STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086001	A. BUILDING: ______ B. WING ______	R 05/05/2023

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CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

(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 Surry County Department of Social Services conducted an annual and follow-up survey from 05/02/23 through 05/05/23, with an exit via telephone on 05/05/23.	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 2 of 4 exit doors accessible to residents, who were constantly or intermittently disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Review of the facility's Resident Supervision Policy implemented on 07/10/18 revealed:	D 067		

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-Staff will perform a head count on all residents every 2 hours to account for all residents.
-Staff will perform 30 minute supervision checks on all new admissions for the first 24 hours.
-The 15 to 30 minute supervision check were in place for any potential flight (elopement) risk.
-No information for door alarms was included.

Review of seven residents' records identified by their physician on the current FL2s as being intermittently or constantly disoriented revealed:
-There were four of seven residents who were intermittently disoriented.
-There were two of seven residents who were constantly disoriented.
-There was one of seven residents who had a dementia diagnosis and no information for orientation.

Observations of the facility's exit doors at various times on 05/02/23 from 9:30 am - 5:00pm, on 05/03/23 from 7:00am to 7:00pm, and on 05/04/23 from 6:30am to 8:45pm revealed:
-Residents, visitors and staff were observed entering and exiting through the back door to a parking lot throughout the day on 05/02/23, 05/03/23, and 05/04/23 and no alarm sounded when the doors were opened.
-Residents and staff were observed entering and exiting the facility via the front door to the smoking area throughout the day on 05/02/23, 05/03/23, and 05/04/23 and no alarms sounded.

Review of Resident #2's current hospital FL2 dated 04/08/23 revealed:
-Diagnoses included dementia.
-Resident #2 was intermittently disoriented.

Observation of Resident #2 on 05/04/23 at 11:40am revealed:

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D 067	Continued From page 2 -The resident was in the hall near the medication aide (MA) office. -The resident was looking around and was disoriented. Review of Resident #2's progress notes revealed: -On 11/12/22 at 3:30pm, Resident #2 was located down the road from the facility and brought back to the facility by a facility staff. -On 04/24/23, Resident #2 walked to the road and was picked up at a local store across the road approximately 0.75 miles away from the facility by a staff . -On 04/27/23, staff were alerted by another resident that Resident #2 was seen leaving the facility in the rain. Interview with a medication aide (MA) on 05/04/23 at 5:00pm revealed: -The front and back exit doors were not locked and alarmed. -The residents were allowed to exit the facility anytime they pleased. -She had never been instructed to lock the front door or set the front door alarm -The exit doors at each end of the facility were alarmed activated and sounded anytime they were opened. -She had never had a resident set off the alarm at the exit doors. -Resident #2 was the only resident she had seen with exit seeking behaviors. -Other residents had reported to her about Resident #2 going out of the facility recently at least 3 times on her shift. -On 04/27/23, she went out in the rain to redirect Resident #2 back into the facility from the field located in the back of the facility. Observation of the medication aide Supervisor	D 067		

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(MA/S) testing the alarm on the front door on 05/04/23 at 5:55pm revealed the Supervisor activated a switch for the front door on an overhead panel, opened the front door and it sounded a loud audible alarm.

Interview with the MA/S on 05/04/23 at 5:58pm revealed:
-The front and back doors of the facility were not alarmed.
-Resident #2 was the only resident that had eloped from the facility.
-Resident #2 was allowed to sign out of the facility and walk to the local store when he was admitted in 2021.
-Resident #2 recently had a decline in his mental status and started leaving the facility without letting staff know.
-She had picked Resident #2 up one time at the local store and he seemed to not recognize her.
-The front door was not alarmed because residents were allowed to go outside all hours of the day and night, particularly smokers.
-If the front door was alarmed, staff would not be able to get work done for letting residents out of the door.
-If the front door was alarmed, residents would be constantly awakened by the loud alarm day and night by smokers entering and exiting the door.
-The facility used to have established smoking times, but no longer.
-The Administrator would be responsible to instruct staff regarding activating the door alarms on the front door.

Interview with the Administrator on 05/04/23 at 4:30pm revealed:
-The facility had alarms on all the exit doors.
-The door alarms on the exit doors on both ends of the facility were activated at all times.

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D 067	Continued From page 4	D 067		

-The exit door alarm on the front door was in functional operation, but was not activated because residents who smoked were going out of the front door to the designated smoking area (front porch) at all times of the day and night.
-Activating the front door alarm would create a lot of door alarm activations for smokers constantly going to the front porch area to smoke.
-The exit door in the rear of the facility was used by staff to enter the facility and the door alarm was not routinely activated.
-She was aware the exit doors were supposed to be alarmed if the facility had residents who were intermittently/constantly disoriented or who were known to wander, but she had not instructed staff to activate the front and rear door alarms at all times unless staff was watching the door constantly.
-Resident #2's dementia and mental status had seemed to decline over the last 6 months, maybe because of his recent hip replacement surgery and hospital visits for urinary infections and pneumonia.
-She did not know Resident #2 had eloped from the building several times in the last 2 months.

[Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]

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The facility failed to ensure the alarms on 2 of 4 exit doors to the facility had an audible sounding device when activated. These doors were accessible by 7 residents who were constantly or intermittently disoriented, including Resident #2 who had eloped from the facility at least 2 times in the last month requiring staff to return the resident to the facility. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/23.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2023.

D 074 — 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings — D 074

10A NCAC 13F .0306 Housekeeping And Furnishings
(a) Adult care homes shall:
(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the walls, ceilings, and floors were kept clean and in good repair in 7 of 23 resident rooms (Rooms A1, A2, A3, A4, A8, A10 and B16) related to residents' rooms with broken or missing closet doors.

The findings are:

Review of the environmental inspection report from the local county health department dated 08/31/22 revealed:
-The facility received 19 demerits.
-There was documentation of an observation of broken closet doors.

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D 074	Continued From page 6	D 074		

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Review of the environmental inspection report from the local county health department dated 04/11/23 revealed:
-The facility received 14 demerits.
-There was documentation of an observation of rooms with doors and fixtures needing repair.

Observations of resident rooms during the initial tour of the facility on 05/02/23 at 9:15am revealed:
-Resident room B16 was shared by two residents.
-The closet door in resident room B16 was two wood doors held up by a two wheeled sliding track at the top of the doors.
-There was no track at the bottom.
-The residents 'clothes were hanging in the closet.
-The inside door was off the track and it leaned against the outside door.
-If the outside door was moved, the inside door would fall forward.
-The doors were heavy and posed a safety hazard to the residents.

Interview with the two residents who resided in resident room B16 revealed:
-The closet doors were "old style" and always off the track.
-When using the doors the residents had to use caution.
-One resident said the doors had been that way since he moved into the facility five months ago.
-The second resident said the doors had been that way since he moved into the facility almost one year ago.

Observations of resident rooms during the initial tour of the facility on 05/02/23 at 10:40am revealed:
-There were three residents residing in resident

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room A2.
-The closet doors in room A2 were two wood doors held up by a two prone wheeled track at the top of the door.
-The residents' clothes were hanging in the closet.
-The doors to the closet could not close because the inside closet door was off the track and it leaned against the outside door.
-If the outside door was moved, the heavy door could fall forward and posed a safety hazard.

Interview with one of the residents who resided in resident room A2 on 05/02/23 at 10:43am revealed:
-The closet door was off the track.
-The door was never put on the track.
-When going to the closet he reached around the door.

Observation of resident room A1 on 05/03/23 at 10:43am revealed:
-Two residents resided in the room.
-The closet doors were off the track and propped inside the closet.

Observation of resident room A3 on 05/03/23 at 10:57am revealed:
-Two residents resided in the room.
-The closet opening was bare.
-The 2 closet doors were missing.

Observation of resident room A4 on 05/03/23 at 11:00am revealed:
-One resident resided in the room.
-One closet door was off the track but propped in the closet.

Observation of resident room A8 on 05/03/23 at 11:07am revealed:

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-Two residents resided in the room.
-There were no closet doors for the closet.

Observation of resident room A10 on 05/03/23 at 11:10am revealed:
-One resident resided in the room.
-The closet doors were off the track and propped inside the closet.

Telephone interview with the Assistant Administrator (AA) on 05/05/23 at 3:00pm revealed:
-The facility did not have a designated maintenance staff person.
-He was responsible to ensure the facility furnishings, including closet doors, were maintained.
-He had not done a facility walk-through recently to make a list of needed repairs.
-The facility staff could let him know if specific repairs were needed.
-He did not know residents rooms had missing or broken closet doors.
-He had spoken to the maintenance staff at a sister facility and was going to bring the staff to the facilty for painting and repairs, but had not done so as of yet.

Telephone interview with the Administrator on 05/05/23 at 4:35pm revealed:
-She or the AA were responsible for checking the residents' rooms for condition of the room.
-She had not had residents complain to her about missing closet doors.
-The Administrator had not done a facility walk-through checking rooms for damages or things needing repairs in several months if not close to a year.

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D 076	Continued From page 9	D 076		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings	D 076		

10A NCAC 13F .0306 Housekeeping And Furnishings
(a) Adult care homes shall:
(3) have furniture clean and in good repair;
This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the chest of drawers in 2 residents' rooms (A5 and B16) and the nightstand in 1 resident's room (B16) were kept in good repair.

The findings are:

Review of the environmental inspection report from the local county health department dated 04/11/23 revealed:
-The facility received 14 demerits.
-There was documentation of an observation of damaged furniture and furniture needing repair.

Observation of resident room A5 on 05/03/23 at 10:57 revealed:
-One resident resided in the room.
-There was a chest of 6 drawers located on the center of the wall to the left of the entrance door .
-There were 3 drawers on each side of the dresser.
-The top drawer on the left side was missing the entire drawer.
-The resident had clothing stuffed into the space where the drawer usually slid into place.

Interview with the resident who resided in room A5 on 05/03/23 at 11:00am revealed:

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-The top dresser drawer had been missing for a long time.
-He was not sure how long it was missing or if it was missing when he moved into the room.
-He had not told facility staff about the missing drawer.

Observation of resident room B16 during the initial tour of the facility on 05/02/23 at 10:43am revealed:
-Two residents resided in the room.
-There was a six drawer dresser between the two beds.
-The top dresser drawer near the bed by the door was broken and had no balance bar in the middle to keep the drawer on track.
-When opened, the drawer fell down and would not stay up.
-There were no knobs on the drawer.
-The second drawer down had no knobs to open and close the drawer.
-The top drawer on the opposite side of the dresser near the window had holes for two knobs, but there was only one knob.
-The second drawer down had no knobs to open and close the drawer.

Observation of the nightstand in resident room B16 on 05/02/23 at 10:43am revealed:
-There was a nightstand by the bed near the door.
-There were no knobs on the nightstand to open and close the drawer.
-When opened, the drawer had no balance bar in the middle to keep the drawer on track.
-When opened the nightstand drawer fell down to the floor unless it was held up by someone.

Interview with one of the residents who resided in room B16 on 05/02/23 at 10:44am revealed:

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D 076	Continued From page 11	D 076		

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-He had lived at the facility for three months and the drawers on the nightstand and dresser were broken and missing knobs when he moved in.
-When he opened the nightstand drawer, he had to try and balance the drawer with one hand and he searched for what he wanted out of the drawer with the other hand.
-It was hard to balance the drawer to keep it from falling to the floor.
-He had not complained to the Administrator or the Assistant Administrator (AA) because he did not see them.
-He had told staff and they said they would tell the Administrator and AA but nothing had been done.

Interview with the second resident who resided in room B16 on 05/02/23 at 10:46am revealed:
-He had lived at the facility for almost one year.
-The dresser drawer had been missing knobs since he moved in.
-When he opened the drawer, he used the tips of his fingers to wiggle the drawer open.
-He was used to doing it that way.
-He had not complained because he knew nothing would be done.

Interview with the housekeeper on 05/03/23 at 10:15am revealed:
-She had observed that furniture throughout the facility needed repairs.
-She had made the repair needs known to the Resident Care Coordinator (RCC) and she said that she would let the AA and the Administrator know.

Telephone interview with the AA on 05/05/23 at 3:00pm revealed:
-The facility did not have a designated maintenance staff person.
-He was responsible to ensure the facility

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D 076	Continued From page 12 furnishings were maintained. -He had not done a facility walk-through recently to make a list of needed repairs. -The facility staff could let him know if specific repairs were needed. -He did not know residents' rooms had broken dresser drawers with missing knobs. -He did not know a resident's room had broken nightstand drawers. -He had spoken to the maintenance staff at a sister facility and was going to bring the staff to the facilty for painting and repairs, but had not done so as of yet. Telephone interview with the Administrator on 05/05/23 at 4:35pm revealed: -She or the AA were responsible for checking the residents' rooms for condition of the furniture. -She had not had residents complain to her about dresser drawers and nightstands needing repair. -The Administrator had not done a facility walk-through checking rooms for damaged furniture in several months if not close to a year.	D 076		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews and	D 079		

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D 079	Continued From page 13	D 079		

interviews, the facility failed to ensure the facility was clean and free of hazards as evidenced by the presence of live bed bugs activity in two resident bedrooms (rooms A8 and B17).

The findings are:

Review of the environmental inspection report from the local county health department dated 08/31/22 revealed:
-The facility received 19 demerits.
-There was documentation of an observation of live bed bugs present in resident rooms B17 and A8.

Review of the follow-up environmental inspection report from the local county health department dated 10/28/22 revealed:
-The facility received 16 demerits.
-There was an observation of live bed bugs present in resident rooms B14 and B17.

Review of the third environmental inspection report from the local county health department dated 04/11/23 revealed:
-The facility received 14 demerits.
-There was an observation of dead bed bugs in resident room A8 as well as live bed bug activity in resident rooms A2 and B17.

Observation of resident room A8 on 05/03/23 at 11:41am revealed:
-The room was shared by two residents.
-There was a bed against the wall next to the door that led into the resident room and a bed on the opposite wall next to the window.
-A resident was lying in the bed and got up.
-The resident left the room and said he was going to lunch.
-There was a live bed bug crawling on the covers

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of the bed.
-The bed next to the window had blood smear on the sheet.

Interview with one resident who resided in resident room A8 on 05/03/23 at 4:03pm revealed:
-There were bed bugs in the room.
-He did not know if he was bitten by the bugs, but he itched and previously had a rash.

Observation of resident room B17 on 05/03/23 at 12:05pm revealed:
-There were no live bed bugs observed.
-There were blood smears on the zipper cover of the mattress.

Interview with one of the residents who resided in room B17 on 05/03/23 at 12:06pm revealed:
-The bed bugs were better, but he was still getting bitten.
-The last time he actually saw a bed bug was 2 weeks ago.

Interview with the housekeeper on 05/02/23 at 9:55am revealed:
-There were bed bugs in resident rooms A2, A8, A12 and B17.
-When she started working at the facility in June 2022, she identified bed bugs in the dining room.
-She told the Assistant Administrator (AA) and he told her to keep an eye on the bed bugs.
-She tried to keep the rooms clean to get rid of the bed bugs.
-The facility had been treated once since she started working at the facility by a pest control company.
-There was no system in place to continually spray for the bed bugs so the bed bugs came back.

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-Recently, the AA said he talked with someone from a pest control company and they recommended a chemical that was very expensive to treat the bed bugs.
-The AA purchased the chemical and told her to use it when she cleaned.
-She treated the rooms with the chemical weekly; however, in the past two weeks she had not used the chemical because it was locked in the AA's office and he was not available.
-Residents had not complained about getting bitten, but residents in room B17 and A2 had complained about itching and having rashes.
-She was not getting rid of the bed bugs and felt as if she was not going to get it under control until there were no more bed bugs.

Interview with the housekeeper on 05/03/23 at 10:13am revealed:
-Other than cleaning and spraying for the bed bugs, no instructions had been given as to how to treat the resident rooms that had bed bugs.
-There was no systems for special handling of the bedding and clothes for the residents who had bed bugs in their rooms.
-All the residents' bedding and clothing were washed together, with the exception of the residents who washed their own clothes.

Interview with the Resident Care Coordinator (RCC) on 05/03/23 at 1:05pm revealed:
-The housekeeper made her aware she saw bed bugs in the residents' rooms, and she told the AA.
-A pest control company came to the facility monthly and treated for roaches, but she was not sure if they treated for bed bugs.
-The pest control was scheduled by the owner and/or Administrator.

Telephone interview with a representative from

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the pest control company on 05/03/23 at 1:15pm revealed:
-He treated the facility monthly for general pests like, spiders, ants and roaches.
-In September 2022, he was asked to treat the facility for bed bugs.
-He had not been asked to treat for bed bugs since September 2022.
-He did not follow-up on the bed bug treatment because he was not asked to do so by the facility.
-Using the spray for bed bugs was the facility's idea and not recommended by him.
-There were special treatments and processes recommended that included prepping rooms and special handling of clothes.
-The facility's dryer did not heat hot enough to kill bed bugs, he suggested taking bedding and clothes to the laundromat.

Interview with a personal care aide (PCA) on 05/02/23 at 10:05am revealed:
-There were bed bugs in the facility.
-It was a little uncomfortable.
-No instructions had been given regarding ways to clean or handle residents' bedding and clothes.
-No residents had complained they were getting bitten.
-The housekeeper had been cleaning and spraying for the bed bugs.

Interview with a third shift medication aide (MA) on 05/04/23 at 9:12am revealed:
-She had not seen bed bugs but was made aware the facility had bed bugs.
-No residents had complained to her about getting bitten by bed bugs.

Interview with the Administrator on 05/02/23 at 4:40pm revealed:
-She was not involved with the treatment of the

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D 079	Continued From page 17 bed bugs because the AA was handling that. -She was aware the AA had purchased a chemical for the bed bugs, and the chemical was out and on back order. -She had tried to reorder the chemical since 04/12/23. -She had not checked with other sources to get the chemical and had not asked the pest control company to treat for the bed bugs. -The facility had been heat treated about two years ago for the bed bugs, but they continued to come back. -She was unable to recall any instructions provided the pest control company regarding putting systems in place for staff related to the handling of residents' bedding and clothes for rooms with bed bugs. -The only system the facility had was for the housekeeper to clean and spray for the bed bugs. Interview with the AA on 05/02/23 at 4:50pm revealed: -The pest control company came monthly. -He was not sure of the type of treatment provided. -The facility had bed bugs last year and the pest control company treated for them. -He did not recall any treatment recommendations from the pest control company related to the bed bugs. -There were no bed bugs for a long time, but then they came back last year. -He had purchased the chemical for the bed bugs this year and had the housekeeper spraying for the bed bugs.	D 079		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings	D 083		

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10A NCAC 13F .0306 Housekeeping And Furnishings
(a) Adult care home shall:
(9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy;
This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to provide window blinds that were not damaged in 10 of 22 sampled resident rooms (rooms A1, A2, A3, A7, A9, A11, B15, B20, B23 and B24) and window coverings for 2 of 2 windows in the common spa rooms (Spa #1, and Spa#2).

The findings are:

Review of the environmental inspection report from the local county health department dated 04/11/23 revealed:
-The facility received 14 demerits.
-There was an observation of no blinds.

Observation of resident room A1 on 05/03/23 at 10:43am revealed:
-Two residents resided in room A1.
-The room had one window that faced the back parking lot on ground level with vertical blinds covering the window.
-There were 9 slats missing on the window covering.

Interview with a resident who resided in room A1 on 05/03/23 at 10:43am revealed:
-She did not like that the window blind was missing slats.
-Anybody that came into the back parking lot at

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night could see right into the window.
-The blinds slats had been missing since she moved in, in February 2023.

Observation of resident room A2 on 05/03/23 at 10:45am revealed:
-Three residents resided in room A2.
-The room had one window that faced the back parking lot on ground level with vertical blinds covering the window.
-There were 5 slats missing on the window covering.

Interview with a resident who resided in room A2 on 05/03/23 at 10:45am revealed the window blinds had been missing slats since he moved in on 06/30/22.

Observation of resident room A3 on 05/03/23 at 10:57am revealed:
-Two residents resided in room A3.
-The room had one window that faced the back parking lot on ground level with vertical blinds covering the window.
-There was 1 slat missing on the window covering.

Observation of resident room A7 on 05/03/23 at 11:05am revealed:
-One resident resided in room A7.
-The room had one window that was on ground level in the front of the facility, facing the main highway.
-There were vertical blinds covering the window.
-There were 2 slats missing on the window covering.

Interview with the resident who resided in room A7 on 05/03/23 at 11:05am revealed:
-He did not like that the window blinds were

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D 083	Continued From page 20 missing slats. -He would like his window blinds to close completely with no open spaces. Observation of resident room A9 on 05/03/23 at 11:09am revealed: -One resident resided in room A9. -The room had one window that was on ground level in the front of the facility. -There were vertical blinds covering the window. -There were 2 slats missing on the window blinds. Observation of resident room A11 on 05/03/23 at 11:12am revealed: -Two residents resided in room A11. -The room had one window that was on ground level in the front of the building, facing the main highway. -There were vertical blinds covering the window. -There were 4 slats missing on the window blinds. Observation of resident room B15 on 05/03/23 at 11:32am revealed: -One resident resided in room B15. -The room had one window that was on ground level in the rear of the facility. -There were vertical blinds covering the window. -There were 4 slats missing on the window blinds. Observation of resident room B20 on 05/03/23 at 11:17am revealed: -One resident resided in room B20. -The room had one window that was on ground level in the front of the facility, facing the main highway. -There were vertical blinds covering the window. -There was 1 slat missing on the window blinds. Observation of resident room B23 on 05/03/23 at 11:20am revealed:	D 083		

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-One resident resided in room B23.
-The room had one window that was on ground level of the facility.
-There were vertical blinds covering the window.
-There were 2 slats missing on the window blinds.

Observation of resident room B24 on 05/03/23 at 11:22am revealed:
-One resident resided in room B24.
-The room had one window that was on ground level in the front of the facility, facing the main highway.
-There were vertical blinds covering the window.
-There was 4 slats missing on the window blinds.

Observation of Spa #2 on the B Hall during the initial tour on 05/02/23 from 9:15am to 10:40am revealed:
-Spa#2 had one window that was on ground level in the front of the facility and faced the main highway.
-There was no window covering for the spa bathroom window.

Interview with a resident who resided in the room across from Spa#2 on 05/02/23 at 3:58pm and 05/03/23 at 6:40pm revealed:
-She asked if something could "please" be done about the bathroom window with no blinds.
-She had to use that bathroom because it was near her room.
-Each time she had to go to the bathroom she had anxiety because she knew people were able to see her inside the bathroom.
-She was "traumatized" by the fact she had to bathe with no window covering.

Observation of Spa #1 on the A Hall on 05/04/23 at 11:30am revealed:
-Spa#1 had one window that was on ground level

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D 083	Continued From page 22 in the back of the facility, facing the back parking lot. -There was no window covering for the spa window. Telephone interview with the Assistant Administrator (AA) on 05/05/23 at 3:00pm revealed: -The facility did not have a designated maintenance staff person. -He was responsible to ensure the facility furnishings, including window coverings, were maintained. -He had not done a facility walk-through recently to make a list of needed repairs. -The facility staff could let him know if specific repairs were needed. -He had replaced the curtains in the bathroom and put up partitions at showers and tubs a few months ago. -Residents must have torn the curtains down. -He had spoken to the maintenance staff at a sister facility and was going to bring the staff to the facilty for painting and repairs, but had not done so as of yet.	D 083		
D 091	10A NCAC 13F .0306(b)(5)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; (6) additional chairs available, as needed, for use by visitors;	D 091		

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D 091	Continued From page 23 This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a comfortable chair for each resident in 8 of 22 resident rooms (A1, A2, A3, A4, A8, A10, B16 and B17) on the A and B halls. The findings are: Review of the environmental inspection report from the local county health department dated 08/31/22 revealed: -The facility received 19 demerits. -There was an observation of damaged chairs. Review of the environmental inspection report from the local county health department dated 10/28/22 revealed: -The facility received 16 demerits. -There was an observation of cracks in the padding of the chairs. Review of the environmental inspection report from the local county health department dated 04/11/23 revealed: -The facility received 14 demerits. -There was an observation of damaged furniture, furniture needing repair and cracks in the padding of the chairs. Observation of resident room A1 on 05/04/23 at 8:43am revealed: -Two residents resided in the room. -There was a brown leather chair in the room. -The chair was located at the end of the resident's bed that was by the door. -There was no chair for the second resident who	D 091		

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resided in room A1.

