continued From page 58 to treat moderate to severe pain.) Review of Resident #8's prescription order dated 10/05/22 revealed an order for Oxycodone/APAP 10/325mg every 4 hours. Review of Resident #8's prescription order dated 11/16/22 revealed an order for Oxycodone/APAP 10/325mg every 4 hours. Review of Resident #8's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone/APAP 10/325mg every 4 hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm. -The following 13 doses were documented on hold: 11/14/22 at 6:00pm and 10:00pm, 11/15/22 at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm and 10:00pm, and 11/16/22 at 2:00am, 6:00am, 10:00am, 2:00pm and 6:00pm. Review of Resident #8's controlled substance report (CSR) for Oxycodone/APAP revealed: -The remaining count was 0 tablets on 11/4/22 at 2:08pm. -90 tablets were received on 11/16/22 at 10:26pm. Review of Resident #8's provider notification form dated 11/14/22 revealed: -A medication aide (MA) documented a request to hold Oxycodone. -The primary care provider signed the request on 11/28/22. Review of Resident #8's provider notification form dated 11/14/22 revealed: -A MA documented a request to hold Oxycodone	D 358		

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D 358	Continued From page 59 at 6:00pm. -The PCP signed the request on 11/28/22. Review of Resident #8's provider notification form dated 11/15/22 revealed: -The Lead Supervisor documented a request to hold Oxycodone for the 10:00am, 2:00pm and 6:00pm doses. -The primary care provider (PCP) signed the request on 11/28/22. Review of Resident #8's provider notification form dated 11/15/22 revealed: -A MA documented a request to hold Oxycodone. -The PCP signed the request on 11/28/22. Review of Resident #8's provider notification form dated 11/15/22 revealed: -A MA documented a request to hold Oxycodone at 2:00am and 6:00am. -The PCP signed the request on 11/28/22. Review of Resident #8's electronic progress note dated 11/15/22 revealed: -The Resident Care Director (RCC) documented she requested a refill of the resident's Oxycodone from the pharmacy. -She was told the oxycodone would be filled and sent with the next pharmacy run. Review of Resident #8's provider notification form dated 11/16/22 revealed: -A MA documented a request to hold Oxycodone. -The PCP signed the request on 11/28/22. Review of Resident #8's provider notification form dated 11/16/22 revealed: -A MA documented a request to hold Oxycodone at 10:00am. -The PCP signed the request on 11/28/22.	D 358		

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D 358	Continued From page 60 Review of Resident #8's provider notification form dated 11/16/22 revealed: -A MA documented a request to hold Oxycodone at 2:00pm. -The PCP signed the request on 11/28/22. Review of Resident #8's provider notification form dated 11/16/22 revealed: -A MA documented a request to hold Oxycodone at 6:00pm. -The PCP signed the request on 11/28/22. Interview with Resident #8 on 12/05/22 at 1:04pm revealed: -Her pain medications ran out for 3 days a couple of weeks ago (11/14/22-11/16/22). -The pain in her feet was "bad" for those 3 days. Interview with Resident #8's primary care provider (PCP) on 12/06/22 at 11:48am revealed: -Resident #8 could experience withdrawal symptoms after 4 hours of a missed dose. -Withdrawal symptoms included flu like symptoms with body aches and generalized unwell feeling. -She signed hold orders when she came to the facility weekly. -She was not called each time for a telephone order to hold medications. -The hold order was because a medication was not available from the pharmacy. b. Review of Resident #8's FL-2 dated 10/24/22 revealed an order for Clonazepam 0.5mg three times daily. (Clonazepam is a controlled substance used to treat anxiety.) Upon request on 11/29/22 and 12/06/22, a prescription order for Clonazepam 0.5mg for	D 358		

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D 358	Continued From page 61 Resident #8 was not provided for review. Review of a pharmacy delivery slip dated 10/24/22 revealed 90 tablets of Clonazepam 0.5mg for Resident #8 were delivered to the facility. Review of Resident #8's provider notification form dated 11/24/22 revealed: -A medication aide (MA) documented a request to hold Clonazepam. -The primary care provider (PCP) signed the request on 11/28/22. Review of Resident #8's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Clonazepam 0.5mg three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -The following 5 doses were documented as on hold: 11/24/22 at 8:00pm, 11/25/22 at 8:00am and 2:00pm, and 11/26/22 at 8:00am and 2:00pm. Review of Resident #8's controlled substance report (CSR) for Clonazepam revealed: -The remaining count was 0 tablets on 11/24/22 at 1:37pm. -90 tablets were received on 11/26/22 at 8:36pm. -The dosage strength of the clonazepam tablets was not documented. Interview with Resident #8 on 12/05/22 at 1:04pm revealed: -Her anxiety medication (Clonazepam) was cut in half when she was discharged from the hospital (10/21/22). -She was having a difficult time with the reduced dosage and found it hard to sleep at night.	D 358		

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D 358	Continued From page 62 Interview with Resident #8's primary care provider (PCP) on 12/06/22 at 11:48am revealed: -Resident #8 could experience withdrawal symptoms from missed doses of Clonazepam which was a benzodiazepine. -Withdrawal symptoms from benzodiazepines included seizures, dizziness, anxiety and difficulty sleeping. -She was not aware the facility was holding medications in the eMAR system without notifying her at the time they held the medication. Interview with the Lead Supervisor on 12/05/22 at 12:43pm revealed: -The facility switched to a new pharmacy at the beginning of October 2022. -Refills for controlled substance medications required a hard copy prescription order. -The Resident Care Coordinator (RCC) was responsible for getting hard copy prescriptions from the primary care provider (PCP) when she was at the facility. -She, the RCC or MAs contacted the PCP for hard copy prescriptions needed between her visits. -Everyone was different on when they requested hard copy prescriptions, she did not know of a policy on when to request. -She usually contacted the PCP when there were 7 days of medications left available for administration. 4. Review of Resident #9's current FL-2 dated 09/15/22 revealed: -Diagnoses included hypertension, cerebral vascular accident, gastro-esophageal reflux disease and left hemiplegia. -An order for Systane 0.6% ophthalmic 1 drop in both eyes four times daily. (Systane ophthalmic is used to treat dry eyes.)	D 358		

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D 358	Continued From page 63 a. Interview with Resident #9 on 11/30/22 revealed: -In early November 2022, a medication aide (MA) picked up another resident's eye drops and put the drops in her right eye. -The drops caused immediate burning in her right eye. -The MA and another staff member helped her to irrigate her eyes right away. -She did not see her primary care provider (PCP) for follow up. Review of Resident #9's October and November 2022 electronic medication administration records (eMARs) revealed: -There was an entry for Systane 0.6% ophthalmic 1 drop in each eye four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was no documentation of errors with administration. Interview with the RCC on 12/06/22 at 11:23am revealed: -Resident #9 was given COVID testing solution in her right eye instead of Systane eye drops. -The MA could not say how that happened. -The MA simply did not check the medication against the order on the eMAR prior to administering to the resident. -Normally, the MA who made the error was responsible for contacting the PCP and documenting on the medication error report. -The completed medication error report was given to her and the Administrator. Upon request on 12/02/22 and 12/06/22, Resident #9's medication error report related to eye drops was not provided for review.	D 358		

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D 358	Continued From page 64 Interview with the Administrator on 12/02/22 at 2:19pm revealed: -She was told immediately after it happened by the MA that Resident #9 received the wrong eye drops. -Poison control was contacted, and they said there was nothing dangerous about the drops placed in Resident #9's right eye. -Resident #9's PCP was notified. Telephone interview with the medication aide (MA) on 12/06/22 at 12:59pm revealed: -She removed the bottle of COVID testing solution from Resident #9's prescription bottle for the Systane eye drops. -The COVID testing solution bottle looked like Resident #9's eye drops. -She put drops in Resident #9's right eye and saw that the drops were clear and not milky. -That was when she realized she must not have thoroughly looked at the bottle before administering the drops to Resident #9. -She immediately went to the RCC and returned to the resident with the RCC. -Resident #9 said her right eye was burning. -The Administrator was present and put eye wash in the resident's eyes. -Resident #9 said her eyes felt better after the eye wash. -The MA on duty prior to her had been doing COVID testing and put the COVID testing solution in Resident #9's prescription bottle and put her eye drops in the COVID testing kit. Interview with Resident #9's PCP on 12/06/22 at 11:48am revealed: -She did not know Resident #9 received COVID testing solution in her right eye instead of Systane eye drops. -Resident #9 could have experienced an allergic	D 358		

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reaction, irritation, and inflammation to her sclera from having a solution placed in her eye that was not intended for ophthalmic use.

Second interview with the RCC on 12/06/22 at 12:55pm revealed:
-COVID testing at the facility was discontinued and there were no testing supplies at the facility.
-She had no idea how the MA confused the testing solution with eye drops.
-The testing solution was in a bottle similar to eye drops but was clearly labeled COVID testing solution.

Second interview with the Administrator on 12/06/22 at 1:10pm revealed:
-The MA told her she put COVID testing solution in Resident #9's eye instead of Systane eye drops.
-She washed the resident's eyes at the emergency eye wash station and called poison control.
-Poison control advised her to watch the resident's eye.
-She removed the COVID testing solution from the medication cart.
-The incident occurred approximately one week before the MA stopped working at the facility on 10/21/22.
-The MA was responsible for contacting the PCP and completing the medication error report.
-She and the RCC were responsible for reviewing the medication error report.

b. Review of Resident #9's provider notification form dated 10/07/22 revealed:
-A medication aide (MA) documented to hold Systane drops.
-The primary care provider (PCP) signed the request on 10/21/22.