Interview with one of the residents who resided in room A1 on 05/04/23 at 8:45am revealed:
-The chair at the end of the bed by the door belonged to her.
-When she moved into the facility two months ago, she brought the chair with her.
-There were no other chairs in the room.

Interview with the second resident who resided in room A1 on 05/04/23 at 8:50am revealed:
-She did not have a chair in the room to sit in.
-When she wanted to sit down, she sat on her bed.
-If she had visitors, they sat on the bed because there was no chair to sit in.

Observation of resident room B16 on 05/02/23 at 10:42am revealed:
-Two residents resided in room B16.
-There were no chairs in the room.

Interview with one of the residents who resided in room B16 on 05/02/23 at 10:44am revealed:
-He had resided in the facility for three months and no chair was provided in the room for him to sit in.
-He had to sit on the bed because there were no chairs in the room.
-Most times when sitting on the bed he was uncomfortable, so he laid down and usually ended up going to sleep.

Interview with the second resident who resided in room B16 on 05/02/23 at 10:46am revealed:
-He had resided at the facility for almost a year and there had never been a chair in his room.
-He sat on the bed to watch television.
-If there were visitors in the room, they had to sit

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on the bed because there were no chairs in the room.

Observation of resident room A2 on 05/03/23 at 10:45am revealed:
-Three residents resided in the room.
-There was no chair for either resident.

Interview with one of the residents who resided in room A2 on 05/03/23 at 10:45am revealed:
-He did not know why there was no chair for him or his roommates.
-There had not been a chair in his room since he moved in on 06/30/22.

Observation of resident room A3 on 05/03/23 at 10:57am revealed:
-Two residents resided in the room.
-There was no chair for either resident.

Observation of resident room A4 on 05/03/23 at 11:00 am revealed:
-One resident resided in the room.
-There was no chair for the resident.

Interview with the resident residing in room A4 on 05/03/23 at 11:00am revealed she did not know why she did not have a chair.

Observation of resident room A8 on 05/03/23 at 11:07am revealed:
-Two residents resided in the room.
-There was no chair for one resident.

Observation of resident room A10 on 05/03/23 at 11:10am revealed:
-Two residents resided in the room.
-There was no chair for one resident.

Observation of resident room B17 on 05/03/23 at

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11:12am revealed:
-Two residents resided in the room.
-There was no chair for one resident.

Telephone interview with the Administrator on 05/05/23 at 4:35pm revealed:
-She or the Assistant Administrator (AA) were responsible for checking the residents' rooms for furniture like chairs.
-She had not had residents complain to her about missing furniture or no chairs for sitting in their rooms.
-The Administrator had not done a facility walk-through checking rooms for missing furniture in several months if not to close to a year.

Telephone interview with the AA on 05/05/23 at 3:00pm revealed:
-The facility did not have a designated maintenance staff person.
-He was responsible to ensure the facility furnishings, including chairs, were maintained.
-He had not done a facility walk-through recently to make a list of missing furniture.
-The facility staff could let him know if specific repairs were needed.

D 113 10A NCAC 13F .0311(d) Other Requirements D 113

10A NCAC 13F .0311 Other Requirements
(d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and

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existing facilities.

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

Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 7 of 7 fixtures (6 sinks and 1 shower) used by the residents.

The findings are:

Observation of the facility during the initial tour on 05/02/23 from 9:45am to 11:20am revealed:
-The facility was a single-story structure.
-The facility was divided into 2 halls with A hall having 12 residents' rooms and B hall with 11 residents' rooms.

Observation of the hot water temperature at the sink in the common spa on the A hall (Spa #2) on 05/02/23 at 9:58am revealed the hot water temperature at the sink was 124 degrees F.

Interview with a resident who resided on the A hall on 05/02/23 at 10:04am revealed:
-He groomed independently and used the sink in Spa #2 to shave sometimes.
-He had not been burned by the hot water.
-He knew to add cold water to the hot water to adjust to a temperature comfortable to him.

Interview with a personal care aide (PCA) on 05/02/23 at 10:06am revealed:
-No resident had complained about the hot water temperature being too hot.
-She had never been asked by maintenance staff to check hot water temperatures at the facility.

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Observation of the hot water temperature at the sink in the second common spa on A hall (Spa #1) on 05/02/23 at 10:20am revealed the hot water temperature at the sink was 126 degrees F.

Interview with a resident who resided in a room close to Spa #1 revealed:
-He knew the hot water in Spa #1 was very hot most days.
-It took the hot water a long time to get hot, but then it got very hot.
-He had not been burned by the hot water.
-He had not talked to the facility staff about hot water temperatures being too hot.

Observation of the hot water temperature at the sink in the common bathroom between resident rooms A9 and A10 on 05/02/23 at 10:25am revealed the hot water temperature was 122 degrees F.

Observation of the hot water temperature as the sink in the common bathroom #1 on the B Hall on 05/02/23 at 10:22am revealed the hot water temperature was 118 degrees F.

Observation of the hot water temperature at the shower in the common bathroom #1 on the B Hall on 05/02/23 at 10:26am revealed the hot water temperature was 120 degrees F.

Observation of the hot water temperature at the sink in the common bathroom #2 on the B Hall on 05/02/23 at 10:35am revealed the hot water temperature was 118 degrees F.

Interview with the two residents who resided in room B16 near the common bathrooms #1 & #2 on the B Hall on 05/02/23 at 10:42am revealed:

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-Both residents had not realized the water was too hot.
-A few months ago, they did not have any hot water because there was something wrong with the system.
-The owner replaced the hot water tank.
-Both residents said they were able to mix in cold water to their comfort level if the water was hot.

Interview with a resident who resided in room B14 near the common bathroom #1 on 05/02/23 at 10:48am revealed he had not experienced the water being too hot, but some of the residents had complained that water was too hot.

On 05/02/23 at 11:00am, the Administrator and Assistant Administrator (AA) were informed that signs were to be posted alerting residents hot water temperatures were elevated and for residents to have assistance from staff before using the hot water.

Review of the facility's hot water temperature log on 05/02/23 revealed there was no temperature logs available to review.

Interview with the AA on 05/02/23 at 12:00 noon revealed:
-He would adjust the hot water mixing valve to a cooler temperature.
-He would provide information when the hot water temperatures were within the 100-116 degrees F range and ready for rechecking.

Observation on 05/02/23 at 12:30pm revealed signs were posted alerting residents of elevated hot water temperatures.

On 05/02/23 at 3:30pm, an ice water slurry was used to check the surveyors' thermometers with a

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reading of 32 degrees F registered on both thermometers.

On 05/03/23 at 3:40pm, an ice water slurry was used to check the facility's thermomenter with a reading of 32.8 degrees F registered on the thermometer.

Recheck of the hot water temperature at the sink in the A Hall common spa (Spa #1) on 05/02/23 at 2:45 revealed a temperature of 100 degrees F.

Recheck of the hot water temperature at the sink in the A Hall common spa (Spa #2) on 05/02/23 at 2:53 revealed a temperature of 116 degrees F.

Recheck of the hot water temperature at the sink in the common bathroom between resident rooms A9 and A10 on 05/02/23 at 2:50pm revealed the hot water temperature was 100 degrees F.

Recheck of the hot water temperature at the shower in the common bathroom #1 on the B Hall on 05/02/23 revealed at 2:38pm the hot water temperature was 110 degrees F.

Recheck of the hot water temperature at the sink in the common bathroom #1 on the B Hall on 05/02/23 revealed at 2:40pm the hot water temperature was 110 degrees F.

A recheck of the hot water temperature at the sink in the common bathroom #2 on the B Hall on 05/02/23 revealed at 2:44pm the hot water temperature was 92 degrees F.

Interview with the Administrator on 05/02/23 at 2:35pm revealed:
-She was no able to locate current hot water temperature logs for review.

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-The facility did not have a designated maintenance staff.
-The facility used a part-time employee to provide general maintenance and hired plumbers or construction companies for most large repairs.
-The facility kept water temperature logs in the past for monitoring hot water temperatures and would begin using the logs again immediately.

____
The facility failed to ensure hot water temperatures for 6 fixtures used by residents were maintained between 100-116 degrees F. A hot water temperature of 122 degrees F could result in a first degree burn in 2 to 6 minutes and a second degree burn in 4 to 10 minutes. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

____
The facility a plan of protection in accordance with G.S. 131D-34 on 05/02/23 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2023.

D 129 — 10A NCAC 13f .0404 (2) Qualifications Of Activity Director — D 129

10A NCAC 13f .0404 Qualifications Of Activity Director
Adult care homes shall have an activity director who meets the following qualifications:
(2) The activity director hired after September 30, 2022 shall complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the

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Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies:
(a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C;
(b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting;
(c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; or
(d) be certified as an Activity Director by the National Certification Council for Activity Professionals.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure the Activity Director had completed the basic activity course within 9 months of employment.

The findings are:

Review of the Activity Director's (AD) personnel record revealed:
-She was hired in 2001 as a personal care aide (PCA).
-She was hired as the AD in 2016.
-There was no documentation of completion of the activities training within 9 months of being

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hired.

Observation of activities on 05/02/23 at various times from 10:00am to 3:00pm revealed:
-The AD was not participating in activities, but was performing PCA duties.
-At 1:00pm staff including the AD were behind the medication room counter talking with each other for 15 to 20 minutes and no activities were being conducted with the residents.
-At 3:00pm some residents were in the living room and the television was on.
-No other activities occurred the remainder of the day.

Observation on 05/03/23 at 10:45am, 11:30am 1:10pm and 3:05pm revealed staff including the AD were behind the medication room counter talking with each other and no activities were being conducted with the residents.

Observation on 05/03/23 at various times between 9:00am and 5:00pm revealed:
-Some residents were in the living room and the television was on.
-Some residents were in the front of the facility smoking.
-There were 7 to 10 residents at various times lined up in the hallway near the medication room.
-No activities were being done and no one asked the residents to participate in activities.
-There were no other activities available for residents to participate in the entire day.
-The AD was doing PCA duties.

Attempted interview with the AD on 05/04/23 at 8:25am was unsuccessful.

Interview with the Administrator on 05/04/23 at 11:40am revealed:

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D 129	Continued From page 34 -The AD had not completed activities training. -She had not scheduled the AD for activities training. -She assisted the AD with completing the activities calendar. -She had a previous employee who she hired as a PCA, and that employee was doing some activities with the residents. -She intended on scheduling that employee for the activities training, but she quit before she could schedule the training. -She was responsible for ensuring staff had completed the required trainings and filing the documentation in the personnel record.	D 129		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B and C) had no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B previously worked at the facility in 2018. -She was rehired on 04/11/23.	D 137		

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-There was no documentation a HCPR check was completed prior to Staff B's hire on 04/11/23.

Interview with Staff B on 05/04/23 at 5:20pm revealed she thought the Administrator had completed a HCPR check on her on 04/11/23 when she was rehired as an MA.

Interview with the Administrator on 05/04/23 at 5:30pm revealed:
-She was responsible for making sure staff qualifications were completed, including HCPR checks.
-Staff B had previously worked at the facility in 2018.
-Staff B came back to work at the facility on 04/15/23.
-She could not locate a HCPR check which was completed for Staff B before her hire on 04/15/23.
-She thought she had completed a HCPR check but it was not in Staff B's personnel record

2. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C had previously worked at the facility in 2021.
-Staff C came back to work at the facility in September 2022.
-There was no documentation a HCPR check was completed prior to Staff C's hire in September 2022.

Interview with Staff C on 05/04/23 at 5:45pm revealed:
-She came back to work at the facility in September 2022.
-She did not remember if a HCPR was completed when she was rehired in September 2022.

Interview with the Administrator on 05/04/23 at

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D 137	Continued From page 36 6:00pm revealed: -Staff C had worked at the facility several times. -She could not locate all of Staff C's personnel record. -She thought she had completed a HCPR check for Staff C, but she could not find the notebook Staff C's personnel record was in.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff (B and C) had a criminal background check completed upon hire. The findings are: 1. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired on 04/11/23. -A criminal background check was completed for Staff B on 05/02/23. Interview with Staff B on 05/04/23 at 5:10pm revealed she did not know if a criminal background check was completed before she was hired on 04/11/23. Interview with the Administrator on 05/04/23 at 5:18pm revealed:	D 139		

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-She did not realize that she had not completed a criminal background check on Staff B before she was hired.
-She completed the criminal background check on Staff B on 05/02/23.

2. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C previously worked at the facility in 2021.
-She was rehired as in September 2022.
-There was a criminal background check dated 06/23/21.
-There was no documentation a criminal background check was completed on Staff C prior to being rehired in September of 2022.

Interview with Staff C on 05/04/23 at 5:45pm revealed she did not know if a criminal background check was completed before she was rehired in September 2022.

Interview with the Administrator on 05/04/23 at 6:00pm revealed:
-She thought she had completed a criminal background check on Staff C when she was rehired in September of 2022.
-She could not locate all of Staff C's personnel record.
-She could not find the notebook Staff C's personnel record was in.

D 140 — D 140

10A NCAC 13F .0407(a)(8) Other Staff Qualifications

10A NCAC 13F .0407 Other Staff Qualifications
(a) Each staff person at an adult care home shall:
(8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results

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available in the staff person's personnel file;

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure documentation of an examination and screening for the presence of controlled substances was completed for 3 of 3 sampled staff (A, B and C).

The findings are:

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A previously worked at the facility in 2018.
-She was rehired on 01/22/21.
-There was no documentation Staff A completed a drug screening when she was hired on 01/22/21.

Interview with Staff A on 05/04/23 at 5:01 pm revealed she was not sure, but thought she had completed a drug screen when she was rehired on 01/22/21.

Interview with the Administrator 05/04/23 at 4:45pm revealed:
-She was responsible to ensure all new staff completed hiring requirements including drug screenings.
-When Staff A was hired on 01/22/21, Staff A gave excuses about not having childcare as to why she could not go after work hours to complete a drug screen.
-She had provided paperwork to Staff A twice to complete a drug screen.
-She had forgotten that a drug screen was never completed by Staff A.

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2. Review of Staff B's, medication aide (MA), personnel record revealed:
-Staff B previously worked at the facility in 2018.
-She was rehired on 04/11/23.
-There was no documentation Staff B completed a drug screening when she was hired on 04/11/23.

Interview with Staff B on 05/04/23 at 5:10pm revealed she had completed a drug screen the day she was hired.

Interview with the Administrator 05/04/23 at 5:18pm revealed:
-She was responsible to ensure all new staff completed hiring requirements including drug screenings.
-Staff B was hired as a MA on 04/15/23.
-Staff B completed her drug screen when she was rehired.
-The drug screen provider called and told her the drug screen was negative, but they must not have mailed her the results because there were no results in Staff B's personnel record.

3. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C previously worked at the facility in 2021.
-She was rehired in September 2022.
-There was no documentation Staff C completed a drug screening when she was hired in September 2022.

Interview with Staff C on 05/04/23 at 5:45pm revealed:
-She returned to work at the facility sometime in September 2022.
-She could not remember if she completed a drug screening when she returned to work in September 2022.

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D 140	Continued From page 40 Interview with the Administrator on 05/04/2023 at 6:00pm revealed: -She was responsible to ensure all new staff completed hiring requirements including drug screenings. -Staff C had worked at the facility several times. -She thought Staff C had completed the drug screening when she returned to work in September 2022. -She could not locate all of Staff C's personnel record. -She could not find the notebook Staff C's personnel record was in.	D 140		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.	D 176		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record review, the Administrator failed to ensure the management and overall operations of the facility by failing to monitor and maintain compliance in rules related to physical environment, housekeeping and furnishings, other requirements, staff qualifications, personal care and supervision, health care, nutrition and food service, medication administration, and controlled substances.

The findings are:

Confidential interviews with eight residents revealed:
-The Administrator by name was hardly at the facility.
-The Administrator came to the facility maybe once or twice per month, if that often.
-When the Administrator was in the facility, she stayed maybe 1 hour and was gone.
-The Assistant Administrator (AA), a relative to the Administrator, was in the facility weekly.
-When the AA came to the facility he gave out money and sold the residents cigarettes.
-The AA was in the facility one to two hours, and he mostly stayed in the office.
-The AA could have been in the facility longer but they did not see him.

Confidential interview with a staff revealed:
-She seldom saw the Administrator at the facility.
-If the Administrator visited the facility, it was a couple of times per month.

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-When she had a request, she went to the Resident Care Coordinator (RCC).
-The Assistant Administrator (AA) was a relative to the Administrator and he was in the facility weekly.
-When the AA came to the facility, he stayed maybe one to two hours, but he mostly stayed in the office.

Interview with the personal care aide (PCA) 05/02/23 at 10:05am revealed:
-She was unable to recall the last time she saw the Administrator in the facility.
-The Administrator maybe was in the facility one to two times per month.
-The AA was in the facility once weekly to give out money and cigarettes, but he left shortly afterwards.
-If she had a problem, she told the RCC.

Interview with the second shift medication aide (MA) on 05/03/23 at 4:10pm revealed:
-She did not see the Administrator in the facility.
-It could be the shift that she worked, but residents and day shift staff complained the Administrator and AA were never present and did not respond when they asked for assistance.

Telephone interview with the third shift MA 05/04/23 at 9:12am revealed:
-She worked third shift and never saw the Administrator.
-She was unable to recall the last time she saw the Administrator.
-If there was a problem, she made the RCC aware of the problem.

Interview with the medication aide/Supervisor (MA/S) on 05/03/23 at 5:25pm revealed:
-The Administrator was seldom in the facility.

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-The Administrator was in the facility maybe once or twice per month.
-The AA visited the facility weekly; when he visited, he stayed for a couple of hours and mostly stayed in the office.
-She and the RCC made the Administrator and AA aware of issues and concerns at the facility but nothing was done.
-Sometimes they did not respond to the text messages and phone messages left.
-Last week the AA came to the facility on Wednesday and did not come back until Tuesday 05/03/23.
-Residents were complaining, because they wanted cigarettes and money.

Interview with the RCC on 05/03/23 at 1:05pm revealed:
-The Administrator visited the facility maybe two times per month.
-She was the point of contact between the facility staff, the Administrator and AA.
-When there was an issue, she texted and/or called the Administrator and AA to let them know of the problems.
-Sometimes they responded back, but most times they usually did not respond back to her.
-There was only so much she could do, and residents were complaining when they could not get things requested.

Interview with the AA on 05/04/23 at 6:15pm revealed:
-He was at the facility almost every day.
-He did not know why the staff and residents were saying he was not.
-When at the facility, he walked the halls to see if things needed to be repaired.
-There was nothing to validate or show his presence in the facility, but he was there at least

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three to four days per week.
-If the staff needed him, they were able to call or text him any time of the day or night.
-He did not get involved with the records reviews or orders.
-He mostly handled supplies.

Interview with the Administrator on 05/04/23 at 7:35pm revealed:
-She had not been at the facility that often.
-She lost a family member last year and it had been emotionally hard for her.
-She was in the facility more than two times per month.
-Even when she was not in the facility staff were able to call and text her with concerns and/or problems.

Non-compliance was identified in the following rule areas:

1. Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 4 sampled residents (#1, #2, #3 and #5) related to fast-acting and long-acting insulin (#1); medication orders for iron and vitamin C supplements, an antibiotic, a blood thinner and a non-steroidal pain reliever (#2); an antipsychotic and anti-anxiety medications (#5), and a nasal spray and an osteoarthritis medication (#3). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#2) related to a resident diagnosed with dementia who was confused and wandered out of the facility without staff's knowledge. [Refer to Tag D0270, NCAC

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D 176	Continued From page 45 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 4 exit doors accessible to residents, who were constantly or intermittently disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. [Refer to Tag D067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 7 of 7 fixtures (6 sinks and 1 shower) used by the residents. [Refer to Tag D0113, 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to ensure medications were borrowed only in an emergency and replaced promptly and documented for 4 of 4 residents sampled (#2, #5 #7, #8,) related to staff borrowing a Schedule II controlled substance for moderate to severe pain from Resident #7 and administering it to Resident #2, and borrowing a Schedule IV controlled substance for anxiety from Resident #8 and administering it to Resident # 5. [Refer to Tag D0372, 10A NCAC 13F .1004(o) Medication Administration (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled medication for 3 of 5 sampled	D 176		

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residents (#2, #5, #9) related to a Schedule II controlled pain reliever (#2, and #9) and a Schedule IV controlled anti-anxiety medication (#5). [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substance (Type B Violation)].

7. Based on observations and interviews, the facility failed to ensure the walls, ceilings, and floors were kept clean and in good repair in 7 of 23 resident rooms (Rooms A1, A2, A3, A4, A8, A10 and B16) related to residents' rooms with broken or missing closet doors. [Refer to Tag D074, 10A NCAC 13F. 0306(a)(1) Housekeeping and Furnishings].

8. Based on observations and interviews, the facility failed to ensure the chest of drawers in 2 residents' rooms (A5 and B16) and the nightstand in 1 resident's room (B16) were kept in good repair. [Refer to Tag D076, 10A NCAC 13F .0306(a)(3) Housekeeping and Furnishings].

9. Based on observations, record reviews and interviews, the facility failed to ensure the facility was clean and free of hazards as evidenced by the presence of live bed bug activity in two resident bedrooms (rooms A8 and B17). [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings].

10. Based on observations, record reviews, and interviews, the facility failed to provide window blinds that were not damaged in 10 of 22 sampled resident rooms (rooms A1, A2, A3, A7, A9, A11, B15, B20, B23 and B24) and window coverings for 2 of 2 windows in the common spa rooms (Spa #1, and Spa#2). [Refer to Tag D083, 10A NCAC 13F .0306(a)(9) Housekeeping and Furnishings].

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11. Based on observations, interviews and record reviews, the facility failed to provide a comfortable chair for each resident in 8 of 22 resident rooms (A1, A2, A3, A4, A8, A10, B16 and B17) on the A and B halls. [Refer to Tag D091, 10A NCAC 13F .0306(b)(5)(6) Housekeeping and Furnishings].

12. Based on observations, interviews and record reviews, the facility failed to ensure the Activity Director had completed the basic activity course within 9 months of employment. [Refer to Tag D0129, 10A NCAC 13F .0404(2) Qualifications of the Activity Director].

13. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B and C) had no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. [Refer to Tag D0137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications].

14. Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff (B and C) had a criminal background check completed upon hire. [Refer to Tag D0139, 10A NCAC 13F .0407(a)(7) Other Staff Qualifications]

15. Based on interviews and record reviews, the facility failed to ensure documentation of an examination and screening for the presence of controlled substances was completed for 3 of 3 sampled staff (A, B and C). [Refer to Tag D0140, 10A NCAC 13F .0407(a)(8) Other Staff Qualifications].

16. Based on observations, interviews and record reviews, the facility failed to ensure referrals were completed for 2 of 4 sampled residents (#2 and #10) related to physical and occupational

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therapies not started after hip replacement surgery (#2) and a resident who required a referral for podiatry (#10). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care].

17. Based on observations, record review and interviews, the facility failed to implement physician's orders for 1 of 3 sampled residents who had an order to give orange juice for low fingerstick blood sugars and daily blood pressure checks (#1). [Refer to Tag 276 10A NCAC 13F .0902(c) 3-4 Health Care].

18. Based on observations, interviews and record reviews the facility failed to ensure mealtime table service included a non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage container. [Refer to Tag D0286, 10A NCAC 13F .0904(b)(1) Nutrition and Food Service].

19. Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#1 and #6) with physician's orders for a no concentrated sweets (NCS) diet (#1) and an 1800 calorie ADA diet (#6). [Refer to Tag D0296, 10A NCAC 13F .0904(c)(7) Nutrition and Food Service].

20. Based on observations, interviews and record reviews, the facility failed to ensure 14 hours of activities planned each week were provided for the residents. [Refer to Tag D0317, 10A NCAC 13F .0905(d) Activities Program].

21. Based on interviews, observations and record reviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 3 of 4 residents sampled for record

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review (#2, #3, and #5) related to documenting medications were administered when the resident was hospitalized (#2); a steroid nasal spray to treat allergies (#3); and a medication used to treat anxiety/depression (#5). [Refer to Tag D0367, 10A NCAC 13F .1004(j) Medication Administration].

22. Based on interviews and record reviews, the facility failed to ensure the mandatory annual state approved infection control training was completed for 1 of 1 sampled staff (#B) within 30 days of hire and for 2 of 2 sampled staff (A and C) annually. [Refer to Tag D0613, 10A NCAC 13F .1801(a) Infection Prevention & Control Policies and Procedures].