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AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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 358	Continued From page 66 Review of Resident #9's provider notification form dated 10/08/22 revealed: -A MA documented to hold Systane drops. -The PCP signed the request on 10/21/22. Review of Resident #9's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Systane 0.6% ophthalmic 1 drop in each eye four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -The following 2 doses were documented as on hold: 10/08/22 at 4:00pm and 8:00pm. _____ The facility failed to administer medications as ordered to Resident #2 who missed 8 doses of a scheduled narcotic pain medication due to the medication being unavailable resulting in the resident experiencing significant pain in her back and knee and putting the resident at risk of experiencing withdrawal symptoms. Resident #2 missed 4 doses of a medication used to aid in digestion resulting in the resident experiencing diarrhea. Resident #3 was administered another resident's narcotic pain medication instead of the resident's lower strength narcotic pain medication while the MA was being observed by the facility's nurse putting the resident at risk of experiencing increased grogginess and feeling high from the effects of the medication. Resident #8 missed 13 doses of a narcotic pain medication over a 3 day period due to the medication being unavailable resulting in the resident complaining of "bad" foot pain. Resident #9 was administered a viral testing solution in her eyes instead of a lubricant eye drop putting the resident at risk of an allergic reaction and irritation or inflammation to her sclera. This failure of the facility placed the residents at substantial risk of serious physical	D 358		

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D 358	Continued From page 67 harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 5, 2023.	D 358		
D 369	10A NCAC 13F .1004 (l) Medication Administration 10A NCAC 13F .1004 Medication Administration (l) The facility shall assure the development and implementation of policies and procedures governing medication errors and adverse medication reactions that include documentation of the following: (1) notification of a physician or appropriate health professional and supervisor; (2) action taken by the facility according to orders by the physician or appropriate health professional; and (3) charting or documentation errors, unavailability of a medication, resident refusal of medication, any adverse medication reactions and notification of the resident's physician when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure procedures for medication	D 369		

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errors including notifying the primary care provider and documenting action taken by the facility for 1 of 2 sampled residents (#9) who received COVID testing solution in her right eye instead of Systane ophthalmic drops.

The findings are:

Review of Resident #9's current FL-2 dated 09/15/22 revealed:
-Diagnoses included hypertension, cerebral vascular accident, gastro-esophageal reflux disease and left hemiplegia.
-An order for Systane 0.6% ophthalmic 1 drop in both eyes four times daily. (Systane ophthalmic is used to treat dry eyes.)

Interview with Resident #9 on 11/30/22 revealed:
-In early November 2022, a medication aide (MA) picked up another resident's eye drops and put the drops in her right eye.
-The drops caused immediate burning in her right eye.
-The MA and another staff member helped her to irrigate her eyes right away.
-She did not see her primary care provider (PCP) for follow up.

Review of Resident #9's October and November 2022 electronic medication administration records (eMARs) revealed:
-There was an entry for Systane 0.6% ophthalmic 1 drop in each eye four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was no documentation of errors with administration.

Review of Resident #9's electronic progress notes revealed there were no entries between 10/01/22 and 11/30/22.

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D 369	Continued From page 69 Interview with the Administrator on 12/02/22 at 2:19pm revealed: -She was told immediately after it happened by the MA that Resident #9 received the wrong eye drops. -Poison control was contacted, and they said there was nothing dangerous about the drops placed in Resident #9's right eye. -Resident #9's PCP was notified. -She did not know if a medication error report was completed for the wrong eye drops being administered to Resident #9. -She thought the Resident Care Coordinator (RCC) had worked on the medication error report. Interview with the RCC on 12/06/22 at 11:23am revealed: -Resident #9 was given COVID testing solution in her right eye instead of Systane eye drops. -The MA could not say how that happened. -The MA simply did not check the medication against the order on the electronic medication administration record (eMAR) prior to administering to the resident. -She did not complete a medication error report. -The PCP was notified but there was no documentation the PCP was notified. -The poison control center was notified but there was no documentation the poison control center was notified. -Normally, the MA who made the error was responsible for contacting the PCP and documenting on the medication error report. -Completed medication error reports were given to her and the Administrator. Interview with Resident #9's PCP on 12/06/22 at 11:48am revealed: -She did not know Resident #9 received COVID	D 369		

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testing solution in her right eye instead of Systane eye drops.
-Resident #9 could have experienced an allergic reaction, irritation, and inflammation to her sclera from having a solution placed in her eye that was not intended for ophthalmic use.
-No one called or text messaged her about the medication error.
-Staff should have contacted her immediately when that happened.

Second interview with the RCC on 12/06/22 at 12:55pm revealed the testing solution was in a bottle similar to eye drops but was clearly labeled COVID testing solution.

Telephone interview with the medication aide (MA) on 12/06/22 at 12:59pm revealed:
-She removed the bottle of COVID testing solution from Resident #9's prescription bottle for the Systane eye drops.
-The COVID testing solution bottle looked like Resident #9's eye drops.
-She put drops in Resident #9's right eye and saw that the drops were clear and not milky.
-That was when she realized she must not have thoroughly looked at the bottle before administering the drops to Resident #9.
-She immediately went to the RCC and returned to the resident with the RCC.
-Resident #9 said her right eye was burning.
-The Administrator was present and put eye wash in the resident's eyes.
-Resident #9 said her eyes felt better after the eye wash.
-She did not complete a medication error report.
-She notified the RCC and Administrator, she did not know if they notified the PCP.
-The MA on duty prior to her had been doing COVID testing and put the COVID testing solution

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D 369	Continued From page 71 in Resident #9's prescription bottle and put her eye drops in the COVID testing kit. Second interview with the Administrator on 12/06/22 at 1:10pm revealed: -The MA told her she put COVID testing solution in Resident #9's eye instead of Systane eye drops. -She washed the resident's eyes at the emergency eye wash station and called poison control. -Poison control advised her to watch the resident's eye. -She removed the COVID testing solution from the medication cart. -She assumed the MA completed a medication error report, but she did not follow up on it. -The incident occurred approximately one week before the MA stopped working at the facility on 10/21/22. -The MA was responsible for contacting the PCP and completing the medication error report. -She and the RCC were responsible for reviewing the medication error report.	D 369		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE B VIOLATION	D 392		

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D 392	Continued From page 72 Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 2 of 5 residents (#2, #8) sampled with orders for a controlled substance used to treat moderate to severe pain. The findings are: Review of the facility's Controlled Substances Policies and Procedures revised 11/2018 revealed: -Controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. -Accurate accountability of the inventory of all controlled substances is maintained at all times. -When a controlled substance is administered, the staff member administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): date and time of administration (accountability record, MAR); amount administered (accountability record); remaining quantity (accountability record); and initials of staff administering the dose, completed after the medication is actually administered (accountability record, MAR). 1. Review of Resident #2's current FL-2 dated 07/04/22 revealed -Diagnoses included type 2 diabetes, difficulty in walking, and muscle weakness. -There was an order for Oxycodone/Acetaminophen (APAP) 10-325mg take 1 tablet every 6 hours. (Oxycodone/APAP is a controlled substance used to treat moderate to severe pain.	D 392		

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D 392	Continued From page 73 Review of Resident #2's pharmacy dispensing, delivery, and shipping records dated August 2022 - December 2022 revealed: -There were 120 Oxycodone/APAP 10-325mg tablets dispensed on 08/31/22 and delivered to the facility on 08/31/22. -There were 120 Oxycodone/APAP 10-325mg tablets dispensed on 09/25/22 and delivered to the facility on 09/26/22. -There were 120 Oxycodone/APAP 10-325mg tablets dispensed on 10/31/22 and shipped on 10/31/22. -There were 120 Oxycodone/APAP 10-325mg tablets dispensed on 11/28/22 and shipped on 11/28/22. Observation of Resident #2's medications on hand on 12/02/22 at 11:23am revealed: -There were 4 bubble packs of Oxycodone/APAP 10-325mg tablets dispensed on 11/28/22. -The quantity dispensed was 120 tablets with 30 tablets dispensed in each bubble pack. -There were 112 tablets of 120 tablets remaining on hand. Review of Resident #2's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 6:00am, 12:00pm, 6:00pm, and 11:59pm. -Oxycodone/APAP was not documented as administered on 09/14/22 at 12:00pm with no reason noted. Review of Resident #2's September 2022 electronic controlled substance record (CSR) revealed: -On 09/14/22 at 5:41am, after 1 tablet was	D 392		

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administered, there was a balance of 69 tablets.
-On 09/14/22 at 2:48pm, 1 tablet was documented as "return" and the count declined to 68 tablets with no reason documented and no tablet due at that time.
-On 09/16/22 at 5:40am, after 1 tablet was administered, there was a balance of 61 tablets.
-On 09/16/22 at 6:53am, 1 tablet was documented as "return" and the count declined to 60 tablets with no reason documented and no tablet due at that time.

Review of Resident #2's October 2022 eMAR revealed:
-There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 6:00am, 12:00pm, 6:00pm, and 12:00am.
-Oxycodone/APAP 10-325mg was not documented as administered at 12:00am on 10/03/22 due to "duplicate order"
-Oxycodone/APAP 10-325mg was not documented as administered on 10/31/22 at 6:00am, 12:00pm, 6:00pm, or 12:00am due to being "on hold".

Review of Resident #2's October 2022 CSR revealed:
-On 10/03/22 at 11:12am, 1 tablet was documented as "return" and the count declined from 112 to 111 tablets with no reason documented and no tablet due at that time.
-On 10/03/22 at 11:48am, 1 tablet was documented as administered but the balance changed from 111 to -1 (negative 1).
-On 10/03/22 at 1:08pm, 1 tablet was "return" and the balance was 0.
-On 10/03/22 at 1:08pm (9 seconds later), 111 tablets were documented as received and the balance changed from 0 to 110 tablets, with no explanation for the decline in the count.

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D 392	Continued From page 75 -On 10/04/22 at 12:43pm, 1 tablet was documented as wasted because the medication was broken and the resident refused the pill, declining the count to 105 tablets. -There was no dosage due on 10/04/22 at 12:43pm and the 4 scheduled doses for 10/04/22 were also documented as administered on the CSR. Interview with the Lead Supervisor on 12/02/22 at 1:36pm revealed: -On 10/04/22 at 12:43pm, she documented wasting one of Resident #2's Oxycodone/APAP tablets because the resident refused to take it because the tablet was broken and not whole. -She waited until the end of the medication pass to waste the tablet because the other MA was busy administering medications at the time the resident refused it. -She failed to document how the tablet was wasted but it was put in a drug disposal solution that was kept in the medication room. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 6:00am, 12:00pm, 6:00pm, and 12:00am. -Oxycodone/APAP 10-325mg was not documented as administered on 11/01/22 at 6:00am, 12:00pm, 6:00pm, or 12:00am due to being "on hold". Review of Resident #2's November 2022 CSR revealed: -On 11/02/22 at 1:27am, 1 tablet was documented as "return" and the count declined from 119 to 118 tablets with no reason documented and no tablet due at that time. -On 11/03/22 at 2:14pm, 1 tablet was	D 392		

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documented as administered declining the count to 111 tablets but no tablet was due at that time and the 4 scheduled doses were also documented as administered on 11/03/22.
-On 11/14/22 at 12:53pm, 1 tablet was documented as wasted due to dropped medication, gave wrong medication but no medication was due at that time.
-There were 6 doses documented as administered on 11/28/22 at 5:45am, 11:02am, 12:18pm, 12:18pm (22 seconds later), 5:14pm, and 11:08pm.
-No doses were due to be administered at 12:18pm.

Interview with Resident #2 on 11/30/22 at 10:49am revealed:
-She took Oxycodone for pain and the facility had run out of the Oxycodone "about every month".
-She last ran out of Oxycodone last month and she was out of it for the "whole weekend".
-She had surgery on her back 3 times in the past, so she took Oxycodone for lower back pain.
-She also took Oxycodone for her left knee which she had surgery on in the past as well.
-The pain "was bad", when she was out of the Oxycodone.
-When she was out of the Oxycodone last month, her pain level was "probably a 20" on a scale of 0 to 10 with 0 being no pain and 10 being severe pain.

Review of Resident #2's December 2022 eMAR on 12/02/22 revealed:
-There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 6:00am, 12:00pm, 6:00pm, and 12:00am.
-Oxycodone/APAP 10-325mg was documented as administered from 6:00am on 12/01/22 through 6:00am on 12/02/22.

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D 392	Continued From page 77 Review of Resident #2's December 2022 CSR revealed: -On 12/02/22 at 5:08am, 1 tablet of Oxycodone/APAP 10-325mg was documented as administered leaving a balance of 113 tablets. -On 12/02/22 at 7:20am, 1 tablet was documented as wasted due to "crushed in pack", declining the count to 112 but no dose was due at that time. Observation of Resident #2's December 2022 eMAR on the computer screen on 12/02/22 at 11:26am revealed the last dose of Oxycodone/APAP was administered to the resident on 12/02/22 at 5:08am. Interview with the first shift MA on 12/02/22 at 12:40pm revealed: -When she did the CS count that morning, 12/02/22, with the third shift MA, the count did not match. -The third shift MA told her that Resident #2 did not take her Oxycodone/APAP because the tablet was crushed in the bubble card and the resident did not want to take it crushed. -The third shift MA told her that she wasted/destroyed Resident #2's 6:00am dose of Oxycodone/APAP that morning on 12/02/22. -She documented as the verifier (witness) on the CSR along with the third shift MA that the Oxycodone/APAP was wasted. -She did not actually observe the third shift MA waste the Oxycodone/APAP because the third shift MA told her that she had already destroyed it. -The CSR for Resident #2's Oxycodone/APAP on 12/02/22 was not accurate because she did not actually witness the destruction.	D 392		

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D 392	Continued From page 78 Interview with Resident #2 on 12/02/22 at 12:47pm revealed: -The third shift MA administered 1 whole Oxycodone/APAP 10-325mg tablet to her that morning for her 6:00am dosage. -The tablet was not crushed and the MA did not offer a crushed medication to the resident. Attempted telephone interview with the third shift MA on 12/02/22 at 1:00pm was unsuccessful. Refer to interview with a MA on 12/02/22 at 10:55am. Refer to interview with a second MA on 12/02/22 at 3:51pm. Refer to interview with a third MA on 12/05/22 at 12:08pm. Refer to interview with the Lead Supervisor on 12/02/22 at 1:36pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/02/22 at 2:14pm. Refer to interview with the Administrator on 12/02/22 at 3:20pm. 2. Review of Resident #8's current FL-2 dated 10/24/22 revealed diagnoses included chronic obstructive pulmonary disease, obesity, functional paraparesis, sinus bradycardia, type II diabetes mellitus, major depressive disorder, anxiety and dementia. Review of Resident #8's prescription order dated 08/17/22 revealed an order for Oxycodone/Acetaminophen (APAP) 10/325mg every 4 hours dispense 120 tablets.	D 392		

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D 392	Continued From page 79 (Oxycodone/APAP is a controlled substance used to treat moderate to severe pain.) Review of Resident #8's prescription order dated 09/09/22 revealed an order for Oxycodone/APAP 10/325mg every 4 hours dispense 120 tablets. Review of Resident #8's prescription order dated 09/28/22 revealed an order for Oxycodone/APAP 10/325mg every 4 hours dispense 120 tablets. Review of Resident #8's prescription order dated 10/05/22 revealed an order for Oxycodone/APAP 10/325mg every 4 hours dispense 120 tablets. Review of Resident #8's primary care provider (PCP) visit note dated 10/05/22 revealed: -The resident needed a refill of her Oxycodone/APAP today (10/05/22). -She wrote a prescription order for Oxycodone/APAP 10/325mg every 4 hours dispense 120 tablets. Review of Resident #8's prescription order dated 11/16/22 revealed an order for Oxycodone/APAP 10/325mg every 4 hours dispense 120 tablets. Observations of Resident #8's medications on hand on 12/06/22 at 10:00am revealed there were 4 of 30 Oxycodone/APAP 10/325mg tablets remaining in a bubble pack with a pharmacy label indicating 120 tablets were dispensed on 11/15/22. Review of Resident #8's dispensing record from the facility's former contracted pharmacy revealed 120 Oxycodone/APAP 10/325mg tablets were dispensed on 09/09/22 and 09/28/22. Review of packing slips from the facility's current	D 392		

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contracted pharmacy revealed 120 Oxycodone/APAP 10/325mg tablets were shipped on 10/18/22 and 11/15/22.

Upon request on 12/06/22, the pharmacy dispensing and delivery receipt for Resident #8's prescription order dated 10/05/22 was not provided for review.

Review of Resident #8's September 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone/APAP 10/325mg every 4 hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm.
-On 09/29/22 at 6:00pm Oxycodone/APAP was not administered because the resident was unavailable.

Review of Resident #8's controlled substance record (CSR) for 09/01/22 through 09/30/22 for Oxycodone/APAP revealed:
-On 09/01/22 at 1:40am the remaining count was 64 tablets.
-On 09/10/22 at 4:40pm 120 tablets were received, and the remaining count was 127 tablets.
-On 09/29/22 at 4:25am 120 tablets were received, and the remaining count was 136 tablets.
-On 09/29/22 at 5:51pm 1 tablet was returned reducing the count by 1 tablet leaving 132 tablets.
-On 09/30/22 at 11:43pm 1 tablet was wasted reducing the count by 1 tablet leaving 124 tablets.
-There was a comment that 1 tablet was not in the package from the pharmacy.

Review of Resident #8's October 2022 eMAR revealed:

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D 392	Continued From page 81 -There was an entry for Oxycodone/APAP 10/325mg every 4 hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm. -On 10/10/22 at 10:00pm Oxycodone/APAP was not administered because the resident refused. -On 10/18/22 at 2:00pm, 6:00pm and 10:00pm Oxycodone/APAP was not administered because the resident was unavailable. -From 10/19/22 at 2:00am through 10/22/22 at 6:00am Oxycodone/APAP was not administered because the resident was in the hospital. Review of Resident #8's CSR for 10/01/22 through 10/31/22 for Oxycodone/APAP revealed: -On 10/02/22 at 9:47pm the remaining balance was 112 tablets. -The next date order entry was on 10/03/22 at 2:37am with 1 tablet removed for administration leaving minus 1 tablet as the remaining balance. -The next date order entry was on 10/03/22 at 6:05am with 1 tablet removed for administration leaving minus 2 tablets as the remaining balance. -The next date order entry was on 10/03/22 at 6:09am with 2 tablets received leaving 0 tablets as the remaining balance. -The next date order entry was on 10/03/22 at 6:10am with 2 tablets returned leaving a remaining balance of 110 tablets. -The next date order entry was on 10/03/22 at 9:35am with 1 tablet removed for administration leaving minus 1 tablet as the remaining balance. -The next date order entry was on 10/03/22 at 10:48am with 110 tablets returned leaving a remaining balance of 0 tablets. -The next date order entry was on 10/03/22 at 10:48am with 110 tablets received leaving 109 tablets as the remaining balance. -No tablets were removed between 10/18/22 at 10:12am and 10/22/22 at 10:51am.	D 392		

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-On 10/19/22 at 3:16pm 120 tablets were received, and the remaining count was 140 tablets.
-On 10/31/22 at 5:07pm 1 tablet was returned reducing the count by 1 tablet leaving a remaining balance of 82 tablets.
-There were no comments documented.

Upon request on 12/06/22, the pharmacy dispensing and delivery receipt for Resident #8's Oxycodone/APAP 120 tablets received on 10/19/22 was not provided for review.

Review of Resident #8's November 2022 eMAR revealed:
-There was an entry for Oxycodone/APAP 10/325mg every 4 hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm.
-The following 13 doses were documented on hold: 11/14/22 at 6:00pm and 10:00pm, 11/15/22 at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm and 10:00pm, and 11/16/22 at 2:00am, 6:00am, 10:00am, 2:00pm and 6:00pm.
-On 11/23/22 at 2:00pm Oxycodone/APAP was not administered because the resident was unavailable.