____

The Administrator failed to ensure the management and total operations of the facility and to ensure compliance with the rules for adult care homes, as evidenced by exit doors not having audible sounding devices resulting in a resident who was constantly disoriented eloping from the facility placing the resident at risk of physical harm by being struck by passing automobiles; medications not being administered as ordered which placed residents at risk for serious physical harm and neglect resulting in a resident having a fever and altered mental status with a return hospital visit after an antibiotic was not started (#2), long-acting and fast-acting insulin not administered as ordered placing the resident at risk for heart failure, kidney damage and loss of eye sight (#1), antipsychotic and an anti-anxiety medication resulting in the resident experiencing shaking hands and sleepless nights (#5); staff borrowing medications placing a resident who had hip replaced surgery at risk for running out of pain medication and experiencing pain (#2); and inaccurate accounting of controlled

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substances were not maintained for narcotic pain medications for two residents and anti-anxiety medications with no documentation the residents received the controlled substances. These failures resulted in serious physical harm and neglect to the residents which constitutes a Type A1 Violation.

____
The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/08/23 for this violation.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 4, 2023.

D 270 — 10A NCAC 13F .0901(b) Personal Care and Supervision — D 270

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 A2 VIOLATION

Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#2) related to a resident diagnosed with dementia who was confused and wandered out of the facility without staff's knowledge.

The findings are:

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D 270	Continued From page 51 Review of the facility's Resident Supervision Policy revealed: -Staff will perform a head count on all residents every 2 hours to account for all residents. -Staff will perform 30 minute supervision checks on all new admissions for the first 24 hours. -The 15 to 30 minute supervision checks were in place for any potential flight (elopement) risk. Review of Resident #2's current hospital FL2 dated 04/08/23 revealed: -Diagnoses included dementia and symptoms post total right hip arthroplasty (replacement). -Hospital diagnoses included severe sepsis and urinary tract infection (UTI). -The Resident required personal care assistance with bathing, feeding and dressing. -He was intermittently disoriented and ambulatory. -The recommended level of care was Domiciliary (Rest Home). Review of Resident #2's care plan dated 05/26/22 revealed: -The resident was ambulatory with no assistive device. -The resident required limited assistance with toileting. -The resident was independent with dressing, grooming, bathing, and transfers. Observation of the facility's location on 05/02/23 revealed: -The facility was located 300 feet off the road on a major 2 lane highway headed southwest of the town. -There was an interstate within 1 mile northeast of the facility. -There was a local department store	D 270		

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approximately 0.3 to 0.4 miles southwest of the facility and on the opposite side of the major highway.
-There was an open field behind the facility with residential houses visible from the facility, but more than 1000 feet away.

Review of Resident #2's progress notes dated 11/22/22 (Saturday) at 3:30pm revealed:
-Resident #2 went walking, then went walking on the main road.
-The resident's family member and the Supervisor were called.
-Resident #2 was picked up by a staff (no information where picked up) and brought back to the facility.
-Resident #2 was placed on 15 minute watches.

Review of Resident #2's progress notes dated 04/16/23 revealed:
-At 3:00pm, "Called mobile crisis due to resident kept going in the road" was documented by a second shift medication aide (MA).
-At 4:30pm, "Mobile crisis called saying resident should be admitted to a lock down unit due to memory loss. Recommend to send resident out to the hospital cause he is sick" was documented by the same MA. (Oxygen saturation documented as 71 percent on room air.)
-At 5:00pm, Resident #2 was sent out to the local hospital.
-At 7:21pm, Resident #2 returned to the facility with a medication order for an antibiotic.

Review of Resident #2's progress notes dated 04/24/23 (Monday) at no time listed, revealed "Resident walked to the road and was found walking past a local department store and picked him up. Resident jumped into the car with SIC [Supervisor] not knowing who I was."

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Interview with a second shift MA on 05/04/23 at 5:00pm revealed:
-Resident #2 had been going out the front door to the road several times over the last 3 to 4 days.
- "One minute he was here beside her, the next time she turned around he was walking along the side of the road".
-Last Thursday (04/27/23), Resident #2 was reported by another resident to be outside in the rain.
-The personal care aide (PCA) working with her at the time went out the rear door of the facility to find Resident #2.
-The MA followed the PCA outside of the facility.
-The MA called the resident's name, but the resident lifted his arms into the air and kept walking toward a house behind the facility.
-The MA caught up to Resident #2 and redirected him into the facility. (Both the resident and MA were wet from the rain.)
-She did not write an incident report or document in the progress notes because the PCA was responsible to document the incident since she was the staff that first observed the incident.
-She was not aware of any increased supervision in place for Resident #2 other than she tried to "keep an eye on him" to know his whereabouts.

Interview with Resident #2's Physician's Assistant (PA) from the primary care provider's (PCP) office on 05/04/23 at 11:00am revealed:
-Resident #2's dementia seemed to have worsened since his hip replacement surgery in March 2023.
-Resident #2 was less cognitive of his health status and less able to respond to health questions.
-He thought the anesthesia used during surgery and his subsequent urinary tract and pneumonia

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infection all added to his confusion and dementia.
-He was not aware Resident #2 was exhibiting wandering behaviors because he did not recall facility staff commenting on Resident #2 constantly going to the road.
-He expected the staff to provide supervision for Resident #2 to the extent needed to keep the resident safe.

Telephone interview with Resident #2's family member (Guardian) on 05/04/23 at 11:12am revealed:
-Resident #2 had dementia that was progressing.
-Resident #2 seemed to be more disoriented when he spoke to him on the phone with less ability to communicate with the family member.
-Resident #2's memory and communication was worse since his hip surgery in March 2023.
-In the past, Resident #2 had experienced periods of decreased ability to communicate and increased cognitive loss after an illness or hospitalization.
-The facility had notified him about a recent incident when the resident was found at the local department store and was brought back to the facility by staff. He was told the resident wanted to go to town.
-When Resident #2 came to the facility in 2021, the family member had given permission for the resident to walk to the local department store because he was more mentally alert and oriented.
-He did not believe it was safe currently, for Resident #2 to go outside the facility especially up the road without staff supervision.
-The facility administration had mentioned that the facility staff did not have the ability to provide one on one supervision for Resident #2.
-Due to financial limitations, he was not able to relocate Resident #2 to a locked facility.

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D 270	Continued From page 55 -He had not discussed options for supervision with the facility. -He did not know what supervision was in place for Resident #2. Telephone interview with Resident #2's Nurse Practitioner (NP) from the mental health provider's (MHP) office on 05/04/23 at 1:50pm revealed: -She saw Resident #2 on monthly visits to the facility (routinely the first or second week of the month). -Resident #2 may have been in the hospital on her last monthly visit in April 2023. -She had not seen documentation related to Resident #2 eloping on 04/24/23. -She did not know Resident #2 was wandering (eloping) from the facility. -She would expect the facility to increase the level of supervision of Resident #2 to prevent him from eloping. -She would have made recommendation to alarm all exit doors if she had known. Interview with the medication aide/Supervisor (MA/S) on 05/04/23 at 1:46pm revealed: -Resident #2 was the only resident with dementia that wandered outside of the facility. -Resident #2's family member had allowed Resident #2 to go to the local department store in the past. -Resident #2 had displayed increased dementia symptoms in that he required more redirecting to find his room, be informed about mealtime, and wandering about the facility. -She picked Resident #2 up at the local department store on 04/24/23 and he did not seem to recognize her. -Staff did "keep a closer eye on" Resident #2 because of his dementia diagnosis and recent	D 270		

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wandering behaviors.
-She had not recommended increased supervision checks other than the routine 2 hour checks performed by staff for all residents.

Interview with the Administrator on 05/04/23 at 4:30pm revealed:
-Resident #2's dementia and mental status seemed to decline over the last 6 months, maybe because of his recent hip replacement surgery and hospital visits for urinary tract infections and pneumonia.
-Staff routinely conducted 2 hours resident supervision checks.
-The facility used 15 or 30 minute supervision checks in the past for residents that wandered; there was a form staff used to document increased supervision.
-There was no documented increased supervision for Resident #2.
-The facility had a door alarm monitoring device that was activated by a bracelet worn by residents, but the facility had not used the device in a long time. The facility did not have bracelets to use with the device at present.
-She did not know Resident #2 wandered outside of the facility on 04/27/23, because no staff had told her about the incident and there was no report or progress note written about the incident.
-She had not read Resident #2's progress notes from 04/24/23 and was not aware the resident was brought back to the facility by the Supervisor.
-She had not recommended any kind of increased supervision for Resident #2 since she had not been made aware he was leaving the facility without staffs' knowledge.
-All staff should be reporting to her by phone call, or text at the time of the incident, but the RCC and the Supervisor were responsible to ensure that she was made aware of any residents

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D 270	Continued From page 57 wandering outside of the facility. -The RCC and the Supervisor could initiate increased supervision for residents for any reason. ________________________ The facility failed to ensure supervision for a resident with a diagnosis of dementia and exhibited wandering behaviors leaving out of the facility without staff's knowledge (Resident #2) placing the resident at risk for being struck by passing automobiles or physical harm if picked up by a stranger. This failure placed Resident #2 at substantial risk for physical harm and neglect and constitutes a Type A2 Violation. ________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 4, 2013.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure referrals were completed for 2 of 4 sampled residents (#2 and #10) related to physical and occupational therapies not started after hip replacement surgery (#2) and a resident who required a referral for podiatry (#10).	D 273		

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The findings are:

1. Review of Resident #2's current hospital FL-2 dated 04/08/23 revealed diagnoses included severe sepsis, urinary tract infection, dementia, and status post total right hip arthroplasty (replacement).

Review of Resident #2's previous hospital FL2 dated 03/28/23 revealed:
-Diagnosis included right hip arthroplasy (replacement) on 03/22/23.
-There was an order for home health physical therapy (PT) and occupational therapy (OT) on the FL2.

Review of Resident #2's home health progress notes revealed there were no notes related to a home health evaluation or treatment from 03/28/23 to 05/04/23.

Interview with the Administrator on 05/03/23 at 4:30pm revealed:
-She did not have a system in place to routinely audit physicians' orders.
-She relied on the Resident Care Coordinator (RCC) and medication aide/Supervisor (MA/S) to ensure orders for treatment or medications were referred to the appropriate provider.
-She did not know Resident #2 was ordered PT/OT after his hip surgery.

Telephone interview with Resident #2's family member (guardian) on 05/04/23 at 11:12am revealed:
-The facility usually contacted him for any health care requests involving a cost or any outside service.
-He was not contacted by the facility regarding an order for PT and OT.

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-He did not know Resident #2 was not receiving PT or OT after hip replacement.

Interview with the MA/S on 05/04/23 at 5:30pm revealed:
-The primary care provider's (PCP) Nurse Practitioner (NP) routinely reviewed all orders written for residents and initialed the orders once reviewed.
-The medication aides (MAs) received residents' orders when the residents returned from a hospitalization or physician's visits.
-The MAs would placed the orders in a folder/box in the medication room designated for the NP's review.
-The RCC or MA/S was responsible to review the resident's orders the next business day they worked and ensure the orders were filed in the residents' records.

Telephone interview with a nurse at Resident #2's orthopedic clinic on 05/05/23 at 1:40pm revealed:
-Receiving PT/OT post hip replacement surgery was routine practice to help with strengthening and prevention of complications like blood clots.
-There was no documentation from the facilty regarding PT/OT had not been started for Resident #2 as ordered on the hospital discharge summary.
-Resident #2 was seen in the orthopedic clinic on 05/04/23 for a follow-up post hip replacement but was unable to provide information due to impaired mental status.
-There was documentation the hospital staff faxed information to a home health provider to begin PT/OT prior to the hospital discharge on 03/28/23.
-The orthopedic clinic did not receive a call from the home health agency with any questions or notifications of not proceeding with PT/OT.

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-The facility should have called the clinic to follow-up on the PT/OT order if there were concerns.
-Resident #2 appeared to be very mobile and able to ambulate well.

Telephone interview with a nurse from the local home health agency on 05/05/23 at 2:00pm revealed:
-She routinely arranged for PT/OT evaluations and treatments for the home health agency.
-Resident #2 had documented PT/OT services in July 2023.
-There was no documentation or request for review regarding a hospital referral for PT/OT in March 2023 or subsequently.
-The home health agency was not contacted by the facility for PT/OT services for Resident #2 in March 2023.

2. Review of Resident #10's current FL2 dated 02/27/23 revealed:
-Diagnoses included seizure disorder, mood disorder, chronic pain, hypertension, psychosis, paranoid, dyslipidemia, major depressive disorder with psychosis, and gastroesophageal reflux disease with esophagitis.
-He was intermittently disoriented.
-He was ambulatory with a walker.

Review of Resident #10's Care Plan dated 02/27/23 revealed:
-He required supervision with toileting, ambulation and transferring.
-He required limited assistance with bathing, dressing and grooming and personal hygiene.

Observation of Resident #10 on 05/03/23 at 8:30am revealed:
-He was lying in his bed without socks and his

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feet were uncovered.
-His great toenails on both feet were very long, greater than one inch in length past the tops of the toes.
-The toenails on the other four toes of both feet were three-fourths to one-half inch long in length.
-The toenails were curved over, thick, and yellow-colored.
-The skin on his feet was extremely dry, scaly, and flaky.

Observation of Resident #10 on 05/03/2023 at 11:55am revealed:
-When walking, Resident #10's feet did not completely touch the floor.
-The resident walked with his heels first touching the floor.
-The resident rolled his feet so his toes did not touch the floor.

Observation of Resident #10 on 05/04/23 at 3:40pm revealed:
-There was a growth between his third and fourth toe on his left foot.
-The growth extended between the toes to the first knuckle on the toe.

Review of Resident #10's record revealed:
-He was seen by a podiatrist on 09/13/22.
-There was no documentation of podiatry care after 09/13/22.

Interview with Resident #10 on 05/04/23 at 3:40pm revealed it hurt for staff to move his toes and to touch his toenails.

Interview with a personal care aide (PCA) on 05/04/23 at 3:25pm revealed she had told the medication aide Supervisor (MA/S) and the Resident Care Coordinator (RCC) that Resident

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D 273	Continued From page 62 #10 needed his toenails cut, but she did not recall when she told them. Interview with a MA on 05/04/23 at 3:15pm revealed: -She knew Resident #10 needed his toenails trimmed. -She had told the MA/S and the RCC his toenails needed to be trimmed, but could not recall when she told them. -The podiatrist had not been to the facility for a long time, and she did not know why. Interview with the MA/S on 05/04/23 at 4:21pm revealed no one had said anything to her about Resident #10 needing his toenails trimmed. Interview with the RCC on 05/04/23 at 3:50pm revealed: -The PCAs did not provide nail care to the residents. -Her understanding was the Activity Director provided nail care as an activity. -No resident at the facility had received foot care from the podiatrist since September 2022. -She was unable to provide a reason why podiatry care had not been sought for the residents at the facility since September 2022. -Two weeks ago, she had contacted the agency who provided podiatry care to the facility about coming out to the facility, but they had not come out yet. -She had told the Assistant Administrator (AA) about the podiatrist not coming out to the facility and he told her to talk with the Administrator. -She had emailed the podiatrist about coming to the facility on 04/25/23. -They requested resident information, and she faxed them the facility roster. -They had not provided her with any information	D 273		

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about coming to the facility.
-She had not contacted the podiatrist prior to 04/25/23.

Review of an email dated 04/25/23 from the podiatrist revealed:
-An email was sent by the RCC to the podiatrist on 04/25/23 asking when they would be coming to the facility to provide podiatry care.
-An email was sent from the podiatrist on 04/25/23 stating she would follow up with the scheduling team and ask about the next date for the facility.
-There was no documentation of communication with the podiatrist or another agency regarding residents' foot care.

Telephone interview with the contracted podiatrist on 05/04/23 at 4:00pm revealed:
-He had not had a contracted podiatrist for the area where the facility was located for several months.
-He did not have a start date for a podiatrist for the area.
-The last visit to the facility was in September 2022.

Interview with the Administrator on 05/04/23 at 4:27pm revealed:
-She was not aware of the condition of Resident #10's feet until this afternoon on 05/04/23.
-She observed Resident #10's feet this afternoon on 05/04/23.
-She observed the growth between Resident #10's toes.
-She knew that the podiatrist had not been to the facility in a while.
-She had not talked with the podiatrist to ask why they had not been to the facility.
-She had not tried to locate another podiatrist.

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10A NCAC 13F .0902 Health Care
(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to implement physician's orders for 1of 3 sampled residents who had an order to give orange juice for low fingerstick blood sugars (FSBS) and daily blood pressure checks (#1).

The findings are:

Review of Resident #1's current FL2 dated 08/29/22 revealed diagnoses included diabetes mellitus type 2, anxiety, traumatic brain injury, and hypertension.

Review of Resident #1's current FL2 dated 08/29/22 revealed:
-There was an order to check the resident's fingerstick blood sugar (FSBS) before meals and at bedtime.
-There was an order to give orange juice (OJ) for FSBS less than 60.

Review of Resident #1's physician's orders revealed:
-There was an order dated 10/06/22 to check the resident's FSBS before meals and at bedtime and to give OJ for FSBS less than 60 as needed

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(PRN).
-There was an order dated 04/06/23 to check the resident's FSBS before meals and at bedtime and to give OJ for FSBS less than 60 PRN.

Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry to give OJ for FSBS less than 60 PRN.
-There was documentation Resident #1's FSBS was less than 60 for 7 of 124 opportunities from 03/01/23 through 03/31/23 with examples as follows:
-On 03/15/23 at 11:30am, FSBS was 43; there was no documentation OJ was given.
-On 03/21/23 at 7:30am, FSBS was 43; there was no documentation OJ was given.
-On 03/26/23 at 11:30am, FSBS was 37; there was no documentation OJ was given.

Review of Resident #1's April 2023 eMAR revealed:
-There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry to give OJ for FSBS less than 60 PRN.
-There was documentation Resident #1's FSBS was less than 60 for 10 of 120 opportunities from 04/01/23 through 04/30/23 with examples as follows:
-On 04/05/21 at 11:30am, FSBS was 52; there was no documentation OJ was given.
-On 04/15/23 at 7:30am, FSBS was 52; there was no documentation OJ was given.
-On 04/28/23 at 7:30am, FSBS was 43; there was

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no documentation OJ was given.

Review of Resident #1's May 2023 eMAR (05/01/23 through 05/04/23) revealed there were no FSBS less than 60.

Interview with Resident #1 on 05/03/23 at 1:53pm revealed:
-The MA checked his FSBS several times per day.
-He did not know when his FSBS were high or low because staff did not tell him, and he did not feel any different.

Interview with Resident #1's primary care provider (PCP) on 05/04/23 at 10:22am revealed:
-Resident #1 was a "brittle diabetic."
-Sometimes the resident's FSBS were "all over the place."
-He was aware that sometimes the resident's FSBS dropped low, which was why he ordered OJ for FSBS less than 60.
-He was not aware staff did not give the OJ.
-A low FSBS, could cause unconsciousness, light headiness and confusion.

Interview with the medication aide supervisor (MA/S) on 05/04/23 at 9:35am revealed:
-When an FL2 was received it was faxed to the pharmacy.
-The pharmacy entered the orders on the eMAR.
-The MAs were to document medications and treatment on the eMAR, however some FSBS were documented on the facility's FSBS reading sheet.
-If there was no documentation OJ was given, she could not say staff administered OJ.
-If the order was on the eMAR it should be followed.
-She was unable to explain why Resident #1 was

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not given OJ.

Telephone interview with the third shift MA on 05/04/23 at 9:12am revealed:
-She did not know there was an entry on the eMAR to give OJ for FSBS less than 60.
-When she checked Resident #1's FSBS if it was low, she did not give him OJ because the resident was usually going to a meal.
-The resident was usually going to the dining room to eat shortly afterwards.

Interview with the second shift MA on 05/03/23 at 4:10pm:
-Resident #1 seldom had low FSBS on her shift.
-She did not know there was an order on the eMAR to give OJ for FSBS less than 60.
-When the resident had a low FSBS she did not recall giving the resident OJ.
-She did not know if the facility had a protocol or policy to follow for low FSBS.

Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 2:09pm revealed:
-The facility did not have a system in place to review the eMARs and ensure orders were followed.
-The facility did not have a policy or protocol as to what to do when FSBS were low.

Refer to the interview with the Administrator on 05/03/23 at 4:30pm.

b. Review of Resident #1's current FL2 dated 08/29/22 revealed there was an order for daily blood pressure checks.

Review of Resident #1's February, March, April and May (05/01/23 through 05/04/23) 2023 electronic medication administration record

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(eMAR) revealed:
-There was no entry for daily blood pressure checks for Resident #1.
-There was an entry for monthly vital signs that included a BP check.

Interview with Resident #1 on 05/03/23 at 1:53pm revealed:
-Staff did not check his BP daily.
-He was unable to recall the last time his BP was checked.

Interview with a medication aide (MA) on 05/03/23 at 4:10pm:
-Resident #1's blood pressure was not checked daily because there was no order on the eMAR for daily BP checks.
-When orders were received, they were faxed to the pharmacy and the pharmacy was supposed to enter the order on the eMAR.
-The pharmacy missed the order on the FL2.

Interview with the medication aide supervisor (MA/S) on 05/03/23 at 6:06pm revealed:
-She did not know about Resident #1's order for daily BPs because the order was not on the eMAR.
-When orders were received, they were faxed to the pharmacy by the MA on duty.
-If there were orders for treatment her or the Resident Care Coordinator (RCC) made sure the orders were carried out.

Interview with the RCC 05/03/23 at 5:43pm revealed:
-The facility's PCP visited weekly, on Thursday.
-When he left orders, the MA on duty was supposed to fax all orders to the pharmacy.
-The pharmacy entered the orders on the eMAR.
-Orders entered by the pharmacy were flagged by

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the system for review by the RCC and MA/S to approve.
-The RCC and the MA/S were to review the orders in the eMAR system and compare them to the order to ensure nothing was missed.
-The FL2s were sent to the pharmacy and filed in the resident's record.
-She did not know about the order for daily BPs because it was not on the eMAR.
-The pharmacy was supposed to put all order on the eMAR.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/05/23 at 11:43am revealed:
-The facility staff faxed orders to the pharmacy and the pharmacy entered the orders on the eMAR.
-If the pharmacy missed an order or treatment, the facility should contact the pharmacy and let them know it was missed.
-No one from the facility made them aware the order for daily BP checks for Resident #1 was not entered on the eMAR.

Attempted telephone interview with Resident #1's PCP on 05/05/23 3:50pm was unsuccessful.

Refer to the interview with the Administrator on 05/03/23 at 4:30pm.
____
Interview with the Administrator on 05/03/23 at 4:30pm revealed:
-The facility did not have a system in place to routinely audit eMARs to ensure treatment orders were being followed.
-She expected the MAs to review the eMAR, right in front of them and follow the orders.

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D 286	Continued From page 70	D 286		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure mealtime table service included a non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage container. The findings are: Observation of the lunch meal service on 05/02/23 from 11:30am to 12:01pm revealed: -The tables were setup with the residents' names at a specific table. -There were place settings that consisted of a napkin, plastic spoon, brown paper bowl and styrofoam cup. -There was no knife or fork served. -There were 28 residents present for the meal at various times. -The meal included tropical fruit in a paper bowl, white beans, riblets, corn fritter and cucumbers. Observation of the kitchen on 05/02/23 at 1:05pm revealed:	D 286		

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-There were 19 spoons, 14 forks and no knives in the cabinet drawer.
-There were 16 bowls in the cabinet.
-There were 20 coffee cups in another the cabinet.

Interviews with five residents on 05/02/23 from 12:50pm to 1:30pm revealed:
-The facility provided served one plastic spoon for months.
-The kitchen staff did not want to wash dishes and used the disposable spoons, bowls and cups.
-Two residents thought the disposable spoons, bowls and cups were used because residents threw silverware into the trash.

Interview with the dietary aide on 05/02/23 at 11:54am revealed:
-Plastic spoons, styrofoam cups and paper bowls were the normal place setting at the meals.
-She thought there was not enough silverware, bowls and cups to serve all the residents.

Interview with the cook on 05/02/23 at 11:30am revealed:
-She gave the residents a plastic spoons with the meal because she did not have enough spoons to serve all the residents silverware at the same time.
-She used the styrofoam cups because she did not have the time to wash the cups after the breakfast meal.
-She used the paper bowls because the facility did not have enough bowls to serve all the residents.
-The Administrator purchased the paper bowls and told her to use them.
-The paper bowls had been used for at least three months or longer.
-She had never served a knife and fork with

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meals because there were not enough to give all the residents a full place setting.

Second interview with the cook on 05/02/23 at 11:33am revealed:
-The styrofoam cups were already out in the dining room, so she used them because she was working alone in the kitchen and did not have time to set out the regular coffee cups.
-There was a dietary aide that assisted her, but the aide had just gotten to work, and she had to setup the tables for the meal.

Interview with Resident Care Coordinator (RCC) on 05/02/23 at 1:25pm revealed:
-She observed the meals in the dining room.
-She did not know why the cook used plastic spoons, paper bowls and Styrofoam cups.
-She had observed that most meals were served as they were today.

Interview with the Administrator on 05/02/23 at 4:25pm revealed:
-There should be no reason why the cook gave residents a plastic spoon to use for the meal.
-She had receipts where she gave the cook money to buy silverware from the local store.
-She had not purchased or told the cook to use the paper bowls.
-She did not know where the paper bowls came from.
-She did not observe meals to ensure non-disposable place settings were not being used.

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D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service	D 296		

10A NCAC 13F .0904 Nutrition And Food Service

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(c) Menus in Adult Care Homes:
(7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#1 and #6) with physician's orders for a no concentrated sweets (NCS) diet (#1) and an 1800 calorie ADA diet (#6).

The findings are:

1. Review of Resident #1's current FL2 dated 08/29/22 revealed:
-Diagnoses included diabetes mellitus type 2, anxiety, traumatic brain injury, and hypertension.
-There was an order for NCS diet.

Observation of the kitchen on 05/02/23 at 11:01am between 11:15am revealed:
-There was a diet list posted in the kitchen that was updated on 05/02/23.
-Resident #1 was to be served a NCS diet.
-There were no therapeutic diet menus available for a NCS diet.

Observation of Resident #1's lunch meal service on 05/02/23 from 11:30pm to 1:10pm revealed:
-Resident #1 was served riblets, cucumbers, white beans, corn fritters, mixed tropical fruit.

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-The resident consumed 100% of the meal.
-It could not be determined if Resident #1 was served the correct therapeutic diet due to a NCS menu was not available for guidance.

Interview with Resident #1 on 05/02/23 at 3:05pm revealed:
-He was a diabetic and he was administered insulin.
-If he was ordered a special diet like NCS, he did not know it.
-He did not know if he was given sugar free desserts or beverages.
-When he went to meals, he was served the same foods as the other residents in the dining room.

Interview with the dietary aide on 05/02/23 at 11:54am revealed:
-The cook prepared and served the beverages.
-She was not aware if the beverages were sugar free.
-She did not know if the desserts were sugar free; the cook would know that.
-When a resident asked for seconds of the beverage she gave them the beverage and did not know if it was sugar free.

Interview with Resident #1's primary care provider (PCP) on 05/04/23 at 10:22am revealed:
-Resident #1 was a "brittle diabetic."
-The resident would do best on an NCS diet because his blood sugars were "all over the place."
-The resident's last hemoglobin A1c was 10.1 (lab test that measures the average blood sugar levels over the previous three months; a level of 6.5% or more is indicative of diabetes), which was high meaning he needed measures to help control his diabetes.

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Review of Resident #1's fingerstick blood sugars FSBS revealed:
-In March 2023, FSBS ranged between 37 and greater than 600.
-In April 2023, FSBS ranged between 43 and greater than 600.
-In May 2023, FSBS ranged between 110 and greater than 600.

Refer to the interview with the cook on 05/02/23 at 11:38am.

Refer to the interview with the Administrator on 05/02/23 at 1:40pm.

2. Review of Resident #6's current FL2 dated 03/10/23 revealed:
-Diagnoses included diabetes.
-There was an order for an 1800 calorie ADA diet.

Review of a physician's order sheet dated 10/06/22 revealed Resident #6 was ordered a NCS diet.

Review of the diet list posted in the kitchen on 05/02/23 revealed:
-The listed was updated on 05/02/23.
-According to the posted diet list, Resident #6 was to be served an NCS diet and mechanical soft (eggs only) diet.

Observation of the kitchen on 05/02/23 at from 11:01am through 11:15am revealed:
-There was a diet list posted in the kitchen that was updated on 05/02/23.
-Resident #6 was to be served a NCS diet.
-There were no therapeutic diet menus available for a NCS or an 1800 calorie ADA diet.

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Observation of Resident #6's lunch meal service on 05/02/23 from 11:30 to 1:10pm revealed:
-Resident #6's meal was served to the resident in his room.
-The meal consisted of tropical fruit, riblets, white beans, corn fritters, and cucumbers.
-There were no beverages given the resident.
-The resident consumed 100% of the meal.
-It could not be determined if Resident #6 was served the correct therapeutic diet due to menus were not available for a NCS or 1800 calorie ADA diet.

Interview with Resident #6 on 05/02/23 at 10:48am revealed:
-He was a diabetic.
-His FSBS was checked four times daily and insulin was administered for FSBS greater than 150.
-He seldom ate meals in the dining room but thought he had the same meal as all the residents in the facility.
-He did not think he was ordered a special diet.
-He had regular sugar sodas in his room.

Review of Resident #6's fingerstick blood sugars (FSBS) revealed:
-In March 2023, FSBS ranged between 88 and greater than 354.
-In April 2023, FSBS ranged between 70 and greater than 591.
-In May 2023, FSBS ranged between 190 and 450.

Interview with Resident #6's primary care provider (PCP) on 05/04/23 at 10:28am revealed:
-Resident #6 was a diabetic.
-He did not know why the resident's diet order was for an 1800 calorie ADA diet.
-It was his understanding the facility did not have

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D 296	Continued From page 77 the means to calculate an 1800 calorie ADA diet. -He wanted Resident #6 to be served a NCS diet. Refer to the interview with the cook on 05/02/23 at 11:38am. Refer to the interview with the Administrator on 05/02/23 at 1:40pm. ____________ Interview with the cook on 05/02/23 at 11:38am revealed: -She used the seven day week at-a-glance menus when preparing meals. -She cooked the foods that were available in the facility and substituted as needed. -The Assistant Administrator ordered the foods, and she did not know if he ordered foods based on the menus. -She was aware diabetics were to have sugar free desserts and beverages, and she served the sugar free if that was available. Interview with the Administrator on 05/02/23 at 1:40pm revealed: -The menus were ordered from a food service vendor. -She thought that she had seen NCS diet menus. -She checked today and was unable to find them. -The cook should have let her know there were no menus to follow. -No sugar should be added to beverages like tea.	D 296		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative	D 317		

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expression, increased knowledge, and learning of new skills.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure 14 hours of activities planned each week were provided for the residents.

The findings are:

Observation of the facility's monthly activities calendar on 05/02/2023 at 10:10am revealed:
-The calendar did not correspond to the current month of May 2023.
-The first day on the posted activities calendar started on a Wednesday.
-The first day of May 2023 occurred on a Sunday.
-There were activities listed on the calendar.
-The dates on the calendar did not match the current month, so it could not be determined what, if any activities were scheduled for the current date.
-There was at least 14 hours of scheduled activities weekly.

Observation of activities on 05/02/23 at 10:00am revealed:
-The activity observed was a church group arrived at the facility and played guitars and sang hymns with 4-5 residents in the living room for 1 and 1/2 hours.
-The Activity Director (AD) was not participating in activities, but was performing personal care aide (PCA) duties.
-The activity calendar that was posted did not match the current month's date; however, the activity on the first Tuesday of the month

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(05/02/23) was exercise class from 9:00am to 10:00am.
-There was no exercise activities observed for the rest of the day on 05/02/23.

Observation on 05/02/23 at 1:00pm revealed:
-Staff including the AD were behind the medication room counter talking with each other for 15 to 20 minutes and no activities were being conducted with the residents.
-The activity calendar that was posted did not match the current month; however, the activity scheduled on the first Tuesday of the month (05/02/23) was word search scheduled from 1:00pm to 2:00pm, and this did not occur.

Observation on 05/02/23 at 3:00pm revealed:
-Some residents were in the living room and the television was on.
-No other activities occurred the remainder of the day.
-The AD was doing PCA duties during the day.
-The dates on the calendar posted did not match the current month; however, there was no activity scheduled on the first Tuesday of the month (05/02/23) at 3:00pm.

Observation on 05/03/23 at 10:45am, 11:30am 1:10pm and 3:05pm, revealed staff including the AD were behind the medication room counter talking with each other and no activities were being conducted with the residents.

Observation on 05/03/23 at various times between 9:00am and 5:00pm revealed:
-Some residents were in the living room and the television was on.
-Some residents were in the front of the facility smoking.
-There were 7 to 10 residents at various times

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lined up in the hallway near the medication room.
-No activities were being done and no one asked residents to participate in activities.
-There were no other activities available for residents to participate in the entire day.
-The AD was doing PCA duties.
-The activity calendar posted was not current with the month; however, the activities listed on the first Wednesday of the month (05/03/23) were "fancy fingers" from 10:00am to 11:00am and "movie day" from 1:00pm to 2:00pm.

Observation on 05/04/2023 at 1:00pm revealed:
-Staff were behind the medication room counter talking for several minutes with each other.
-Residents were lined up in the hallway sitting and no one asked if they wanted to do any type of activity.

Observation on 05/04/23 at various times from 9:30am through 6:30pm revealed:
-Some residents were in the living room and the television was on.
-Some residents were lined up in the hallway.
-Some residents were outside smoking.
-Some residents were in their room in the bed.
-There were no other activities available for residents to participate in the entire day.
-The AD was not in the facility.
-The activity calendar posted did not match the current month with dates; however, the activity on the first Thursday of the month (05/04/23) was music hour from 9:00am to 10:00am, room visit from 10:30am to 11:00am, and Bingo from 1:00pm to 2:00pm.

Observation of the activity room (where all activity supplies were stored) on 05/04/2023 at 8:20am revealed the door was locked.

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Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 8:35am revealed:
-She did not have a key to the activity room.
-The only staff person with the key was the AD and she was on vacation.

Interview with the Administrator on 05/04/23 at 8:40am revealed she thought she had a key for the activity room door.

Observation on 05/04/23 at 8:45am revealed the Administrator tried her keys and none fit the activity room door.

Interview with a resident on 05/04/23 at 10:30am revealed:
-He had been at the facility for a few months.
-The facility did not provide activities.
-The dining room was the only place big enough for all the residents to gather and there were not enough chairs for everyone to sit in.
-There was a staff person who worked a few weeks who tried to do activities with the residents at Christmas, but she quit.
-The activities listed on the activity calendar were not offered to the residents.
-They did not have activities like bowling, volleyball, or exercise class.
-The facility did not have a van to transport residents to any activities away from the facility.
-Staff occasionally took him to the store.

Interview with a second resident on 05/04/23 at 10:40am revealed:
-The only activities he observed were singing and preaching.
-Not everyone wanted to participate in singing and preaching.

Interview with a third resident on 05/04/23 at

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10:48am revealed:
-There was a staff person who was supposed to do activities.
-Instead of doing activities with the residents, the AD sat in the medication room office and played on her cell phone.
-No one was ever in the activity room doing any activities.
-No one had ever asked him what kind of activities he liked.
-There were singers that came to the facility.
-They occasionally played Bingo, but not recently.
-They had colored and done crossword puzzles in the past.
-It had been over a month since they had any coloring activities.
-There was a preacher and singers that came on Fridays.
-There was a singing group that came once a month.

Interview with a fourth resident on 05/04/23 at 10:57 revealed:
-They never provided the activities listed on the board.
-They used to do the activities in the hall like bowling and volleyball, but it had been over 6 months since they had done those activities.
-It had been 6 months since they had played Bingo, read Bible verses, or played games.
-The AD used to do activities with the residents, but she did not do anything with them anymore.
-A church group came and sang one Tuesday every month.
-Another church group came every Friday and sang and preached.
-There were not any other activities except the singing and the preaching.

Interview with a PCA on 05/04/23 at 11:09am

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revealed:
-The AD was supposed to do activities.
-The AD had been filling in as a PCA.
-The AD had not been doing any activities for a while.

Interview with a second PCA on 05/04/23 at 11:18am revealed:
-The AD was supposed to do activities.
-The AD completed the activity calendar.
-The AD had been helping the PCAs for a while.
-The only activities going on currently were singing and preaching.

Interview with a third PCA on 05/04/23 at 11:30am revealed:
-The AD was supposed to do activities with the residents.
-The AD had been doing PCA duties.
-The AD was not doing activities when she worked as a PCA.
-There were times when the facility was not busy and the AD could do activities with the residents.

Interview with an Administrator on 05/04/23 at 11:40am revealed:
-The AD had been completing the activities calendar.
-The AD set up volunteers like singers and musicians to come to the facility.
-She usually checked the activities calendar.
-She had not looked at the activities calendar for the month of May.
-She did not know the activities calendar was not for the current month.
-The AD had been working a lot as a PCA due to staff shortage.
-The AD did activities when the facility was not very busy.
-She had another employee who had been doing

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D 317	Continued From page 84 some activities, but she quit. -She expected the AD to try to do activities when she was not busy. -No one had told her anything about activities not being done with the residents. -Staff took individual residents out shopping a lot, but staff did not take the residents anywhere as a group.	D 317		
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 A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 4 sampled residents (#1, #2, #3 and #5) related to fast-acting and long-acting insulin (#1); medication orders for iron and vitamin C supplements, an antibiotic, a blood thinner and a non-steroidal pain reliever (#2); an antipsychotic and anti-anxiety medications (#5), and a nasal spray and an osteoarthritis medication (#3). The findings are: Review of the facility's medication policy dated	D 358		

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02/01/10 revealed:
-When a resident was admitted to the facility, all prescription and non-prescription medications will be entered on the electronic medication administration record (eMAR).
-When a medication was discontinued, write "DC' d" and the date, and make a line through the discontinued entry and highlight box in yellow.
-When a new prescription changes the dosage or frequency of a previously prescribed medication, discontinue the previous entry by writing "Dc'd" and the date, and make a line through the discontinued entry. Enter the new prescription as a new medication order.
-If a dose of a regularly scheduled medication is held because the administration parameters are not met (e.g., "hold if pulse rate <60"), circle the time in the correct space on the eMAR, write "held", and initial. Indicate the reason that the medication was held. If more than two doses in a row are held, report this to the nurse/Executive Director/Administrator for follow up with the physician and/or responsible party.
-PRN (as needed) medications are monitored only by designated, authorized staff. When an "as needed" medication is required or requested the following documentation is provided: date, time, dose, and route of administration. Document the complaints or symptoms for which the medication was taken, document the results achieved from taking the dose and time that results were noted. Document the signature and initials of the person recording administration and effects.
-Medications are to be given within 1 hour before and 1 hour after the scheduled administration time, except medications to be given with food, or before or after meals., which are administered precisely as ordered. If there is a question about the specific time a medication should be given, consult with the pharmacist or pharmacy provider.

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1. Review of Resident #1's current FL2 dated 08/29/22 revealed:
-Diagnoses included diabetes mellitus type 2, anxiety, traumatic brain injury, and hypertension.
-There was an order for fingerstick blood sugar (FSBS) checks before meals and at bedtime (four times daily).
-There was an order for Novolog (fast-acting insulin used to help lower blood glucose) inject 8 units subcutaneously as needed (PRN) for FSBS greater than 350 . Recheck in 1 hour and if FSBS still greater than 350, repeat 8 unit dose.

Review of Resident #1's physician's orders revealed:
-There was an order dated 10/06/22 for FSBS before meals and at bedtime and Novolog 8 units PRN for FSBS greater than 350. Recheck in 1 hour and if FSBS still greater than 350, repeat 8 unit dose.
-There was an order dated 04/06/23 for FSBS before meals and at bedtime and Novolog 8 units PRN for FSBS greater than 350. Recheck in 1 hour and if FSBS still greater than 350, repeat 8 unit dose.
-There was an order dated 04/20/23 for FSBS four times daily and insulin before meals, with frequency of injections four times daily before meals.

Review of a physician's progress notes revealed:
On 03/16/23, the physician noted that Resident #1 had a known history of diabetes mellitus and was seen due to elevated blood sugars. The physician asked staff to continue to check the residents FSBS as ordered and to continue medications as ordered.
-On 03/24/23, the physician noted that Resident #1 had a history of diabetes mellitus and elevated

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blood sugars. He wanted facility staff to continue all medications as ordered.
-On 04/13/23, the physician noted that Resident #1 had a history of diabetes mellitus and continued to have elevated blood sugar readings. The physician made readjustments to the insulin dosage; and he wanted staff to continue to check the resident's FSBS before meals and nightly, and continue all medications as ordered.

Review of Resident #1's lab report dated 03/15/23 revealed the resident's hemoglobin A1c was 10.6, which was considered "high". (Hemoglobin A1c is a blood test that measures the average blood sugar levels over the past 3 months; a level of 6.5% or more indicates diabetes.)

Review of Resident #1's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry for Novolog inject 8 units as needed for FSBS greater than 350, recheck in 1 hour and if FSBS still greater than 350, repeat 8 units dose.
-There was documentation Resident #1's FSBS was greater than 350 and required 8 units of Novolog 48 out of 112 opportunities from 02/01/23 through 02/28/23.
-There was no documentation 8 units of Novolog were administered 7 of 48 opportunities when FSBS were greater than 350 as follows: on 02/04/23 at 11:30am FSBS was 571; on 02/05/23 at 7:30am FSBS was 559; on 02/12/23 at 11:30am FSBS was 583; on 02/18/23 at 11:30am FSBS was 382; on 02/19/23 at 7:30am FSBS 598; 02/25/23 at 7:30am FSBS was 404; and on

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02/26/23 at 7:30am FSBS was 440.
-There was no documentation Resident #1's FSBS was rechecked 34 of 48 opportunities 1 hour after FSBS was greater than 350 to determine if 8 units of Novolog was needed from 02/01/23 through 02/28/23.
-There was no documentation 8 units of Novolog were administered for 6 of 14 rechecked FSBS greater than 350 were as follows: on 02/01/23 at 5:57pm FSBS was 351, on 02/17/23 at 7:31am FSBS was 415; on 02/22/23 at 7:11am FSBS was 413; on 02/22/23 at 6:23pm FSBS was 356 and on 02/23/23 at 8:35am FSBS was 562; and on 02/27/23 at 7:13am FSBS was 424.
-Resident #1's FSBS ranged between 55 and greater than 600 "hi" from 02/01/23 through 02/28/23.

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry for Novolog inject 8 units as needed for FSBS greater than 350, recheck in 1 hour and if FSBS still greater than 350, repeat 8 unit dose.
-There was documentation Resident #1's FSBS was greater than 350 and required 8 units of Novolog 58 out of 124 opportunities from 03/01/23 through 03/31/23.
-There was no documentation 8 units of Novolog were administered 6 of 58 times when FSBS were greater than 350 as follows: on 03/05/23 at 7:30am FSBS was 598; on 03/11/23 at 7:30am FSBS was 438; on 03/12/23 at 7:30am FSBS was 482; on 03/18/23 at 7:30am FSBS was 500; on 03/19/23 at 7:30am FSBS 581; and on 03/26/23 at 7:30am FSBS was 422.
-There was no documentation Resident #1's

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D 358	Continued From page 89 FSBS were rechecked 32 of 58 times 1 hour after the initial FSBS reading was greater than 350 to determine if 8 units of Novolog was needed from 03/01/23 through 03/31/23. -There was no documentation 8 units of Novolog were administered for 8 of 26 rechecked FSBS greater than 350 as follows: on 03/01/23 at 8:14am FSBS was 414, on 03/03/23 at 7:21am FSBS was 440; on 03/08/23 at 5:21pm FSBS was 460; on 03/09/23 at 11:54am FSBS was 390; on 03/10/23 at 7:17am FSBS was 421; and on 03/13/23 at 8:20am FSBS was 396; on 03/15/23 at 5:07pm FSBS was 369; and on 03/17/23 at 8:25am FSBS was 575. -Resident #1's FSBS ranged between 37 and greater than 600 (hi) from 03/01/23 through 03/31/23. Review of Resident #1's April 2023 eMAR revealed: -There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Novolog inject 8 units as needed for FSBS greater than 350, recheck in 1 hour and if FSBS still greater than 350, repeat 8 units dose. -There was documentation Resident #1's FSBS was greater than 350 and required 8 units of Novolog 42 out of 120 opportunities from 04/01/23 through 04/30/23. -There was no documentation 8 units of Novolog were administered 6 of 42 times when FSBS were greater than 350 as follows: on 04/01/23 at 7:30am FSBS was 439; on 04/14/23 at 4:30pm FSBS was 369; on 03/16/23 at 4:30pm FSBS was 574; on 04/23/23 at 11:30am FSBS was 350; on 04/24/23 at 4:30pm FSBS 352; and on 04/30/23 at 11:30am FSBS was 356. -There was no documentation Resident #1's	D 358		

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FSBS were rechecked 30 of 42 times 1 hour after the initial FSBS reading was greater than 350 to determine if 8 units of Novolog was needed from 04/01/23 through 04/30/23.
-Resident #1's FSBS ranged between 52 and greater than 600 from 04/01/23 through 04/30/23.

Review of Resident #1's May 2023 eMAR (05/01/23 through 05/03/23) revealed:
-There was an entry for FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry for Novolog inject 8 units as needed for FSBS greater than 350, recheck in 1 hour and if FSBS still greater than 350, repeat 8 units dose.
-There was documentation Resident #1's FSBS was greater than 350 and required 8 units of Novolog 3 out of 10 opportunities from 05/01/23 through 05/03/23; and Novolog was administered for the initial FSBS greater than 350.
-There was no documentation Resident #1's FSBS was rechecked 1 of 3 times 1 hour after the initial FSBS reading was greater than 350 as ordered from 05/01/23 through 05/03/23.
-Resident #1's FSBS ranged between 80 and greater than 600 from 05/01/23 through 05/03/23.

Observation of Resident #1's medications on hand on 05/04/23 at 10:38am revealed there were two pens of Novolog available for administration.

Interview with Resident #1 on 05/03/23 at 1:53pm revealed:
-He was a diabetic.
-The medication aide (MA) checked his FSBS several times a day, he think it was three to four times daily.
-The MA administered insulin, but he was not

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sure how much.
-He did not know if he was ordered a sliding scale insulin.
-He was not aware when his FSBS was high or low because he felt the same all the time.

Telephone interview with Resident #1's family member on 05/05/23 at 12:11pm revealed:
-In the past, maybe a year ago, Resident #1's FSBS was "really high", and he had to go to the hospital.
-When the resident's FSBS was high the facility staff usually "catch it" and they knew what to do to get his FSBS down, if they could not get the FSBS down then they sent Resident #1 to the hospital.

Interview with the MA on 05/03/23 at 4:10pm revealed:
-She checked Resident #1's FSBS twice daily on her shift.
-The order documented on the eMAR was when the resident's FSBS was greater than 350 his FSBS should be rechecked.
-After two checks she did not check the FSBS again.
-She did not administer Novolog 8 units each time the resident's FSBS was greater than 350 because she was afraid of the resident's FSBS dropping too low.

Interview with the Medication Aide/Supervisor (MA/S) on 05/03/23 at 5:25pm revealed:
-She was aware Resident #1 had orders for Novolog 8 units of insulin for FSBS greater than 350.
-Sometimes the resident's FSBS dropped low and she was afraid to give the 8 units of Novolog every hour because that would cause a low FSBS.

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-The MAs were aware they could check the resident's FSBS and administer insulin for FSBS greater than 350.
-The Resident Care Coordinator (RCC) and her did record audits every six months.
-They did not check to ensure medications were administered as ordered.
-They did not check the eMARs and did not check the medications on the cart.
-She relied on the pharmacy to check the medications and eMARs quarterly to ensure medications were administered as ordered.
-The facility did not have a system in place to audit eMARs and medications to ensure FSBS were checked and insulin was administered as ordered outside of what the pharmacy did quarterly.