Review of Resident #8's CSR for 11/01/22 through 11/30/22 for Oxycodone/APAP revealed:
-On 11/02/22 at 1:28am 1 tablet was received adding 1 tablet to the count leaving a remaining balance of 76 tablets.
-On 11/14/22 at 2:08pm 1 tablet was removed for administration leaving a remaining balance of 0 tablets.
-No tablets were removed between 11/14/22 at 2:08pm and 11/16/22 at 10:26pm.
-On 11/16/22 at 10:26pm 120 tablets were received leaving a remaining balance of 120

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tablets.
-There were no comments documented.

Interview with Resident #8 on 12/05/22 at 1:04pm revealed:
-Her pain medications ran out for 3 days a couple of weeks ago (11/14/22-11/16/22).
-The pain in her feet was "bad" for those 3 days.

Review of Resident #8's December 2022 eMAR revealed:
-There was an entry for Oxycodone/APAP 10/325mg every 4 hours scheduled at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm.
-There was documentation Oxycodone/APAP was administered as scheduled from 12/01/22 at 2:00am through 12/05/22 at 2:00pm.

Review of Resident #8's CSR for 12/01/22 through 12/05/22 for Oxycodone/APAP revealed on 12/05/22 at 6:05pm 1 tablet was removed leaving a remaining balance of 7 tablets.

Telephone interview with the Front End Manager at the facility's former contracted pharmacy provider on 12/02/22 at 1:08pm revealed they dispensed 120 Oxycodone/APAP 10-325mg tablets for Resident #8 on 09/28/22.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/22 at 4:25pm revealed:
-The first order received was dated 08/01/22 for Oxycodone/APAP 10/325mg for Resident #8.
-The 08/01/22 order was not a paper prescription and was for the resident's medication profile in preparation for the transition from one pharmacy to another.
-On 10/03/22, the pharmacy started filling

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prescriptions for the facility.
-120 tablets of Oxycodone/APAP 10/325mg every 4 hours was filled on 10/17/22 and delivered on 10/19/22 from a paper prescription dated 09/28/22 for Resident #8.
-120 tablets of Oxycodone/APAP 10/325mg every 4 hours was filled on 11/15/22 from a paper prescription dated 08/17/22 for Resident #8 that was mailed to the pharmacy.
-The pharmacy received a prescription via mail dated 11/16/22 for Resident #8 that had not yet been filled.
-Paper prescriptions were mailed to the pharmacy in advance for staff to request refills.
-There was no record of the prescription dated 10/05/22 for Oxycodone/APAP 10/325mg for Resident #8.
-He did not know why the paper prescriptions were sent one at a time out of date order.
-120 tablets were a 20 day supply for Resident #8.
-The pharmacy was not able to refill Oxycodone/APAP for Resident #8 without a valid prescription on file at the pharmacy.
-There was a 3 day minimum turn around time for refill requests.
-All medications were sent by courier and delivered Monday through Saturday.
-There were no deliveries on Sunday.

Interview with a medication aide (MA) on 12/06/22 at 10:00am revealed:
-Resident #8's prescription dated 09/28/22 for Oxycodone/APAP was sent to the former and current contracted pharmacies.
-The order was filled by the former pharmacy because the current pharmacy did not take over filling medication orders until 10/05/22.
-She did not know why a prescription dated 08/17/22 was used to fill an order on 10/17/22.

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D 392	Continued From page 85 -The Resident Care Coordinator (RCC) sent prescriptions to the current pharmacy by mail. -Copies of all prescriptions were kept in the resident's record. -She had never seen a CSR and could not explain what received, returned and wasted meant when documented. -She did not have access to the electronic reports for controlled substances. Interview with the Resident Care Coordinator (RCC) on 12/06/22 at 11:23am revealed: -Received was documented on the controlled substance record (CSR) when medications were received from the pharmacy. -She did not know why 1-2 tablets were documented as received on 10/03/22 and 11/02/22 when there was no pharmacy delivery. -She did not know why 1 tablet was returned on 09/29/22 and 10/31/22. Refer to interview with a MA on 12/02/22 at 10:55am. Refer to interview with a second MA on 12/02/22 at 3:51pm. Refer to interview with a third MA on 12/05/22 at 12:08pm. Refer to interview with the Lead Supervisor on 12/02/22 at 1:36pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/02/22 at 2:14pm. Refer to interview with the Administrator on 12/02/22 at 3:20pm. Interview with a medication aide (MA) on	D 392		

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D 392	Continued From page 86 12/02/22 at 10:55am revealed: -The MAs did controlled substance (CS) counts at each shift change. -If the CS count did not match, the MAs called the Resident Care Coordinator (RCC) because she could pull up the information on the computer system and see what the actual count should be. -The RCC would tell the MAs if they needed to add one (receive) or subtract one (return) to make the CS count match. -She was not sure but she thought there were "glitches" in the computer system that caused the count to be off but one could be added or subtracted for it to match up. Interview with a second MA on 12/02/22 at 3:51pm revealed: -If "return" was documented on the controlled substance record (CSR), it was because the MA had taken 1 out of the system either because the count was off or because a pill was accidentally crushed in the medication cart when it was packed too tightly. -Sometimes, she did not know why the CS count did not match. -If the count did not match after the third try, the MAs had to call the RCC or the Lead Supervisor. -The RCC or the Lead Supervisor would tell the MA to add or subtract a tablet to make the count match. Interview with a third MA on 12/05/22 at 12:08pm revealed: -The MAs did CS counts at each shift change. -If the CS count of the medications on hand did not match the balance in the electronic CSR, the MAs had to recount. -After 3 tries, if the count did not match, the MAs had to call the RCC or the Lead Supervisor. -The MAs were told by the RCC or the Lead	D 392		

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D 392	Continued From page 87 Supervisor to waste or return controlled substances on the CSR to make it match the count on hand. Interview with the Lead Supervisor on 12/02/22 at 1:36pm revealed: -At the end of each shift, the oncoming MA and the MA going off shift physically counted the controlled substances in the medication cart and entered the numbers into the computer system. -The MAs could not see what the balance was supposed to be. -If the count did not match, the computer system would flag the specific medication and the MAs would have to recount that medication. -The MAs had 3 attempts to get it correct because the system would lock after 3 incorrect attempts. -The MAs were supposed to call her or the RCC after 2 attempts so they would not get locked out of the computer system. -She and the RCC were the only two staff who could see what the actual CS count was supposed to be. -If the MAs called her with a count that did not match, she would look at the electronic medication administration record (eMAR) to see if administration was documented correctly. -If the CS count did not match, it was usually because there was a "glitch" in the computer system because of a new order or a duplicate order. -If the CS count did not match, she would have the MAs enter the correct number into the computer system and document it was a system error. -The MAs would enter "return" to decrease the count or "received" to increase the count. -She assumed having the MAs to add or subtract to make the count match was correcting a "glitch"	D 392		

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D 392	Continued From page 88 in the computer system. -She could print a CS reconcile report but it did not show administration, or receipt of controlled substances; it just noted "reconciled". -She had been the Lead Supervisor for about 2 months. -She was not aware of a monitoring system to check the CSRs with the eMARs for accuracy. Interview with the RCC on 12/02/22 at 2:14pm revealed: -Each time a MA came on duty, the MAs had to count the controlled substances. -The MAs could not see what the count was supposed to be in the computer system; the MAs just entered the numbers of what they counted. -If the count did not match, the MAs had to count a second time and re-enter the numbers. -After the third attempt, if the count did not match, it would lock them out of the computer system. -The MAs would have to call her or the Lead Supervisor. -She and the Lead Supervisor were the only two staff that could access the CS reports. -If the MAs called her with a count that did not match, she would look at the computer system. -Sometimes, the MAs were correct and she would have them log out of the system and back in and re-enter the information and it would be correct. -If that did not work, she sometimes came to the facility recounted the medication and if it still did not match, she or the Lead Supervisor could override the system and correct the count. -Sometimes, if the count did not match, it may have been caused by the MAs added the wrong number into the computer system when a new supply was received or they may have clicked too many times when administering a medication, which could cause a negative balance.	D 392		

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D 392	Continued From page 89 -She could print a CS tracking log that usually just showed what the whole balance should be so she was not sure what "return" meant on the CSR because she had never seen it. -There were some computer glitches in July 2022 but those glitches were repaired. -She was not aware of any current issues with the computer system. Interview with the Administrator on 12/02/22 at 3:20pm revealed: -She was in the process of learning about checking medications and reading medication reports. -There was a system for checking controlled substances but she did not know what that system was. -The MAs had to count the controlled substances and make sure the count was accurate when they exchanged keys to the medication cart. -The corporation had a strict controlled substance policy and it would be difficult for anyone to take medications off the medication cart without anyone knowing. -She was not aware of CS counts not matching. -No one had reported any concerns with the CS counts not matching or any "glitches" in the computer system. _____ The facility failed to ensure controlled substance records (CSR) for 2 residents (#2, #8) accurately reconciled the administration, receipt, and disposal of controlled substances. The facility's failure resulted in negative balances on the CSR; extra doses documented as administered when not ordered or due on the CSR; single doses documented as returned or received without explanations; and inaccurate remaining balances contributing to 1-3 days without controlled substances for two residents receiving a	D 392		

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D 392	Continued From page 90 controlled substance for moderate to severe pain, resulting in Resident #2 experiencing severe pain in her back and knee and Resident #8 experiencing "bad" foot pain when the pain medications were unavailable. 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 12/05/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2023.	D 392		
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident.	D 394		

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D 394	Continued From page 91 The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure controlled substances including lorazepam and clonazepam for 2 of 5 sampled residents (#4 and #8) were destroyed following discontinuation or expiration and witnessed by the Administrator or designee and licensed Pharmacist or designee. The findings are: Review of the facility's medication diversion policy dated September 2021 revealed:	D 394		

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-Only single dose destruction/disposal could be done at the Community.
-Another staff member must witness the disposition of the narcotic and initial the count sheet.
-Any narcotic medication that was expired, discontinued, or no longer required, should be removed from the cart and written up on the Medication Destruction form.