Interview with the MA/S on 05/04/23 at 9:35am revealed:
-When Resident #1's FSBS was checked and the reading was greater than 350, the MA should give the resident 8 units of insulin.
-The MA should then recheck the resident's FSBS in 1 hour, and if still greater than 350, the resident should get another 8 units of insulin.
-It was the facility's policy to only give insulin twice for FSBS greater than 350 because they were afraid of the Resident #5's FSBS dropping low.

Interview with the RCC on 05/03/23 at 1:05pm revealed:
-The MAs were supposed to document all Resident #1's FSBS on the eMAR and on the FSBS readings sheet.
-The MA should administer 8 units of Novolog for all FSBS greater than 350.
-She was aware that Resident #1 was a "brittle" diabetic, meaning his FSBS dropped low very quickly.

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-The MA should recheck the FSBS and if it was greater than 350 and administer insulin.
-There should be documentation to show the FSBS were rechecked.
-Resident #1 was a brittle diabetic and there was a concern about the resident's FSBS dropping low.
-There was no system in place for auditing the eMARs and medications on hand to ensure medications were administered as ordered.

Interview with Resident #1's Primary Care Provider (PCP) on 05/04/23 at 10:22am revealed:
-He expected Resident #1's FSBS to be checked four times daily.
-He ordered a sliding scale for FSBS greater than 350.
-Novolog should be administered for FSBS greater than 350.
-If the FSBS was greater than 350, 8 units of Novolog should be administered.
-He did not put a limit on the number times to check the FSBS and administer 8 units of Novolog; however if after 2 to 3 times FSBS were greater than 350, he should be notified.
-The facility should recheck the FSBS as ordered and administer Novolog if needed.
-If the staff did not understand the order, they should have contacted him. Someone in his office was available 24 hours a day, seven days a week.

b. Review of Resident #1's current FL2 dated 08/29/22 revealed there was an order for basaglar 60 units daily (long-acting insulin used to lower blood sugar). Hold if FSBS less than 150.

Review of Resident #1's physician's orders revealed:
-There was an order dated 11/23/22 for basaglar

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45 units subcutaneously every morning. There was no order to hold basaglar.
-There was an order dated 03/16/23 for basaglar 50 units subcutaneously once daily. There was no order to hold basaglar.
-There was an order dated 04/06/23 for basaglar 50 units subcutaneously daily. There was no order to hold basaglar.

Review of Resident #1's physician's progress notes revealed:
-On 03/16/23 the physician noted that Resident #1 was seen due to elevated blood sugars. He increased basaglar to 50 units per day.
-One 03/24/23 the physician noted the resident continued to have elevated blood sugars, and the facility staff were to continue all medications as ordered.
-On 04/13/23 the physician noted Resident #1's FSBS continued to be elevated. He had readjusted and increased the resident's long-acting insulin basaglar to 50 units in the morning.

Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for basaglar inject 45 units subcutaneously every morning scheduled for administration at 6:00am from 03/01/23 through 03/16/23.
-There was an entry for basaglar inject 50 units subcutaneously every morning scheduled for administration at 6:00am from 03/17/23 through 03/31/23
-There was documentation basaglar was not administered and held 5 of 31 opportunities from 03/01/23 through 03/31/23.
-There was documentation on the eMAR as justification why basaglar was not administered

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"withheld per DR/RN orders" for FSBS as follows:
-On 03/09/23 at 6:11am, FSBS was 84, basaglar was held.
-On 03/14/23 at 6:07am, FSBS was 73, basaglar was held.
-On 03/21/23 at 5:48am, FSBS was 43, basaglar was held.
-On 03/28/23 at 6:13am, FSBS was 75, basaglar was held.
-On 03/31/23 at 6:13am, FSBS was 74, basaglar was held.

Review of Resident #1's April 2023 eMAR revealed:
-There was an entry for basaglar inject 50 units subcutaneously every morning scheduled for administration at 6:00am.
-There was documentation basaglar was not administered and held 5 of 30 opportunities from 04/01/23 through 04/30/23.
-There was documentation on the eMAR as justification why basaglar was not administered "withheld per DR/RN orders" for FSBS as follows:
-On 04/11/23 at 6:05am FSBS was 79, held basaglar.
-On 04/13/23 at 6:00am FSBS was 65, held basaglar.
-On 04/18/23 at 6:08am FSBS was 72, held basaglar.
-On 04/20/23 at 6:13am FSBS was 60, held basaglar.
-On 04/28/23 at 5:46am FSBS was 43, held basaglar.

Review of Resident #1's May 2023 eMAR (05/01/23 through 05/03/23) revealed:
-There was an entry for basaglar inject 50 units subcutaneously every morning scheduled for administration at 6:00am.
-There was documentation basaglar was not

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administered and held 1 of 3 opportunities from 05/01/23 through 05/03/23.
-There was documentation on the eMAR as justification why basaglar was not administered "withheld per DR/RN orders" for FSBS on 05/02/23 at 6:06am, FSBS was 110, basaglar was held.

Interview with Resident #1 on 05/03/23 at 1:53pm revealed:
-He was a diabetic.
-He was administered insulin daily, but he did not know the names of his medications.

Interview with the third shift medication aide (MA) on 05/03/23 at 4:10pm revealed:
-When she worked the third shift, she was the only MA in the building.
-There were two medication carts in the facility.
-She signed onto the eMAR system on both medication carts because she was the only MA in the building.
-In the morning she administered medications to residents on the B hall and the MA/S administered medications to residents on the A hall, which was where Resident #1 resided.
-The MA/S was supposed to sign her off before administering medication but sometimes she did not.
-Her initials were on the eMAR for withholding Resident #1's basaglar but she did not document on the eMAR.
-The MA/S would have been the one that withheld the basaglar and not her.

Interview with the MA/S on 05/03/23 at 5:25pm revealed:
-When she came to the facility in the morning, she assisted the third shift MA with administering medications.

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D 358	Continued From page 97 - Resident #1 had previous orders to hold basaglar if FSBS were less than 100 or 150 (she was unable to recall the exact number). -Resident #1's FSBS dropped quickly and she feared giving the resident too much insulin, so she felt it was best to hold basaglar when FSBS were low. -She had not discussed holding the basaglar with the resident's Primary Care Provider (PCP). -She had not made the PCP aware that she was afraid of the resident's FSBS dropping too low and that she withheld the basaglar. Interview with the Resident Care Coordinator (RCC) on 05/03/23 at 1:05pm revealed: -She mostly worked the medication cart after 7:00am, when the third shift MA left. -She did not check the eMARs daily. -She was not aware some staff were holding Resident #1's basaglar. -The facility did not have a routine system for auditing the eMARs and medications. Interview with Resident #1's PCP on 05/04/23 at 10:22am revealed: -He expected Resident #1's medications to be administered as ordered. -Basaglar was a long-acting insulin and should not cause an immediate drop in the resident's FSBS. -Resident #1's FSBS always seemed to be elevated and staff holding the basaglar could be a contributing factor. -In order to determine how to treat the resident's diabetes the medications ordered should be administered as ordered, so he could determine what to change or add to the medication regimen. -If there was a previous order to hold basaglar it was not written by him. -He had not written any orders to hold basaglar.	D 358		

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-If the staff did not understand the order, they should have contacted him.
-Someone was in his office and available 24 hours a day, seven days a week.

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Telephone interview with the Administrator on 05/05/23 at 3:24pm revealed:
-She was not aware Resident #1's insulin was not administered as ordered.
-She expected medications to be administered as ordered.
-If the MAs were not sure they needed to administer a medication, they should contact the PCP.
-No one made her aware they were afraid of Resident #1's FSBS dropping too low.
-The facility staff were able to call or text her and/or the assistant Administrator at any time of the day or night if they had questions.

2. Review of Resident #5's current FL2 dated 02/06/23 revealed diagnoses included chronic lumbar pain, hypertension and anxiety.

a. There were no orders for seroquel (an antipsychotic medication used to treat bipolar disorder) in the resident's record.

Review of Resident #5's April eMAR revealed:
-There was an entry for seroquel 25mg 1 tablet once daily scheduled for administration at 7:00pm
-There was a second entry for seroquel 25mg take 1 to 2 tablets every evening scheduled for administration 7:00pm.
-There was documentation seroquel 25mg 1 to 2 tablets were administered once daily from 04/01/23 through 04/19/23.
-There was documentation seroquel 25mg was administered twice daily from 04/19/23 through 04/24/23.

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-There was documentation seroquel was administered once daily from 04/25/23 through 04/30/23.

Review of Resident #5's May eMAR (05/01/23 to 05/03/23) revealed:
-There was an entry for seroquel 25mg 1 tablet daily at bedtime scheduled for administration at 7:00pm.
-There was documentation seroquel 25mg was administered on 05/01/23 and 05/02/23.
-There was documentation on 05/03/23 that seroquel was not available for administration.

Observation of Resident #5's medications on hand at the facility on 05/04/23 at 10:46am revealed seroquel was not available for administration.

Interview with Resident #5 on 05/04/23 at 11:00am revealed:
-She had been without seroquel for 5 days.
-The medication aide (MA) told her the pharmacy would not dispense the medication but did not tell her why.
-She had anxiety and she really needed seroquel because it helped her sleep.
-Without seroquel she was shaky and having trouble going to sleep.
-When she did go to sleep, she did not sleep very long, 2 to 3 hours then she woke up.
-When she had seroquel, she slept a full 8 hours without interruption.
-The MAs had always administered her 2 tablets of seroquel totaling 50mg.
-She did not realize the order had changed from 1 to 2 tablets and was now 1 tablet once daily, which was 25mg.
-That was why she was out of the medication.
-She wondered why the Medication

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Aide/Supervisor (MA/S) or the MA would not tell her that instead of saying the pharmacy would not deliver the medication.

Observation of Resident #5 on 05/04/23 at 11:02am revealed when the resident extended her hands there was trembling and shaking with frequent jerks every few seconds.

Telephone interview with a pharmacist at the resident's previous pharmacy on 05/04/23 at 5:36pm revealed:
-The pharmacy received an order dated 02/08/23 for seroquel 25mg 1 to 2 tablets every evening.
-The pharmacy dispensed 60 tablets on 02/08/23.
-The pharmacy received another order dated 03/14/23 for seroquel 25mg 1 to 2 tablets every evening.
-The pharmacy filled and dispensed a quantity of 60 tablets on 03/14/23.
-There was no reason Resident #5 should be without seroquel because the order received on 03/14/23 had several refills; the staff just needed to call and request the refill.
-The medication was not automatically refilled because a request had to be made by the staff for the pharmacy to put the medication on automatic refill.
-The pharmacy was also able to deliver the medication to the facility, but the staff had to request delivery.
-As of today's (05/04/23) date, no one at the facility had requested Resident #5's seroquel be refilled, or put on automatic refill, and no one had requested the medication be delivered to the facility.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:51pm revealed:

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-The pharmacy received an order dated 04/18/23 for 25mg of seroquel at bedtime.
-The pharmacy filled and dispensed the medication for a quantity of 22 tablets.
-The pharmacy did not cycle fill the medication and did not dispense the medication again because an order was needed.
-The pharmacy informed the facility that a new medication order was needed in order to refill seroquel on 04/28/23.

Interview with the morning MA on 05/04/23 at 6:25am revealed:
-She administered medications to Resident #5.
-Resident #5 was a new admission to the facility.
-Resident #5 had a bottle of seroquel from an outside pharmacy provider when she came to the facility.
-She was not sure why seroquel was on the eMAR when Resident #5 initially came to the facility.
-She thought the MAs administered seroquel at bedtime per the directions on the prescription bottle brought to the facility.
-Resident #5 had been complaining to the MA for the past two or three days that she had not been administered seroquel for 3 to 4 nights.

Interviews with the MA/S 05/04/23 at 10:47am and 5:50pm revealed:
-She was aware Resident #5 was without seroquel.
-She thought the medication had been out for 3 to 4 days.
-When the seroquel was almost out, she verbally told Resident #5 that she was almost out of the medication.
-She told the resident because Resident #5 was active with knowing her medications and sometimes went to the pharmacy and picked up

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her own medications.
-Resident #5's seroquel 25mg once daily did not last long because she found out the MAs were administering 2 tablets, instead of 1 tablet as ordered on 04/18/23.
-She had not made anyone aware of the error made by the MAs.
-She told the resident the pharmacy could not refill the medication but did not tell the resident why.
-She had not contacted the resident's provider who ordered the seroquel to let him/her know the resident was not getting the medication or that staff administered 2 tablets instead of one tablet as ordered.
-She had not made the Administrator aware of the error by the MAs and/or had not tried any other means to get the medication for Resident #5.

Interview with the Administrator on 05/04/23 at 4:43pm revealed:
-The MA/S had not made her aware that Resident #5 was out of seroquel.
-A resident should not be without a medication at all.
-If not getting the medication could not be helped and there was a problem beyond staff control, then the PCP and her should be notified.
-There should be documentation to show why there was a problem getting the medication.
-If the medication not being available was due to a staff error, then the facility would have to "eat the cost" of replacing the medication; so that the resident did not go without a medication.
-The staff were able to call her at any time of the day and/or night and they should when a resident was without a medication.
-She realized there was no system for checking medications on the cart with the eMAR to ensure they matched but the RCC and the MA/S should

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ensure the MAs understood the orders when administering medications.

Attempted telephone interview with Resident #5's Mental Health Provider on 05/04/23 at 2:28pm was unsuccessful.

Attempted telephone interview with Resident #5's Primary Care Provider 05/04/23 at 2:33pm was unsuccessful.

b. Review of Resident #5's current FL2 dated 02/06/23 revealed:
-Diagnoses included chronic lumbar pain, limited mobility, osteoarthritis, hypertension and anxiety.
-There was an order for alprazolam 1mg at bedtime (used to treat anxiety/depression).

Review of Resident #5's physician's orders revealed:
-There was an order dated 02/23/23 for alprazolam 1mg every 12 hours.
-There was an order dated 03/06/23 for alprazolam 1mg every 12 hours (twice daily).
-There was an order dated 04/07/23 for alprazolam 0.5mg 1 tablet once every 8 hours as needed (PRN) "patient will ask for it when needed."

Review of Resident #5's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for alprazolam 1mg, 1 tablet every 12 hours scheduled for administration at 6:00am and at 6:00pm.
-There was an entry for alprazolam 0.5mg take 1 tablet every 8 hours as needed.
-There was documentation alprazolam 1mg was administered twice daily from 04/01/23 through 04/30/23 totaling 60 administrations.

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-There was documentation alprazolam 0.5mg was administered once on 04/09/23, once on 04/10/23, once on 04/13/23, twice on 04/17/23, once on 04/18/23, twice on 04/19/23, once on 04/20/23, once on 04/21/23, once on 04/24/23, and once on 04/28/23, totaling 12 administrations.

Review of Resident #5's May 2023 (05/01/23 through 05/04/23) eMAR revealed:
-There was an entry for alprazolam 1mg, 1 tablet every 12 hours scheduled for administration at 6:00am and at 6:00pm.
-There was an entry for alprazolam 0.5mg take 1 tablet every 8 hours as needed.
-There was documentation alprazolam 1mg was administered twice daily at 6:00am and 6:00pm from 05/01/23 through 05/04/23.
-There was documentation alprazolam 0.5mg was administered once on 05/01/23 for anxiety and outcome was effective.

Observation of Resident #5's medications on hand at the facility on 05/04/23 at 10:46am revealed:
-There were no alprazolam 1mg tablets available for administration.
-There was one card of alprazolam 0.5mg tablets available for administration.
-Based on the medication label, alprazolam 0.5mg was filled and dispensed on 4/27/23 for a quantity of 60 tablets.
-There were 31 tablets remaining.

Interview Resident #5 on 05/04/23 at 8:43am revealed:
-She was administered two alprazolam twice daily.
-She believed the alprazolam administered was 0.5mg because the color was different from the

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1mg alprazolam.
-When she requested a PRN alprazolam it was the same color as the alprazolam given twice daily.
-She did not know why she was not getting the 1mg alprazolam any more.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:51pm revealed:
-The pharmacy received an order dated 02/28/23 for alprazolam 1mg at bedtime.
-On 02/28/23, the pharmacy filled and dispensed 30 tablets of 1mg alprazolam.
-The pharmacy received an order dated 03/06/23 for alprazolam 1mg every 12 hours (twice daily).
-On 03/06/23, the pharmacy filled and dispensed 60 tablets of 1mg alprazolam.
-The 1mg alprazolam has not been refilled because the facility or physician had not given a new order.
-The pharmacy made the facility aware in April 2023 that a new order was needed to fill alprazolam 1mg.
-The pharmacy received another order dated 04/07/23 for alprazolam 0.5mg every 8 hours as needed.
-On 04/07/23, the pharmacy filled and dispensed a quantity of 60 tablets of alprazolam 0.5mg.
-On 04/27/23, a refill request was made for alprazolam 0.5mg and a quantity of 60 tablets were dispensed on 04/27/23.

Telephone interview with the third shift medication aide (MA) on 05/04/23 at 9:40am revealed:
-Resident #5 had been out of the 1mg alprazolam for almost one month.
-When she administered the resident's medications she borrowed two of the 0.5mg.
-She did not know why the 1mg had not been

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delivered by the pharmacy, but the MA/S was aware and told her to use the 0.5mg.

Interview with the MA/S on 05/04/23 at 12:48pm revealed:
-When she administered Resident #5's medication, she used 2 tablets of alprazolam 0.5mg.
-She was unable to explain if she gave 1 of the 0.5mg each time or 2.
-The MAs were supposed to do the same twice daily.
-She did not observe the MAs administering the medication.
-She did not check behind the MAs to ensure they were administering 2 tablets of 0.5mg alprazolam.
-The facility did not have a system of auditing the eMAR and medications on hand to ensure medications were administered as ordered or that medications were available for administration.

Interview with the RCC on 05/04/23 at 1:13pm revealed:
-Medications should be reordered before they ran out.
-If a medication was not available the MA should let her know.
-She was unable to explain if Resident #5's alprazolam was administered as ordered.
-She thought maybe the MAs were only administering 2 tablets of the 0.5mg twice daily, which was not according to the order.

Interview with the Administrator on 05/04/23 at 6:40pm revealed:
-She expected medications to be available and in the facility.
-If there was a problem getting a medication the RCC or MA/S should try to find out why, and they

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should let her know.
-The MAs were supposed to reorder a medication before the medication was out.

Attempted telephone interview with Resident #5's Mental Health Provider on 05/04/23 at 2:28pm was unsuccessful.

Attempted telephone interview with Resident #5's Primary Care Provider 05/04/23 at 2:33pm was unsuccessful.

Based on eMAR review, observation of medications on hand, and staff interviews the following was revealed:
-There was documentation Resident #5 was administered 60 tablets of 1mg alprazolam from 04/01/23 through 04/30/23.
-There was documentation Resident #5 was administered 8 tablets of alprazolam 1mg twice daily from 05/01/23 through 05/04/23.
However, there were no 1mg alprazolam tablets available for administration after 04/06/23.
-There was documentation on the Control Substance Count Sheet (CSCS) that staff borrowed the 0.5mg alprazolam 12 times and administered it for the 1mg tablet from 04/09/23 through 04/29/23; and six times from 05/01/23 through 05/03/23.
-In addition, there was documentation the 0.5mg alprazolam was administered PRN with effective results 12 times in April 2023 and 1 time in May 2023, totaling 13 tablets.
-If the MAs borrowed the 0.5mg to make up the 1mg, they would have to borrow 4 tablets per day. The medication would have lasted for 15 days if administered as ordered, meaning there would not be enough tablets available for PRN administration.
-There were 60 tablets of alprazolam 0.5mg

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dispensed on 04/07/23 and on 04/27/23 totaling 120 tablets.
-There were 31 of the 0.5mg alprazolam remaining, meaning 89 tablets of alprazolam 0.5mg had been administered from 04/07/23 through 05/04/23.
-If alprazolam was administered as ordered, including the PRN dose there would be no alprazolam remaining with medications not available for 5 of the documented dates on the eMAR from 04/28/23 through 05/03/23.

3. Review of Resident #2's current hospital FL2 dated 04/08/23 revealed:
-Diagnoses included dementia and symptoms post total right hip arthroplasty (replacement).
-Hospital diagnoses included severe sepsis and urinary tract infection (UTI).

Review of Resident #2's hospital discharge summary dated 04/08/23 revealed
-Resident #2 presented to the emergency room (ER) on 04/05/23 with altered mental status and fever.
-Resident #2 was admitted to the hospital and discharged on 04/08/23.
-Resident #2 was treated with an intravenous antibiotic while hospitalized.
-Resident #2 was discharged with orders for an oral antibiotic, iron supplement, and vitamin supplement.

Review of Resident #2's subsequent local ER discharge summary dated 04/16/23 revealed:
-Resident #2 presented to the ER with cough and congestion and reported low oxygen.
-Resident #2 was diagnosed with community acquired pneumonia and discharged from the ER on 04/16/23 with an order for an antibiotic for 5 days.

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a. Review of Resident #2's hospital discharge summary dated 04/08/23 revealed there was an order for cefdinir 300mg (an antibiotic used to treat severe infection) twice a day for 7 days.

Review of Resident #2's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for cefdinir 300mg one capsule twice a day listed on the eMAR listed on the eMAR and scheduled for administration at 6:00am and 7:00pm daily.
-There was no documentation for administration of cefdinir 300mg from 04/08/23 to 04/14/23.
-Cefdinir should have been administered from 04/08/23 to 04/14/23 as ordered on the 04/08/23 hospital discharge summary.
-There was documentation cefdinir 300mg was administered at 6:00am and 7:00pm daily from 04/21/23 to 04/27/23.

Observation of Resident #2's medications on hand for administration on 05/04/23 revealed there was no cefdinir 300mg available for administration.

Interview with Resident #2's Nurse Practitioner (NP) from the primary care provider's (PCP) office on 05/04/23 at 11:00am revealed:
-He had reviewed Resident #2's hospital discharge summary from 04/16/23 with a diagnosis of community acquired pneumonia on his visit on 04/20/23.
-He recalled Resident #2 was started on an antibiotic to treat pneumonia on 04/16/23.
-He had not seen Resident #2's hospital discharge summary dated 04/08/23 and did not know Resident #2 had cefdinir 300mg ordered after a hospital discharge on 04/08/23.

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D 358	Continued From page 110 -He did not know Resident #2 was in the hospital from 04/05/23 until 04/08/23 until he read about a previous hospital stay when he saw the ER discharge information from 04/16/23. -If Resident #2 had received cefdinir 300mg to treat sepsis and UTI starting on 04/08/23 or 04/09/23, he may not have been back in the ER on 04/16/23 with pneumonia. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:30pm revealed: -The facility was responsible to fax all FL2s, hospital discharge summaries, and physician's orders to the pharmacy when the facility received the orders. -Resident #2's order for cefdinir 300mg was received at the pharmacy on 04/20/23. -The order entry staff at the facility's contracted pharmacy entered the order for cefdinir 300mg dated 04/08/23 when it was received on 04/20/23 and cefdinir 300mg was sent to the facility for administration on 04/20/23. Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 5:30pm revealed: -She had not seen Resident #2's discharge summary or the medication orders from 04/08/23; facility staff must have filed the discharge summary in Resident #2's record without placing in the PA's box for review and RCC or MA/S review. -The MA on duty should have faxed the order for cefdinir 300mg to the pharmacy on 04/08/23. -The RCC was not sure why the order for cefdinir 300mg that was entered on 04/20/23 but dated 04/08/23 was released for the eMAR without reviewing the order except that the medication and the order matched and maybe it was faxed straight to the pharmacy without a copy at the	D 358		

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facility.

Interview with the medication aide/Supervisor (MA/S) on 05/04/23 at 5:30pm revealed:
-She had not seen Resident #2's discharge summary or the medication orders from 04/08/23; facility staff must have filed the discharge summary in Resident #2's record without placing in the PA's box for review.
-She was not sure why the order for cefdinir 300mg that was entered on 04/20/23 but dated 04/08/23 was released for the eMAR without reviewing the order except that the medication and the order matched and maybe it was faxed straight to the pharmacy without a copy at the facility.

b. Review of Resident #2's hospital discharge summary dated 04/08/23 revealed:
-The resident had acute anemia after hip surgery (03/28/23) and was administered intravenous iron infusions and at discharge would have iron and vitamin supplementation.
-There was an order for ferrous sulfate (iron) 325mg with lunch. (Ferrous sulfate is an iron supplement used to treat low iron levels in the blood).
-There was an order for ascorbic acid 500mg with lunch, take with iron tablet. (Ascorbic acid is a vitamin C supplement).

Review of Resident #2's April 2023 eMAR revealed:
-There was an entry for ferrous sulfate (iron) 325mg with lunch scheduled for administration at 12:00pm daily.
-There was no documentation ferrous sulfate 325mg was administered from 04/08/23 to 04/20/23.
-There was documentation ferrous sulfate 325mg

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was administered from 04/21/23 to 04/30/23.
-There was an entry for ascorbic acid 500mg with lunch, take with iron tablet scheduled for administration at 12:00pm daily with documented administration from 04/21/22 to 04/30/23.
-There was no documentation ascorbic acid 500mg was administered from 04/08/23 to 04/20/23.
-There was documentation ascorbic acid 500mg was administered from 04/21/23 to 04/30/23.

Observation of Resident #2's medications on hand for administration on 05/04/23 revealed:
-There was a partial bingo card of ferrous sulfate 325mg labeled one tablet daily dispensed on 04/20/23 for 20 tablets with 7 tablets remaining.
-There was a partial bingo card of ascorbic acid 500mg labeled one tablet daily dispensed on 04/20/23 for 20 tablets with 7 tablets remaining.

Interview with Resident #2's Nurse Practitioner (NP) for the primary care provider (PCP) on 05/04/23 at 11:00am revealed:
-He did not know Resident #2 was in the hospital from 04/05/23 until 04/08/23 until he read about a previous hospital stay when he saw the hospital discharge information from 04/16/23.
-He had not seen Resident #2's hospital discharge summary dated 04/08/23 and did not know Resident #2 had ascorbic acid 500mg and ferrous sulfate 325mg ordered after a hospital discharge on 04/08/23.
-The facility should have started ascorbic acid 500mg and ferrous sulfate 325mg on 04/08/23 or 04/09/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:30pm revealed:
-The facility was responsible to fax all FL2,

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hospital discharge summaries, and physician's orders to the pharmacy when the facility received the orders.
-Resident #2's order for ascorbic acid 500mg and ferrous sulfate 325mg were received at the pharmacy on 04/20/23.
-The order entry staff at the facility's contracted pharmacy entered the orders for ferrous sulfate 325mg and ascorbic acid 500mg dated 04/08/23 when it was received on 04/20/23 and sent the medications to the facility on 04/20/23 for administration.

Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 5:30pm revealed:
-She had not seen Resident #2's discharge summary or the medication orders from 04/08/23; facility staff must have filed the discharge summary in Resident #2's record without placing in the PA's box for review and RCC or MA/S review.
-The MA on duty should have faxed the orders for ferrous sulfate 325mg and ascorbic acid 500mg to the pharmacy on 04/08/23.

Interview with the MA/S on 05/04/23 at 5:30pm revealed:
-She had not seen Resident #2's discharge summary or the medication orders from 04/08/23; facility staff must have filed the discharge summary in Resident #2's record without placing in the PA's box for review.
-The MA on duty should have faxed the orders for ferrous sulfate 325mg and ascorbic acid 500mg to the pharmacy on 04/08/23.

c. Review of Resident #2's hospital discharge summary dated 04/08/23 revealed there was an order to discontinue meloxicam 15mg (used to treat joint pain).

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Review of Resident #2's April 2023 eMAR revealed:
-There was an entry for meloxicam 15mg scheduled for administration at 6:00am daily.
-Meloxicam 15mg was documented as administered from 04/09/23 to 04/30/23.

Review of Resident #2's May 2023 eMAR from 05/01/23 to 05/05/23 revealed:
-There was an entry for meloxicam 15mg scheduled for administration at 6:00am daily.
-Meloxicam 15mg was documented for administered from 05/01/23 to 05/05/23.

Observation of medication on hand for administration on 05/04/23 at 11:30am revealed there were 4 tablets remaining of 30 tablets dispensed on 04/06/23.

Interview with Resident #2's Nurse Practitioner (NP) for the primary care provider (PCP) on 05/04/23 at 11:00am revealed:
-He had reviewed Resident #2's ER discharge from 04/16/23 with a diagnosis of community acquired pneumonia.
-He had not seen Resident #2's hospital discharge summary dated 04/08/23 and did not know Resident #2 was administered meloxicam 15mg after a hospital discharge on 04/08/23 until the RCC and MA/S and asked for an order to discontinue Resident #2's meloxicam 15mg today (05/04/23).
-Resident #2 may not need meloxicam 15mg now that his right hip had been replaced and the meloxicam was for pain in his hip.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:20pm revealed:

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-The facility was responsible to fax all FL2s, hospital discharge summaries, and physician's orders to the pharmacy when the facility received the orders.
-There was no documentation the pharmacy received the discharge summary dated 04/08/23 and no order to discontinue meloxicam 15mg available for review.

Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 5:30pm revealed:
-She had not seen Resident #2's discharge summary or the medication orders from 04/08/23; facility staff must have filed the discharge summary in Resident #2's record without placing in the PA's box for review or placing in the RCC box for review.
-The RCC was not aware Resident #2 had an order dated 04/08/23 to discontinue meloxicam 15mg.

Interview the MA/S on 05/04/23 at 5:30pm revealed:
-She had not seen Resident #2's discharge summary or the medication orders from 04/08/23; facility staff must have filed the discharge summary in Resident #2's record without placing in the PA's box for review or in the RCC or MA/S file for review..
-The MA/S was not aware Resident #2 had an order dated 04/08/23 to discontinue meloxicam 15mg.

d. Review of Resident #2's previous FL2 dated 03/28/23 revealed:
-Diagnoses included right hip arthroplasty on 03/22/23, pain management, gastro-esophageal reflux disease, dementia, traumatic brain injury, and cognitive loss.
-There was an order dated 03/28/23 for Xarelto

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(used to prevent blood clotting, especially after surgery) 10mg daily for 35 days post-op [after surgery].

Review of Resident #2's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Xarelto 10mg once daily for 34 days to prevent blood clots scheduled for administration at 6:00am daily.
-Xarelto 10mg was documented for administration daily at 6:00am from 03/16/23 to 03/31/23.

Review of Resident #2's April 2023 eMAR revealed:
-There was an entry for Xarelto 10mg once daily for 34 days to prevent blood clots scheduled for administration at 6:00am daily.
-Xarelto 10mg was documented for administration daily at 6:00am from 04/01/23 to 04/19/23.
-There was a stop date of 04/19/23 preprinted on the eMAR.
-Xarelto 10mg was discontinued on 04/19/23.
-There was no Xarelto 10mg documented as administered from 04/19/23 until 04/30/23.
-Xarelto 10mg should have been administered for 35 days from 03/28/23 (till 05/04/23) as ordered.

Review of Resident #2's May 2023 eMAR from 05/01/23 to 05/04/23 revealed:
-There was no entry for Xarelto 10mg once daily for 34 days.
-There was no Xarelto 10mg documented as administered from 05/01/23 to 05/04/23.
-Xarelto 10mg should have been administered for 35 days from 03/28/23 (till 05/04/23) as ordered.

Observation of medication on hand for

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administration on 05/04/23 at 11:30am revealed there was no Xarelto 10mg available for administration.

Interview with Resident #2's Nurse Practitioner (NP) for the primary care provider (PCP) on 05/04/23 at 11:00am revealed:
-He had reviewed Resident #2's hospital discharge summary dated 03/28/23 after hip replacement surgery.
-Routine practice was to place surgery patients on a blood thinner post hip surgery to help decrease the risk of complications from a blood clot.
-Resident #2 may have received an order for Xarelto 10mg at a pre-operation visit to a surgery clinic (03/15/23 was date of pre-operation visit).
-He had not seen Resident #2's eMAR for Xarelto 10mg being discontinued prior to 35 days post-op (which would have been 04/30/23).
-Resident #2 would be outside the critical risk for blood clots post-surgery at this time (05/04/23).

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/ at 3:20pm revealed:
-The facility was responsible to fax all FL2s, hospital discharge summaries, and physician's orders to the pharmacy when the facility received the orders.
-Resident #2's had an order dated 03/15/23 from a visit to the orthopedic clinic for Xarelto 10mg daily for 35 days dispensed on 03/16/23 for 30 tablets and 5 tablets on 04/15/23.
-There was no documentation the pharmacy received a hospital discharge summary or FL2 dated 03/28/23 with physician's orders to administer Xarelto for 35 days post-operative (3/22/23 surgery date).
-The pharmacy staff did not know to change the

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stop date of the Xarelto.

Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 5:30pm revealed:
-She had not seen Resident #2's discharge summary or the medication orders from 03/28/23; facility staff must have filed the discharge summary in Resident #2's record without placing in the PA's box for review or the RCC's folder for review..
-The RCC did not know Resident #2 had an order dated 03/28/23 for Xarelto 10mg to be administered 35 days after hip surgery on 03/22/23.

Interview with a MA/S on 05/04/23 at 5:30pm revealed:
-The MA/S had not seen Resident #2's discharge summary or the medication orders from 03/28/23; facility staff must have filed the discharge summary in Resident #2's record without placing in the NP box for review.
-The MA/S did not know Resident #2 had an order dated 03/28/23 for Xarelto 10mg to be administered 35 days after hip surgery on 03/22/23.

Telephone interview with a nurse at Resident #2's orthopedic clinic on 05/05/23 at 1:40pm revealed:
-Resident #2 was seen in the orthopedic clinic on 05/04/23 for 6 weeks follow-up post hip replacement.
-Resident #2 had a pre-operation appointment on 03/15/23.
-Resident #2 most likely was given orders for Xarelto to be sure he had an order for the medication after surgery.
-Resident #2 should have received additional instructions for continuing Xarelto post-surgery.
-Resident #2 should been administered Xarelto

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for 35 days beginning on 03/22/23 (day of surgery).
-Resident #2 was outside the high-risk time frame with his 6 weeks follow-up visit on 05/04/23.

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

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Interview with the Administrator on 05/03/23 at 4:30pm revealed:
-She did not have a system in place to routine audit medication orders compared to the residents eMAR for accuracy and completeness.
-She relied on the RCC and medication aide/Supervisor to to perform routine audits to ensure medications were administered as ordered.
-She had not been made aware of any discrepancies with medications for residents.

Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 5:30pm revealed:
-The medication aides (MAs) received residents' orders when the residents returned from hospitalization or physician's visits.
-The MAs were supposed to fax all orders to the facility's contracted pharmacy for entry onto the eMAR.
-The MAs placed the orders in a folder/box in the medication room designated for the PA's review.
-The RCC was responsible to review the resident's orders the next business day they worked and ensure the orders were filed in the resident's records for documentation.
-Orders received after the RCC left for the day, or on weekends, were not reviewed until the next day the RCC worked and were sometimes found in different areas of the medication room.

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Interview with a MA/S on 05/04/23 at 5:30pm revealed:
-The medication aides (MAs) received residents' orders when the residents returned from hospitalization or physician's visits.
-The MAs were supposed to fax all orders to the facility's contracted pharmacy for entry onto the eMAR.
-The MA/S was responsible to review the resident's orders.
-Orders received after the MA/S left for the day, or on weekends, were not reviewed until the next day the MA/S worked and were sometimes found in different areas of the medication room.
-Orders entered on the eMARs by the pharmacy staff were flagged for the RCC and MA/S to approve after review.

4. Review of Resident #3's current FL2 dated 10/03/22 revealed diagnoses included demand ischemia of myocardium, chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia and hypercapnia and anxiety.

a. Review of Resident #3's current FL2 dated 10/03/22 revealed there was an order for fluticasone (used to treat allergies) 50mcg 1 spray into each nostril once daily.

Review of Resident #3's physician's order dated 02/23/23 revealed there was an order for fluticasone 50 mcg, 1 spray into each nostril once daily.

Review of Resident #3's April 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for fluticasone 50mcg spray, instill 1 spray into each nostril once daily at

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6:00am.
-There was documentation that fluticasone 50mcg spray was administered daily from 04/01/23 through 04/30/23.

Review of Resident #3's May 2023 eMAR revealed Resident #3 was out of the facility 05/01/23 through 05/03/23.

Observation of medication on hand for Resident #3 on 05/03/2023 at 3:40 pm revealed there was no fluticasone 50mcg spray available for administration.

Interview with the Medication Aide Supervisor (MA/S) on 05/03/23 at 3:45pm revealed:
-Resident #3 ran out of fluticasone 50mcg spray on 04/25/23.
-She put in a request with the pharmacy on 04/25/23 to refill Resident #3's fluticasone.
-The pharmacy told her it was too soon to refill the prescription.
-They had not received the fluticasone from the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/03/23 at 4:00pm revealed:
-They received a request from the facility to refill Resident #1's Fluticasone on 04/25/23.
-The pharmacy could not fill the request on 04/25/23 because it was too soon to refill.
-They last dispensed fluticasone 50mcg on 04/10/23.
-They were refilling the Fluticasone today, 05/03/23.

Interview with the MA/S on 05/03/23 at 4:10pm revealed:
-She was helping the MA to get medications out

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of the cart on 04/25/23.
-They could not find Resident #3's fluticasone 50mcg in the medication cart.
-They do not know what happened to Resident #3's fluticasone.

Interview with a MA on 05/03/23 at 5:18pm revealed:
-Resident #3's fluticasone was not in the medication cart on 04/29/23.
-She found Resident #3's fluticasone in Resident #3's room on 04/29/23.
-She administered fluticasone to Resident #3 on 04/29/23 and 04/30/23.
-She put Resident #3's fluticasone back into the medication cart after administering it.
-She did not know what happened to the fluticasone after 04/30/23.

Interview with a second MA on 05/04/23 at 9:00am revealed:
-Resident #3 resided on A hall.
-She normally did not administer 6:00am medications to residents on A hall, including Resident #3.
-Resident #3 did not always get up to take her medications at 6:00am.
-There were two medication carts; when she worked, she signed onto both carts because she was the only MA on the third shift.
-In the morning she passed medications on the B hall.
-The MA/S usually came in the mornings and helped her with the med-pass, and the MA/S passed medications to residents on the A hall.
-She did not administer fluticasone to Resident #3 on 04/25/23, 04/26/23, 04/27/23 and 04/28/23 because she did not work the medication cart.
-The MA/S must not have logged her off and signed herself in on the dates showing her initials

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on the eMAR.

Interview with the MA/S on 05/04/23 at 2:24pm revealed:
-She usually arrived at work at 5:40am.
-There had been times when staff did not log off and log in correctly, meaning she administered medications using another staff initials.
-The MA usually gave Resident #3 all her medications before the MA/S arrived at work.

b. Review of Resident #3's physician order dated 02/23/23 revealed there was an order for meloxicam 7.5mg (used to treat osteoarthritis) 1 tablet once daily after meals.

Review of the package insert for the medication revealed the most common side effects included abdominal pain, anemia and edema, and was best taken with food or a meal to help prevent an upset stomach.

Review of Resident #3's April 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for meloxicam 7.5mg 1 tablet once daily after meals.
-There was documentation that meloxicam was administered 29 times from 04/01/23 through 04/30/23 at 7:00am.

Interview with the dietary manager on 05/02/23 at 11:40am revealed:
-She tried to start serving breakfast by 7:00am each day.
-Sometimes it was a little after 7:00am when she served breakfast, but she never served breakfast earlier than 7:00am.

Interview with a third shift medication aide (MA)

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on 05/04/23 at 9:00am revealed:
-She worked from 11:00pm to 7:00am.
-She knew Resident #3's meloxicam was supposed to be administered after breakfast.
-She never administered Resident #3's meloxicam because her shift ended before breakfast was served.

Interview with the medication aide/Supervisor (MA/S) on 05/04/23 at 2:24pm revealed:
-Resident #3 was supposed to receive meloxicam at 8:00am after breakfast.
-She never administered meloxicam to Resident #3.
-When she arrived to work between 5:30am and 5:40 am, the third shift MA had already administered meloxicam with the 6:00am medications.
-She had not said anything to anyone about the MA administering meloxicam too early.

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The facility failed to ensure medications were administered as ordered for 4 of 4 sampled residents related to a resident who went to the emergency room and was diagnosed with severe sepsis and UTI and was not administered an antibiotic as ordered resulting in the resident having a fever and altered mental status with a return hospital visit (#2); a resident who had a history of diabetes and was ordered a long-acting and fast-acting insulin that was not administered as ordered and the resident's FSBS ranged from 37 to greater than 600 which placed the resident at risk for heart failure, kidney damage and loss of eye sight (#1); a resident not administered antipsychotic and anti-anxiety medications which caused the resident to experience shaking hands and sleepless nights (#5); and a medication that was ordered after meals was administered before meals which could result in stomach discomfort

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and irritation (#3). This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation.

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The facility provided a Plan of Protection on 05/03/23 in accordance with G.S.131D-34 for this violation.

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 4, 2023.

D 367 | 10A NCAC 13F .1004(j) Medication Administration | D 367

10A NCAC 13F .1004 Medication Administration
(j) The resident's medication administration record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

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This Rule is not met as evidenced by:
Based on interviews, observations and record reviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 3 of 4 residents sampled for record review (#2, #3, and #5) related to documenting medications were administered when the resident was hospitalized (#2); a steroid nasal spray to treat allergies (#3); and a medication used to treat anxiety/depression (#5).

The findings are:

1. Review of Resident #2's current hospital FL2 dated 04/08/23 revealed:
-Diagnoses included dementia and symptoms post total right hip arthroplasty (replacement).
-Hospital diagnoses included severe sepsis and urinary tract infection (UTI).
-Resident #2 was hospitalized from 04/05/23 to 04/08/23.

Review of Resident #2 hospital discharge summary dated 03/28/23 revealed Resident #2 was hospitalized from 03/22/23 to 03/28/23.

Review of Resident #2's March 2023 electronic medication administration record (eMAR) revealed:
-Medication were documented as administered when Resident #2 was in the hospital as follows:
-Donepezil (used to treat dementia) 10 mg at bedtime was documented as administered at 7:00pm on 03/25/23, 03/26/23, 03/27/23.
-Melixocam (used to treat joint pain) 10mg daily was documented as administered at 6:00am on 03/25/23 and 03/26/23.
-Methylphenidate (used to treat dementia) Extended Release 20mg every morning was documented as administered at 6:00am on

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03/25/23 and 03/26/23.
-Memantine (used to treat dementia) 10mg every evening was documented as administered at 7:00pm on 03/25/23, 03/26/23, and 03/27/23.
-Olanzapine (used to treat agitation with certain mental disorders)5mg at bedtime was documented as administered at 7:00pm on 03/25/23, 03/26/23, and 03/27/23.
-Omeprazole (used to treat acid reflux) 20mg daily was documented as administered at 6:00am on 03/25/23 and 03/26/23.
-Quetiapine (used to treat depression) 100mg at bedtime was documented as administered at 7:00pm on 03/25/23, 03/26/23, and 03/27/23.
-Trazadone (used to treat depression) 50mg at bedtime was documented as administered at 7:00pm on 03/25/23, 03/26/23, and 03/27/23.

Review of Resident #2's current hospital FL2 dated 04/08/23 revealed Resident #2 was hospitalized from 04/05/23 to 04/08/23.

Review of Resident #2's April 2023 eMAR revealed medication were documented as administered when Resident #2 was in the hospital as follows:
-Donepezil 10 mg at bedtime was documented as administered at 7:00pm on 04/06/23 and 04/07/23.
-Methylphenidate Extended Release 20mg every morning was documented as administered at 6:00am on 04/08/23 prior to the resident returning to the facility.
-Memantine 10mg every evening was documented as administered at 7:00pm on 04/06/23 and 04/07/23.
-Olanzapine 5mg at bedtime was documented as administered at 7:00pm on 04/06/23 and 04/07/23.
-Omeprazole 20mg daily was listed, scheduled

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for administration at 6:00am, and documented 04/08/23 prior to the resident returning to the facility.
-Quetiapine 100mg at bedtime was documented as administered at 7:00pm on 04/06/23 and 04/07/23.
-Trazadone 50mg at bedtime was documented as administered at 7:00pm on 04/06/23 and 04/07/23.

Interview with a third shift medication aide (MA) on 05/04/23 at 7:15am revealed:
-She administered the morning medication for 2 medications carts at the end of her shift.
-She may have incorrectly documented medications administered when a resident was out of the facility on occasion.
-There was no system for auditing eMARs for accuracy by the MAs or administration as far as she knew.

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

Refer to the interview with the Resident Care Coordinator (RCC) on 05/04/23 at 1:13pm.

Refer to the interview with the Administrator on 05/04/23 at 6:40pm

2. Review of Resident #3's current FL-2 dated 10/03/22 revealed diagnoses included demand ischemia of myocardium, chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia and hypercapnia and anxiety.

Review of Resident #3's physician's order dated 02/23/23 revealed there was an order for

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fluticasone 50mcg (a steroid nasal spray used to treat allergy) 1 spray into each nostril once daily.

Review of Resident #3's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone 50mcg 1 spray in each nostril once daily.
-There was documentation that fluticasone 50mcg spray was administered at 6:00am from 04/01/23 to 04/30/2023.

Review of Resident #3's May 2023 (eMAR) revealed Resident #3 was out of the facility from 05/01/23 through 05/3/23.

Observation of medication on hand for Resident #3 on 05/03/23 at 3:40pm revealed there was no fluticasone 50mcg spray available for administration.

Interview with Resident #3 on 05/04/23 at 8:08am revealed:
-She thought she received all her medications most of the time.
-She did not know if she had not received any medications.
-Staff usually brought her morning medications to her in her room.

Telephone interview with a representative from the facility's contracted pharmacy on 05/03/23 at 4:00pm revealed:
-The pharmacist dispensed medications for Resident #3.
-The pharmacist received a medication order from the resident's primary care provider (PCP) on 02/02/23 for fluticasone 50mcg 1 spray into each nostril once daily.
-The pharmacist dispensed a 60-day supply of

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fluticasone on 02/02/23.
-The pharmacist last dispensed fluticasone for a 60-day supply on 04/10/23.
-The pharmacist received a refill order on 04/25/23 for fluticasone 50mcg 1 spray into each nostril once daily.
- Fluticasone 50mcg could not be refilled for Resident #3 on 04/25/23 because the resident should have had fluticasone on hand if used as directed per physician order.
-They were refilling the fluticasone today, 05/03/23.

Interview with a medication aide (MA) on 05/03/23 at 5:18pm revealed:
-Resident #3's fluticasone 50mcg was not in the medication cart on 04/29/23 when she went to administer the medications at 6:00am.
-She found Resident #3's fluticasone 50mcg in Resident #3's room on 04/29/23.
-She administered fluticasone 50mcg to Resident #3 on 04/29/23 and 04/30/23.
-She put Resident #3's fluticasone 50mcg back into the medication cart after administering it.
-She did not know what happened to the fluticasone after 04/30/23.

Interview with a another MA on 05/04/23 at 9:00am revealed:
-She normally did not administer 6:00am medications to Resident #3.
-Resident #3 did not always get up to take her medications at 6:00am.
-Even though the eMAR showed she administered fluticasone to Resident #3 on 04/25/23, 04/26/23, 04/27/23 and 04/28/23, she did not administer fluticasone 50mcg to Resident #3.
-The MA/S must not have logged her off and must not have signed herself in on those days.

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-She did not know if Resident #3 received the fluticasone on those days.

Interview with the MA/S on 05/03/23 at 3:45pm revealed:
-Resident #3 ran out of fluticasone 50mcg spray on 04/25/23.
-She put in a request with the pharmacy on 04/25/23 to refill Resident #3's fluticasone 50mcg.
-They had not received the fluticasone from the pharmacy.
-The pharmacy stated it was too soon to refill the prescription.

Interview with the MA/S on 05/03/23 at 4:10pm revealed:
-She was helping the MA to get medications out of the cart on 04/25/23.
-They could not find Resident #3's fluticasone 50mcg in the medication cart.
-They did not know what happened to Resident #3's fluticasone.

Interview with the MA/S on 05/04/23 at 2:24pm revealed:
-She usually arrived at work at 5:40am.
-There had been times when staff did not log off and log in correctly.
-The MA usually had given Resident #3 all her medications before the MA/S arrived at work.
-She did not administer fluticasone 50mcg to Resident #3 on 04/25/23, 04/26/23, 04/27/23 and 04/28/23.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/04/23 at 1:13pm.

Refer to the interview with the Administrator on 05/04/23 at 6:40pm.