1. Review of Resident #4's current FL-2 dated 10/17/22 revealed diagnoses included cerebral vascular disease, dementia, intracranial arteriosclerosis, type II diabetes mellitus, hypertension and coronary arteriosclerosis.

Review of Resident #4's provider order dated 10/05/22 revealed an order for Lorazepam 0.25mg (0.5mg one half tablet) three times daily as needed (PRN) for anxiety/agitation. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #4's FL-2 clarification order dated 10/21/22 revealed an order for Lorazepam 0.25mg (0.5mg one half tablet) three times daily PRN for anxiety/agitation.

Review of Resident #4's prescription order dated 11/09/22 revealed an order for Lorazepam 0.25mg (0.5mg one half tablet) three times daily PRN for anxiety.

Review of Resident #4's subsequent provider orders revealed there was no order to discontinue the Lorazepam.

Review of Resident #4's dispensing record from the facility's former contracted pharmacy revealed no Lorazepam was dispensed for the resident

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D 394	Continued From page 93 09/01/22 through 12/06/22. Review of packing slips from the facility's current contracted pharmacy revealed 15 Lorazepam 0.5mg tablets were shipped on 11/09/22 for Resident #4. Review of Resident #4's controlled substance record (CSR) for Lorazepam revealed: -On 09/03/22 at 10:53am the remaining count was 78 tablets. -On 11/10/22 at 5:23pm 30 tablets were received leaving a remaining balance of 95 tablets. -There was documentation 14 tablets were removed for administration between 09/03/22 and 11/17/22. -On 11/17/22 at 8:57pm 64 tablets were returned leaving a remaining balance of 30 tablets. Review of Resident #4's Medication Destruction Record revealed: -64 Lorazepam 0.5mg tablets were destroyed on 11/17/22. -The destruction was witnessed by the two medication aides (MAs). -The method of destruction was not documented. -There was no licensed Pharmacist or designee signature. Interview with a medication aide (MA) on 12/06/22 at 9:34am revealed: -Resident #4 had an old bubble pack of Lorazepam that was dispensed from the former contracted pharmacy. -The pharmacy instructed staff to destroy remaining medications when the new pharmacy began service instead of returning the medications. -The Lorazepam was destroyed with the Lead Supervisor witnessing her place the tablets in the	D 394		

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drug buster.
-They both signed on the Medication Destruction Record kept in the Resident Care Coordinator's (RCC's) office.

Interview with the Lead Supervisor on 12/06/22 at 11:05am revealed:
-She witnessed the waste of Resident #4's 64 tablets of lorazepam.
-There was no witness documented on the resident's controlled substance record (CSR) because the medication aide (MA) documented the 64 tablets were returned instead of wasted.
-There was a handwritten waste log in the Resident Care Coordinator's (RCC's) office that documented the resident, medication, strength and number of tablets wasted.
-The waste log had the signatures of the staff wasting the medication and the witness.
-Looking at the waste log it was not her that witnessed the waste of Resident #4's 64 lorazepam tablets, it was another MA.
-Controlled substance medications were put in a drug buster.
-There were 2 drug busters in the facility, one in each medication room locked in medication carts.

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

Refer to telephone interview with a pharmacist at the facility's new contracted pharmacy on 12/05/22 at 4:21pm.

Refer to interview with the RCC on 12/06/22 at 12:36pm.

Refer to interview with the Administrator on 12/06/22 at 1:10pm.

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D 394	Continued From page 95 2. Review of Resident #8's current FL-2 dated 10/24/22 revealed diagnoses included chronic obstructive pulmonary disease, obesity, functional paraparesis, sinus bradycardia, type II diabetes mellitus, major depressive disorder, anxiety and dementia. a. Review of Resident #8's current FL-2 dated 10/24/22 revealed an order for Lorazepam 0.5mg every 4 hours as needed (PRN) for anxiety/shortness of breath. (Lorazepam is a controlled substance used to treat anxiety.) Review of Resident #8's dispensing record from the facility's former contracted pharmacy revealed 120 Lorazepam 0.5mg tablets were dispensed on 09/27/22. Review of packing slips from the facility's current contracted pharmacy revealed 120 Lorazepam 0.5mg tablets were shipped on 11/04/22 for Resident #8. Review of Resident #8's subsequent provider orders revealed there was no order to discontinue Lorazepam 0.5mg every 4 hours PRN. Review of Resident #8's November and December 2022 electronic medication records revealed: -There was an entry for Lorazepam 0.5mg every 4 hours PRN anxiety/shortness of breath. -There was documentation 1-4 doses of Lorazepam 0.5mg were administered daily from 11/01/22 through 12/05/22. Review of Resident #8's controlled substance report (CSR) for Lorazepam revealed on 11/08/22 at 11:52am 32 tablets were wasted by a	D 394		

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medication aide (MA) and witnessed by the Lead Supervisor.

Review of Resident #8's Medication Destruction Record revealed:
-32 Lorazepam 0.5mg tablets were destroyed via the drug buster on 11/08/22.
-The destruction was witnessed by the Lead Supervisor and a medication aide (MA).
-There was no licensed Pharmacist or designee signature.

Interview with the Lead Supervisor on 12/06/22 at 11:05am revealed:
-All medications and orders had been switched from the old to the new pharmacy.
-Looking at the waste log, 32 tablets of lorazepam were wasted on 11/08/22 because all controlled substance medications dispensed by the old pharmacy were destroyed.

b. Review of Resident #8's prescription order dated 09/17/22 revealed an order for Clonazepam 1mg three times daily. (Clonazepam is a controlled substance used to treat anxiety.)

Review of Resident #8's dispensing record from the facility's former contracted pharmacy revealed 90 Clonazepam 1mg tablets were dispensed on 09/24/22.

Review of Resident #8's current FL-2 revealed and order for Clonazepam 0.5mg three times daily.

Review of packing slips from the facility's current contracted pharmacy revealed 90 Clonazepam 0.5mg tablets were shipped on 10/24/22.

Review of Resident #8's controlled substance

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D 394	Continued From page 97 report (CSR) for Clonazepam (dosage strength not indicated) dated 10/25/22 revealed at 5:20pm 45 tablets were wasted by a medication aide (MA) and witnessed by the Resident Care Coordinator (RCC). Review of Resident #8's Medication Destruction Record revealed: -44 Clonazepam 1mg tablets were destroyed via the drug buster on 10/24/22. -The destruction was witnessed by the Resident Care Coordinator and a medication aide (MA). -There was no licensed Pharmacist or designee signature. Refer to telephone interview with a pharmacist at the facility's new contracted pharmacy on 12/05/22 at 4:21pm. Refer to interview with the RCC on 12/06/22 at 12:36pm. Refer to interview with the Administrator on 12/06/22 at 1:10pm. _____ Telephone interview with a pharmacist at the facility's new contracted pharmacy on 12/05/22 at 4:21pm revealed: -They started providing services to the facility on 10/03/22. -They did not accept returns of any medications, either controlled substances or non-controlled substances. -Any medications needing destruction were to be destroyed at the facility by the facility staff. Interview with the RCC on 12/06/22 at 12:36pm revealed: -The facility's new pharmacy did not take back any medications.	D 394		

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D 394	Continued From page 98 -For any medications that needed to be destroyed, they had to fill out a destruction form and destroy the medications at the facility. -The Administrator's designee, which was usually her or the Lead Supervisor, and a MA had to be present during the destruction of the medications. -They would remove the pills from the packaging and put them in a drug destroying solution. -All the witnesses had to sign the destruction form. -The witnesses were required whether they were destroying controlled substances or non-controlled substances. -They usually destroyed the medications as soon as it was needed; they did not hold them until they had a certain amount to destroy. -She kept the destruction records on file at the facility. Interview with the Administrator on 12/06/22 at 1:10pm revealed: -She did not witness the waste of large numbers of controlled substance medications. -She guessed the RCC would have been her designee. -She did not have an answer for why the RCC (Staff G) remained responsible for witnessing the destruction of large numbers of controlled substances given the allegations of controlled substance diversion against the RCC. -She had not seen the controlled substance waste log before today and was unfamiliar with the process. -She did not know anything about reimbursement to residents for medications that were destroyed.	D 394		
D 398	10A NCAC 13F .1008 (g) Controlled Substance 10A NCAC 13F .1008 Controlled Substance	D 398		

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D 398	Continued From page 99 (g) A dose of a controlled substance accidentally contaminated or not administered shall be destroyed at the facility. The destruction shall be conducted so that no person can use, administer, sell, or give away the controlled substance. The destruction shall be documented on the medication administration record (MAR) or the controlled substance record showing the time, date, quantity, manner of destruction, and the initials or signature of the person destroying the substance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a controlled substance not administered was destroyed and documented on the medication administration record or controlled substance record in accordance with the facility's policies and including the manner of destruction for 1 of 5 residents (#2) sampled who had orders for a controlled substance used to treat moderate to severe pain. The findings are: Review of the facility's Controlled Substances Policies and Procedures revised 11/2018 revealed: -Controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. -When a dose of a controlled substance is removed from the container for administration but refused by the resident or not administered for any reason, it is not placed back in the container. -It must be destroyed according to facility policy.	D 398		

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-It is destroyed in the presence of two licensed facility personnel as permitted by regulations and the disposal is documented on the accountability record on the line representing that dose.

Review of Resident #2's current FL-2 dated 07/04/22 revealed
-Diagnoses included type 2 diabetes, difficulty in walking, and muscle weakness.
-There was an order for Oxycodone/Acetaminophen (APAP) 10-325mg take 1 tablet every 6 hours. (Oxycodone/APAP is a controlled substance used to treat moderate to severe pain.

Observation of Resident #2's medications on hand on 12/02/22 at 11:23am revealed:
-There were 4 bubble packs of Oxycodone/APAP 10-325mg tablets dispensed on 11/28/22.
-The quantity dispensed was 120 tablets with 30 tablets dispensed in each bubble pack.
-There were 112 tablets of 120 tablets remaining on hand.

Review of Resident #2's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 6:00am, 12:00pm, 6:00pm, and 12:00am.
-Oxycodone/APAP 10-325mg was not documented as administered at 12:00am on 10/03/22 due to "duplicate order"
-Oxycodone/APAP 10-325mg was not documented as administered on 10/31/22 at 6:00am, 12:00pm, 6:00pm, or 12:00am due to being "on hold".

Review of Resident #2's October 2022 electronic controlled substance record (CSR) revealed:

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-On 10/04/22 at 12:43pm, 1 tablet was documented as wasted because the medication was broken and the resident refused the pill.
-The wasted dose was documented by the medication aide (MA) who administered it and a second MA as the verifier (witness) but the method of destruction was not documented.
-There was no dosage due on 10/04/22 at 12:43pm and the 4 scheduled doses for 10/04/22 were also documented as administered on the CSR.

Interview with the Lead Supervisor on 12/02/22 at 1:36pm revealed:
-On 10/04/22 at 12:43pm, she worked as a MA and documented wasting one of Resident #2's Oxycodone/APAP tablets because the resident refused to take it because the tablet was broken and not whole.
-She waited until the end of the medication pass to waste the tablet because the other MA was busy administering medications at the time the resident refused it.
-She failed to document how the tablet was wasted but it was put in a drug disposal solution that was kept in the medication room.

Review of Resident #2's November 2022 eMAR revealed:
-There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 6:00am, 12:00pm, 6:00pm, and 12:00am.
-Oxycodone/APAP 10-325mg was not documented as administered on 11/01/22 at 6:00am, 12:00pm, 6:00pm, or 12:00am due to being "on hold".

Review of Resident #2's November 2022 electronic CSR revealed:
-On 11/14/22 at 12:53pm, 1 tablet was

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documented as wasted due to dropped medication, gave wrong medication but no medication was due at that time.
-One MA documented the medication was wasted and a second MA documented as the verifier (witness) but there was no documentation of how the medication was wasted.

Interview with a MA on 12/02/22 at 10:55am revealed:
-On 11/14/22, another MA told her she had administered Resident #2's Oxycodone/APAP to the wrong resident.
-She did not observe Resident #2's Oxycodone/APAP being destroyed on 11/14/22 and she did not observe the other MA administer the Oxycodone/APAP to the wrong resident.
-She had no explanation when asked why she documented as being the verifier (witness) of the destruction of Oxycodone/APAP on 11/14/22.

Interview with a second MA on 12/02/22 at 3:51am revealed:
-She accidentally administered Resident #2's Oxycodone/APAP to another resident in error on 11/14/22.
-The documentation on the CSR was not accurate because she did not waste the medication because it was administered to the wrong resident.

Review of Resident #2's December 2022 eMAR on 12/02/22 revealed:
-There was an entry for Oxycodone/APAP 10-325mg take 1 tablet every 6 hours scheduled for 6:00am, 12:00pm, 6:00pm, and 12:00am.
-Oxycodone/APAP 10-325mg was documented as administered from 6:00am on 12/01/22 through 6:00am on 12/02/22.

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D 398	Continued From page 103 Review of Resident #2's December 2022 CSR revealed: -On 12/02/22 at 5:08am, 1 tablet of Oxycodone/APAP 10-325mg was documented as administered leaving a balance of 113 tablets. -On 12/02/22 at 7:20am, 1 tablet was documented as wasted due to "crushed in pack", declining the count to 112 but no dose was due at that time. -One MA documented the tablet was wasted and a second MA documented as the verifier (witness) but the method of destruction was not documented. Observation of Resident #2's December 2022 eMAR on the computer screen on 12/02/22 at 11:26am revealed the last dose of Oxycodone/APAP was administered to the resident on 12/02/22 at 5:08am. Interviews with the first shift MA on 12/02/22 at 11:26am and 12:40pm revealed: -When she came on duty that morning, 12/02/22, she did the CS count with the third shift MA. -She found one of Resident #2's Oxycodone/APAP 10-325mg tablets in the bottom of the controlled substance drawer. -She taped the Oxycodone/APAP tablet back into Resident #2's bubble card. -The CS count did not match. -The third shift MA told her that Resident #2 did not take her Oxycodone/APAP because the tablet was crushed in the bubble card and the resident did not want to take it crushed. -The third shift MA told her that she wasted/destroyed Resident #2's 6:00am dose of Oxycodone/APAP that morning on 12/02/22. -She documented as the verifier (witness) on the CSR along with the third shift MA that the Oxycodone/APAP was wasted.	D 398		

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D 398	Continued From page 104 -She did not actually observe the third shift MA waste the Oxycodone/APAP because the third shift MA told her that she had already destroyed it. -The CSR for Resident #2's Oxycodone/APAP on 12/02/22 was not accurate because she did not actually witness the destruction. -The MAs were supposed to have another MA witness destruction of controlled substances and they usually put the wasted pills in a drug disposal solution. Attempted telephone interview with the third shift MA on 12/02/22 at 1:00pm was unsuccessful. Interview with Resident #2 on 12/02/22 at 12:47pm revealed: -The third shift MA administered 1 whole Oxycodone/APAP 10-325mg tablet to her that morning for her 6:00am dosage. -The tablet was not crushed and the MA did not offer a crushed medication to the resident. Interview with the Resident Care Coordinator (RCC) on 12/02/22 at 2:14pm revealed: -If a controlled substances was wasted, the MA had to get a witness which could be another MA or a Supervisor. -She was not aware Resident #2's Oxycodone/APAP was wasted that morning, 12/02/22, with no witness. -MAs should not document they witnessed destruction of medication if they did not actually observe it. -MAs should document the method of destruction which was putting the wasted medication into a drug destroying solution. -If a loose tablet was found in the medication cart, it should be wasted and not taped back in the bubble pack due to contamination issues.	D 398		

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D 398	Continued From page 105 Interview with the Lead Supervisor on 12/02/22 at 1:36pm revealed: -The MAs were required to have another MA witness the destruction of controlled substances. -The witness was required to document in the computer system when they witnessed the wasting of controlled substances.	D 398		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to report allegations of suspected drug diversion of residents' controlled substance medications to the pharmacy. The findings are: Review of the facility's Medication Diversion policy dated September 2021 revealed: -The facility will assure that all Federal and State	D 399		

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D 399	Continued From page 106	D 399		

regulations relevant to the control of narcotic medications are followed.
-If a medication is not found or accounted for, either the Care Coordinator or the Administrator will direct staff to notify and report the situation to local law enforcement, the Health Care Personnel Registry (HCPR), the Department of Social Services (DSS), the dispensing pharmacy, and the resident's physician.
-Staff implicated in diversion will be suspended until completion of an investigation.

Telephone interview with a former staff on 11/29/22 at 3:20pm revealed:
-A personal care aide (second former staff) told her on 10/28/22 she was given "anything she wanted" from residents' pain medications kept on medication carts from Staff E (Lead Supervisor).
-Staff E would put the medication in a cigarette wrapper and give to the PCA.
-Sometimes Staff E would sell the medication to the PCA if Staff E needed money.
-The former staff reported this to the Administrator at the end of October 2022 and the Director of Employee Relations in mid-November 2022.
-She was told not to talk about it because the Administrator did not want the "state" to come to the facility.

Interview with a resident on 11/30/22 at 10:23am revealed:
-Things were bad at the facility a few months ago.
-There were a couple of medication aides (MAs) taking residents' pain medications.
-She did not want to say which MAs were involved in taking residents' pain medications.
-Talking about the details of what happened caused the resident anxiety and she did not want to discuss details.

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D 399	Continued From page 107 Interview with RCC on 12/02/22 at 2:14pm revealed: -There was a social media post on 11/14/22 by a former staff member that included allegations of drug diversion about her and the Lead Supervisor (Staff E) taking controlled substances. -The Administrator was aware of the social media post with the allegations of drug diversion around 11/14/22, when it was posted. -The allegations of drug diversion were not reported to the pharmacy to her knowledge. -The Administrator did not interview her about the allegations of drug diversion. -Someone from their corporate human resources came to the facility about 2 weeks ago and interviewed staff about the allegations of drug diversion and the social media post. Review of a social media audio recording post dated 11/14/22 revealed: -One recording narrates, "Because our staff members give her, replace her med, pain meds with Tylenol and keep the pain meds for themselves." Review of the written description underneath the audio recording dated 11/14/22 revealed the speaker was identified as the executive director (Administrator). Review of a second social media audio recording post dated 11/14/22 revealed: -A second recording narrates, "My personal opinion, and if my personal opinion leaves this room, my personal opinion is that there is med diversion going on." Review of the second written description underneath the second audio recording dated	D 399		

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D 399	Continued From page 108 11/14/22 revealed the speaker was identified as the executive director (Administrator). Interview with the former employee on 12/02/22 at 4:44pm revealed: -She posted the audio recordings on her social media on 11/14/22. -The recordings were from a conversation at the end of October 2022 between her and the Administrator. -The conversation occurred after she reported to the Administrator that Staff E took residents' pain medications and sold or gave them to the second former staff. -The voice heard in the audio recordings was the Administrator. Interview with the Administrator on 12/02/22 at 2:19pm revealed: -The online recording was not of her referring to an accusation made by a family member that staff were replacing residents' pain medications with Tylenol. -Her statement of opinion was referring to the family member being the one taking pain medications from a resident. -There had been an investigation into narcotic medications before she started as the Administrator, and she did not know the outcome of the investigation. -Staff E was the Lead Supervisor, responsible for staff scheduling and was the direct go to person for PCAs and MAs. -Staff E worked as a MA as needed (prn) and completed medication cart audits. -When she became aware of complaints posted on social media on 11/14/22 she called the Regional Director of Operations (RDO) and Human Resources. -She did not have any concerns related to	D 399		

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controlled substances and staff.
-She did not know the system or process of monitoring controlled substances in the facility.
-She was still learning the process of oversight of controlled substance medications and how to review related reports.
-Medication cart audits were completed by Staff G (RCC) and Staff E (Lead Supervisor).
-The facility had strict policies related to controlled substances.
-It would have been very difficult for a staff to get a controlled substance medication from the medication cart without someone knowing about it.
-The Director of Employee Relations and RDO were at the facility on 11/16/22 or 11/17/22.