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3. Review of Resident #5's current FL2 dated 02/06/23 revealed:
-Diagnoses included chronic lumbar pain, limited mobility, osteoarthritis, hypertension and anxiety.
-There was an order for alprazolam 1mg at bedtime (used to treat anxiety/depression).

Review of Resident #5's physician's orders revealed:
-There was an order dated 02/23/23 for alprazolam 1mg every 12 hours.
-There was an order dated 03/06/23 for alprazolam 1mg every 12 hours (twice daily).

Observation of Resident #5's medications on hand on 05/04/23 at 10:46am revealed there was no alprazolam 1mg tablets available for administration.

Review of Resident #5's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for alprazolam 1mg 1 tablet every 12 hours scheduled for administration at 6:00am and at 6:00pm.
-There was documentation alprazolam 1mg was administered twice daily from 04/01/23 through 04/30/23.

Review of Resident #5's May 2023 (05/01/23 through 05/03/23) eMAR revealed:
-There was an entry for alprazolam 1mg 1 tablet every 12 hours scheduled for administration at 6:00am and at 6:00pm.
-There was documentation alprazolam 1mg was administered twice daily at 6:00am and 6:00pm from 05/01/23 through 05/04/23.

Interview Resident #5 on 05/04/23 at 8:43am revealed:

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-She was administered two alprazolam twice daily.
-She believed the alprazolam administered was 0.5mg because the color was different from the 1mg alprazolam.
-She did not know why she was not getting the 1mg alprazolam any more.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:51pm revealed:
-The pharmacy received an order dated 02/28/23 for alprazolam 1mg at bedtime.
-On 02/28/23 the pharmacy filled and dispensed 30 tablets of 1mg alprazolam.
-The pharmacy received an order dated 03/06/23 for alprazolam 1mg every 12 hours (twice daily).
-The pharmacy filled and dispensed 60 tablets of 1mg alprazolam, which would have lasted until 04/06/23.

Telephone interview with the third shift medication aide (MA) on 05/04/23 at 9:40am revealed:
-Resident #5 had been out of the 1mg alprazolam for almost a month.
-The medication aide/supervisor (MA/S) said to use the 0.5mg.
-She documented on the eMAR that she administered the 1mg.

Interview with the MA/S on 05/04/23 at 12:48pm revealed:
-Resident #5 did not have alprazolam 1mg available for administration.
-The medication had been out since last month.
-The eMAR documentation for 1mg alprazolam was because she administered the 0.5mg tablet.

Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 1:13pm revealed if the MA

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borrowed the correct amount of the 0.5mg alprazolam for the 1mg, then the documentation on the eMAR should be for the 1mg.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/04/23 at 1:13pm.

Refer to the interview with the Administrator on 05/04/23 at 6:40pm

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Interview with the RCC on 05/04/23 at 1:13pm revealed:
-She did not review eMARs for documentation accuracy.
-There was no system to ensure eMAR documentation was accurate.

Interview with the Administrator on 05/04/23 at 6:40pm revealed:
-Medications should be available for administration and eMAR documentation should be accurate based on the medication order.
-The RCC and the MA/S were responsible to ensure the eMAR was accurate.

D 372 — 10A NCAC 13F .1004 (o) Medication Administration — D 372

10A NCAC 13F .1004 Medication Administration

(o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented.

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

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Based on observations, interviews and record reviews, the facility failed to ensure medications were borrowed only in an emergency and replaced promptly and documented for 4 of 4 residents sampled (#2, #5 #7, #8,) related to staff borrowing a Schedule II controlled substance for moderate to severe pain from Resident #7 and administering it to Resident #2, and borrowing a Schedule IV controlled substance for anxiety from Resident #8 and administering it to Resident # 5.

The findings are:

1. Review of Resident #7's current FL2 dated 11/18/22 revealed:
-Diagnoses included closed fracture right distal radius, anxiety and back pain.
-There was an order for Norco (a Schedule II controlled substance for moderate to severe pain) 5/325mg one tablet every 6 hours.

Review of Resident #7's physician's orders dated 04/06/23 revealed an order for Norco 5/325mg one tablet every 6 hours.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/03/23 at 3:30pm revealed:
-On 04/06/23, Resident #7 was dispensed 120 tablets of Norco 5/325mg.
-The pharmacy dispensed 4 bingo cards with 30 Norco 5/325mg in each card.
-The pharmacy sent a controlled substance count sheet (CSCS) for each of the 30 count bingo cards to be used for documentation of administration of the Norco 5/325mg.

Review of Resident #7's April 2023 electronic medication administration record (eMAR) from

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D 372	Continued From page 136 04/13/23 to 04/30/23 revealed: -There was an entry for hydrocodone/acetaminophen (generic for Norco) 5/325mg take 1 tablet every 6 hours with scheduled administration times of 12:00am, 6:00am, 12:00pm, and 6:00pm. -Hydrocodone/acetaminophen 5/325mg was documented as administered 4 times a day from 04/01/23 to 04/30/23 except at 12:00am on 04/16/23 (unable to awaken resident) and 12:00pm on 04/23/23 (blank for documentation and no reason for missed documentation noted on the eMAR). -There were 70 tablets of hydrocodone/acetaminophen 5/325mg documented as administered from 04/13/23 to 04/30/23. -There was no documentation any medication was borrowed from Resident #7. -There was no documentation any medication was replaced or paid back to Resident #7. Review of Resident #7's CSCS records for the supply of hydrocodone/acetaminophen 5/325mg dispensed on 04/06/23 revealed: -There was a CSCS for 30 hydrocodone/acetaminophen 5/325mg with "12:00am" handwritten at the top of the CSCS. -There were 10 rows on the CSCS with a handwritten note "borrowed for [name]" documented at various times and days of administration from 04/14/23 to 05/02/23 and 2 rows without documentation the medication was signed out to another resident. -The name indicated on the note was the same on each line. -The inventory count decreased after each sign-out. Examples of dates and times sign out on	D 372		

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Resident #7's CSCS (with handwritten time of administration 12:00am) for hydrocodone/acetaminophen 5/325mg dispensed on 04/06/23 and documented as "borrowed for [name]" were as follows:
-On 04/14/23 at 6:00am, one tablet was signed out and the count decreased by one tablet to 29 tablets.
-On 04/16/23 at 6:00am, one tablet was signed out decreasing the on-hand count from 29 to 27.
-On 04/17/23 at 12:00am, one tablet was signed out decreasing the on-hand count from 27 to 25.
-On 04/18/23 at 10:00pm, one tablet was signed out decreasing the on-hand count from 24 to 22.
-On 04/20/23 at 11:00pm, one tablet was signed out decreasing the on-hand count from 20 to 18.
-On 04/26/23 at 12:00am, one tablet was signed out decreasing the on-hand count from 11 to 9.
-On 04/28/23 at 6:00am, one tablet was signed out and the count decreased by one tablet from 8 to 6 tablets.
-On 04/29/23 at 6:00am, one tablet was signed out decreasing the on-hand count from 7 to 5.
-There was no documentation on the CSCS, the dose that was borrowed from Resident #7 and administered to another resident was paid back to Resident #7 for any of the doses signed out.

Review of Resident #7's CSCS records for the supply of hydrocodone/acetaminophen 5/325mg dispensed on 04/06/23 revealed:
-There was a second CSCS for 30 hydrocodone/acetaminophen 5/325mg with "6:00am" handwritten at the top of the CSCS.
-There were 2 rows on the CSCS with a handwritten note "borrowed for [name]" documented at various times and days of administration from 04/14/23 to 05/04/23.
-The name indicated on the note was the same on each line.

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-The inventory count decreased after each sign-out.
-There was no documentation the dose that was borrowed from Resident #7 and administered to another resident was paid back to Resident #7 for any of the doses signed out.
-Dates and times sign out on Resident #7's CSCS (with handwritten time of administration 6:00am) and documented as "borrowed for [name]" were as follows:
-On 04/18/23 at 6:00am, one tablet was signed out decreasing the on-hand count from 24 to 22.
-On 04/21/23 at 6:00am, one tablet was signed out decreasing the on-hand count from 20 to 18.

Interview with Resident #7 during the initial tour on 05/02/23 at 10:20am revealed:
-He had not been out of any of his medications recently.
-Staff routinely administered his medications on time.
-His pain was maintained by his current pain medication

Based on record reviews, and interviews there were 12 tablets of 120 hydrocodone/acetaminophen 5/325mg dispensed on 04/06/23 borrowed from Resident #7 and administered to another resident with no record of replacing the medication.

Refer to the interview with the Administrator on 05/03/23 at 4:30pm.

Refer to the interview with an evening medication aide (MA) on 05/03/23 at 5:15pm.

Refer to the interview with a morning shift MA on 05/04/23 at 7:30am.

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Refer to the interview with the facility's primary care provider's Nurse Practitioner (NP) on 05/04/23 at 11:00am.

Refer to the interview with the Supervisor on 05/04/23 at 3:30pm.

Refer to the telephone interview with the contracted Pharmacy Consultant on 05/04/23 at 4:50pm.

2. Review of Resident #2's current hospital FL-2 dated 04/08/23 revealed:
-Diagnoses included severe sepsis, urinary tract infection, dementia, and status post total right hip arthroplasty (replacement).
-There was an order for hydrocodone-acetaminophen 5/325mg (a Schedule II controlled substance used to treat moderate to severe pain) one tablet every 4 hours as needed.

Review of Resident #2's physician's orders revealed an order dated 03/23/23 for hydrocodone-acetaminophen 5/325mg one every 4 to 6 hours as needed for pain.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:20pm revealed:
- Resident #2 was dispensed 42 tablets of hydrocodone-acetaminophen 5/325mg on 03/23/23 labeled for one tablet every 4 to 6 hours as needed for pain.
-The pharmacy sent a controlled substance count sheet (CSCS) with each dispensing of controlled substances to assist the facility with documenting administration and accurate accounting for the medication.

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Review of Resident #2's March 2023 and April 2023 from 04/01/23 to 04/12/23 electronic medication administration records (eMARs) compared to the CSCS for 42 tablets of hydrocodone-acetaminophen 5/325mg dispensed on 03/23/23 revealed:
-There was an entry one the eMARs for hydrocodone-acetaminophen 5/325mg one tablet every 4 to 6 hours as needed (PRN) for pain scheduled PRN administration.
-Hydrocodone-acetaminophen 5/325mg was documented as administered for 3 tablets on the eMAR from 03/28/23 to 03/31/23 with 2 tablets on 03/28/23 and one tablet on 03/31/23.
-Hydrocodone-acetaminophen 5/325mg was documented as administered for 5 tablets on the eMAR from 04/01/23 to 04/30/23 with one tablet on 04/01/23, 04/02/23, 04/04/23, 04/08/23, and 04/12/23.
-Hydrocodone-acetaminophen 5/325mg was signed out for 10 tablets on the CSCS from 03/28/23 to 03/31/23.
-Hydrocodone-acetaminophen 5/325mg was signed out for 32 tablets on the CSCS from 04/01/23 to 04/14/23.
-The CSCS sheet documented administration of 42 tablets leaving a zero balance on 04/14/23.

Review of Resident #2's April 2023 eMARs compared to the CSCS for 42 tablets of hydrocodone-acetaminophen 5/325mg dispensed on 03/23/23 revealed:
-There was an entry for hydrocodone-acetaminophen 5/325mg one tablet every 4 to 6 hours as needed for pain scheduled PRN administration on the eMARs.
-There was no documentation hydrocodone 5/325mg was administered to Resident #2 on the eMAR from 04/16/23 to 04/30/23.
-There was no documentation doses of

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hydrocodone/acetaminophen 5/325mg was borrowed from another resident and administered to Resident #2 on the eMAR.

Review of another resident's (Resident #7) CSCS records for the supply of hydrocodone/acetaminophen 5/325mg dispensed on 04/06/23 revealed:
-There was a CSCS for 30 hydrocodone/acetaminophen 5/325mg with "12:00am" handwritten at the top of the CSCS.
-There were 10 rows on the CSCS with a handwritten note "borrowed for [Resident #2's name]" documented at various times and days of administration from 04/14/23 to 05/02/23 and 2 rows without documentation the medication was signed out to another resident.
-There was no documentation the dose that was borrowed from Resident #7 and administered to Resident #2 was paid back to Resident #7 for any of the doses signed out.
-Examples of dates and times signed out on Resident #7's CSCS (with handwritten time of administration 12:00am) and documented as "borrowed for Resident #2's name" were as follows:
-On 04/16/23 at 6:00am, one tablet signed out as administered to Resident #2.
-On 04/17/23 at 12:00am, one tablet signed out as administered to Resident #2.
-On 04/18/23 at 10:00pm, one tablet signed out as administered to Resident #2.
-On 04/20/23 at 11:00pm, one tablet signed out as administered to Resident #2.
-On 04/26/23 at 12:00am, one tablet signed out as administered to Resident #2.
-On 04/29/23 at 6:00am, one tablet signed out as administered to Resident #2.

Continued review of Resident #7's CSCS records

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for the supply of hydrocodone/acetaminophen 5/325mg dispensed on 04/06/23 revealed:
-There was a CSCS for 30 hydrocodone/acetaminophen 5/325mg with "6:00am" handwritten at the top of the CSCS.
-There were 2 rows on the CSCS with a handwritten note "borrowed for [Resident #2]" documented at various times and days of administration from 04/14/23 to 05/04/23.
-Dates and times sign out on Resident #7's CSCS (with handwritten time of administration 6:00am) and documented as "borrowed for [Resident #2's name]" were as follows:
-On 04/18/23 at 6:00am, one tablet signed out for Resident #2 and on 04/21/23 at 6:00am, one tablet signed out for Resident #2.
-There was no documentation the dose that was borrowed from Resident #7 and administered to Resident #2 was paid back to Resident #7 for any of the doses signed out.

Based on observations, interviews, and record review, Resident #2 was not interviewable.

Refer to the interview with the Administrator on 05/03/23 at 4:30pm.

Refer to the interview with an evening medication aide (MA) on 05/03/23 at 5:15pm.

Refer to the interview with a morning shift MA on 05/04/23 at 7:30am.

Refer to the interview with the facility's primary care provider's Nurse Practitioner (NP) on 05/04/23 at 11:00am.

Refer to the interview with the Supervisor on 05/04/23 at 3:30pm.

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D 372	Continued From page 143 Refer to the telephone interview with the contracted Pharmacy Consultant on 05/04/23 at 4:50pm. 3. Review of Resident #8's current FL2 dated 08/29/22 revealed diagnosis included schizophrenia. Review of Resident #8's physician's orders dated 04/20/23 revealed an order for alprazolam (used to treat anxiety) 0.5mg once daily as needed for anxiety. Telephone interview with the pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:20pm revealed: -On 04/20/23, Resident #8 was dispensed 30 tablets of alprazolam 0.5mg with directions for one tablet once daily as needed for anxiety. -The pharmacy sent a controlled substance count sheet (CSCS) with each dispensing of controlled substances to assist the facility with documenting administration and accurate accounting for the medication. Review of Resident #8's April 2023 electronic medication administration record (eMAR) compared to the CSCS for alprazolam 0.5mg dispensed on 04/20/23 revealed: -There was an entry for alprazolam 0.5mg one tablet once daily as needed for anxiety on the eMAR. -There was documentation alprazolam 0.5mg was administered once daily on 04/24/23, 04/25/23, 04/26/23, and 04/27/23 on the eMAR and for corresponding dates on the CSCS. -There was documentation alprazolam 0.5mg was signed out on the CSCS with "borrowed for [name]" documented on the CSCS as follows: -On 04/24/23 at 9:00pm, one tablet was signed	D 372		

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out on the CSCS with "borrowed for [name]" documented on the CSCS.
-On 04/25/23 at 6:00am, two tablets were signed out on the CSCS with "borrowed for [name]" documented on the CSCS.
-On 04/25/23 at 6:00pm, two tablets were signed out on the CSCS with "borrowed for [name]" documented on the CSCS.
-On 04/26/23 at 6:00am, two tablets were signed out on the CSCS with "borrowed for [name]" documented on the CSCS.
-On 04/27/23 at 6:00am, two tablets were signed out on the CSCS with "borrowed for [name]" documented on the CSCS.
-There was no documentation any medication was borrowed from Resident #8 on the eMAR or replaced (paid back) to Resident #8 on the eMAR or the CSCS.

Observation of medication on hand for administration for Resident #8 on 05/03/23 revealed there were 15 Alprazolam 0.5mg tablets on hand matching the count on the CSCS for alprazolam 0.5mg dispensed on 04/20/23..

Interview with Resident #8 on 05/04/23 at 10:00am revealed:
-He asked for his alprazolam 0.5mg when he was anxious.
-He only asked for the alprazolam 0.5mg a few times in the last couple of weeks.
-He did not recall having been out of medication in the past if he asked for alprazolam to help him feel calmer.

Refer to the interview with the Administrator on 05/03/23 at 4:30pm.

Refer to the interview with an evening medication aide (MA) on 05/03/23 at 5:15pm.

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Refer to the interview with a morning shift MA on 05/04/23 at 7:30am.

Refer to the interview with the facility's primary care provider's Nurse Practitioner (NP) on 05/04/23 at 11:00am.

Refer to the interview with the Supervisor on 05/04/23 at 3:30pm.

Refer to the telephone interview with the contracted Pharmacy Consultant on 05/04/23 at 4:50pm.

4. Review of Resident #5's current FL2 dated 02/06/23 revealed:
-Diagnoses included chronic lumbar pain, limited mobility, osteoarthritis, hypertension and anxiety.
-There was an order for alprazolam 1mg at bedtime (used to treat anxiety/depression).

Review of Resident #5's physician's orders revealed:
-There was an order dated 02/23/23 for alprazolam 1mg every 12 hours.
-There was an order dated 03/06/23 for alprazolam 1mg every 12 hours (twice daily).

Observation of Resident #5's medications on hand at the facility on 05/04/23 at 10:46am revealed there was no alprazolam 1mg tablets available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:51pm revealed:
-The pharmacy received an order dated 02/28/23 for alprazolam 1mg at bedtime.
-On 02/28/23 the pharmacy filled and dispensed

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30 tablets of 1mg alprazolam.
-The pharmacy received an order dated 03/06/23 for alprazolam 1mg every 12 hours (twice daily).
-On 03/06/23 the pharmacy filled and dispensed 60 tablets of 1mg alprazolam.
-The 1mg alprazolam had not been refilled because the facility or physician had not given a new order.

Review Resident #5's control substance count sheets (CSCS) for alprazolam 1mg revealed there were no CSCS for the 1mg alprazolam after 04/06/23.

Review of Resident #5's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for alprazolam 1mg, 1 tablet every 12 hours scheduled for administration at 6:00am and at 6:00pm.
-Alprazolam 1mg was documented as administered twice daily from 04/01/23 through 04/30/23 for 60 doses.
-There was no documentation alprazolam 1mg was borrowed from another resident for Resident #5 on the eMAR.
-There was no documentation alprazolam 1mg was replaced or paid back to another resident on the eMAR.

Review of a second resident's (Resident #8's) CSCS for alprazolam 0.5mg dispensed on 04/20/23 and the electronic medication administration record (eMAR) for April 2023 for the resident revealed:
-There was documentation alprazolam 0.5mg was administered once daily on 04/24/23, 04/25/23, 04/26/23, and 04/27/23 on the eMAR and for corresponding dates on the CSCS for the resident.

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-There was documentation alprazolam 0.5mg was signed out on the CSCS with "borrowed for [Resident #5's name]" documented on the CSCS as follows:
-On 04/24/23 at 9:00pm, one tablet was signed out on the CSCS with "borrowed for [Resident #5's name]" documented on the CSCS.
-On 04/25/23 at 6:00am, two tablets were signed out on the CSCS with "borrowed for [Resident #5's name]" documented on the CSCS.
-On 04/25/23 at 6:00pm, two tablets were signed out on the CSCS with "borrowed for [Resident #5's name]" documented on the CSCS.
-On 04/26/23 at 6:00am, two tablets were signed out on the CSCS with "borrowed for [Resident #5's name]" documented on the CSCS.
-On 04/27/23 at 6:00am, two tablets were signed out on the CSCS with "borrowed for [Resident #5's name]" documented on the CSCS.

Based on record review there were 10 alprazolam 0.5mg borrowed from Resident #8 for administration to Resident #5 with no documentation the medication was replaced or repaid to Resident #8.

Refer to the interview with the Administrator on 05/03/23 at 4:30pm.

Refer to the interview with an evening medication aide (MA) on 05/03/23 at 5:15pm.

Refer to the interview with a morning shift MA on 05/04/23 at 7:30am.

Refer to the interview with the facility's primary care provider's Nurse Practitioner (NP) on 05/04/23 at 11:00am.

Refer to the interview with the Supervisor on

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05/04/23 at 3:30pm.

Refer to the telephone interview with the contracted Pharmacy Consultant on 05/04/23 at 4:50pm.

[Refer to Tag D 0392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)

____

Interview with the Administrator on 05/03/23 at 4:30pm revealed:
-She did not have a system in place to routinely audit medication orders compared to the residents' eMARs for accuracy and completeness.
-She relied on the Resident Care Coordinator (RCC) and medication aide/Supervisor (MA/S) to perform routine audits to ensure medications were administered as ordered, including controlled medications.
-The facility did not have a policy for borrowing controlled substances between residents.
-Staff were not trained to borrow medications including controlled medications.
-Borrowing controlled medications would stop immediately.
-The staff should be ordering medications ahead of time and not running out.
-Staff should document out of stock or not available on the eMAR if there was no medication available to administer.
-She had not been made aware of any discrepancies with controlled medications for residents.

Interview with an evening medication aide (MA) on 05/03/23 at 5:15pm revealed:
-She was fairly new to the facility but had worked previously as a MA at another facility.
-The facility's policy was to reconcile controlled

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D 372	Continued From page 149 substances on the medication cart by 2 staff auditing the controlled substance available for administration compared to the CSCS for the medications maintained in the CSCS binders on the 2 medication carts. -The MAs were supposed to complete the 2 person count prior to exchanging the medication cart keys. -She was told when she was trained by another MA that she could borrow a controlled medication of the same name from a second resident if the resident was out of medication but was in pain. -She was told to log the medication as borrowed on the CSCS for the medication from which it was borrowed. -She was not told how quickly to replace the medication borrowed. -She had not repaid medications borrowed from residents because she was not familiar with a system to track medications borrowed and repaid. Interview with a morning shift MA on 05/04/23 at 7:30am revealed: -The MAs were responsible to document all controlled medications on the corresponding CSCS when the medication was removed from its original container and document administration on the eMAR when it was administered. -She had borrowed controlled medications from residents to administer to residents with an order for the same medication but were out of the medications. -She documented who received the medication by using "borrowed for [name]" on the original CSCS. -She tried to repay the medications when the resident's medication was supplied but may have forgotten and never repaid. -She did not maintain any kind of list for borrowed	D 372		

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medications.
-There were a lot of borrowed medications, but she could not say how many.

Interview with the facility's primary care provider's (PCP's) Nurse Practitioner (NP) on 05/04/23 at 11:00am revealed:
-He did not know MAs were borrowing medications between residents.
-He was available by on-site weekly visits, telephone call or page, and through the answering service at all times.
-He would expect the MAs to contact him if a resident needed a medication instead of borrowing from other residents.
-He was concerned that borrowing medications would place the resident from which the medication was borrowed at risk for running short of medication themselves causing possible unnecessary suffering by the resident.
-Medications administered as needed but borrowed to administer to another resident could cause difficulty in monitoring symptoms and managing pain properly.
-The NP could not properly monitor therapeutic outcomes of medications if they were not properly administered to the correct resident.

Interview with the MA/S on 05/04/23 at 3:30pm revealed:
-She and the RCC were responsible for monitoring and tracking controlled substances.
-She knew MAs were borrowing controlled substances between residents if a resident was out of pain medication and was waiting on an order to refill the pain medication.
-She was not sure when borrowing medications started but it had been going on for a while.
-She did not have a system for tracking borrowing and immediate repayment of medications.

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-She had seen documentation for borrowing controlled medications when doing random cart audits.
-She had not discussed borrowing medications, including controlled medications, with the Administrator.

Telephone interview with the contracted Pharmacy Consultant on 05/04/23 at 4:50pm revealed:
-She was on-site at the facility for quarterly reviews routinely.
-She was last on-site in February 2023.
-She did not know MAs at the facility were borrowing medications between residents, including controlled substances.
-When she looked at controlled substances during pharmacy reviews, she routinely spot checked a quantity of medication on hand compared to the decreasing count on the CSCS for accuracy.
-She did not recall seeing notations on the CSCS she reviewed indicating controlled medications had been administered or borrowed for another resident.
-She would have recommended the facility cease borrowing controlled medications.