Interview with the Divisional Vice President of Operations (DVPO) on 12/02/22 at 2:19pm revealed:
-Regional corporate staff had been onsite at the facility since 11/16/22 or 11/17/22.
-A sample of controlled substance records (CSRs) for two months were reviewed and compared to electronic medication administration records (eMARs).
-There had not been any problems identified on review of the sampled CSRs and eMARs.

Second interview with the Administrator on 12/06/22 at 1:10pm revealed:
-No one had reported to her that MAs were taking residents' controlled substance medications from the medication cart.
-She did not report suspected drug diversion to either pharmacy following the allegations posted on social media on 11/14/22.
-She was ultimately responsible for reporting suspected drug diversion to the pharmacy.
-She was not aware of the allegations until

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someone sent her a screen shot of the social media post.
-She did not remember when she was sent the screen shot.
-She had not conducted any investigations prior to the social media post.
-The social media post referred to past allegations and did not say it was a current issue.
-Nothing was done at the time of the social media post because it was a social media rant of a disgruntled employee.
-Prior to the social media post, none of the allegations had been brought to her attention by staff or residents.
-She did not have an answer for why Staff E and Staff G were left in charge of monitoring controlled substances in the facility without conducting an investigation into the allegations posted on social media.

Telephone interview with the Front End Manager at the facility's former contracted pharmacy on 12/02/22 at 1:08pm revealed:
-Their service ended with the facility on 10/03/22.
-The facility had not reported any known or suspected drug diversion to the pharmacy to her knowledge.
-The pharmacy did not typically document drug diversion unless it was diverted in their chain of custody.

Telephone interview with a pharmacist at the facility's newly contracted pharmacy on 12/05/22 at 4:21pm revealed:
-They started servicing the facility on 10/03/22.
-No one from the facility had reported any known or suspected drug diversion to the pharmacy.

[Refer to Tag D392, 10A NCAC 13F .1008(a) Controlled Substances.]

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D 399	Continued From page 111 [Refer to Tag D394, 10A NCAC 13F .1008(d) Controlled Substances.] [Refer to Tag D398, 10A NCAC 13F .1008(g) Controlled Substances.] _____ The facility failed to report allegations of suspected diversion of residents' controlled substance medications to the pharmacy. The facility's failure resulted in a lack of oversight and examination into the facility's controlled substances management which was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/02/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2023.	D 399		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to initiate a 24 hour report, complete	D 438		

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an investigation and submit 5 day reports to the health care personnel registry for allegations against 2 staff for taking controlled substances from supplies prescribed to residents in the facility.

The findings are:

Review of the facility's Medication Diversion policy dated September 2021 revealed:
-The facility will assure that all Federal and State regulations relevant to the control of narcotic medications are followed.
-If a medication is not found or accounted for, either the Care Coordinator or the Administrator will direct staff to notify and report the situation to local law enforcement, the Health Care Personnel Registry (HCPR), the Department of Social Services (DSS), the dispensing pharmacy, and the resident's physician.
-The Administrator will be responsible for the completion of any necessary HCPR 24-hour report and 5-day report.
-This reporting is mandatory.
-Staff implicated in diversion will be suspended until completion of an investigation.

Telephone interview with a former staff on 11/29/22 at 3:20pm revealed:
-A personal care aide told her on 10/28/22 she was given "anything she wanted" from residents' pain medications kept on medication carts from Staff E.
-Staff E would put the medication in a cigarette wrapper and give to the PCA.
-Sometimes Staff E would sell the medication to the PCA if Staff E needed money.
-The former staff reported this to the Administrator at the end of October 2022 and the Director of Employee Relations in mid-November

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2022.
-She was told to not talk about it because the Administrator did not want the "state" to come to the facility.

Interview with a resident on 11/30/22 at 10:23am revealed:
-Things were bad at the facility a few months ago.
-There were a couple of medication aides (MAs) taking residents' pain medications.
-She did not want to say which MAs were involved in taking residents' pain medications.
-Talking about the details of what happened caused the resident anxiety and she did not want to discuss details.

Review of a social media audio recording post dated 11/14/22 revealed:
-One recording narrates, "Because our staff members give her, replace her med, pain meds with Tylenol and keep the pain meds for themselves."

Review of the written description underneath the audio recording dated 11/14/22 revealed the speaker was identified as the executive director (Administrator).

Review of a second social media audio recording post dated 11/14/22 revealed:
-A second recording narrates, "My personal opinion, and if my personal opinion leaves this room, my personal opinion is that there is med diversion going on."

Review of the second written description underneath the second audio recording dated 11/14/22 revealed the speaker was identified as the executive director (Administrator).

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D 438	Continued From page 114 Interview with the Administrator on 12/02/22 at 2:19pm revealed: -The online recording was not of her referring to staff replacing residents' pain medications with Tylenol (mild over-the-counter pain reliever) but of a family member making that accusation. -Her statement of opinion was referring to the family member being the one taking pain medications from a resident. -There had been an investigation into narcotic medications before she started as the Administrator, and she did not know the outcome of the investigation. -Staff E was the Lead Supervisor, responsible for staff scheduling and was the direct go to person for personal care aides (PCAs) and medications aides (MAs). -Staff E worked as a MA on an as needed basis and completed medication cart audits. -When she became aware of complaints posted on social media on 11/14/22 she called the Regional Director of Operations (RDO) and Human Resources. -She did not have any concerns related to controlled substances and staff. -She did not know the system or process of monitoring controlled substances in the facility. -She was still learning the process of oversight of controlled substance medications and how to review related reports. -Medication cart audits were completed by Staff G and Staff E. -The facility had strict policies related to controlled substances. -It would have been very difficult for a staff to get a controlled substance medication from the medication cart without someone knowing about it. -The Director of Employee Relations and RDO were at the facility on 11/16/22 or 11/17/22.	D 438		

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D 438	Continued From page 115 -She did not complete a HCPR 24 Hour report, investigation and a 5 Day report for the allegations related to suspected diversion of controlled substances by Staff E and Staff G because she thought the allegations were old and previously investigated. Second telephone interview with a former staff on 12/02/22 at 4:44pm revealed: -She posted the recording on social media on 11/14/22 of the Administrator's response to her reporting Staff E. -She told the Administrator Staff E took residents' pain medications and sold them to another staff at the end of October 2022. -She recorded the Administrator's response to her reporting Staff E at the end of October 2022, and included the recording on the social media post. -The Administrator responded saying in her opinion medication diversion was going on and that staff members were replacing pain medications with Tylenol and kept the pain medications for themselves. -She reported Staff E to the Director of Employee Relations on 11/11/22. -She was not contacted for any further information on the allegations of narcotic pain medication diversion by staff. Interview with Resident Care Coordinator (RCC) on 12/02/22 at 2:14pm revealed: -There was a social media post on 11/14/22 by a former staff member that included allegations of drug diversion about her and the Lead Supervisor (Staff E) taking controlled substances. -The Administrator was aware of the social media post with the allegations of drug diversion around 11/14/22, when it was posted. -She did not know if the Administrator reported the allegations of drug diversion to the HCPR.	D 438		

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D 438	Continued From page 116 -The Administrator did not interview her about the allegations of drug diversion. -Someone from their corporate human resources came to the facility about 2 weeks ago and interviewed about the allegations of drug diversion and the social media post. Telephone interview with the Director of Employee Relations on 12/06/22 at 2:02pm revealed: -The Administrator called him on 11/10/22 or 11/11/22 regarding a social media post by a former employee. -He contacted the former employee on 11/11/22 and asked that she remove the social post, which she did. -The former employee then made a lengthier post on social media on 11/14/22. -He investigated at the facility based on what the former employee had told him in their phone conversation and forwarded to him electronically. -The social media post on 11/14/22 had more information than what the former employee told him on 11/11/22. -He did not complete 24 hour or 5 day reports for the Health Care Personnel Registry (HCPR) because that was an operational decision. -The former employee alleged that Staff G substituted less cognitive residents' narcotic pain medications with Tylenol to sell or give to other staff. -His investigation turned up nothing. -The Administrator would get instructions from the operational corporate staff. Second interview with the Administrator on 12/06/22 at 1:10pm revealed: -No one had reported to her that MAs were taking residents' controlled substance medications from the medication cart.	D 438		

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D 438	Continued From page 117 -She was not aware of the allegations until someone sent her a screen shot of the social media post. -She did not remember when she was sent the screen shot. -She had not conducted any investigations prior to the social media post. -The social media post referred to past allegations and did not say it was a current issue. -Nothing was done at the time of the social media post because it was a social media rant of a disgruntled employee. -Prior to the social media post, none of the allegations had been brought to her attention by staff or residents. -She did not have an answer for why Staff E and Staff G were left in charge of monitoring controlled substances in the facility without conducting an investigation into the allegations posted on social media. [Refer to Tag D392, 10A NCAC 13F .1008(a) Controlled Substances.] [Refer to Tag D394, 10A NCAC 13F .1008(d) Controlled Substances.] [Refer to Tag D398, 10A NCAC 13F .1008(g) Controlled Substances.] _____ The facility failed to initiate 24 hour reporting, complete an investigation and submit 5 day reports to the health care personnel registry for allegations against 2 staff for taking controlled substances from supplies prescribed to residents in the facility. The facility's failure resulted in the accused staff having continued access to resident medications and records and responsibility for care of residents without a reporting and investigative process into the	D 438		

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D 438	Continued From page 118 allegations which was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/02/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2023.	D 438		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations, as evidenced by the failure to implement and maintain substantial compliance with the rules and statutes governing adult care homes as related to physical environment, personal care and supervision, residents' rights, medication administration, controlled substances, and health care personnel registry. The findings are: Interview with a resident on 11/30/22 at 9:23am	D980		

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revealed:
-She stopped going to the Administrator with any concerns because the Administrator kept "blowing her off."
-The atmosphere in the facility was "off" because the Administrator told residents what they could and could not do but did not listen to concerns of residents.