____

The facility failed to ensure medications were borrowed only in an emergency and replaced promptly and documented for 4 of 4 residents sampled (#2, #5 #7, #8,) related to staff borrowing 12 doses of scheduled hydrocodone-acetaminophen 5/325mg from Resident #7, who had a diagnosis of pain, to administer to Resident #2, who had a recent hip replacement surgery and pain, placing Resident #7 at risk for running out of pain medication early and experiencing pain; and borrowing 10 doses of alprazolam 0.5mg ordered as need from

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Resident #8 to administer to Resident #5 placing Resident #8 at risk of incorrect assessment of his anxiety by his PCP due to the appearance of extra use of his as needed (prn) medication. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

____

The facility a plan of protection in accordance with G.S. 131D-34 on 05/03/23 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2023.

D 392 — 10A NCAC 13F .1008 (a) Controlled Substances — D 392

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

Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled medication for 3 of 5 sampled residents (#2, #5, #9) related to a Schedule II controlled pain reliever (#2, and #9) and a Schedule IV controlled anti-anxiety medication (#5).

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The findings are:

1. Review of Resident #9's current FL2 dated 02/28/23 revealed:
-Diagnoses included dementia with behavioral disturbances, Alzheimer's disease, osteoarthritis, and degenerative disk disease (DJD).
-Medication orders included Norco (a Schedule II controlled substance for moderate to severe pain) 5/325mg three times daily.

Interview with the Resident Care Coordinator (RCC) on 05/03/23 at 4:15pm revealed Resident #9 was transferred to a skilled nursing facility on 02/28/23.

Review of Resident #9's physician's orders revealed there was an order dated 01/19/23 for Norco 5/325mg one tablet 3 times a day.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:20pm revealed:
- Resident #9 was dispensed 90 tablets of Norco 5/325mg labeled one tablet 3 times a day on 01/19/23.
-The pharmacy routinely sent controlled substance count sheets (CSCS) along with the controlled substances dispensed to assist the facility with tracking administration of the medication.
-Resident #9 should have received 3 bingo cards of 30 Norco tablets each and 3 corresponding CSCS.

Review of the facility's CSCS logs revealed:
-There were 2 CSCS of 30 tablets (total of 60 tablets) on each documenting administration or disposition for 60 of 90 Norco 5/325mg dispensed on 01/19/23.

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-The CSCS had handwritten labeling for 2:00pm and 10:00pm.
-There was not a third CSCS for 30 Norco 5/325mg dispensed on 01/19/23 available for review.

Review of Resident #9's CSCS for Norco 5/325mg dispensed on 01/19/23 compared to Resident #9's January 2023 eMAR revealed:
-There was an entry for Norco 5/325mg take one tablet 3 times daily scheduled for administration at 10:00am, 2:00pm, and 10:00pm daily on the eMAR.
-Norco 5/325mg was documented as administered on the eMAR 10:00am, 2:00pm and 10:00pm from 01/21/23 to 01/31/23.
-There were 9 doses signed out as administered daily on the CSCS with handwritten label for administered at "2:00 pm" from 2:00pm on 01/23/23 to 2:00pm on 01/31/23 corresponding to administration documented on the eMAR.
-There were 4 doses signed out as administered daily on the CSCS with handwritten label for administered at "10:00pm" on 01/28/23 to 10:00pm on 01/31/23 corresponding to administration documented on the eMAR.
-There was no CSCS available for review for 30 Norco 5/325mg dispensed on 01/19/23 with handwritten label for administration at "10:00am" (5 doses not accounted for).

Review of Resident #9's Resident #9's CSCS for Norco 5/325mg dispensed on 01/19/23 compared to Resident #9's February 2023 eMAR revealed:
-There was an entry for Norco 5/325mg take one tablet 3 times daily scheduled for administration at 10:00am, 2:00pm, and 10:00pm daily on the eMAR.
-Norco 5/325mg was documented as administered on the eMAR at 10:00am, 2:00pm

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and 10:00pm from 02/01/23 to 02/28/23 except for when the resident was in the hospital from 10:00pm on 02/15/23 to 10:00pm on 02/23/23.
-There were 21 doses signed out as administered daily on the CSCS with handwritten label for administered at "2:00pm" from 02/01/23 to 2:00pm on 02/28/23 corresponding to administration documented on the eMAR completing the CSCS documentation for 30 tablets.
-There were 20 doses signed out as administered daily on the CSCS with handwritten label for administered at "10:00pm" on 02/01/23 to 2:00pm on 02/28/23 corresponding to administration documented on the eMAR with 6 doses documented for destruction.
-There was no CSCS available for review for 30 Norco 5/325mg dispensed on 01/19/23 with handwritten label for administration at "10:00am" (20 doses not accounted for).

Observation of Resident #9's medications on hand on the medication cart on 05/03/23 at 5:05pm revealed the resident did not have any medications on the medication cart.

Interview with the MA/S on 05/04/23 at 3:00pm revealed:
-Resident #9 was discharged from the facility to a skilled nursing facility 02/28/23.
-Resident #9's Norco 5/325mg tablets dispensed on 01/19/23 were used for Resident #9 until discharge on 02/28/23.
-There were 6 tablets left when the bingo card was used by staff for another resident.
-The CSCS had been altered to change the name and directions and the remaining 5 tablets were used from 03/20/23 to 03/22/23 for the other resident.
-There was not an accurate accounting for 30 of

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Resident #9's Norco 5/325mg.

Based on record review and interview, there 30 doses of Norco 5/325mg for Resident #9 not accounted for due to a missing CSCS with 25 of the 30 doses of Norco 5/325mg documented on Resident # 9's January 2023 and February 2023 eMARs.

Refer to interview with the Administrator on 05/03/23 at 4:30pm.

Refer to interview with an evening medication aide (MA) on 05/03/23 at 5:15pm.

Refer to interview with a third shift MA on 05/04/23 at 7:30am.

2. Review of Resident #2's current hospital FL-2 dated 04/08/23 revealed:
-Diagnoses included severe sepsis, urinary tract infection, dementia, and status post total right hip arthroplasty (replacement).
-There was an order for hydrocodone-acetaminophen 5/325mg (a Schedule II controlled substance used to treat moderate to severe pain) one tablet every 4 hours as needed.

Review of Resident #2's physician's orders revealed an order dated 03/23/23 for hydrocodone-acetaminophen 5/325mg one every 4 to 6 hours as needed for pain.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:20pm revealed:
- Resident #2 was dispensed 42 tablets of hydrocodone-acetaminophen 5/325mg on 03/23/23 labeled for one tablet every 4 to 6 hours

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as needed for pain.
-The pharmacy sent a controlled substance count sheet (CSCS) with each dispensing of controlled sunstances to assist the facility with documenting administration and accurate accounting for the medication.
-There were no additional hydrocodone-acetaminophen 5/325mg dispensed for Resident #2.

Review of Resident #2's March 2023 electronic medication administration record (eMAR) compared to the CSCS for 42 tablets of hydrocodone-acetaminophen 5/325mg dispensed on 03/23/23 revealed:
-There was an entry for hydrocodone-acetaminophen 5/325mg one tablet every 4 to 6 hours PRN for pain.
-Hydrocodone-acetaminophen 5/325mg was documented as administered for 3 tablets on the eMAR from 03/28/23 to 03/31/23 with 2 tablets on 03/28/23 and one tablet on 03/31/23.
-Hydrocodone-acetaminophen 5/325mg was signed out for 10 tablets on the CSCS from 03/28/23 to 03/31/23.
-On 03/29/23 at 3:15am, 7:15am, and 8:30pm, hydrocodone-acetaminophen 5/325mg was signed out on the CSCS but not documented for time administered or effectiveness on the eMAR.
-On 03/30/23 at 1:00am, 6:00am, and 11:30pm, hydrocodone-acetaminophen 5/325mg was signed out on the CSCS but not documented as for time administered or effectiveness on the eMAR.
-On 03/31/23 at 4:30am, hydrocodone-acetaminophen 5/325mg was signed out on the CSCS but not documented for time administered or effectiveness on the eMAR.

Review of Resident #2's April 2023 eMAR

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compared to the CSCS for 42 tablets of hydrocodone-acetaminophen 5/325mg dispensed on 03/23/23 revealed:
-There was an entry for hydrocodone-acetaminophen 5/325mg one tablet every 4 to 6 hours PRN for pain
-Hydrocodone-acetaminophen 5/325mg was documented as administered for 5 tablets on the eMAR from 04/01/23 to 04/30/23 with one tablet on 04/01/23, 04/02/23, 04/04/23, 04/08/23, and 04/12/23.
-On 04/08/23 at 6:16pm, hydrocodone-acetaminophen 5/325mg was documented as administered on the eMAR but not signed out on the CSCS.
-Hydrocodone-acetaminophen 5/325mg was signed out for 32 tablets on the CSCS from 04/01/23 to 04/14/23.
-The CSCS sheet documented adminstration of 42 tablets signed out leaving a zero balance on 04/14/23.

Examples of opportunities when hydrocodone-acetaminophen 5/325mg was signed out as administered on the CSCS for hydrocodone-acetaminophen 5/325mg dispensed on 03/23/23 for Resident #2 but not documented for administration on the April 2023 eMAR included:
-On 04/01/23 at 12:00pm, hydrocodone-acetaminophen 5/325mg was signed out on the CSCS but not documented for time administered or effectiveness on the eMAR.
-On 04/02/23 at 11:00pm, hydrocodone-acetaminophen 5/325mg was signed out on the CSCS but not documented for time administered or effectiveness on the eMAR.
-On 04/09/23 at 11:00pm, hydrocodone-acetaminophen 5/325mg was signed out on the CSCS but not documented for

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time administered or effectiveness on the eMAR.
-On 04/12/23 at 3:00am, hydrocodone-acetaminophen 5/325mg was signed out on the CSCS but not documented for time administered or effectiveness on the eMAR.
-On 04/14/23 at 7:00pm, hydrocodone-acetaminophen 5/325mg was signed out on the CSCS but not documented for time administered or effectiveness on the eMAR.

Based on observation, interview and record review, there were 35 of 42 hydrocodone-acetaminophen 5/325mg dispensed for Resident #2 on 03/23/23 that did not have an accurate accounting for administration for the residents eMAR compared to the CSCS, including time of administration and effectiveness.

Observation of medication on hand for administration to Resident #2 on 05/04/23 at 11:30am revealed there were no hydrocodone-acetaminophen 5/325mg tablets available for administration to the resident.

Interview with a third shift MA on 05/04/23 at 7:30am revealed:
-Resident #2 did not verbalize his discomfort from the hip relacement on 03/28/23 but grimaced when he was getting in bed and tossed and turned.
-She had previuos experience working at a rehabilitation facilty where residents presented post hip replacement.
-She administered hydrocodone-acetaminophen 5/325mg to help with his pain when she worked even though he did not verbalize he wanted pain medication.
-She was busy with residents' care and 2 hours checks and forgot to document on the eMAR but

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always focused on signing the medication out on the CSCS.

Interview with the facilty's contracted primary care provider's Nurse Practitioner (NP) on 05/04/23 at 11:15am revealed:
-Resident #2 had experienced increase cognitive loss after the anesthesia during surgery and recent infections.
-Resident #2 was not a good historian and could not provide information regarding his pain other than maybe visual clues.
-He did not audit the facility's eMARs compared to the pharmacysheets for control medications.
-The facility had not mentioned any discrepancies related to controlled substances during his weekly visits.

Refer to interview with the Administrator on 05/03/23 at 4:30pm.

Refer to interview with an evening medication aide (MA) on 05/03/23 at 5:15pm.

Refer to interview with a third shift MA on 05/04/23 at 7:30am.

3. Review of Resident #5's current FL2 dated 02/06/23 revealed:
-Diagnoses included chronic lumbar pain, limited mobility, osteoarthritis, hypertension and anxiety.
-There was an order for alprazolam 1mg at bedtime (a Schedule IV controlled substance used to treat anxiety/depression).

Review of Resident #5's physician's orders revealed:
-There was an order dated 02/23/23 for alprazolam 1mg every 12 hours.
-There was an order dated 03/06/23 for

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alprazolam 1mg every 12 hours (twice daily).
-There was an order dated 04/07/23 for alprazolam 0.5mg 1 tablet once every 8 hours as needed (PRN) "patient will ask for it when needed." In addition to 1mg alprazolam at bedtime.

Review of Resident #5's CSCS for the 1mg alprazolam revealed there were no CSCS for the 1mg alprazolam after 04/06/23.

Review of Resident #5's CSCS for the 0.5mg alprazolam PRN every 8 hours dated 04/07/23 revealed:
-The pharmacy filled and dispensed a quantity of 60 tablets on 04/07/23.
-The CSCS sheet had three column sections titled with the date, time, number (count of the medication) and signature columns.
-Each column started with a quantity to show number tablets dispensed (90, 60, and 30).
-The counted down was by 30 for each column ending with 0 in column 3.
-For an accurate accounting of the controlled medication the person administering the medication should circle the quantity/number and put in the date, time and signature.
-There was documentation in the second column showing Resident #5 started with 60 tablets of 0.5mg alprazolam.
-There was documentation 0.5mg alprazolam was signed out daily from 04/09/23 through 04/24/23, with no PRN documentation as administered on the eMAR.
-There was documentation 0.5mg alprazolam was signed out between 1 to 5 times on the same date with no corresponding documentation on the eMAR.
-There were two documented dates when the PRN 0.5mg alprazolam was signed out as

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borrowed for the 1mg scheduled alprazolam on 04/09/23 and 04/11/23.

Review of Resident #5's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for alprazolam 1mg, 1 tablet every 12 hours scheduled for administration at 6:00am and at 6:00pm.
-There was an entry for alprazolam 0.5mg take 1 tablet every 8 hours as needed.
-There was documentation alprazolam 1mg was administered twice daily from 04/01/23 through 04/30/23 totaling 60 doses all of which were not documented on the CSCS.
-There was documentation alprazolam 0.5mg was administered once on 04/09/23, once on 04/10/23, once on 04/13/23, twice on 04/17/23, once on 04/18/23, twice on 04/19/23, once on 04/20/23, once on 04/21/23, once on 04/24/23, and once on 04/28/23, totaling 12 times, with 6 of the 12 being documented on the CSCS.
-The eMAR documentation did not match the CSCS and it could not be determined if Resident #5 was administered the medication as documented.

Review of Resident #5's CSCS for the 0.5mg alprazolam PRN every 8 hours dated 04/27/23 revealed:
-The pharmacy filled and dispensed a quantity of 60 tablets on 04/27/23.
-The CSCS for medication dispensed on 04/27/23 started with documentation there were 30 tablets and not 60.
-There was documentation six tablets were signed out with 24 tablets remaining as of 04/29/23.
-In another column there was documentation alprazolam 0.5mg count started with 52 tablets.

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-There was documentation 21 tablets were signed out and 31 tablets remained as of 05/04/23.
-There was documentation on five dates that 0.5mg alprazolam was borrowed for the scheduled 1mg alprazolam; however the quantity documented as borrowed on the CSCS did not correspond with the quantity documented on the eMAR.

Review of Resident #5's May 2023 eMAR revealed:
-There was an entry for alprazolam 1mg, 1 tablet every 12 hours scheduled for administration at 6:00am and at 6:00pm.
-There was an entry for alprazolam 0.5mg take 1 tablet every 8 hours as needed.
-There was documentation alprazolam 1mg was administered twice daily at 6:00am and 6:00pm from 05/01/23 through 05/04/23.
-There was documentation alprazolam 0.5mg was administered once on 05/01/23 for anxiety and outcome was effective.
-The dates on the CSCS for the administration of alprazolam 0.5mg and the administration of 1mg alprazolam did not correspond with the dates and quantity administered on the eMAR.
-There were inconsistencies and it could not be determined if Resident #5 was administered the medication as documented.

Observation of Resident #5's medications on hand at the facility on 05/04/23 at 10:46am revealed:
-There was no alprazolam 1mg tablets available for administration.
-There was one card of alprazolam 0.5mg tablets available for administration.
-Based on the medication label, the medication was filled and dispensed on 4/27/23 for a quantity

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of 60 tablets.
-There were 31 tablets remaining.

Based on the review of the eMAR and CSCS documentation, observation of the medications on hand, and interviews the following was revealed:
-Resident #5 had no alprazolam 1mg available for administration after 04/06/23.
-There were 31 tablets of 0.5mg alprazolam remaining as of 05/04/23.
-Based on eMAR documentation from 04/01/23 through 04/30/23, Resident #5 was administered 1mg of alprazolam twice daily, which would be 4 tablets of 0.5mg.
-If the 0.5mg alprazolam was borrowed and used for 1mg alprazolam, the medication would have been out and not available on 04/23/23.
-There was documentation on the eMAR that 0.5mg was administered 12 times from 04/01/23 through 04/30/23.
-The documentation on the CSCS did not correspond with the eMAR and medication quantity remaining.
-There were 45 tablets of 0.5mg alprazolam unaccounted for based the CSCS.

Interview with Resident #5 on 05/04/23 at 8:43am revealed:
-She had anxiety and her orders for alprazolam had changed.
-The last order that she knew about was for 1mg once daily.
-She was administered two alprazolam twice daily.
-She was "okay" with that because she got the same amount.
-She believed the alprazolam administered was 0.5mg because the color was different from the 1mg alprazolam.

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-When she requested a PRN alprazolam, it was the same color as the alprazolam given twice daily.
-She did not know why she was not getting the 1mg alprazolam tablet.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/04/23 at 3:51pm revealed:
-The pharmacy received an order dated 02/28/23 for alprazolam 1mg at bedtime.
-On 02/28/23 the pharmacy filled and dispensed 30 tablets of 1mg alprazolam.
-The pharmacy received an order dated 03/06/23 for alprazolam 1mg every 12 hours (twice daily).
-On 03/06/23 the pharmacy filled and dispensed 60 tablets of 1mg alprazolam.
-The 1mg alprazolam had not been refilled because the facility or physician had not given a new order.
-The pharmacy had made the facility aware in April 2023 that a new order was needed to fill alprazolam 1mg.
-The pharmacy received another order dated 04/07/23 for alprazolam 0.5mg every 8 hours as needed.
-On 04/07/23, the pharmacy filled and dispensed a quantity of 60 tablets of 0.5mg alprazolam.
-On 04/27/23, a refill request was made for alprazolam 0.5mg and a quantity of 60 tablets was dispensed on 04/27/23.
-When the pharmacy dispensed a controlled drug medication, they sent CSCS with the medication to be used by the facility.
-The facility could use the 0.5mg but they would have to use 4 tablets a day, meaning the 60 tablets dispensed would only last 15 days, and the resident would not have any PRN alprazolam for anxiety.
-Based on the remaining quantity it could not be

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determined if the facility was borrowing for the scheduled dose or not documenting the use of the PRN.

Interview with the medication aide supervisor (MA/S) on 05/04/23 at 12:48pm revealed:
-When she administered Resident #5's controlled medications, it should be documented on the CSCS and on the eMAR.
-The MAs were supposed to do the same each time they administered alprazolam.
-She did not observe the MAs administering the medication.
-She did not check behind the MAs to ensure the documentation on the CSCS and the eMAR matched.
-The facility did not have a system of comparing controlled medications on the hand with the eMAR and CSCS to ensure accurate documentation.
-The MAs were supposed to count off on controlled medications at the end/beginning of each shift.
-If there were discrepancies, they were to track the error and make her or the Resident Care Coordinator (RCC) aware.
-She had not checked with the pharmacy to find out why the 1mg of alprazolam had not been refilled.

Interview with the RCC on 05/04/23 at 1:13pm revealed:
-There was no system in place that checked the CSCS in comparison with the eMAR and medications on hand to ensure accurate documentation.
-The MAs were aware they should use the CSCS when administering controlled medications.
-She did not know and was unable to explain why Resident #5's 1mg alprazolam was not available.

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	HAL086001	A. BUILDING: ______ B. WING ______	R 05/05/2023

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-She understood if the MA used the PRN 0.5mg the medication would be used up and there would not be 31 tablets remaining.

Attempted telephone interview with Resident #5's Mental Health Provider on 05/04/23 at 2:28pm was unsuccessful.

Attempted telephone interview with Resident #5's Primary Care Provider 05/04/23 at 2:33pm was unsuccessful.

Refer to interview with the Administrator on 05/03/23 at 4:30pm.

Refer to interview with an evening medication aide (MA) on 05/03/23 at 5:15pm.

Refer to interview with a third shift MA on 05/04/23 at 7:30am.

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Interview with the Administrator on 05/03/23 at 4:30pm revealed:
-She did not have a system in place to routine audit medication orders compared to the residents eMAR for accuracy and completeness.
-She relied on the Resident Care Coordinator (RCC) and medication aide/Supervisor (MA/S) to perform routine audits to ensure medications were administered as ordered, including controlled medications.
-The RCC and the MA/S were responsible to ensure accurate accounting for control substances.
-She had not been made aware of any discrepancies with controlled medications for the residents.

Interview with an evening medication aide (MA) on 05/03/23 at 5:15pm revealed:

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-She was fairly new to the facility but had worked previously as a medication aide at another facility.
-The facility's policy was to reconcile controlled substances on the medication cart by 2 staff auditing the controlled substance available for administration compared to the controlled substance count sheets (CSCS) for the medications maintained in the CSCS binders on the 2 medication carts.
-The MAs were supposed to complete the 2 person count prior to exchanging the medication cart keys.
-Completed CSCS were moved from the medication cart to the MA office for the RCC and MA/S to file.

Interview with a third shift MA on 05/04/23 at 7:30am revealed:
-The MAs were responsible to document all controlled medications on the corresponding CSCS when the medication was removed from its original container and document administration on the eMAR when it was administered.
-All CSCS sheets that were completed were moved to the MA office and the RCC and Supervisor filed them in another book.

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The facility failed to ensure there was an accurate record of controlled substances being maintained for two residents with physician orders for a narcotic pain medication (#2 and #9) related to 30 doses of a hydrocodone/acetaminophen 5/325mg not properly accounted for (#9), and 35 of 42 doses of hydrocodone/acetaminophen 5/325mg not properly accounted for (#2); and one resident with anti-anxiety medications with 45 doses of anti-anxiety medication unaccounted for (#5) resulting in the potential for these residents to have an increased pain and/or anxiety. This failure was detrimental to the safety, health, and

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D 392	Continued From page 169 welfare of the residents and constitutes a Type B Violation. ______________ The facility submitted a Plan of Protection in accordance with G.S.131D-34 for this violation on 05/03/23. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2023.	D 392		
D 613	10A NCAC 13F .1801 (d) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the mandatory annual state approved infection control training was completed for 1 of 1 sampled staff (#B) within 30 days of hire and for 2 of 2 sampled staff (A and C) annually. The findings are:	D 613		

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D 613	Continued From page 170 1.Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A previously worked at the facility in 2018. -She was rehired on 01/22/21. -There was no documentation Staff A had completed the mandatory annual state approved infection control training since 10/20/21. Interview with Staff A on 05/04/23 at 5:01pm revealed she did not remember if she completed the mandatory annual state approved infection control training within the past year. Refer to the interview with Administrator on 05/04/23 at 6:10pm. 2. Review of Staff B's, medication aide (MA) personnel record revealed: -Staff B previously worked at the facility in 2018. -She was rehired on 04/11/23. -There was no documentation Staff B had completed the mandatory annual state approved infection control training since 02/15/21. Interview with Staff B on 05/04/23 at 5:10pm revealed she did not remember if she had completed an infection control training when she was rehired on 04/11/23. Refer to the interview with Administrator on 05/04/23 at 6:10pm. 3. Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C previously worked at the facility in 2021. -She was rehired in September 2022. -There was no documentation Staff C had completed the mandatory annual state approved infection control training since 12/30/21.	D 613		

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Interview with Staff C on 05/04/23 at 5:45pm revealed she did not remember if she had completed an infection control training when she was rehired in September 2022.

Refer to the interview with Administrator on 05/04/23 at 6:10pm.

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Interview with the Administrator on 05/04/23 at 6:10pm.
-She was responsible for making sure staff qualifications including infection control training were completed including infection control training.
-She was not aware the infection control trainings were not current for Staff A, B and C.