Telephone interview with a former staff on 12/03/22 revealed:
-During the first week of November 2022, she heard Staff B tell a resident that came to her for a cup of ice, "Jesus Christ, you couldn't have went to someone on the back hall? You had to bother me?"
-She reported the incident to the Administrator, but Staff B continued to ignore and speak disrespectfully to residents.
-Staff B was reported to the Resident Care Coordinator (RCC) and Administrator several times.
-The RCC and Administrator did not see how staff treated residents because they never came out of their offices.

Interview with a resident's family member on 12/05/22 at 1:05pm revealed:
-She was related to two residents that shared a room and visited them daily.
-She would report any concerns she had to the Administrator in her office.
-She was frustrated because the Administrator was in her office most of the time she visited.
-She had reported her concern of limited towels and washcloths to the Administrator.
-She had purchased 20 washcloths and 20 towels for both family members a year ago and written their names on them.
-She had reported her concern to the

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Administrator a few times in the past 2 months that she was unable to find their washcloths and towels and the residents deserved to have the towels and washcloths she had purchased for their personal use.
-She was frustrated because the Administrator would tell her that she would take care of her concerns, but the issue was never resolved.
-She felt that her concerns were not taken seriously by the Administrator and visited her family to be sure they did not need anything.

Interview with a personal care aide (PCA) on 12/06/22 at 9:18am revealed:
-She had reported her concerns of limited towels and washcloths to the Administrator several times; most recently the beginning of November 2022.
-The Administrator had informed her that she would address the issue of limited washcloths and towels each time she reported her concern; however, there was never any improvement.
-She had informed the Administrator several times that she was concerned that the facility did not have enough staff to care for residents.
-She told the Administrator that when there was not enough staff to care for residents that it put the residents at an increased risk of falls and residents did not get the care they needed because they were waiting on assistance due to the staff shortage at times.
-The Administrator was usually in her office all day.
-The past few days had been the most she had seen the Administrator out of her office.
-Yesterday (12/05/22), she asked the Administrator to supervise residents in the dining room during lunch because she needed to escort a resident back to her room.
-The Administrator told her she was not able to

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help her because she had paperwork to complete.
-She asked a medication aide (MA) to supervise residents in the dining room, and the MA was able to supervise the residents in the dining room while she returned a resident to her room.

Interview with the Administrator on 12/02/22 at 2:19pm revealed:
-She had been the Administrator at the facility since the middle of July 2022.
-She was still learning the process for supervision and interventions for falls.
-Corporate leadership was still teaching her about several policies and procedures at the facility.
-She relied on the RCC and corporate leadership to assist her with the process of implementing interventions and increased supervision because she was still learning her responsibilities.

A second interview with the Administrator on 12/06/22 at 2:08pm revealed:
-When she was not in the facility, the RCC was in charge.
-When management was not in the facility the MA was in charge.
-If there was an emergency or a concern that the MA had when management was not in the facility the MA was able to call her or the RCC.
-She had provided several family members with her cell phone number so they could reach her if they had any issues or concerns.
-She was always available to speak with family members and staff.

Interview with RCC on 12/02/22 at 2:14pm revealed:
-There was a social media post on 11/14/22 by a former staff member that included allegations of drug diversion about her and the Lead

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Supervisor.
-The Administrator was aware of the social media post with the allegations of drug diversion around 11/14/22, when it was posted.
-The Administrator did not interview her about the allegations of drug diversion.

Interview with a MA on 12/02/22 at 10:55am revealed:
-If the controlled substance (CS) count did not match, the MAs called the RCC because she could pull up the information on the computer system and see what the actual count should be.
-The RCC would tell the MAs if they needed to add one (receive) or subtract one (return) to make the CS count match.

Interview with a second MA on 12/02/22 at 3:51pm revealed:
-If the count did not match after the third try, the MAs had to call the RCC or the Lead Supervisor.
-The RCC or the Lead Supervisor would tell the MA to add or subtract a tablet to make the count match.

Interview with a third MA on 12/05/22 at 12:08pm revealed:
-After 3 tries, if the CS count did not match, the MAs had to call the RCC or the Lead Supervisor.
-The MAs were told by the RCC or the Lead Supervisor to adjust controlled substances on the controlled substance record (CSR) to make it match the count on hand.

A third interview with the Administrator on 12/02/22 at 3:20pm revealed:
-She was in the process of learning about checking medications and reading medication reports.
-There was a system for checking controlled

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substances but she did not know what that system was.
-The MAs had to count the controlled substances and make sure the count was accurate when they exchanged keys to the medication cart.
-The corporation had a strict controlled substance policy and it would be difficult for anyone to take medications off the medication cart without anyone knowing.
-She was not aware of CS counts not matching.
-No one had reported any concerns with the CS counts not matching or any "glitches" in the computer system.

Telephone interview with a fourth MA on 12/05/22 at 11:04am revealed:
-The MAs were holding medications without an order to hold the medications because they were not allowed to document a medication was unavailable.
-This was done for any medication, including controlled substances.
-She was trained to do this by other MAs, MA Supervisors, the Lead Supervisor, and the RCC.

A fourth interview with the Administrator on 12/05/22 at 1:55pm revealed:
-She was not aware of or familiar with the facility's policy for ordering medications.
-She relied on the RCC to oversee the medication ordering process.
-She was not aware residents' medications were unavailable.
-She would eventually expect to be notified when medications were unavailable but she was still learning the system.
-She then changed her answer after prompting by corporate staff and said she would expect to be notified if a medication was needed and not in the facility.

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D980	Continued From page 124 -She did not review any reports related to the electronic medication administration records (eMARs) yet because she was still being taught how to read those reports. Interview with the Lead Supervisor on 12/06/22 at 2:22pm revealed: -She was responsible for supervising PCAs and MAs. -She reported to the RCC and the Administrator. A second interview with the RCC on 12/06/22 at 2:26pm revealed: -She had been the RCC for 5 or 6 years. -She was responsible for overall coordination of care including orders, skin assessments and appointments. -She reported to the Administrator. -The Administrator and the Area Clinical Director (ACD) were responsible for overseeing what she did. -She was constantly in and out of her office observing staff during times and medication passes and checking resident rooms and the environment. -She completed rounds randomly so staff would not know when she might pop up. Interview with the ACD on 12/06/22 at 2:33pm revealed: -She did not oversee any staff at the facility. -She taught staff skills and acted as a resource when completing licensed health professional support (LHPS) evaluations for residents. -If she identified staff learning needs through her LHPS evaluations she let the RCC and Administrator know to have a time set up for training. A fifth interview with the Administrator on 12/06/22	D980		

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at 1:10pm revealed:
-She was responsible for whatever went on in the facility.
-She was proactive and interactive with residents.
-She made rounds daily checking housekeeping and residents.
-She made sure the environment was clean and residents were clean and cared for.
-Since staring as the Administrator on 07/05/22, she was transitioning from a Business Office Manager role to Administrator.
-She has been in a continuous process of learning.
-She relied on the RCC to show her clinical systems and processes.
-She had training at the corporate home office and with the Regional Director of Operations (RDO) and the Administrators of sister facilities.
-The ACD worked with the RCC for oversight while she was learning clinical processes.
-Regional and divisional corporate staff were available to her 24/7.

The following rule areas were cited at a violation level:

1. Based on observations, interviews and record reviews, the facility failed to ensure 7 of 8 exit doors that were accessible to residents with known disorientation and wandering behaviors, were equipped with sounding devices that sounded when the exit doors were opened to alert staff. [Refer to Tag 067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)].

2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 10 sampled residents (#1, #6) which resulted in a closed head injury, contusions to the

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face and shoulder and a right shoulder fracture (#1) and a resident diagnosed with Alzheimer's disease who was confused and wandered out of the facility without staff's knowledge (#6). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A1 Violation)].

3. Based on observations, interviews and record reviews, the facility failed to ensure that the rights of all residents were maintained related to residents being treated with respect and dignity and residents being free of mental and physical abuse. [Refer to Tag 338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation)].

4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 8 residents (#2, #3, #8, #9) sampled for record review including errors with medications for moderate to severe pain (#2, #3, #8), a medication used to aid in the digestion of food (#2), medications for anxiety (#2, #8), and a lubricant eye drop for dry eyes (#9). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 2 of 5 residents (#2, #8) sampled with orders for a controlled substance used to treat moderate to severe pain. [Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].

6. Based on interviews and record reviews, the facility failed to report allegations of suspected drug diversion of residents' controlled substance medications to the pharmacy. [Refer to Tag 399,

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D980	Continued From page 127 10A NCAC 13F .1008(h) Controlled Substances (Type B Violation)]. 7. Based on interviews and record reviews, the facility failed to initiate a 24 hour report, complete an investigation and submit 5 day reports to the health care personnel registry for allegations against 3 staff for taking controlled substances from supplies prescribed to residents in the facility [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry. (Type B Violation)]. _____ The Administrator failed to ensure the management and total operations of the facility, as evidenced by the failure to implement and maintain substantial compliance with the rules and statutes governing adult care homes as related to physical environment, personal care and supervision, medication administration, controlled substances and health care personnel registry. The Administrator's failure resulted in 7 of 8 doors without sounding devices with 2 residents in the facility with confusion and exit seeking behaviors; falls for 2 residents with injuries including bone fractures and head contusions; residents being treated roughly, disrespectful and not considered; narcotic pain medications and pancreatic digestive medications not being administered and residents experiencing severe pain and diarrhea; inaccurate accounting, disposal and oversight of controlled substances including Oxycodone/Acetaminophen, Lorazepam, and Clonazepam; and unreported allegations of staff taking residents' controlled substance medications. These failures resulted in serious injury, neglect and exploitation and constitutes a Type A1 Violation. _____	D980		

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D980	Continued From page 128 The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 5, 2023.	D980		